REQUIRES TWO-THIRDS MAJORITY VOTE
(§§ 21, 22, 253)

S.B. 75

SENATE BILL NO. 75–COMMITTEE ON COMMERCE AND LABOR

(ON BEHALF OF THE DIVISION OF INSURANCE OF THE DEPARTMENT OF BUSINESS AND INDUSTRY)

PREFILED NOVEMBER 17, 2026

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to insurance. (BDR 57-184)

FISCAL NOTE: Effect on Local Government: Increases or Newly Provides for Term of Imprisonment in County or City Jail or Detention Facility.
Effect on the State: May have Fiscal Impact.
Effect on the State Highway Fund: No.

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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 insurance; revising the powers and duties of the Commissioner of Insurance; revising provisions relating to hearings before the Commissioner; standardizing the definitions of certain terms; revising certain recordkeeping requirements; revising provisions relating to the financial condition of insurers; increasing certain fines and fees; revising provisions relating to administrators; revising provisions relating to adjusters; revising the criteria for licensure as a surplus lines broker; revising provisions relating to certain trade practices and frauds; revising provisions relating to funeral and burial services; revising various requirements and restrictions on various policies of insurance; revising provisions relating to service contract providers; revising provisions relating to captive insurers; revising provisions relating to businesses related to bail; revising provisions relating to industrial insurance; repealing provisions governing insurance for home protection; making various other changes to the Nevada Insurance Code; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law contains the Nevada Insurance Code and requires the Commissioner of Insurance to regulate insurance in this State and enforce the provisions of the Code. (Title 57 of NRS)

Section 1 of this bill requires any person engaged in the business of insurance to respond to any inquiry from the Division of Insurance of the Department of Business and Industry within 5 working days after receipt of the inquiry.

Section 3 of this bill authorizes the Commissioner to perform financial analysis in accordance with certain publications. **Section 9** of this bill provides for the confidentiality of any document created in the performance of financial analysis.

Existing law sets forth certain procedures for the conduct of hearings before the Commissioner. (NRS 679B.310-679B.370) **Section 10** of this bill provides that, with certain exceptions, those procedures are applicable to all hearings held before the Commissioner. **Section 11** of this bill provides a person appointed by the Commissioner to conduct a hearing with the powers and duties of the Commissioner with respect to the hearing. **Sections 10 and 12** of this bill revise certain procedures for the conduct of hearings before the Commissioner. **Sections 13, 18, 20, 24, 37, 43, 59, 60, 119, 123, 217, 218, 226, 228, 229, 232, 233, 248, 333, 336, 341, 342 and 372** of this bill revise various provisions of the Code which authorize certain actions to be taken after a hearing to specify that only an opportunity for a hearing is required before taking the action.

Section 4 of this bill authorizes the Commissioner to issue a cease and desist order for certain violations under certain circumstances. **Section 260** of this bill provides that the provisions of **section 4** apply to fraternal benefit societies. **Section 7** of this bill authorizes an attorney authorized by the Commissioner to act as legal counsel to the Division and the Commissioner in matters pertaining to the administration and enforcement of the Code.

Sections 5, 114, 348, 349 and 371 of this bill revise the definitions of "health carrier," "health care services" and "health benefit plan" for certain purposes.

Existing law requires: (1) the Commissioner to deliver to the Secretary of State a copy of the order of the Commissioner or of the district court prohibiting an insurer from transacting insurance in this State as a corporation limited-liability company, limited partnership or limited-liability partnership; and (2) the Secretary of State, upon receiving the order, to nullify the charter of a corporation or limited-liability company or the certificate of the limited partnership or limited-liability partnership. Existing law also prohibits the Secretary of State from accepting for filing a document with the same name as a corporation, limited-liability company, limited partnership or limited-liability partnership whose charter or certificate has been nullified. (NRS 679B.142) **Section 6** of this bill revises this provision to change the reference from an "insurer" to a "person."

Existing law authorizes the Commissioner to employ experts to take certain actions if any accounts or records are found to be inadequate or inadequately kept or posted. (NRS 679B.250) **Section 8** of this bill specifies that failing to maintain any records for the period and in the manner required by any applicable statute or regulation constitutes the inadequate keeping of records for the purpose of those provisions.

Existing law sets forth certain powers and duties of the Commissioner with respect to investigations relating to insurance fraud or violations of certain provisions of existing law governing insurance. (NRS 679B.600-679B.700) **Sections 15 and 390** of this bill authorize the Commissioner to have access to any information in the Central Repository for Nevada Records of Criminal History for the purposes of carrying out his or her duties with respect to investigations relating to insurance fraud. **Section 391** of this bill clarifies that such records are required to be disseminated to the Commissioner to carry out any of his or her duties,

including, without limitation, the duties relating to investigations relating to insurance fraud.

Existing law requires an insurer, to qualify for a certificate of authority to transact insurance in this State, to possess and maintain a certain amount of capital stock, basic surplus and free surplus, depending on the type of insurer and the type of insurance the insurer transacts. (NRS 680A.120) Existing law also requires the Commissioner to adopt regulations concerning the amount of risk-based capital required to be maintained by each insurer licensed to do business in this State that is transacting property, casualty, life or health insurance in this State. Under existing law, the Commissioner may exempt certain insurers from the requirements concerning risk-based capital. (NRS 681B.550)

Section 16 of this bill requires the minimum amount of capital stock, basic surplus and free surplus that is required to be possessed and maintained under existing law to qualify for a certificate of authority to be possessed and maintained only: (1) if the insurer has never been authorized to transact insurance in any state; and (2) for 1 year after the insurer is issued a certificate of authority. For any other insurer, the insurer is required to possess and maintain the minimum capital and surplus required under the applicable provisions of the Code and the regulations adopted pursuant thereto, including, without limitation, the regulations concerning risk-based capital and the regulations adopted pursuant to **section 16**, which authorizes the Commissioner to adopt regulations establishing capital and surplus requirements for insurers to which the requirements concerning risk-based capital do not apply. **Section 17** of this bill revises requirements concerning the amount of cash and securities that are required to be deposited and maintained by an insurer. **Sections 234 and 235** of this bill revise certain financial requirements imposed on a domestic mutual insurer to conform with the changes made in **section 16**.

Sections 18, 38, 40, 42-44, 48, 59, 60, 63, 92, 105 and 227 of this bill raise the amount of various fines that may be imposed by the Commissioner. **Sections 19, 45 and 58** of this bill lengthen the amount of time for which the Commissioner may suspend certain licenses and other authorizations issued by the Commissioner. **Sections 21 and 22** of this bill raise the amount of various fees charged by the Commissioner.

Sections 23, 386, 388 and 403 of this bill repeal and remove provisions of existing law governing the issuance of insurance for home protection. **Section 215 and 385** of this bill make conforming changes to reflect the repeal of those provisions.

Existing law provides for the administration and regulation of administrators by the Commissioner. (NRS 683A.0805-683A.0893) **Section 26** of this bill requires an administrator to report to the Commissioner certain information concerning administrative actions and criminal prosecutions against the administrator and certain criminal convictions of a responsible person of the administrator. **Section 27** of this bill makes certain information that an administrator is required to submit to the Commissioner confidential with certain exceptions. **Section 30** of this bill makes a conforming change so that defined terms applicable to provisions of existing law governing administrators apply to **sections 26 and 27**.

Existing law sets forth the persons who constitute an administrator and who are therefore required to obtain a certificate of registration as an administrator issued by the Commissioner. (NRS 683A.025, 683A.085) **Section 29** of this bill includes among the persons who constitute an administrator a person who directly or indirectly underwrites or collects charges or premiums from or adjusts or settles claims of residents of this State or any other state from within this State in connection with stop-loss coverage for losses relating to health insurance coverage. **Section 32** of this bill requires the income statement and balance sheet required to be included in an application for a certificate of registration as an administrator to be prepared in accordance with either generally accepted accounting principles or

statutory accounting principles. **Section 33** of this bill requires an administrator to submit an updated statement of the business plan to and obtain the approval of the Commissioner before changing the lines, classes or types of insurance that the administrator administers on behalf of an insurer in this State. **Section 34** of this bill revises bond requirements for an administrator. **Section 36** of this bill revises recordkeeping requirements for an administrator. **Section 37** revises the circumstances under which the certificate of registration of an administrator may be revoked.

Existing law authorizes an administrator who has obtained a certificate of registration, with the approval of the Commissioner, to delegate certain duties to an administrator who has not obtained a certificate of registration. (NRS 683A.086) **Sections 31 and 35** of this bill eliminate that authorization. Instead, **section 35** prohibits: (1) the delegation, assignment or assumption by a third party of the rights or obligations of an administrator set forth in a written agreement with an insurer or any liability under the agreement; and (2) an insurer from allowing a person other than the administrator to perform any duties of the administrator set forth in the agreement.

Existing law prohibits, with certain exceptions, a person from selling, soliciting or negotiating insurance in this State for any class of insurance unless the person is licensed as a producer of insurance for that class of insurance. (NRS 683A.201) **Sections 28 and 41** of this bill authorize an insurer to authorize a person to sell, solicit and negotiate any policy of group insurance without the person having first obtained a license as a producer of insurance. Under **section 28**, an insurer is prohibited from authorizing such a person from selling, soliciting or negotiating more than one policy of group insurance. **Section 74** of this bill makes a violation of that prohibition an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Existing law provides for the licensure and regulation of independent adjusters, public adjusters, company adjusters and staff adjusters by the Commissioner. (Chapter 684A of NRS) **Section 47** of this bill eliminates the staff adjuster and company adjuster license types and instead consolidates those license types into the independent adjuster license type. **Sections 46, 48-50, 54-57, 393 and 394** of this bill make conforming changes to reflect that consolidation.

Existing law, in general, exempts a person who is licensed as an adjuster in another state from the requirement to take and pass an examination to obtain a license as an adjuster in this State. (NRS 684A.100, 684A.105, 684A.115) **Sections 51-53** of this bill require a person to take and pass such an examination if the home state of the person requires a nonresident applicant for a license as an adjuster to take and pass an examination for licensure.

Section 61 of this bill revises the criteria for licensure as a surplus lines broker.

Section 62 of this bill revises provisions relating to the acceptance by the Commissioner of service of process on behalf of an unauthorized insurer in certain circumstances.

Existing law authorizes a self-insured private employer or its parent, a subsidiary of its parent or an affiliate of the self-insured private employer to administer industrial insurance claims from a location in or outside of this State under certain circumstances. (NRS 616B.0275) **Section 394** eliminates that authority and instead authorizes a person who acts as a third-party administrator to a self-insured private employer to administer claims from a location in or outside of this State under certain circumstances.

Existing law governs trade practices and frauds relating to the insurance business and gives the Commissioner exclusive jurisdiction to regulate trade practices in the insurance business. (Chapter 686A of NRS) **Sections 64-106** of this bill revise and add to the provisions of existing law governing trade practices and frauds for the purpose of, in part, conforming more closely to the Unfair Trade

Practices Act and the Insurance Fraud Prevention Model Act adopted by the National Association of Insurance Commissioners. **Section 384** of this bill makes a conforming change to reflect the revision of and addition to such provisions of existing law governing trade practices and frauds.

Section 68 imposes certain requirements for recordkeeping by an insurer. **Sections 69 and 86** prohibit certain acts by an insurer constituting unfair discrimination. **Section 70** provides immunity from liability for a person who furnishes certain information concerning insurance fraud under certain circumstances. **Section 71** sets forth certain requirements concerning the provision of certain information concerning claims history for an insurer that issues a policy of property or casualty insurance. **Sections 72, 83, 89 and 94** establish certain requirements and restrictions governing insurance activities engaged in by a bank. **Sections 73, 74 and 109** of this bill impose certain requirements upon an insurer with respect to long-term care insurance. **Sections 73-75** make a violation of certain requirements an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. **Section 76** requires an insurer to implement certain antifraud initiatives. **Section 77** requires, with certain exceptions, an application for insurance or a claim form to contain a certain statement.

Section 81 prohibits a person from engaging in certain actions as an inducement to purchase insurance. **Section 82** revises provisions that prohibit a person from disseminating or otherwise placing before the public certain untrue, deceptive or misleading communications concerning the insurance business to additionally prohibit the dissemination of such communications through certain electronic means. **Section 85** sets forth certain actions relating to value-added products or services and certain other activities that do not constitute prohibited discrimination or rebates.

Section 187 of this bill makes a conforming change to refer to provisions renumbered by **section 109**. **Sections 84-87, 94-98 and 101-104** add references to a producer of insurance to various provisions referencing agents, brokers and solicitors to specify that such provisions apply to a producer.

Sections 89-92 revise provisions setting forth procedures by which the Commissioner may take certain action against a person engaged in any unfair method of competition or any unfair or deceptive act or practice in the business of insurance. **Sections 14, 116, 118, 124, 220, 304, 332, 335, 337, 338, 373 and 377** of this bill expand the provisions for which a violation constitutes an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Existing law makes certain activities relating to claims unfair practices. (NRS 686A.310) **Section 102** provides that the specified activities constitute unfair practices only if the activity is engaged in: (1) flagrantly and in conscious disregard of the provisions of existing law governing unfair practices with respect to claims activities and any regulations adopted pursuant thereto; and (2) with such frequency so as to indicate that it is a general business practice for the insurer to engage in the activity. **Section 387** of this bill makes a conforming change to refer to provisions renumbered by **section 102**.

Section 110 of this bill revises the dates by which the Commissioner is required to provide each insurer or other organization providing health coverage a data request concerning compliance with certain federal laws and the date by which an insurer or organization is required to submit to the Commissioner the data request or certain alternative materials to demonstrate compliance.

Section 115 of this bill clarifies the applicability of certain provisions of existing law governing life insurance and annuity contracts.

Sections 117, 120-122 and 125 of this bill standardize certain terminology in provisions of existing law governing funeral and burial services to eliminate references to "preneed" contracts and sales agreements and instead refer to "prepaid" contracts and sales agreements.

Existing law requires a health benefit plan for an individual to provide an option of coverage for the screening for and diagnosis and treatment of autism spectrum disorders for certain persons. (NRS 689A.0435) **Section 149** of this bill instead requires that coverage, rather than the option of coverage, be provided in such a health benefit plan. **Section 155** of this bill provides that certain disclosures concerning the reinstatement of certain policies are not required to be included in a health benefit plan.

Existing law requires every policy of group health insurance to contain a provision which reduces the liability of the insurer because of benefits under other valid group coverage. (NRS 689B.034) **Section 177** of this bill requires the provision to define the term "other valid group coverage" in a manner approved by the Commissioner that meets certain requirements.

Section 403 repeals a repetitive and unnecessary definition of the term "dependent" for the purposes of provisions governing voluntary purchasing groups. **Section 216** of this bill makes a conforming change to ensure that the definition of another term applicable to such provisions continues to apply.

Existing law provides for the registration and regulation of providers of service contracts by the Commissioner. (Chapter 690C of NRS) **Sections 21 and 222** of this bill: (1) reduce from 2 years to 1 year the length of time that a certificate of registration for a service contract provider is valid; and (2) proportionally reduce the fees for registration and renewal to reflect annual instead of biennial registration. **Sections 221 and 222** of this bill revise provisions governing the registration of service contract providers for the purpose of clarifying that a person must obtain a certificate of registration before the person is authorized to act as a service contract provider. **Section 223** of this bill revises provisions relating to the financial security which is required of a service contract provider. **Section 224** of this bill requires a service contract to include the name of the holder of the service contract. **Section 225** of this bill revises certain requirements for the keeping of records by a service contract provider.

Existing law sets forth the Insurers Conservation, Rehabilitation and Liquidation Law, which sets forth various procedures and requirements concerning insurers that are impaired or insolvent. (Chapter 696B of NRS) **Section 403** repeals the definition of the term "impairment" for the purpose of the Law and replaces that term with the term "impaired financial condition," which **section 375** of this bill defines to mean that an insurer does not have admitted assets at least equal to all its liabilities and the minimum capital and surplus required under the Code. **Sections 236-239, 309 and 380-382** of this bill revise provisions of existing law concerning impairments of an insurer to account for the elimination of the term "impairment" and to instead set forth certain procedures and requirements concerning impaired financial conditions. **Section 16** requires an insurer to continuously operate in a financial condition that is not an impaired financial condition. **Section 376** of this bill revises the statute of limitations for certain actions brought against an insurer subject to delinquency proceedings or brought by the receiver for such an insurer. **Section 378** of this bill revises the circumstances under which an insurer is insolvent. **Section 379** of this bill makes a conforming change to include the provisions of **sections 375 and 376** among the provisions of the Law governing delinquency proceedings.

Existing law provides for the licensure and regulation of various types of captive insurers. (Chapter 694C of NRS) **Sections 243-245, 247, 249, 250 and 252** of this bill eliminate the rental captive license type. **Section 244** applies certain provisions governing the purchase or acquisition by a domestic insurer of shares of its own stock to captive insurers. **Section 246** of this bill prohibits a captive insurer from using a name that the Commissioner deems to be misleading as to the type or nature of the company. **Section 247** reduces, from $500,000 to $350,000, the amount of unimpaired paid-in capital and unencumbered surplus a sponsored

captive insurer is required to possess and maintain. **Sections 251 and 252** of this bill revise certain deadlines for a branch captive insurer to file certain reports.

Existing law authorizes a captive insurer to transact various types of insurance. (NRS 694C.300) **Section 249** prohibits a captive insurer from providing workers' compensation insurance but maintains the authorization set forth under existing law for a captive insurer to provide excess workers' compensation insurance and to reinsure workers' compensation insurance under certain circumstances.

Existing law imposes a tax on the premiums of a captive insurer. (NRS 694C.450) **Section 252** requires a deficiency in the amount of the tax required to be paid that is discovered during an annual audit to be paid within 60 days after the submission of the audit. **Section 253** of this bill provides for the imposition of an administrative fine for the failure to satisfy the required deadlines for the payment of the tax. **Section 253** raises, from $175,000 to $350,000, the maximum aggregate tax to be paid by a captive insurer in any year. **Section 253** also revises the definition of "net direct premiums" for the purpose of provisions governing the imposition of the tax.

Existing law requires 25 percent of the revenues from the imposition of the tax on the premiums of a captive insurer to be deposited in the Fund for Insurance Administration and Enforcement and the remaining 75 percent to be deposited in the State General Fund. (NRS 694C.450) **Section 253** requires 2 percent of the revenues collected from the tax on the premiums of a captive insurer that would be deposited in the Fund for Insurance Administration and Enforcement under existing law to instead be deposited in the Account for Outreach and Promotion of Captive Insurance created by **section 241** of this bill. **Section 242** of this bill authorizes the money in the Account to be used for certain purposes.

Sections 230 and 231 of this bill transfer certain duties imposed by the Code on the Commissioner of Financial Institutions to the Commissioner of Mortgage Lending.

Section 282 of this bill eliminates certain restrictions on certain group contracts for hospital, medical or dental services.

Sections 306 and 307 of this bill replace requirements concerning the working capital of a health maintenance organization with requirements concerning the capital and surplus of a health maintenance organization.

Section 339 of this bill revises certain deadlines for the requesting and conduct of a hearing concerning a denial of a certificate of authority for a prepaid limited health service organization.

Section 383 of this bill: (1) authorizes a civil action to be brought against a person who hires or otherwise engages an unlicensed person to perform any function, duty or power of a bail agent, general agent, bail enforcement agent or bail solicitor and the unlicensed person by any person who suffers any damages, injury or loss by the performance of the unlicensed person; and (2) makes the unlicensed person and the person who engaged the unlicensed person jointly and severally liable for such damages, injury or loss.

Sections 395 and 396 of this bill revise certain qualifications and requirements for a self-insured employer. **Section 397** of this bill revises the manner in which the pay of an officer, manager or employee of a corporation or company required to obtain industrial insurance is required to be determined.

Section 389 of this bill lengthens, from 3 years after the commission of the offense to 7 years after the commission of the offense, the time that a prosecution for insurance fraud must be commenced. (NRS 171.085) **Section 399** of this bill clarifies that the amendatory provisions of **section 389** apply to an offense committed: (1) before July 1, 2027, if the applicable statute of limitations has commences but has not expired on July 1, 2027, and (2) on or after July 1, 2027.

Section 392 of this bill increases, from three to four, the number of deputies that the Commissioner may appoint.

Sections 39, 107, 108, 126-132, 158-164, 190-195, 219, 254-259, 261, 280, 305, 334, 340, 343-347, 370 and 398 of this bill reorganize and revise, for consistency throughout various provisions of the Nevada Insurance Code, certain definitions in existing law of the terms "medical management technique," "medical or scientific evidence," "network plan," "provider of health care" and "primary care" as those terms relate to: (1) individual health insurance; (2) group and blanket health insurance; (3) health insurance for small employers; (4) fraternal benefit societies; (5) nonprofit corporations for hospital, medical and dental service; (6) health maintenance organizations; and (7) managed care organizations. **Sections 111-113, 133-157, 165-176, 178-186, 188, 196-214, 262-279, 281, 283-303, 308, 310-331 and 350-369** of this bill make conforming changes to eliminate duplicative references of existing law to which those reorganized definitions apply.

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

Section 1. Chapter 679A of NRS is hereby amended by adding thereto a new section to read as follows:

If a person who is or has been licensed by the Commissioner pursuant to this title or who is or has been engaged in the business of insurance without a license as required by this title receives an inquiry from the Division concerning any matter, the person shall provide to the Division a response to the inquiry within 5 working days after receipt of the inquiry.

Sec. 2. Chapter 679B of NRS is hereby amended by adding thereto the provisions set forth as sections 3 and 4 of this act.

Sec. 3. ***The Commissioner may perform financial analysis in accordance with the most recent version of the Financial Analysis Handbook published by the National Association of Insurance Commissioners.***

Sec. 4. ***1. Except as otherwise provided by specific statute, if the Commissioner has reasonable cause to believe that a person has engaged or is engaging in an act for which a license, certificate of authority, certificate of registration or other authorization of the Commissioner is required without obtaining the license, certificate or authorization or any other act that constitutes a violation of any provision of this title or any regulation adopted pursuant thereto, the Commissioner may issue a statement of charges and an order directing the person to immediately cease and desist from engaging in the act.***

2. If the Commissioner issues a cease and desist order pursuant to subsection 1, the Commissioner shall hold a hearing within 30 days after a request by the person to whom the order was issued in accordance with the provisions of NRS 679B.310.

Sec. 5. NRS 679B.124 is hereby amended to read as follows:

679B.124 1. The Commissioner shall:

(a) Develop, prescribe and make available on an Internet website maintained by the Division a form letter that a health carrier must use to notify a provider of health care of the denial of his or her application to be included in the network of providers of the health carrier. The form letter must include, without limitation, a place for the health carrier to explain the reason for the denial of the application.

(b) Hold hearings to solicit public input when developing the form letter described in paragraph (a) and consider such input when developing the form letter.

2. A health carrier shall:

(a) Maintain a copy of each form letter sent to a provider of health care pursuant to subsection 1 and make each copy available to the Commissioner upon request; and

(b) As frequently as required by the Commissioner pursuant to subsection 3, submit to the Commissioner a report summarizing the form letters sent to a provider of health care pursuant to subsection 1.

3. The Commissioner shall determine the information that is required to be included in a report submitted pursuant to subsection 2 and the frequency with which the report must be submitted by the health carrier to the Commissioner.

4. Except as otherwise provided in subsection 5, the report submitted to the Commissioner pursuant to subsection 2, any form letter requested by the Commissioner pursuant to that subsection and the information contained therein are confidential.

5. The Commissioner shall:

(a) Annually compile a report using aggregated data from the reports and form letters collected pursuant to subsection 2 concerning trends in the denial of applications of providers of health care to be included in the network of providers of a health carrier. The report must include, without limitation, the number of total denials, the number of denials for different types of providers of health care, the number of denials by different carriers and the reasons for such denials.

(b) Post the report on an Internet website maintained by the Division.

(c) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the Legislature.

6. As used in this section, "health carrier" ~~[means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health~~

~~maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.~~] ***has the meaning ascribed to it in NRS 695G.024.***

Sec. 6. NRS 679B.142 is hereby amended to read as follows:

679B.142 1. The Commissioner shall deliver to the Secretary of State a copy of an order of the Commissioner or of the district court prohibiting ~~[an insurer]~~ ***a person*** from transacting insurance in this State as a corporation, limited-liability company, limited partnership or limited-liability partnership.

2. Upon receiving the order, the Secretary of State shall nullify the charter of the corporation or limited-liability company or the certificate of the limited partnership or limited-liability partnership.

3. The Secretary of State shall not accept for filing a document with the same name as a corporation, limited-liability company, limited partnership or limited-liability partnership whose charter or certificate has been nullified.

Sec. 7. NRS 679B.180 is hereby amended to read as follows:

679B.180 1. The Commissioner may invoke the aid of the courts through injunction or other proper process, mandatory or otherwise, to enjoin any existing or threatened violation of any provision of this Code, or to enforce any proper order made by or action taken by the Commissioner.

2. If the Commissioner has reason to believe that any person has violated any provision of this Code, or other law applicable to insurance operations, for which criminal prosecution in the opinion of the Commissioner would be in order, the Commissioner shall give the information relative thereto to the appropriate district attorney or to the Attorney General. The district attorney or Attorney General shall promptly institute such action or proceedings against such person as in the opinion of the district attorney or Attorney General the information may require or justify.

3. Except as otherwise provided in this Code, the Attorney General ***or an attorney authorized by the Commissioner*** shall act as legal counsel to the Division and the Commissioner in all matters pertaining to the administration and enforcement of this Code.

Sec. 8. NRS 679B.250 is hereby amended to read as follows:

679B.250 1. When the Commissioner determines to examine the affairs of any person, the Commissioner shall designate one or more examiners and instruct them as to the scope of the examination. The examiner shall, upon demand, exhibit the official credentials of the examiner to the person under examination.

2. The Commissioner shall conduct each examination in an expeditious, fair and impartial manner.

3. Upon any such examination the Commissioner, or the examiner if specifically so authorized in writing by the Commissioner, may administer oaths, and examine under oath any person as to any matter relevant to the affairs under examination or relevant to the examination.

4. Every person being examined, its officers, attorneys, employees, agents and representatives shall make freely available to the Commissioner or the examiners of the Commissioner the accounts, records, documents, files, information, assets and matters of the person examined in his or her possession or control relating to the subject of the examination and shall facilitate the examination.

5. If the Commissioner or examiner finds any accounts or records to be inadequate, or inadequately kept or posted, ***including, without limitation, by failing to maintain any records for the period and in the manner required by any applicable statute or regulation,*** the Commissioner may employ experts to reconstruct, rewrite, post or balance them at the expense of the person being examined if that person has failed to maintain, complete or correct the records or accounting after the Commissioner or examiner has given the person written notice and a reasonable opportunity to do so.

6. Neither the Commissioner nor any examiner may remove any record, account, document, file or other property of the person being examined from the offices or place of the person examined except with the written consent of the person before removal or pursuant to an order of court duly obtained. This provision does not affect the making and removal of copies or abstracts of any such record, account, document or file.

7. Any person who refuses without just cause to be examined under oath or who willfully obstructs or interferes with the examiners in the exercise of their authority pursuant to this section is guilty of a misdemeanor.

8. This chapter does not limit the Commissioner's authority:

(a) To terminate or suspend an examination in order to pursue other legal or regulatory action.

(b) During any hearing or any legal action, to use and, if so ordered by a court, to make public a final or preliminary report of an examination, working papers or other documents of an examiner or insurer, or any other information discovered or developed during the course of an examination. Such documents must be given their appropriate evidentiary weight and must not be accepted as prima facie evidence of the facts contained therein.

Sec. 9. NRS 679B.285 is hereby amended to read as follows:

679B.285 1. The Commissioner may disclose the content of a report, preliminary report, or the results of an examination, or any

matter relating thereto, to the Division or any agency of any other state or country that regulates insurance, or to law enforcement officers of this or any other state, or to an agency of the Federal Government at any time, if the agency or office receiving the report or matter relating thereto agrees in writing to hold it confidential in a manner consistent with this chapter. Access may also be granted to the National Association of Insurance Commissioners.

2. All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this chapter are confidential, are not subject to subpoena, and may not be made public by the Commissioner or any other person, except as necessary for a hearing or as provided in this section, subsection 4 of NRS 679B.282 and NRS 239.0115. A person to whom information is given must agree in writing before receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the insurer to which it pertains has been obtained.

3. Any document created in the performance of financial analysis pursuant to section 3 of this act shall be deemed to be a working paper for the purposes of subsection 2.

Sec. 10. NRS 679B.310 is hereby amended to read as follows:

679B.310 1. The Commissioner may hold a hearing, without request by others, to determine whether an insurer or an employee of an insurer has engaged in unsuitable conduct and for any other purpose within the scope of this Code.

2. The Commissioner shall hold a hearing:

(a) If required by any other provision of this Code; or

(b) Upon written application for a hearing by a person aggrieved by any act, or failure of the Commissioner to act, that is related to the business of insurance, or by any report, rule, regulation or order of the Commissioner, other than an order for the holding of a hearing, or an order issued on a hearing of which the person had notice. The application must be filed in the Division within 60 days after the person knew or reasonably should have known of the act, failure, report, rule, regulation or order, unless a different period is provided for by any other law applicable to the particular matter, in which case the other law governs.

3. Any such application for a hearing must briefly state the respects in which the applicant is so aggrieved, together with the grounds to be relied upon as a basis for the relief to be sought at the hearing.

4. If the Commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established and that the grounds otherwise justify the

hearing, the Commissioner shall hold the hearing within 60 days after the filing of the application, unless postponed by mutual consent. Failure to hold the hearing upon application therefor of a person entitled thereto as provided in this section constitutes a denial of the relief sought, and is the equivalent of a final order of the Commissioner on hearing for the purpose of an appeal pursuant to NRS 679B.370.

5. Pending the hearing and decision thereon, the Commissioner may suspend or postpone the effective date of the previous action of the Commissioner.

6. Except as otherwise provided by specific statute, ***the procedures set forth in NRS 679B.310 to 679B.370, inclusive, and any applicable regulations adopted pursuant to this chapter apply to all hearings held before*** the Commissioner ~~[shall issue a final order in a contested case within 45 days after the close of the hearing on the contested case. As used in this subsection, "contested case" has the meaning ascribed to it in NRS 233B.032.]~~ ***pursuant to this title.***

Sec. 11. NRS 679B.330 is hereby amended to read as follows:

679B.330 1. The Commissioner may hold a hearing in Carson City, Nevada, or any other place of convenience to parties and witnesses, as the Commissioner determines. The Commissioner, a deputy or assistant of the Commissioner, or a person appointed by the Commissioner, shall preside at the hearing, and shall expedite the hearing and all procedures involved therein.

2. The Commissioner may appoint a person who is not associated with the Division to conduct a hearing if the hearing requires a disinterested or impartial hearing officer. A person so appointed shall comply with the provisions which govern hearings conducted by the Commissioner. An order issued by such a person has the same effect as an order issued by the Commissioner.

3. Testimony may be taken orally or by deposition, and any party has the same right to introduce evidence by interrogatories or deposition as the party would have in a district court.

4. Upon good cause shown the Commissioner shall permit to become a party to the hearing by intervention, if timely, only such persons, not original parties thereto, whose pecuniary interests are to be directly and immediately affected by the Commissioner's order made upon the hearing.

5. The Commissioner shall cause a record of the proceedings to be made. If transcribed, a copy of the record must be part of the Commissioner's record of the hearing and a copy must be furnished to any other party to the hearing, at the request and expense of the other party. If no such record is transcribed, the Commissioner shall prepare a summary record of the proceedings and evidence.

6. A person appointed by the Commissioner to preside over or conduct a hearing pursuant to subsection 1 or 2 has the authority of the Commissioner established in the provisions of this title governing hearings before the Commissioner and must comply with the procedures and requirements applicable to the Commissioner set forth in the provisions of this title governing the conduct of hearings before the Commissioner. For the purpose of such provisions, any statutory reference to the Commissioner shall be deemed to be a reference to a person appointed by the Commissioner to preside over or conduct a hearing pursuant to subsection 1 or 2.

Sec. 12. NRS 679B.360 is hereby amended to read as follows:

679B.360 1. In the conduct of hearings ~~[under this Code]~~ ***before the Commissioner*** and making an order thereon, the Commissioner shall act in a quasi-judicial capacity.

2. Except as otherwise provided in this subsection, within ~~[30]~~ ***45*** days after termination of a hearing, or of any rehearing thereof or reargument thereon, or within such other period as may be specified ~~[in this Code]~~ ***by specific statute*** as to particular proceedings, the Commissioner shall make an order on hearing covering matters involved in such hearing, and give a copy of the order to each party to the hearing in the same manner as notice of the hearing was given to such party. With respect to hearings held concerning merger, consolidation, bulk reinsurance, conversion, affiliation or change of control of a domestic insurer as provided in chapter 693A of NRS (corporate powers, procedures of domestic stock and mutual insurers), where notice of the hearing was given to all stockholders and policyholders or to all stockholders or policyholders of an insurer involved, the Commissioner is required to give a copy of the order on hearing to the corporation and insurer parties, to intervening parties, to a reasonable number of such stockholders or policyholders as representative of the class, and to other parties only upon written request of such parties.

3. The order shall contain:

(a) A concise statement of facts found by the Commissioner upon evidence adduced at the hearing;

(b) A concise statement of the Commissioner's conclusions from the facts so found;

(c) The order, and the effective date thereof; and

(d) ~~[Citation]~~ ***A citation*** of the provisions of this Code upon which the order is based ***,*** ~~[;]~~ but failure ~~[so]~~ to designate a particular provision ~~[shall]~~ ***does*** not deprive the Commissioner of the right thereafter to rely thereon.

4. The order may affirm, modify or rescind action theretofore taken or may constitute taking of new action within the scope of the notice of the hearing.

Sec. 13. NRS 679B.460 is hereby amended to read as follows:

679B.460 1. An insurer who willfully or repeatedly violates or fails to comply with a provision of NRS 679B.400 to 679B.440, inclusive, or a regulation adopted pursuant to NRS 679B.430 is subject, after notice and ***the opportunity for*** a hearing held pursuant to NRS 679B.310 to 679B.370, inclusive, to payment of an administrative fine of not more than $1,000 for each day of the violation or failure to comply, up to a maximum fine of $50,000.

2. An insurer who fails or refuses to comply with an order issued by the Commissioner pursuant to NRS 679B.430 is subject, after notice and ***the opportunity for*** a hearing held pursuant to NRS 679B.310 to 679B.370, inclusive, to suspension or revocation of the insurer's certificate of authority to transact insurance in this State.

3. The imposition of an administrative fine pursuant to this section must not be considered by the Commissioner in any other administrative proceeding unless the fine has been paid or a court order for payment of the fine has become final.

Sec. 14. NRS 679B.630 is hereby amended to read as follows:

679B.630 The Commissioner shall establish a program within the Division to investigate any act or practice which:

1. Violates the provisions of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive ~~[,]~~ ***, and sections 65 to 77, inclusive, of this act;*** or

2. Defrauds or is an attempt to defraud an insurer.

Sec. 15. NRS 679B.660 is hereby amended to read as follows:

679B.660 1. Every person in charge of an investigative or law enforcement agency within this State shall:

(a) Cooperate with the Commissioner and the investigators of the Commissioner, and the Attorney General and the members of the Fraud Control Unit; and

(b) Upon request, furnish the Commissioner or Attorney General, as appropriate, with any information necessary for the investigation of insurance fraud.

2. The Commissioner and the Attorney General shall:

(a) Assist any official of an investigative or a law enforcement agency of this State, any other State or the Federal Government who requests assistance in investigating any act of insurance fraud; and

(b) Furnish to those officials any information, not otherwise confidential, concerning his or her investigation or his or her report on insurance fraud.

3. In addition to the records of criminal history specified in NRS 179A.100, the Commissioner, in carrying out the duties set

forth in NRS 679B.600 to 679B.700, inclusive, may have access to the information that is contained in the Central Repository for Nevada Records of Criminal History pursuant to NRS 179A.075.

Sec. 16. NRS 680A.120 is hereby amended to read as follows:

680A.120 1. Except as provided in subsections 2 and 5, to qualify for authority to transact any one kind of insurance as defined in NRS 681A.010 to 681A.080, inclusive, or combinations of kinds of insurance as shown below, an insurer shall ***:***

(a) Except as otherwise provided in paragraph (c), possess and thereafter maintain ~~[unimpaired paid-in capital stock, if a stock insurer, or unimpaired basic surplus, if a mutual or a reciprocal insurer, and free surplus not less than 100 percent of]~~ the minimum ~~[required]~~ capital ~~[stock or minimum required basic]~~ ***and*** surplus ~~[, and when first so authorized shall]~~ ***required to be maintained by the insurer pursuant to the applicable provisions of this title and the regulations adopted pursuant thereto, including, without limitation, the regulations adopted pursuant to subsection 6 or NRS 681B.550, as applicable;***

(b) Continuously operate in a financial condition that is not an impaired financial condition, as defined in section 375 of this act; and

(c) For an insurer that has never been authorized to transact insurance in any state, at the time the certificate of authority is issued and for 1 year thereafter, rather than the capital and surplus required by paragraph (a), possess ***and maintain the minimum required capital stock or minimum required basic surplus and*** initial free surplus, all in amounts not less than as determined from the following table:

	STOCK INSURERS		FOREIGN MUTUAL INSURERS		RECIPROCAL INSURERS	
Kind or Kinds of Insurance	Minimum Required Capital Stock	Initial Free Surplus	Minimum Required Basic Surplus	Initial Free Surplus	Minimum Required Basic Surplus	Initial Free Surplus
Life	500,000	1,000,000	500,000	1,000,000	N/A	N/A
Health, Property, Casualty, Surety, Marine & Transportation Multiple line	500,000	1,000,000	500,000	1,000,000	500,000	1,000,000
Title	500,000	750,000	N/A	N/A	N/A	N/A

Kind or Kinds of Insurance	STOCK INSURERS Minimum Required Capital Stock	STOCK INSURERS Initial Free Surplus	FOREIGN MUTUAL INSURERS Minimum Required Basic Surplus	FOREIGN MUTUAL INSURERS Initial Free Surplus	RECIPROCAL INSURERS Minimum Required Basic Surplus	RECIPROCAL INSURERS Initial Free Surplus
Financial Guarantee	10,000,000	40,000,000	N/A	N/A	N/A	N/A

2. At the discretion of the Commissioner, a domestic insurer holding a valid certificate of authority to transact insurance in this State immediately prior to January 1, 1992, may, if otherwise qualified therefor, continue to be so authorized while possessing the amount of paid-in capital stock, if a stock insurer, or surplus, if a mutual insurer, required by the laws of this State for such authority immediately before January 1, 1992, for a period not to exceed 2 years. On or before January 1, 1994, the insurer shall meet the requirements of subsection 1. The Commissioner shall not grant such an insurer authority to transact any other or additional kinds of insurance unless it then fully complies with the requirements as to capital and surplus, as applied to all kinds of insurance which it then proposes to transact, as provided by this section for like foreign insurers applying for original certificates of authority pursuant to this Code.

3. Capital and surplus requirements are based upon all the kinds of insurance transacted by the insurer in any and all areas in which it operates or proposes to operate, whether or not only a portion of such kinds are to be transacted in this State.

4. As to surplus required for qualification to transact one or more kinds of insurance and thereafter to be maintained, domestic mutual insurers are governed by chapter 693A of NRS and domestic reciprocal insurers are governed by chapter 694B of NRS.

5. An insurer who transacts financial guaranty insurance in this State must transact only one kind of insurance and possess and maintain the minimum capital and surplus requirements pursuant to subsection 1.

6. The Commissioner may adopt regulations establishing requirements for the minimum amount of capital and surplus that is required to be maintained by an insurer to which the requirements set forth in the regulations adopted pursuant to NRS 681B.550 apply.

Sec. 17. NRS 680A.140 is hereby amended to read as follows:

680A.140 1. The Commissioner shall not authorize an insurer to transact insurance in this State, other than an alien insurer

or a title insurer, unless ~~[it]~~ ***for the protection of the policyholders of the insurer or the policyholders and creditors of the insurer in the United States of America, the insurer:***

(a) For an insurer who has been authorized to transact insurance in any other state, makes and thereafter continuously maintains on deposit in this State, through the Commissioner, cash or securities eligible for such deposit under the laws of this State of a fair market value not less than the minimum amount of capital and surplus required by paragraph (a) of subsection 1 of NRS 680A.120.

(b) For an insurer who has been authorized to transact insurance in any other state, makes and ~~[thereafter]~~ ***for 1 year after the date on which the certificate of authority is issued by the Commissioner*** continuously maintains on deposit in this State, through the Commissioner, cash or securities eligible for such deposit under the laws of this State of a fair market value not less than its minimum required capital stock, if a stock insurer, or minimum required basic surplus, if a mutual or reciprocal insurer ***.*** ~~[,~~ ~~for the protection of the insurer's policyholders or of its policyholders and creditors in the United States of America.]~~ ***Thereafter, the insurer shall comply with the requirements of paragraph (a).***

➥ The Commissioner may adopt regulations which allow the use of securities as a deposit without delivery of the securities to the Commissioner.

2. ~~[The]~~ ***Except as otherwise provided in this subsection, the*** Commissioner shall not so authorize a title insurer unless it so deposits and maintains such cash or securities of fair market value not less than its minimum ~~[required]~~ capital ~~[stock]~~ ***and surplus required by paragraph (a) of subsection 1 of NRS 680A.120*** as a guaranty fund for the security and protection of the holders of, or beneficiaries under, the title insurance contracts issued by the insurer. ***If the title insurer has never been authorized to transact insurance in any other state, for 1 year after the date on which the certificate of authority is issued by the Commissioner, the cash and securities required for the guaranty fund must have a fair market value of not less than its minimum capital stock required pursuant to paragraph (c) of subsection 1 of NRS 680A.120 rather than the capital and surplus required by paragraph (a) of subsection 1 of NRS 680A.120.***

3. The Commissioner shall not so authorize an alien insurer unless it so makes and thereafter continuously maintains such a deposit, representing money in excess of all the insurer's liabilities under insurance contracts in force in the United States of America, of a fair market value of not less than that required under

subsection 1, as to a like foreign insurer. The deposit must be held in trust for the protection of all the insurer's policyholders, or policyholders and creditors, in the United States of America.

4. In lieu of such a deposit made or maintained in this State, the Commissioner shall accept the certificate in proper form of the public officer having general supervision of insurers in any other state to the effect that a deposit of like quality and amount, or part thereof, by an insurer is being maintained for like purposes in public custody or control pursuant to the laws of that state, if the Commissioner is satisfied as to the like quality and amount of the deposit.

5. All such deposits in this State are subject to the applicable provisions of chapter 682B of NRS.

Sec. 18. NRS 680A.200 is hereby amended to read as follows:

680A.200 1. Except as otherwise provided in NRS 616B.472, the Commissioner may refuse to continue or may suspend, limit or revoke an insurer's certificate of authority if the Commissioner finds after ***the opportunity for*** a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has:

(a) Violated or failed to comply with any lawful order of the Commissioner;

(b) Conducted business in an unsuitable manner;

(c) Willfully violated or willfully failed to comply with any lawful regulation of the Commissioner; or

(d) Violated any provision of this Code other than one for violation of which suspension or revocation is mandatory.

➥ In lieu of such a suspension or revocation, the Commissioner may levy upon the insurer, and the insurer shall pay forthwith, an administrative fine of not more than ~~[$2,000]~~ ***$5,000*** for each act or violation.

2. Except as otherwise provided in chapter 696B of NRS, the Commissioner shall suspend or revoke an insurer's certificate of authority on any of the following grounds if the Commissioner finds after ***the opportunity for*** a hearing thereon that the insurer:

(a) Is in unsound condition, is being fraudulently conducted, or is in such a condition or is using such methods and practices in the conduct of its business as to render its further transaction of insurance in this State currently or prospectively hazardous or injurious to policyholders or to the public.

(b) With such frequency as to indicate its general business practice in this State:

(1) Has without just cause failed to pay, or delayed payment of, claims arising under its policies, whether the claims are in favor of an insured or in favor of a third person with respect to the liability of an insured to the third person; or

(2) Without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to secure full payment or settlement of such claims.

(c) Refuses to be examined, or its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its books, papers, records, contracts, correspondence or other documents for examination by the Commissioner when required, or refuse to perform any legal obligation relative to the examination.

(d) Except as otherwise provided in NRS 681A.110, has reinsured all its risks in their entirety in another insurer.

(e) Has failed to pay any final judgment rendered against it in this State upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within 30 days after the judgment became final or within 30 days after dismissal of an appeal before final determination, whichever date is the later.

3. In addition to the grounds specified in subsections 1 and 2, the Commissioner may refuse to continue or may suspend, limit or revoke an insurer's certificate of authority if the Commissioner finds after ***the opportunity for*** a hearing thereon, or upon waiver of hearing by the insurer, that the insurer has failed to comply with any provision of NRS 439B.800 to 439B.875, inclusive, if applicable, or any applicable regulation adopted pursuant thereto.

4. The Commissioner may, without advance notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation or other delinquency proceedings have been commenced in any state by the public officer who supervises insurance for that state.

5. No proceeding to suspend, limit or revoke a certificate of authority pursuant to this section may be maintained unless it is commenced by the giving of notice to the insurer within 5 years after the occurrence of the charged act or omission. This limitation does not apply if the Commissioner finds fraudulent or willful evasion of taxes.

Sec. 19. NRS 680A.220 is hereby amended to read as follows:

680A.220 1. Suspension of an insurer's certificate of authority must be for such period as the Commissioner specifies in the order of suspension **.** ~~[, but not to exceed 1 year.]~~ During the suspension period the Commissioner may rescind or shorten the suspension by further order.

2. During the suspension period the insurer shall not solicit or write any new business in this State, but must file its annual statement, pay fees, licenses and taxes as required under this Code,

and may service its business already in force in this State, as if the certificate of authority had continued in full force.

3. Upon expiration of the suspension period, if within such period the certificate of authority has not terminated, the insurer's certificate of authority is automatically reinstated unless the Commissioner finds that the causes of the suspension, being other than a past event, are continuing, or that the insurer is otherwise not in compliance with the requirements of this Code, and of which the Commissioner shall give the insurer notice not less than 30 days in advance of expiration of the suspension period.

4. Upon reinstatement of the insurer's certificate of authority, the authority of its agents in this State to represent the insurer is also reinstated. The Commissioner shall promptly notify the insurer and its agents in this State, of record in the Division, of such reinstatement.

Sec. 20. NRS 680A.320 is hereby amended to read as follows:

680A.320 1. For the purposes of this section:

(a) An "affiliated person" is a person controlled by any combination of the insurer, the parent corporation, a subsidiary or the principal stockholders or officers or directors of any of the foregoing.

(b) "Depository institution" has the meaning ascribed to it in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813(c)(1).

(c) "Financial holding company" means a bank holding company that satisfies the requirements of section 4(l)(1) of the Bank Holding Company Act of 1956, 12 U.S.C. § 1841(l)(1).

(d) "Health facility" has the meaning ascribed to it in NRS 439A.015.

(e) A "subsidiary" is a person of which either the insurer and the parent corporation or the insurer or the parent corporation holds practical control.

2. No insurer may engage directly or indirectly in any transaction or agreement with its parent corporation, a financial holding company, a depository institution, or any subsidiary or affiliated person which will result or tend to result in:

(a) Substitution contrary to the interest of the insurer and through any method of any asset of the insurer with an asset or assets of inferior quality or lower fair market value;

(b) Deception as to the true operating results of the insurer;

(c) Deception as to the true financial condition of the insurer;

(d) Allocation to the insurer of a proportion of the expense of combined facilities or operations which is unfair and unfavorable to the insurer;

(e) Unfair or excessive charges against the insurer for services, facilities, supplies or reinsurance;

(f) Unfair and inadequate charges by the insurer for reinsurance, services, facilities or supplies furnished by the insurer to others;

(g) Payment by the insurer for services, facilities, supplies or reinsurance not reasonably needed by the insurer;

(h) Depletion of the insurer's surplus, through payment of dividends or other distribution or withdrawal, below the amount thereof reasonably required for conduct of the insurer's business and maintenance of growth with safety to policyholders; or

(i) Payment by the insurer for services or products for which the health facility has charged less than fair market value, unless the reduced charge is reflected in the form of reduced premiums. In determining what constitutes fair market value, consideration must be given to reasonable agreements for the preferential provision of health care, in accordance with regulations adopted by the Commissioner. An insurer which pays less than fair market value for services or products in a transaction which is subject to the provisions of this paragraph shall annually file a certification with the Commissioner that the reduced payment has been reflected in the form of reduced premiums, together with documentation supporting the certification.

3. In all transactions between the insurer and its parent corporation, or involving the insurer and any subsidiary or affiliated person, full recognition must be given to the paramount duty and obligation of the insurer to protect the interests of policyholders, both existing and future.

4. If a health facility is a parent, subsidiary or affiliate of an insurer or of a parent or facility of an insurer, and the insurer purchases medical or any other services or products from the health facility, the health facility may not:

(a) Attempt artificially to reduce or increase its margin of profit by altering the charges to the insurer.

(b) Alter its true operating results or financial condition through charges to the insurer for services or products.

➥ This subsection does not prohibit activities authorized pursuant to paragraph (i) of subsection 2.

5. If a health facility is found, after notice and ***the opportunity for*** a hearing, to have violated the provisions of subsection 4, the Commissioner may impose an administrative fine of not more than $5,000 for each violation.

Sec. 21. NRS 680B.010 is hereby amended to read as follows:

680B.010 The Commissioner shall collect in advance and receipt for, and persons so served must pay to the Commissioner, fees and miscellaneous charges as follows:

1. Insurer's certificate of authority:
(a) Filing initial application $2,450
(b) Issuance of certificate:
(1) For any one kind of insurance as defined in NRS 681A.010 to 681A.080, inclusive 283
(2) For two or more kinds of insurance as so defined 578
(3) For a reinsurer 2,450
(c) Each annual continuation of a certificate ..... ~~[2,450]~~ ***5,000***
(d) Reinstatement pursuant to NRS 680A.180, 50 percent of the annual continuation fee otherwise required.
(e) Registration of additional title pursuant to NRS 680A.240 50
(f) Annual renewal of the registration of additional title pursuant to NRS 680A.240 25
2. Charter documents, other than those filed with an application for a certificate of authority. Filing amendments to articles of incorporation, charter, bylaws, power of attorney and other constituent documents of the insurer, each document $10
3. Annual statement or report. For filing annual statement or report $25
4. Service of process:
(a) Filing of power of attorney $5
(b) Acceptance of service of process 30
5. Licenses, appointments and renewals for producers of insurance:
(a) Application and license $125
(b) Appointment fee for each insurer 15
(c) Triennial renewal of each license 125
(d) Temporary license 10
(e) Modification of an existing license 50
6. Surplus lines brokers:
(a) Application and license $125
(b) Triennial renewal of each license 125
7. Managing general agents' licenses, appointments and renewals:
(a) Application and license $125
(b) Appointment fee for each insurer 15
(c) Triennial renewal of each license 125
8. Adjusters', as defined in NRS 684A.030, licenses and renewals:
(a) Application and license $125
(b) Triennial renewal of each license 125

9. Licenses and renewals for appraisers of physical damage to motor vehicles:
(a) Application and license $125
(b) Triennial renewal of each license..... 125
10. Insurance vending machines:
(a) Application and license, for each machine..... $125
(b) Triennial renewal of each license..... 125
11. Permit for solicitation for securities:
(a) Application for permit..... $100
(b) Extension of permit..... 50
12. Securities salespersons for domestic insurers:
(a) Application and license $25
(b) Annual renewal of license..... 15
13. Rating organizations:
(a) Application and license $500
(b) Annual renewal 500
14. Certificates and renewals for administrators licensed pursuant to chapter 683A of NRS:
(a) Application and certificate of registration..... $125
(b) Triennial renewal 125
15. For copies of the insurance laws of Nevada, a fee which is not less than the cost of producing the copies.
16. Certified copies of certificates of authority and licenses issued pursuant to the Code..... $10
17. For copies and amendments of documents on file in the Division, a reasonable charge fixed by the Commissioner, including charges for duplicating or amending the forms and for certifying the copies and affixing the official seal.
18. Letter of clearance for a producer of insurance or other licensee if requested by someone other than the licensee..... $10
19. Certificate of status as a producer of insurance or other licensee if requested by someone other than the licensee..... $10
20. Licenses, appointments and renewals for bail agents:
(a) Application and license $125
(b) Appointment for each surety insurer..... 15
(c) Triennial renewal of each license..... 125
21. Licenses and renewals for bail enforcement agents:
(a) Application and license $125

(b) Triennial renewal of each license $125
22. Licenses, appointments and renewals for general agents for bail:
(a) Application and license $125
(b) Initial appointment by each insurer 15
(c) Triennial renewal of each license 125
23. Licenses and renewals for bail solicitors:
(a) Application and license $125
(b) Triennial renewal of each license 125
24. Licenses and renewals for title agents and escrow officers:
(a) Application and license $125
(b) Triennial renewal of each license 125
(c) Appointment fee for each title insurer 15
25. Certificate of authority and renewal for a seller of prepaid funeral contracts $125
26. Licenses and renewals for agents for prepaid funeral contracts:
(a) Application and license $125
(b) Triennial renewal of each license 125
27. Reinsurance intermediary broker or manager:
(a) Application and license $125
(b) Triennial renewal of each license 125
28. Agents for and sellers of prepaid burial contracts:
(a) Application and certificate or license $125
(b) Triennial renewal 125
29. Risk retention groups:
(a) Initial registration $250
(b) Each annual continuation of a certificate of registration 250
30. Required filing of forms:
(a) For rates and policies $25
(b) For riders and endorsements 10
31. Viatical settlements:
(a) Provider of viatical settlements:
(1) Application and license $1,000
(2) Annual renewal 1,000
(b) Broker of viatical settlements:
(1) Application and license 500
(2) Annual renewal 500
(c) Registration of producer of insurance acting as a viatical settlement broker 250
32. Insurance consultants:

(a) Application and license $125
(b) Triennial renewal 125
33. Licensee's association with or designation, appointment or sponsorship by an organization:
(a) Initial association, designation or sponsorship and renewal of association, designation or sponsorship, for each organization $50
(b) Initial appointment and annual renewal of appointment 15
34. Purchasing groups:
(a) Initial registration and review of an application..... $100
(b) Each annual continuation of registration..... 100
35. Exchange enrollment facilitators:
(a) Application and certificate $125
(b) Triennial renewal of each certificate..... 125
(c) Temporary certificate 10
36. Agent who performs utilization reviews:
(a) Application and registration $250
(b) Renewal of registration 250
37. Motor club:
(a) Filing of application $500
(b) Issuance of certificate..... 283
38. Motor club agent:
(a) Application and license $78
(b) Appointment by each motor club..... 5
(c) Triennial renewal of each license..... 78
39. Title plant company:
(a) Application and license $10
(b) Renewal of license 10
40. Service contract provider:
(a) Application and registration .....~~[$2,000]~~ ***$1,000***
(b) Renewal of registration .....~~[2,000]~~ ***1,000***
41. In addition to any other fee or charge, all applicable fees required of any person, including, without limitation, persons listed in this section, pursuant to NRS 680C.110.

Sec. 22. NRS 680C.110 is hereby amended to read as follows:

680C.110 1. In addition to any other fee or charge, the Commissioner shall collect in advance and receipt for, and persons so served must pay to the Commissioner, the fees required by this section.

2. A fee required by this section must be:

(a) If an initial fee, paid at the time of an initial application or issuance of a license, as applicable;

(b) Except as otherwise provided in NRS 680A.180, 683A.378, 686A.380, 690C.160, 694C.230, 695A.080, 695B.135, 695D.150, 695H.090 and 696A.150, if an annual fee, paid on or before the date established by regulation of the Commissioner;

(c) If a triennial fee, paid on or before the time of continuation, renewal or other similar action in regard to a certificate, license, permit or other type of authorization, as applicable; and

(d) Deposited in the Fund for Insurance Administration and Enforcement created by NRS 680C.100.

3. The fees required pursuant to this section are not refundable.

4. The following fees must be paid by the following persons to the Commissioner:

(a) Associations of self-insured private employers, as defined in NRS 616A.050:

(1) Initial fee $1,300

(2) Annual fee $1,300

(b) Associations of self-insured public employers, as defined in NRS 616A.055:

(1) Initial fee $1,300

(2) Annual fee $1,300

(c) Independent review organizations, as provided for in NRS 616A.469 or 683A.3715, or both:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Annual fee ..... ~~[$60]~~ ***$70***

(d) Producers of insurance, as defined in NRS 679A.117:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(e) Reinsurers, as provided for in NRS 681A.1551 or 681A.160, as applicable:

(1) Initial fee $1,300

(2) Annual fee $1,300

(f) Intermediaries, as defined in NRS 681A.330:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(g) Reinsurers, as defined in NRS 681A.370:

(1) Initial fee $1,300

(2) Annual fee $1,300

(h) Administrators, as defined in NRS 683A.025:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(i) Managing general agents, as defined in NRS 683A.060:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(j) Agents who perform utilization reviews, as defined in NRS 683A.376:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Annual fee ..... ~~[$60]~~ ***$70***

(k) Insurance consultants, as defined in NRS 683C.010:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(l) Independent adjusters, as defined in NRS 684A.030:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(m) Public adjusters, as defined in NRS 684A.030:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(n) Motor vehicle physical damage appraisers, as defined in NRS 684B.010:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(o) Brokers, as defined in NRS 685A.031:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(p) Companies, as defined in NRS 686A.330:

(1) Initial fee $1,300

(2) Annual fee $1,300

(q) Rate service organizations, as defined in NRS 686B.020:

(1) Initial fee $1,300

(2) Annual fee $1,300

(r) Brokers of viatical settlements, as defined in NRS 688C.030:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Annual fee ..... ~~[$60]~~ ***$70***

(s) Providers of viatical settlements, as defined in NRS 688C.080:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Annual fee ..... ~~[$60]~~ ***$70***

(t) Agents for prepaid burial contracts subject to the provisions of chapter 689 of NRS:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(u) Agents for prepaid funeral contracts subject to the provisions of chapter 689 of NRS:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(v) Sellers of prepaid burial contracts subject to the provisions of chapter 689 of NRS:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(w) Sellers of prepaid funeral contracts subject to the provisions of chapter 689 of NRS:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(x) Providers, as defined in NRS 690C.070:

(1) Initial fee $1,300

(2) Annual fee $1,300

(y) Escrow officers, as defined in NRS 692A.028:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(z) Title agents, as defined in NRS 692A.060:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(aa) Captive insurers, as defined in NRS 694C.060:

(1) Initial fee $250

(2) Annual fee $250

(bb) Purchasing groups, as defined in NRS 695E.100:

(1) Initial fee $250

(2) Annual fee $250

(cc) Risk retention groups, as defined in NRS 695E.110:

(1) Initial fee $250

(2) Annual fee $250

(dd) Medical discount plans, as defined in NRS 695H.050:

(1) Initial fee $1,300

(2) Annual fee $1,300

(ee) Club agents, as defined in NRS 696A.040:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(ff) Motor clubs, as defined in NRS 696A.050:

(1) Initial fee $1,300

(2) Annual fee $1,300

(gg) Bail agents, as defined in NRS 697.040:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(hh) Bail enforcement agents, as defined in NRS 697.055:

(1) Initial fee ..... ~~[$60]~~ ***$70***

(2) Triennial fee ..... ~~[$60]~~ ***$70***

(ii) Bail solicitors, as defined in NRS 697.060:

(1) Initial fee..... ~~[$60]~~ ***$70***

(2) Triennial fee..... ~~[$60]~~ ***$70***

(jj) General agents, as defined in NRS 697.070:

(1) Initial fee..... ~~[$60]~~ ***$70***

(2) Triennial fee..... ~~[$60]~~ ***$70***

(kk) Exchange enrollment facilitators, as defined in NRS 695J.050:

(1) Initial fee..... ~~[$60]~~ ***$70***

(2) Triennial fee..... ~~[$60]~~ ***$70***

5. An initial fee of $1,000 must be paid to the Commissioner by each:

(a) Insurer who is authorized to transact casualty insurance, as defined in NRS 681A.020;

(b) Insurer who is authorized to transact health insurance, as defined in NRS 681A.030;

(c) Insurer who is authorized to transact life insurance, as defined in NRS 681A.040;

(d) Insurer who is authorized to transact property insurance, as defined in NRS 681A.060;

(e) Title insurer, as defined in NRS 692A.070;

(f) Fraternal benefit society, as defined in NRS 695A.010;

(g) Corporation subject to the provisions of chapter 695B of NRS;

(h) Health maintenance organization, as defined in NRS 695C.030;

(i) Organization for dental care, as defined in NRS 695D.060; and

(j) Prepaid limited health service organization, as defined in NRS 695F.050.

6. An insurer who is required to pay an initial fee of $1,000 pursuant to subsection 5 shall also pay to the Commissioner an annual fee in an amount determined by the Commissioner. When determining the amount of the annual fee, the Commissioner must consider:

(a) The direct written premiums reported to the Commissioner by the insurer during the previous year;

(b) The number of insurers who are required to pay an annual fee pursuant to this subsection;

(c) The direct written premiums reported during the previous year by all insurers paying such fees; and

(d) The budget of the Division.

7. An insurer who is not required to pay an initial or annual fee pursuant to subsection 4 or subsections 5 and 6 shall pay to the Commissioner an initial fee of $1,300 and an annual fee of $1,300.

Sec. 23. NRS 681A.020 is hereby amended to read as follows:

681A.020 1. "Casualty insurance" includes:

(a) Vehicle insurance. Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability or expense resulting from or incidental to ownership, maintenance or use of any such vehicle, aircraft or animal, together with insurance against accidental injury to natural persons, irrespective of legal liability of the insured, including the named insured, while in, entering, alighting from, adjusting, repairing, cranking, or caused by being struck by a vehicle, aircraft or draft or riding animal, if such insurance is issued as an incidental part of insurance on the vehicle, aircraft or draft or riding animal.

(b) Liability insurance. Insurance against legal liability for the death, injury or disability of any human being, or for damage to property, including liability resulting from negligence in rendering expert, fiduciary or professional services, and provisions of medical, hospital, surgical, disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance.

(c) Workers' compensation and employer's liability. Insurance of the obligations accepted by, imposed upon or assumed by employers under law for death, disablement or injury of employees.

(d) Burglary and theft. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal or concealment, or from any attempt at any of the foregoing, including supplemental coverage for medical, hospital, surgical and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery or theft by another, and, also, insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers and documents, resulting from any cause.

(e) Personal property floater. Insurance upon personal effects against loss or damage from any cause.

(f) Glass. Insurance against loss or damage to glass, including its lettering, ornamentation and fittings.

(g) Boiler and machinery. Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery or apparatus, and to make inspection of and issue certificates of

inspection upon boilers, machinery and apparatus of any kind, whether or not insured.

(h) Leakage and fire extinguishing equipment. Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps and other fire-extinguishing equipment or apparatus, water pipes or containers, or by water entering through leaks or openings in buildings, and insurance against loss or damage to such sprinklers, hoses, pumps and other fire-extinguishing equipment or apparatus.

(i) Credit and mortgage guaranty. Insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured, and insurance of real property mortgage lenders against loss by reason of nonpayment of the mortgage indebtedness.

(j) Elevator. Insurance against loss of or damage to any property of the insured, resulting from the ownership, maintenance or use of elevators, except loss or damage by fire, and to make inspection of and issue certificates of inspection upon, elevators.

(k) Congenital defects. Insurance against congenital defects in human beings.

(l) Livestock. Insurance against loss or damage to livestock, and services of a veterinary for such animals.

(m) Entertainments. Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event or exhibition against loss from interruption, postponement or cancellation thereof due to death, accidental injury or sickness of performers, participants, directors or other principals.

(n) Legal expenses. Insurance against any liability of a person or entity for the costs of any specific legal services or specific legal expenses and which pays or reimburses the person or entity for the costs of such services or expenses. Legal expenses insurance does not include an arrangement through which:

(1) A member of an organization prepays for specific legal services;

(2) The organization of which the person is a member contracts directly with attorneys for the provision of the specific legal services and makes the specific legal services available to the members of the organization or the dependents of the members; and

(3) The organization pays the attorneys with whom the organization has contracted fixed, prearranged payments and the attorneys receive no additional payment or reimbursement for the specific legal services.

(o) Miscellaneous. Insurance against any other kind of loss, damage or liability properly a subject of insurance and not within any other kind of insurance as defined in this chapter, if such

insurance is not disapproved by the Commissioner as being contrary to law or public policy . ~~[, including insurance for home protection issued pursuant to NRS 690B.100 to 690B.180, inclusive.]~~

2. Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under paragraphs (a) (vehicle), (b) (liability), (d) (burglary), (g) (boiler and machinery) and (j) (elevator) of subsection 1 shall for all purposes be deemed to be the same kind of insurance to which it is so incidental, and is not subject to provisions of this Code applicable to life and health insurances.

Sec. 24. NRS 681A.570 is hereby amended to read as follows:

681A.570 1. If the Commissioner believes that the reinsurance intermediary or any other person has not materially complied with NRS 681A.250 to 681A.560, inclusive, or any regulation adopted or order issued pursuant thereto, the Commissioner may, after ***the opportunity for*** a hearing conducted in accordance with NRS 679B.310 to 679B.370, inclusive, order:

(a) For each separate violation, the payment of a penalty in an amount not exceeding $5,000; and

(b) The revocation or suspension of the license of the reinsurance intermediary.

2. If the Commissioner finds that the material noncompliance of the reinsurance intermediary has caused the insurer or reinsurer any loss or damage, the Commissioner may initiate a civil action against the intermediary on behalf of the insurer or reinsurer and the policyholders and creditors of the insurer or reinsurer to recover compensatory damages or other appropriate relief for the benefit of the insurer or reinsurer and the policyholders and creditors.

3. If an order of rehabilitation or liquidation of the insurer has been entered and the receiver appointed by that order determines that:

(a) The reinsurance intermediary or any other person has not materially complied with NRS 681A.250 to 681A.560, inclusive, or any regulation adopted or order issued pursuant thereto; and

(b) The insurer has suffered any loss or damage as a result of that noncompliance,

↪ the receiver may bring a civil action for the recovery of damages or for any other appropriate sanctions on behalf of the insurer.

Sec. 25. Chapter 683A of NRS is hereby amended by adding thereto the provisions set forth as sections 26, 27 and 28 of this act.

Sec. 26. ***An administrator shall report to the Commissioner:***

1. Any administrative action taken against the administrator in another jurisdiction or by another governmental agency in this State, within 30 days after the final disposition of the matter. The

report must include a copy of the complaint filed, the order issued and any other relevant legal documents.

2. Any criminal prosecution against the administrator in any jurisdiction, within 30 days after the initial pretrial hearing. The report must include a copy of the charging document, the order as a result of the pretrial hearing and other relevant legal documents.

3. Any responsible person, as defined in NRS 683A.0892, who has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony within 30 days after the conviction or entry of the plea of guilty, guilty but mentally ill or nolo contendere. The report must include a copy of the charging document, a record of the conviction or plea and any other relevant legal documents.

Sec. 27. ***Any record or file submitted to the Commissioner by an administrator pursuant to NRS 683A.08522, 683A.08524, 683A.08528 and 683A.08529 is confidential and may be revealed in whole or in part only in the course of the necessary administration of this title or upon the lawful order of a court of competent jurisdiction.***

Sec. 28. ***1. An insurer may authorize a person to sell, solicit and negotiate any policy of group insurance offered by the insurer without the person having first obtained a license as a producer of insurance.***

2. An insurer shall not authorize a person who is not licensed as a producer of insurance to sell, solicit and negotiate pursuant to subsection 1 more than one policy of group insurance offered by the insurer. The restriction set forth in this subsection does not apply to a policy of group insurance to be issued to an employer that covers any group of employees or their dependents.

Sec. 29. NRS 683A.025 is hereby amended to read as follows:

683A.025 1. Except as limited by this section, "administrator" means a person who:

(a) Directly or indirectly underwrites or collects charges or premiums from or adjusts or settles claims of residents of this State or any other state from within this State in connection with workers' compensation insurance, life or health insurance coverage ***, including, without limitation, stop-loss coverage for losses relating to health insurance coverage,*** or annuities, including coverage or annuities provided by an employer for his or her employees;

(b) Administers an internal service fund pursuant to NRS 287.010;

(c) Administers a trust established pursuant to NRS 287.015, under a contract with the trust;

(d) Administers a program of self-insurance for an employer;

(e) Administers a program which is funded by an employer and which provides pensions, annuities, health benefits, death benefits or other similar benefits for his or her employees;

(f) Administers a program of pharmacy benefits for an employer, insurer, internal service fund or trust; or

(g) Is an insurance company that is licensed to do business in this State or is acting as an insurer with respect to a policy lawfully issued and delivered in a state where the insurer is authorized to do business, if the insurance company performs any act described in paragraphs (a) to (f), inclusive, for or on behalf of another insurer unless the insurers are affiliated and each insurer is licensed to do business in this State.

2. "Administrator" does not include:

(a) An employee authorized to act on behalf of an administrator who holds a certificate of registration from the Commissioner.

(b) An employer acting on behalf of his or her employees or the employees of a subsidiary or affiliated concern.

(c) A labor union acting on behalf of its members.

(d) Except as otherwise provided in paragraph (g) of subsection 1, an insurance company licensed to do business in this State or acting as an insurer with respect to a policy lawfully issued and delivered in a state in which the insurer was authorized to do business.

(e) A producer of life or health insurance licensed in this State, when his or her activities are limited to the sale of insurance.

(f) A creditor acting on behalf of his or her debtors with respect to insurance covering a debt between the creditor and debtor.

(g) A trust and its trustees, agents and employees acting for it, if the trust was established under the provisions of 29 U.S.C. § 186.

(h) Except as otherwise provided in paragraph (c) of subsection 1, a trust and its trustees, agents and employees acting for it, if the trust was established pursuant to NRS 287.015.

(i) A trust which is exempt from taxation under section 501(a) of the Internal Revenue Code, 26 U.S.C. § 501(a), its trustees and employees, and a custodian, his or her agents and employees acting under a custodial account which meets the requirements of section 401(f) of the Internal Revenue Code, 26 U.S.C. § 401(f).

(j) A bank, credit union or other financial institution which is subject to supervision by federal or state banking authorities.

(k) A company which issues credit cards, and which advances for and collects premiums or charges from credit card holders who have authorized it to do so, if the company does not adjust or settle claims.

(l) An attorney at law who adjusts or settles claims in the normal course of his or her practice or employment, but who does not

collect charges or premiums in connection with life or health insurance coverage or with annuities.

3. As used in this section, "affiliated" means any insurer or other person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another insurer or other person.

Sec. 30. NRS 683A.0805 is hereby amended to read as follows:

683A.0805 As used in NRS 683A.0805 to 683A.0893, inclusive, ***and sections 26 and 27 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 683A.081 to 683A.084, inclusive, have the meanings ascribed to them in those sections.

Sec. 31. NRS 683A.085 is hereby amended to read as follows:

683A.085 ~~[Except as otherwise provided in NRS 683A.086, no]~~ ***No*** person may act as, offer to act as or hold himself or herself out to the public as an administrator, unless:

1. The person has obtained a certificate of registration as an administrator from the Commissioner pursuant to NRS 683A.08524;

2. If the person is an individual and adjusts workers' compensation claims in this State, the person is licensed pursuant to chapter 684A of NRS; and

3. If any employee of the person adjusts workers' compensation claims in this State, each such employee who adjusts workers' compensation claims in this State is licensed pursuant to chapter 684A of NRS.

Sec. 32. NRS 683A.08522 is hereby amended to read as follows:

683A.08522 Each application for a certificate of registration as an administrator must include or be accompanied by:

1. A financial statement of the applicant that has been reviewed by an independent certified public accountant and which includes:

(a) A statement regarding the amount of money that the applicant expects to collect from or disburse to residents of this State during the next calendar year.

(b) Financial information for the 90 days immediately preceding the date the application was filed with the Commissioner.

(c) An income statement and balance sheet for the 2 years immediately preceding the application that are:

(1) Prepared in accordance with ~~[generally]~~ ***:***

(I) Generally accepted accounting principles; ***or***

(II) Statutory accounting principles, as described in the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners effective on

January 1, 2001, and as amended by the National Association of Insurance Commissioners after that date; and

(2) Reviewed by an independent certified public accountant.

(d) A certification of the financial statement by an officer of the applicant.

2. The documents used to create the business association of the administrator, including articles of incorporation, articles of association, a partnership agreement, a trust agreement and a shareholders' agreement.

3. The documents used to regulate the internal affairs of the administrator, including the bylaws, rules or regulations of the administrator.

4. A certificate of registration issued pursuant to NRS 600.350 for a trade name or trademark used by the administrator, if applicable.

5. An organizational chart that identifies each person who directly or indirectly controls the administrator and each affiliate of the administrator.

6. A notarized affidavit from each person who manages or controls the administrator, including each member of the board of directors or board of trustees, each officer, partner and member of the business association of the administrator, and each shareholder of the administrator who holds not less than 10 percent of the voting stock of the administrator. The affidavit must include:

(a) The personal history, business record and insurance experience of the affiant;

(b) Whether the affiant has been investigated by any regulatory authority or has had any license or certificate denied, suspended or revoked in any state; and

(c) Any other information that the Commissioner may require.

7. The complete name and address of each office of the administrator, including offices located outside this State.

8. A statement that sets forth whether the administrator has:

(a) Held a license or certificate to transact any kind of insurance in this State or any other state and whether that license or certificate has been refused, suspended or revoked;

(b) Been indebted to any person and, if so, the circumstances of that debt; and

(c) Had an administrative agreement cancelled and, if so, the circumstances of that cancellation.

9. A statement that describes the business plan of the administrator. The statement must include information:

(a) Concerning the number of persons on the staff of the administrator and the activities proposed in this State or in any other state ~~[.]~~ ***, including, without limitation, a description of the lines,***

classes or types of insurance that the administrator proposes to administer on behalf of an insurer in this State.

(b) That demonstrates the capability of the administrator to provide a sufficient number of experienced and qualified persons for the processing of claims, the keeping of records and, if applicable, underwriting.

10. If the applicant intends to solicit new or renewal business, proof that the applicant employs or has contracted with a producer of insurance licensed in this State to solicit and take applications. An applicant who intends to solicit insurance contracts directly or to act as a producer must provide proof that the applicant is licensed as a producer in this State.

11. If the applicant is not an insurer and is not ~~[domiciled in]~~ ***a resident of*** this State, a copy of the license, certificate or other authorization issued by the state in which the applicant is ~~[domiciled]~~ ***a resident*** which authorizes the applicant to act as an administrator in that state, if any.

12. Any other information required by the Commissioner.

Sec. 33. NRS 683A.08529 is hereby amended to read as follows:

683A.08529 1. An administrator shall notify the Commissioner of any change in:

(a) The members, owners, directors or officers of the administrator within 30 days after the change.

(b) The physical location, mailing address or electronic mail address of an office of the administrator within 30 days after the change.

(c) The legal or fictitious name of the administrator within 30 days after the change.

2. If there is a change in the members, owners, directors or officers of an administrator, the administrator shall submit to the Commissioner a notarized affidavit, as described in subsection 6 of NRS 683A.08522, for each new member, owner, director or officer within 30 days after the change.

3. If an administrator wishes to change the lines, classes or types of insurance that the administrator administers on behalf on an insurer in this State from those described in the statement of the business plan submitted pursuant to subsection 9 of NRS 683A.08522 or an updated statement submitted pursuant to this subsection, as applicable, the administrator must, before the change is implemented, submit to the Commissioner an updated statement of the business plan that includes a description of the change and the Commissioner must approve the statement.

Sec. 34. NRS 683A.0857 is hereby amended to read as follows:

683A.0857 1. Each administrator shall file with the Commissioner a bond which complies with NRS 679B.175, continuous in form and in an amount determined by the Commissioner of not less than $100,000.

2. The Commissioner shall establish schedules for the amount of the bond required, based on the amount of money received and distributed by an administrator.

3. The bond must inure to the benefit of any person damaged by any fraudulent act or conduct of the administrator ***.*** ~~[and must be conditioned upon faithful accounting and application of all money coming into the administrator's possession in connection with his or her activities as an administrator.]~~

4. A replacement bond must meet all requirements for the initial bond.

Sec. 35. NRS 683A.086 is hereby amended to read as follows:

683A.086 1. No person may act as an administrator unless the person has entered into a written agreement with an insurer, and the written agreement contains provisions to effectuate the requirements contained in NRS 683A.08522 to 683A.08528, inclusive, 683A.087 to 683A.0883, inclusive, and 683A.0892 which apply to the duties of the administrator.

2. The written agreement must set forth:

(a) The duties the administrator will be required to perform on behalf of the insurer; and

(b) The lines, classes or types of insurance that the administrator is authorized to administer on behalf of the insurer.

3. A copy of an agreement entered into under the provisions of this section must be retained in the records of the administrator and of the insurer for a period of 5 years after the termination of the agreement.

4. When a policy is issued to a trustee or trustees, a copy of the trust agreement and amendments must be obtained by the administrator and a copy forwarded to the insurer. Each agreement must be retained by the administrator and the insurer for a period of 5 years after the termination of the policy.

5. ~~[Except as otherwise provided in NRS 616B.500 and 616B.503,]~~ ***The rights and obligations of*** an administrator ~~[who has obtained a certificate of registration as]~~ ***, as set forth in a written agreement entered into pursuant to this section, and any liability under the agreement, may not be delegated, assigned or assumed by a third party by contract or any other means. An insurer shall not allow any duty of*** an administrator ~~[from the Commissioner pursuant to NRS 683A.08524 may delegate any of the duties of the~~

~~administrator to an administrator who has not obtained such a certificate of registration only if the delegating~~] ***set forth in such an agreement to be performed by any person other than the*** administrator ***.*** [~~has first obtained the written approval of the Commissioner.~~]

6. The Commissioner may adopt regulations which specify the functions an administrator may perform on behalf of an insurer.

7. The insurer or administrator may, upon written notice to the other party to the agreement and to the Commissioner, terminate the written agreement for any cause specified in the agreement. The insurer may suspend the authority of the administrator while any dispute regarding the cause for termination is pending. The insurer shall perform any obligations with respect to the policies affected by the agreement regardless of any dispute with the administrator.

Sec. 36. NRS 683A.0873 is hereby amended to read as follows:

683A.0873 1. Each administrator shall maintain [~~at his or her principal office~~] adequate books and records of all transactions between the administrator, the insurer and the insured. The books and records must be maintained in accordance with prudent standards of recordkeeping for insurance and with regulations of the Commissioner for a period of 5 years after the transaction to which they respectively relate. After the 5-year period, the administrator may [~~remove the books and records from the State,~~] store their contents [~~on microfilm~~] ***electronically*** or return them to the appropriate insurer.

2. The Commissioner may examine, audit and inspect books and records maintained by an administrator under the provisions of this section to carry out the provisions of NRS 679B.230 to 679B.300, inclusive.

3. The names and addresses of insured persons and any other material which is in the books and records of an administrator are confidential except as otherwise provided in NRS 239.0115 and except when used in proceedings against the administrator.

4. The insurer may inspect and examine all books and records to the extent necessary to fulfill all contractual obligations to insured persons, subject to restrictions in the written agreement between the insurer and administrator.

Sec. 37. NRS 683A.0892 is hereby amended to read as follows:

683A.0892 1. The Commissioner:

(a) Shall suspend or revoke the certificate of registration of an administrator if the Commissioner has determined, after notice and ***the opportunity for*** a hearing, that the administrator:

(1) Is in an unsound financial condition;

(2) Uses methods or practices in the conduct of business that are hazardous or injurious to insured persons or members of the general public; or

(3) Has failed to pay any judgment against the administrator in this State within 60 days after the judgment became final.

(b) May suspend or revoke the certificate of registration of an administrator if the Commissioner determines, after notice and ***the opportunity for*** a hearing, that the administrator:

(1) Has knowingly violated or failed to comply with any provision of this Code, any regulation adopted pursuant to this Code or any order of the Commissioner;

(2) Has refused to be examined by the Commissioner or has refused to produce accounts, records or files for examination upon the request of the Commissioner;

(3) Has, without just cause, refused to pay claims or perform services pursuant to the administrator's contracts or has, without just cause, caused persons to accept less than the amount of money owed to them pursuant to the contracts, or has caused persons to employ an attorney or bring a civil action against the administrator to receive full payment or settlement of claims;

(4) Is affiliated with, managed by or owned by another administrator or an insurer who transacts insurance in this State without a certificate of authority or certificate of registration;

(5) Fails to comply with any of the requirements for a certificate of registration;

(6) Has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony, whether or not adjudication was withheld;

(7) Has had his or her authority to act as an administrator in another state limited, suspended or revoked; or

(8) Has failed to file an annual report in accordance with NRS 683A.08528.

(c) May suspend or revoke the certificate of registration of an administrator if the Commissioner determines, after notice and ***the opportunity for*** a hearing, that a responsible person:

(1) Has refused to provide any information relating to the administrator's affairs or refused to perform any other legal obligation relating to an examination upon request by the Commissioner; or

(2) Has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony committed on or after October 1, 2003, whether or not adjudication was withheld.

(d) May, upon notice to the administrator, suspend the certificate of registration of the administrator pending ***the opportunity for*** a hearing if:

(1) The administrator is impaired or insolvent;

(2) A proceeding for receivership, conservatorship or rehabilitation has been commenced against the administrator in any state; or

(3) The financial condition or the business practices of the administrator represent an imminent threat to the public health, safety or welfare of the residents of this State.

(e) ***May revoke the certificate of registration of an administrator if the Commissioner has provided the administrator with notice that the certificate of registration of the administrator has been suspended pursuant to paragraph (d) and the administrator or a responsible person of the administrator has not responded to the notice within 10 days after the date on which the Commissioner transmitted the notice.***

(f) May, in addition to or in lieu of the suspension or revocation of the certificate of registration of the administrator, impose a fine of $2,000 for each act or violation.

2. As used in this section, "responsible person" means any person who is responsible for or controls or is authorized to control or advise the affairs of an administrator, including, without limitation:

(a) A member of the board of directors, board of trustees, executive committee or other governing board or committee of the administrator;

(b) The president, vice president, chief executive officer, chief operating officer or any other principal officer of an administrator, if the administrator is a corporation;

(c) A partner or member of the administrator, if the administrator is a partnership, association or limited-liability company; and

(d) Any shareholder or member of the administrator who directly or indirectly holds 10 percent or more of the voting stock, voting securities or voting interest of the administrator.

Sec. 38. NRS 683A.0893 is hereby amended to read as follows:

683A.0893 Any person who acts as an administrator without having applied for and received from the Commissioner a certificate of registration as an administrator shall be fined ~~[not less than $300 nor more than]~~ $2,000 ~~[.]~~ ***for each act or violation.***

Sec. 39. NRS 683A.179 is hereby amended to read as follows:

683A.179 1. A pharmacy benefit manager shall not:

(a) Prohibit a pharmacist or pharmacy from providing information to a covered person concerning:

(1) The amount of any copayment or coinsurance for a prescription drug; or

(2) The availability of a less expensive alternative or generic drug including, without limitation, information concerning clinical efficacy of such a drug;

(b) Penalize a pharmacist or pharmacy for providing the information described in paragraph (a) or selling a less expensive alternative or generic drug to a covered person;

(c) Prohibit a pharmacy from offering or providing delivery services directly to a covered person as an ancillary service of the pharmacy; or

(d) If the pharmacy benefit manager manages a pharmacy benefits plan that provides coverage through a network plan, charge a copayment or coinsurance for a prescription drug in an amount that is greater than the total amount paid to a pharmacy that is in the network of providers under contract with the third party.

2. The provisions of this section:

(a) Must not be construed to authorize a pharmacist to dispense a drug that has not been prescribed by a practitioner, as defined in NRS 639.0125, except to the extent authorized by a specific provision of law, including, without limitation, NRS 453C.120, 639.28078 and 639.28085.

(b) Do not apply to an institutional pharmacy, as defined in NRS 639.0085, or a pharmacist working in such a pharmacy as an employee or independent contractor.

3. As used in this section, "network plan" ~~[means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.]~~ ***has the meaning ascribed to it in NRS 687B.645.***

Sec. 40. NRS 683A.201 is hereby amended to read as follows:

683A.201 1. A person shall not sell, solicit or negotiate insurance in this State for any class of insurance unless the person is licensed for that class of insurance.

2. An insurer is exempt from the requirement for licensure as a producer of insurance, but this exemption does not extend to an insurer's officers, directors, employees, subsidiaries or affiliates who sell, solicit or negotiate insurance.

3. A person required to be licensed in this State who transacts insurance without a license is subject to an administrative fine of not more than ~~[$1,000]~~ ***$5,000*** for each violation.

Sec. 41. NRS 683A.211 is hereby amended to read as follows:

683A.211 The following persons need not be licensed as producers of insurance:

1. An officer, director or employee of an insurer or of a producer of insurance if the officer, director or employee does not

receive any commission on policies written or sold to insure risks residing, located or to be performed in this State and:

(a) The officer, director or employee's activities are executive, administrative, managerial or clerical, or a combination thereof, and are only indirectly related to the sale, solicitation or negotiation of insurance;

(b) The officer, director or employee's function relates to underwriting, control of losses, inspection or the processing, adjusting, investigating or settling of claims on contracts of insurance; or

(c) The officer, director or employee is acting in the capacity of a special agent or supervisor of an agency assisting producers of insurance where his or her activities are limited to providing technical advice and assistance to licensed producers and do not include sale, solicitation or negotiation of insurance.

2. A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and health insurance, or for the purpose of enrolling natural persons under plans, issuing certificates under plans or otherwise assisting in administering plans, or who performs administrative services related to mass marketed property and casualty insurance, if no commission is paid to the person for the service and the person does not sell, solicit or negotiate insurance. As used in this subsection, "blanket accident and health insurance" has the meaning ascribed to it in NRS 689B.070.

3. An employer or association or its officers, directors or employees, or the trustees of an employees' trust plan, to the extent that the employer, association, officers, directors, employees or trustees are engaged in the administration or operation of a program of employees' benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, if the program involves the use of insurance issued by an insurer and the employer, association, officers, directors, employees or trustees are not compensated by the insurer issuing the contracts.

4. Employees of insurers or organizations employed by insurers who are engaged in the inspection, rating or classification of risks or in the supervision of the training of producers of insurance and are not individually engaged in the sale, solicitation or negotiation of insurance.

5. A person whose activities in this State are limited to advertising, without the intent to solicit insurance in this State, through communications in printed publications or electronic mass media whose distribution is not limited to residents of this State, if

the person does not sell, solicit or negotiate insurance of risks residing, located or to be performed in this State.

6. A salaried full-time employee who counsels or advises his or her employer concerning the interests of the employer, or of the subsidiaries or affiliates of the employer, in insurance, if the employee does not sell or solicit insurance or receive a commission.

7. An employee of a producer of insurance or an insurer who responds to requests from holders of policies previously issued, if the employee is not directly compensated according to the volume of premiums that may result from those services and does not solicit insurance or offer advice concerning terms or conditions of policies.

8. A person authorized by an insurer pursuant to section 28 of this act whose activities are confined to those authorized by that section.

Sec. 42. NRS 683A.379 is hereby amended to read as follows:

683A.379 A person who violates any provision of NRS 683A.375 to 683A.378, inclusive, shall be punished by a fine of ***not less than $500 and not*** more than ~~[$1,000.]~~ ***$5,000.***

Sec. 43. NRS 683A.461 is hereby amended to read as follows:

683A.461 1. If the Commissioner denies an application for, or refuses to renew, a license, the Commissioner shall notify the applicant or licensee and state in writing the reason for the denial or refusal. The applicant or licensee may apply in writing, pursuant to NRS 679B.310, for a hearing before the Commissioner to determine the reasonableness of the denial or refusal. ~~[The hearing must be held within 30 days and conducted pursuant to NRS 679B.330. The applicant or licensee may waive the requirement to hold the hearing within 30 days, in writing, before a hearing is held.]~~

2. The Commissioner may suspend, revoke or refuse to renew the license of a business organization if the Commissioner finds, after ***the opportunity for a*** hearing, that a violation by a natural person was known or should have been known by one or more of the partners, officers or managers acting on behalf of the organization, the violation was not reported to the Commissioner and no corrective action was taken.

3. In addition to or in lieu of a denial, suspension or revocation of, or refusal to renew, a license, an administrative fine of not less than ~~[$25]~~ ***$500*** nor more than ~~[$500]~~ ***$5,000*** may be imposed for each violation or act. An order imposing a fine must specify the date, not less than 15 days nor more than 30 days after the date of the order, before which the fine must be paid. If the fine is not paid when due, the Commissioner shall immediately revoke the license of a licensee and the fine must be recovered in a civil action brought on behalf of the Commissioner by the Attorney General. The

Commissioner shall immediately deposit all such fines collected with the State Treasurer for credit to the State General Fund.

4. The Commissioner retains the authority to enforce the provisions of, and impose any penalty or pursue any remedy authorized by, this title against any person who is under investigation for or charged with a violation of a provision of this title even if the license or registration of the person has been surrendered or has lapsed by operation of law.

5. A licensee must pay all applicable fees, including renewal fees, and maintain any required education during a period of suspension of his or her license.

Sec. 44. NRS 683C.020 is hereby amended to read as follows:

683C.020 1. Except as otherwise provided in subsection 2, no person may engage in the business of an insurance consultant unless a license has been issued to the person by the Commissioner.

2. An insurance consultant's license is not required for:

(a) An attorney licensed to practice law in this State who is acting in his or her professional capacity;

(b) A licensed producer of insurance, broker or surplus lines broker;

(c) A trust officer of a bank who is acting in the normal course of his or her employment; or

(d) An actuary or a certified public accountant who provides information, recommendations, advice or services in his or her professional capacity.

3. A person required to be licensed in this State who acts as an insurance consultant without a license is subject to an administrative fine of not more than ~~[$1,000]~~ ***$5,000*** for each act or violation.

Sec. 45. NRS 683C.120 is hereby amended to read as follows:

683C.120 1. The Commissioner may place an insurance consultant on probation, suspend his or her license for not more than ~~[12]~~ ***36*** months, or revoke or refuse to renew his or her license, or may impose an administrative fine or take any combination of the foregoing actions, for one or more of the causes set forth in NRS 683A.451.

2. The provisions of NRS 683A.461 also apply to an insurance consultant.

Sec. 46. NRS 684A.027 is hereby amended to read as follows:

684A.027 "Home state" means:

1. The District of Columbia or any state or territory of the United States in which an independent ~~[, company, staff]~~ or public adjuster maintains his, her or its principal place of residence or principal place of business and is licensed to act as a resident ~~[independent, company, staff]~~ or public adjuster; or

2. If neither the state in which the adjuster maintains his or her principal place of residence nor the state in which the adjuster maintains his, her or its principal place of business licenses independent ~~[, company, staff]~~ or public adjusters for the line of authority sought by the adjuster, a state:

(a) Which has an examination requirement;

(b) In which the adjuster is licensed; and

(c) Which the adjuster declares to be the home state.

Sec. 47. NRS 684A.030 is hereby amended to read as follows:

684A.030 1. "Independent adjuster" means ~~[an]~~ ***:***

(a) An adjuster who is representing the interests of an insurer or a self-insurer and who:

~~[(a)]~~ ***(1)*** Contracts for compensation with the insurer or self-insurer as an independent contractor or an employee of an independent contractor;

~~[(b)]~~ ***(2)*** Is treated for tax purposes by the insurer or self-insurer in a manner consistent with an independent contractor rather than an employee; and

~~[(c)]~~ ***(3)*** Investigates, negotiates or settles property, casualty or surety claims, including, without limitation, workers' compensation claims, for the insurer or self-insurer.

(b) A salaried employee of an insurer who:

(1) Investigates, negotiates or settles property, casualty or surety claims, including, without limitation, workers' compensation claims; and

(2) Obtains a license pursuant to this chapter.

(c) A person who investigates, negotiates or settles workers' compensation claims under the authority of a third-party administrator who holds a certificate of registration issued by the Commissioner pursuant to NRS 683A.08524.

2. "Public adjuster" means an adjuster employed by and representing solely the financial interests of the insured named in the policy. The term does not include an adjuster who investigates, negotiates or settles workers' compensation claims.

~~[3. "Company adjuster" means a salaried employee of an insurer who:~~

~~(a) Investigates, negotiates or settles property, casualty or surety claims, including, without limitation, workers' compensation claims; and~~

~~(b) Obtains a license pursuant to this chapter.~~

~~4. "Staff adjuster" means a person who investigates, negotiates or settles workers' compensation claims under the authority of a third-party administrator who holds a certificate of registration issued by the Commissioner pursuant to NRS 683A.08524.~~**]**

Sec. 48. NRS 684A.040 is hereby amended to read as follows:

684A.040 1. Except as otherwise provided in NRS 684A.060, no person may act as, or hold himself or herself out to be, an adjuster in this State unless then licensed as such under the applicable adjuster's license issued under the provisions of this chapter.

2. Any person violating the provisions of this section is guilty of a gross misdemeanor.

3. Except as otherwise provided in NRS 684A.060, a person who acts as an adjuster in this State without a license is subject to an administrative fine of not more than ~~[$1,000]~~ ***$5,000*** for each violation.

4. A salaried employee of an insurer who investigates, negotiates or settles workers' compensation claims may, but is not required to, obtain a license as ~~[a company]~~ ***an independent*** adjuster pursuant to this chapter. The provisions of subsections 1, 2 and 3 do not apply to a salaried employee of an insurer. ***A salaried employee of an insurer is subject to the requirements of NRS 616B.0275.***

Sec. 49. NRS 684A.050 is hereby amended to read as follows:

684A.050 ~~[1.]~~ The Commissioner may license an individual as an independent adjuster ~~[,]~~ ***or*** a public ~~[adjuster, a company adjuster or a staff]~~ adjuster. No individual ~~[shall]~~ ***may*** be licensed concurrently under the same license or separate licenses as more than one such type of adjuster.

~~[2. A company adjuster and a staff adjuster shall pay the same fees as provided for an independent adjuster in NRS 680B.010 and 680C.110.]~~

Sec. 50. NRS 684A.090 is hereby amended to read as follows:

684A.090 1. The applicant for a license as an adjuster shall file a written application therefor with the Commissioner on forms prescribed and furnished by the Commissioner. As part of, or in connection with, the application the applicant shall furnish information as to his or her identity, personal history, experience, financial responsibility, business record and other pertinent matters as reasonably required by the Commissioner to determine the applicant's eligibility and qualifications for the license.

2. If the applicant is a natural person, the application must include the social security number of the applicant and include a completed copy of the Uniform Individual Application.

3. If the applicant is a business entity, the application must identify the natural person designated pursuant to paragraph (b) of subsection 1 of NRS 684A.080 and must include:

(a) A completed copy of the Uniform Business Entity Application;

(b) The name of each member, officer and director of the business entity, as applicable;

(c) The name of each executive officer and director who owns more than 10 percent of the outstanding voting securities of the applicant; and

(d) The name of any other individual who owns more than 10 percent of the outstanding voting securities of the applicant.

➥ Each such member, officer, director and individual shall furnish information to the Commissioner as though applying for an individual license.

4. If the applicant is a nonresident of this State, the application must be accompanied by an appointment of the Commissioner as process agent and agreement to appear pursuant to NRS 684A.200.

5. The application must be accompanied by the applicable license fee as specified in NRS 680B.010 ~~[and subsection 2 of NRS 684A.050]~~ and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110 **.** ~~[and subsection 2 of NRS 684A.050.]~~

6. No applicant for such a license may willfully misrepresent or withhold any fact or information called for in the application form or in connection therewith. A violation of this subsection is a gross misdemeanor.

7. If the Commissioner determines that the information contained in a Uniform Individual Application or Uniform Business Entity Application submitted with an application pursuant to this section is not true, correct and complete to the best of the applicant's knowledge and belief, the Commissioner may refuse to issue a license to the applicant or suspend or revoke the applicant's license.

Sec. 51. NRS 684A.100 is hereby amended to read as follows:

684A.100 Each person who intends to apply for a license as an adjuster must, before applying for the license, personally take and pass to the Commissioner's satisfaction a written examination testing the applicant's qualifications and competence to act as an adjuster and his or her knowledge of pertinent provisions of this Code unless:

1. The person:

(a) Is not a resident of this State;

(b) Has passed an examination to become licensed as an adjuster in the person's home state; ~~[and]~~

(c) Is currently licensed and in good standing in the person's home state as an adjuster; ***and***

(d) Is not a person required to take the examination pursuant to paragraph (d) of subsection 1 of NRS 684A.115; or

2. The person was licensed in this State as the same type of adjuster within the 24-month period immediately preceding the date

of the application, unless the previous license was revoked or suspended or its continuation was refused by the Commissioner.

Sec. 52. NRS 684A.105 is hereby amended to read as follows:

684A.105 1. An adjuster whose license expires is exempt from retaking the examination required by NRS 684A.100 if:

(a) The adjuster:

(1) Is not a resident of this State;

(2) Has passed an examination to become licensed as an adjuster in the person's home state; ~~[and]~~

(3) Is currently licensed and in good standing in the person's home state as an adjuster; ***and***

(4) Is not a person required to take the examination pursuant to paragraph (d) of subsection 1 of NRS 684A.115; or

(b) The adjuster was licensed in this State as the same type of adjuster within the 24-month period immediately preceding the date of the application, unless the previous license was revoked or suspended or its continuation was refused by the Commissioner.

2. A person who applies for a license as an adjuster pursuant to NRS 684A.090 is exempt from taking the examination required by NRS 684A.100 if the person:

(a) Is licensed as an adjuster in another state;

(b) ***Is not a person required to take the examination pursuant to paragraph (d) of subsection 1 of NRS 684A.115;***

(c) Establishes legal residency in this State; and

~~[(c)]~~ ***(d)*** Submits an application for a license pursuant to NRS 684A.090 within 90 days after establishing legal residency in this State.

Sec. 53. NRS 684A.115 is hereby amended to read as follows:

684A.115 1. The Commissioner shall issue a nonresident license as an adjuster to a nonresident person if:

(a) The person is currently licensed in good standing as an adjuster in the resident or home state of the person;

(b) The person has submitted the proper request for licensure and has paid the fees required pursuant to NRS 680B.010 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110;

(c) The person has submitted or transmitted to the Commissioner the appropriate completed application for licensure; and

(d) ~~[The]~~ ***Except as otherwise provided in this paragraph, the*** home state of the person awards nonresident licenses as an adjuster to persons of this State on the same basis. ***If the home state of the person requires a nonresident applicant for a license as an adjuster to take and pass an examination in that state which tests the applicant's qualifications and competence to act as an***

adjuster, the person must also take and pass the examination required by NRS 684A.100.

2. The Commissioner may verify the licensing status of the nonresident person through any appropriate database, including, without limitation, the Producer Database maintained by the National Insurance Producer Registry, its affiliates or subsidiaries, or may request that the nonresident person submit proof that the nonresident person is licensed and in good standing in the person's home state as an adjuster.

3. As a condition to the continuation of a nonresident license as an adjuster, the nonresident adjuster shall maintain a resident license as an adjuster in the home state of the adjuster. A nonresident license as an adjuster issued under this section shall be terminated and must be surrendered immediately to the Commissioner if the resident license as an adjuster in the home state is terminated for any reason, unless:

(a) The termination is due to the nonresident adjuster being issued a new resident license as an adjuster in a new home state; and

(b) The new resident license as an adjuster is from a state that has reciprocity with this State.

4. The Commissioner shall give notice of the termination of a resident license as an adjuster within 30 days after the date of the termination to any states that issued a nonresident license as an adjuster to the holder of the resident license. If the resident license as an adjuster was terminated due to a change in the home state of the adjuster, the notice must include both the previous and current address of the adjuster.

5. The Commissioner shall terminate a nonresident license as an adjuster issued pursuant to this section if the adjuster establishes legal residency in this State and fails to apply for a resident license as an adjuster within 90 days after establishing legal residency.

Sec. 54. NRS 684A.120 is hereby amended to read as follows:

684A.120 1. The Commissioner shall prescribe the form of the adjuster license, which shall state:

(a) The licensee's name, business address and a personal identification number;

(b) The classification of the license, whether as an independent adjuster ~~[,]~~ ***or*** a public ~~[adjuster, a company adjuster or a staff]~~ adjuster;

(c) The date of issuance and general conditions as to expiration and termination; and

(d) Such other conditions as the Commissioner deems proper.

2. The Commissioner may not issue a license in a trade name unless the name has been registered as provided by law.

3. In order to assist in the performance of the Commissioner's duties, the Commissioner may contract with any nongovernmental entity, including, without limitation, the National Association of Insurance Commissioners or its affiliates or subsidiaries, to perform any ministerial function, including, without limitation, the collection of fees and data, relating to licensing, that the Commissioner deems appropriate.

Sec. 55. NRS 684A.130 is hereby amended to read as follows:

684A.130 1. Each license issued or renewed under this chapter continues in force for 3 years unless it is suspended, revoked or otherwise terminated. A license may be renewed upon payment of all applicable fees for renewal to the Commissioner, completion of any other requirement for renewal of the license specified in this chapter and submission of the statement required pursuant to NRS 684A.143 if the licensee is a natural person. The statement, if required, must be submitted, all requirements must be completed and all applicable fees must be paid on or before the renewal date for the license.

2. Any license not so renewed expires on the renewal date. The Commissioner may accept a request for renewal received by the Commissioner within 30 days after the expiration of the license if the request is accompanied by:

(a) A fee for renewal of 150 percent of all applicable fees otherwise required, except for any fee required pursuant to NRS 680C.110 **;** ~~[and subsection 2 of NRS 684A.050;]~~

(b) If the person requesting renewal is a natural person, the statement required pursuant to NRS 684A.143;

(c) Proof of successful completion of any requirement for an examination unless exempt pursuant to NRS 684A.105; and

(d) If applicable, a request for a waiver of the time limit for renewal and of any fine or sanction otherwise required or imposed because of the failure of the licensee to renew his or her license because of military service, extended medical disability or other extenuating circumstance.

3. An adjuster who is unable to comply with the procedures and requirements to renew a license due to military service, long-term medical disability or some other extenuating circumstance may request waiver of same and a waiver of any requirement relating to an examination, fine or other sanction imposed for failure to comply with such procedures or requirements.

4. An adjuster shall inform the Commissioner by any means acceptable to the Commissioner of any change in the residence address or business address for the home state or in the legal name of the adjuster within 30 days of the change.

5. In order to assist in the performance of the duties of the Commissioner, the Commissioner may contract with nongovernmental entities, including, without limitation, the National Association of Insurance Commissioners or its affiliates or subsidiaries, to perform any ministerial function, including, without limitation, the collection of fees and data, related to licensing that the Commissioner may deem appropriate.

6. This section does not apply to temporary licenses issued under NRS 684A.150.

7. As used in this section, "renewal date" means:

(a) For the first renewal of the license, the last day of the month which is 3 years after the month in which the Commissioner originally issued the license.

(b) For each renewal after the first renewal of the license, the last day of the month which is 3 years after the month in which the license was last due to be renewed.

Sec. 56. NRS 684A.150 is hereby amended to read as follows:

684A.150 1. In the event of death or inability to act as a licensed independent adjuster ~~[,]~~ ***of the type described in paragraph (a) of subsection 1 of NRS 684A.030,*** the Commissioner may issue a temporary license as an independent adjuster ***of the type described in paragraph (a) of subsection 1 of NRS 684A.030*** to another individual qualified therefor except as to the taking and passing of the required examination, to enable such individual to continue the business of the deceased licensee or the licensee who has a disability.

2. The temporary license shall be valid for 6 months, or until the temporary licensee earlier qualifies for a regular license as an independent adjuster ~~[.]~~ ***of the type described in paragraph (a) of subsection 1 of NRS 684A.030.***

3. A temporary license issued pursuant to this section may be renewed for one additional period of 180 days if:

(a) The temporary licensee, on or before a date specified by the Commissioner as the last day on which the temporary license is renewable, submits to the Commissioner a written request which includes, without limitation, sufficient justification for the renewal; and

(b) The Commissioner approves the request.

Sec. 57. NRS 684A.180 is hereby amended to read as follows:

684A.180 1. Each adjuster shall keep at his or her business address shown on the adjuster's license a record of all transactions under the license.

2. The record shall include:

(a) A copy of each contract between an independent adjuster ***of the type described in paragraph (a) of subsection 1 of NRS 684A.030*** and an insurer or self-insurer.

(b) A copy of all investigations or adjustments undertaken.

(c) A statement of any fee, commission or other compensation received or to be received by the adjuster on account of such investigation or adjustment.

3. The adjuster shall make such records available for examination by the Commissioner at all times, and shall retain the records for at least 3 years after the closure of the claim to which the records apply.

4. An independent adjuster ***of the type described in paragraph (a) of subsection 1 of NRS 684A.030*** shall comply with any record retention policy agreed to in a contract between the independent adjuster and an insurer or self-insurer to the extent that such a policy imposes a requirement to retain records for a longer period than the period required by this section.

Sec. 58. NRS 684A.230 is hereby amended to read as follows:

684A.230 Every order suspending any license shall specify the period during which the suspension shall be effective, which period shall in no event exceed ~~[12]~~ ***36*** months.

Sec. 59. NRS 684A.240 is hereby amended to read as follows:

684A.240 1. In addition to or in lieu of the suspension, revocation or refusal to renew any adjuster's license for any of the causes referred to in NRS 684A.210, after ***the opportunity for a*** hearing thereon or upon waiver of hearing by the licensee, the Commissioner may levy upon the licensee an administrative fine in any amount not less than ~~[$25]~~ ***$500*** nor more than ~~[$500.]~~ ***$5,000.***

2. In his or her order levying the fine the Commissioner shall specify a period of not less than 15 days nor more than 30 days after the date of the order within which the fine must be paid in full.

3. If the fine is not paid when due, the Commissioner shall revoke the license involved, if not already revoked, and the fine must be recovered in a civil action brought by the Attorney General in the Commissioner's behalf.

4. All fines recovered pursuant to this section must be deposited with the State Treasurer for credit to the State General Fund.

Sec. 60. NRS 684B.140 is hereby amended to read as follows:

684B.140 1. In addition to or in lieu of the suspension, revocation or refusal to renew any motor vehicle physical damage appraiser's license for any of the causes referred to in NRS 684B.110, after ***the opportunity for a*** hearing thereon or upon waiver of hearing by the licensee, the Commissioner may levy upon

the licensee an administrative fine in any amount not less than ~~[$25]~~ ***$500*** nor more than ~~[$250.]~~ ***$5,000.***

2. In his or her order levying the fine the Commissioner shall specify a period of not less than 15 days nor more than 30 days from the date of the order within which the fine shall be paid in full.

3. If the fine is not paid when due, the Commissioner shall revoke the license involved, if not already revoked, and the fine shall be recovered in a civil action brought by the Attorney General in the Commissioner's behalf.

4. The Commissioner shall deposit any fine collected by the Commissioner hereunder with the State Treasurer for credit to the State General Fund.

Sec. 61. NRS 685A.120 is hereby amended to read as follows:

685A.120 1. No person may act as, hold himself or herself out as or be a surplus lines broker with respect to subjects of insurance for which this State is the insured's home state unless the person is licensed as such by the Commissioner pursuant to this chapter.

2. Any person ~~[who has been licensed by this State as a producer of insurance for general lines for at least 6 months, or has been licensed in another state as a surplus lines broker and continues to be licensed in that state, and who is deemed by the Commissioner to be competent and trustworthy with respect to the handling of surplus lines]~~ may be licensed as a surplus lines broker ~~[upon:]~~ ***if the person:***

(a) ~~[Application]~~ ***Satisfies one of the following:***

(1) The person is a resident of this State and holds a current license as a producer of insurance for the lines of authority specified in paragraphs (c) and (d) of subsection 1 of NRS 683A.261;

(2) The person is not a resident of this State and holds a current license as a surplus lines broker issued by the state in which the person resides; or

(3) The person is not a resident of this State and is otherwise authorized to act as a surplus lines broker in the state in which the person resides;

(b) Is deemed by the Commissioner to be competent and trustworthy with respect to the handling of surplus lines;

(c) Submits an application for a license and ~~[payment of]~~ ***pays*** all applicable fees for a license;

~~[(b) Submitting]~~

(d) Submits the statement required pursuant to NRS 685A.127; and

~~[(c) Passing]~~

(e) Passes any examination prescribed by the Commissioner on the subject of surplus lines.

3. An application for a license must be submitted to the Commissioner on a form designated and furnished by the Commissioner. The application must include the social security number of the applicant.

4. A license issued or renewed pursuant to this chapter continues in force for 3 years unless it is suspended, revoked or otherwise terminated. The license may be renewed upon submission of the statement required pursuant to NRS 685A.127 and payment of all applicable fees for renewal to the Commissioner on or before the renewal date for the license.

5. A license which is not renewed expires on the renewal date. The Commissioner may accept a request for renewal received by the Commissioner within 30 days after the expiration of the license if the request is accompanied by:

(a) The statement required pursuant to NRS 685A.127;

(b) All applicable fees for renewal; and

(c) A penalty in an amount that is equal to 50 percent of all applicable fees for renewal, except for any fee required pursuant to NRS 680C.110.

6. As used in this section, "renewal date" means:

(a) For the first renewal of the license, the last day of the month which is 3 years after the month in which the Commissioner originally issued the license.

(b) For each renewal after the first renewal of the license, the last day of the month which is 3 years after the month in which the license was last due to be renewed.

Sec. 62. NRS 685B.050 is hereby amended to read as follows:

685B.050 1. Any act of transacting an insurance business as set forth in NRS 685B.030 by any unauthorized insurer is equivalent to and constitutes an irrevocable appointment by such an insurer, binding upon the insurer, the insurer's executor or administrator, or successor in interest if a corporation, of the Commissioner or the successor in office of the Commissioner, to be the true and lawful attorney of such an insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the Commissioner or by the State and upon whom may be served any notice, order, pleading or process in any proceeding before the Commissioner and which arises out of transacting an insurance business in this State by such an insurer. Any act of transacting an insurance business in this State by any unauthorized insurer is signification of its agreement that any such lawful process in such a court action, suit or proceeding and any such notice, order, pleading or process in such an administrative proceeding before the

Commissioner so served is of the same legal force and validity as personal service or process in this State upon such an insurer.

2. Service of process in such an action must be made by delivering to and leaving with the Commissioner, or some person in apparent charge of the office of the Commissioner, ~~[two copies]~~ ***one copy*** thereof and by payment to the Commissioner of the fee prescribed by law. Service upon the Commissioner as attorney is service upon the principal.

3. The Commissioner shall forthwith forward ~~[by certified mail one of the copies]~~ ***the copy*** of such process or such notice, order, pleading or process in proceedings before the Commissioner to the defendant in such a court proceeding or to whom the notice, order, pleading or process in such an administrative proceeding is addressed or directed at its last known principal place of business **.** ~~[and shall keep a record of all process so served on him or her which must show the day and hour of service.]~~ Such service is sufficient if:

(a) Notice of such service and a copy of the court process or the notice, order, pleading or process in such an administrative proceeding are sent within 10 days thereafter by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the Commissioner in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in such an administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding.

(b) The defendant's receipt or receipts issued by the post office with which the letter is certified, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in a court proceeding or of the Commissioner in an administrative proceeding, showing compliance therewith are filed with the clerk of the court in which such an action, suit or proceeding is pending or with the Commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceedings is required to appear or respond thereto, or within such further time as the court or Commissioner may allow.

4. No plaintiff is entitled to a judgment or determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the Commissioner is served under this section until 45 days after the date of filing of the affidavit of compliance.

5. For the purposes of this section, "process" in an action in a court includes only a summons or the initial documents served in such an action. The Commissioner is not required to serve any documents in such an action after the initial service of process.

6. Nothing in this section limits or affects the right to serve any process, notice, order or demand upon any person or insurer in any other manner permitted by law.

Sec. 63. NRS 685B.190 is hereby amended to read as follows:

685B.190 If a person violates an order issued pursuant to NRS 685B.170, the Commissioner may impose an administrative fine after giving notice and a hearing. Such a fine may not be more than ~~[$5,000]~~ ***$10,000*** for each violation.

Sec. 64. Chapter 686A of NRS is hereby amended by adding thereto the provisions set forth as sections 65 to 77, inclusive, of this act.

Sec. 65. ***As used in NRS 686A.010 to 686A.325, inclusive, and sections 65 to 77, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 66 and 67 of this act have the meanings ascribed to them in those sections.***

Sec. 66. ***"Affiliate of a bank" has the meaning ascribed to "affiliate" in NRS 683A.231.***

Sec. 67. ***"Bank" has the meaning ascribed to it in NRS 683A.231.***

Sec. 68. ***1. Except as otherwise provided by subsection 3 and specific statute, an insurer shall maintain all books and records containing data relating to the financial affairs of the insurer, complaints, claims, rates, underwriting or marketing:***

(a) For 5 years after the making of the book or record; or

(b) Until the date on which the Commissioner has completed the first examination of the insurer after the book or record was made,

➥ whichever occurs later.

2. An insurer shall maintain the books and records described in subsection 1 in a form that allows the data to be readily accessible to the Commissioner for examination.

3. An insurer shall maintain a complete record of all complaints received by the insurer since the date upon which the Commissioner completed the most recent examination of the insurer. The record must be maintained in accordance with subsection 1 and contain:

(a) The total number of complaints;

(b) The classification of each complaint by line of insurance;

(c) The nature of each complaint;

(d) The disposition of each complaint; and

(e) The time it took the insurer to process each complaint.

Sec. 69. ***1. Except as otherwise provided in this section, an insurer shall not make or permit any unfair discrimination between insured or property having like insuring or risk***

characteristics by refusing to issue life insurance to, refusing to continue the life insurance coverage of, limiting the amount, extent or kind of life insurance coverage available to a person, or determining the premiums on a policy of life insurance issued to a person on the basis of the lawful past or future travel plans of the person.

2. The provisions of subsection 1 do not apply to any refusal, limitation or determination made by an insurer on the basis of the future plans of a person to travel to a specific destination at a specific time if the insurer, based on sound actuarial principles and actual or reasonably anticipated experience, reasonably anticipates that the risk of loss for persons who travel to that destination at that time will be greater than if the persons did not travel to that destination at that time.

3. A refusal, limitation or determination made by an insurer on the basis that a person plans to travel to a specific destination at a specific time shall be deemed to satisfy the requirements of subsection 2 if, at the time the insurer makes the refusal, limitation or determination:

(a) The Director of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services has issued a highest-level alert or warning concerning the destination, including, without limitation, a recommendation against non-essential travel to the destination, because of a serious condition relating to health; or

(b) There is an ongoing armed conflict involving the military of a foreign sovereign nation at the destination.

4. An insurer shall make any underwriting guidelines relating to actions described in this section and any supporting analysis available to the Commissioner upon request.

5. The Commissioner may adopt regulations as he or she deems necessary to carry out the provisions of this section. Such regulations may include, without limitation, regulations providing for limited exceptions from the provisions of subsection 1 that are based upon national or international emergency conditions which affect the public health, safety and welfare and which are consistent with public policy.

Sec. 70. *1. Except as otherwise provided in subsection 2, a person or governmental entity furnishing information of the kind described in NRS 686A.283 is not subject to civil liability and no cause of action arises against the person or entity as a result of the furnishing of the information if the information is furnished to or received from:*

(a) The Commissioner or the employees, agents or representatives of the Commission;

(b) Another federal, state or local law enforcement or regulatory officer or his or her employees, agents or representatives;

(c) Another person involved in the prevention or detection of insurance fraud or the employees, agents or representatives of the person; or

(d) The National Association of Insurance Commissioners or its employees, agents or representatives.

2. The immunity provided in subsection 1 does not extend to a statement made with actual malice. In an action brought against a person or governmental entity for filing a report or furnishing other information of the kind described in NRS 686A.283, the plaintiff must plead specifically that the defendant acted with actual malice.

3. This section does not supplant or modify any other privilege or immunity at common law or under another statute enjoyed by a person described in subsection 1.

Sec. 71. *1. Except as otherwise provided in subsection 4, an insurer who issues a policy of property or casualty insurance shall, within 30 days after receipt of a written request submitted by a first named insured of the policy, provide the first named insured with the following information for the 3 immediately preceding policy years:*

(a) The date and a description of any occurrence that resulted in a claim and the total amount of all payments made regarding the claim; and

(b) The date and a description of any occurrence relating to the policy that did not result in a claim.

2. Except as otherwise provided in subsection 4, a first named insured of a policy of property or casualty insurance may submit to the insurer that issued the policy a written request for any information that another insurer has requested the first named insured to provide in connection with the prospective issuance of a policy. Within 20 days after receipt of the request, the insurer shall provide to the first named insured the information requested.

3. An insurer shall not request that a person, in connection with the prospective issuance of a policy, provide more detailed loss information than is reasonably required to underwrite the same line or class of insurance.

4. An insurer is not required to provide loss reserve information pursuant to any request submitted pursuant to this section. An insurer shall not refuse to issue a policy of property or casualty insurance to a person solely because the insurer is unable to obtain loss reserve information.

5. The Commissioner may adopt regulations that exempt an insurer from the provisions of subsection 1 with respect to a line or class of insurance if:

(a) The information is not needed for that line or class of insurance; or

(b) The provision of loss information for that line or class of insurance is otherwise required by law.

6. Any information provided to a first named insured pursuant to subsection 2 is not subject to discovery by any party other than the first named insured, the insurer that provided the information and the insurer that requested that the first named insured provide the information.

7. As used in this section:

(a) "First named insured" means the first person named as a named insured in the declarations of a policy.

(b) "Named insured" means a person listed in the declarations of a policy as a policyholder or the legal representative of a policyholder.

Sec. 72. *1. The Commissioner may examine and investigate the insurance activities of any bank to determine whether the bank has engaged in or is engaging in any practice that constitutes an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of the provisions of this chapter.*

2. Before commencing an examination or investigation of a bank, the Commissioner must notify the Commissioner of Financial Institutions or the appropriate federal banking regulatory authority, as applicable, of:

(a) The intention of the Commissioner to commence an examination or investigation of the bank; and

(b) Any practice constituting an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in which the bank is suspected to have engaged or be engaging.

3. The powers of the Commissioner set forth in NRS 679B.340 with respect to a hearing, examination or investigation concerning a bank are limited only to inquiries relating to the insurance activities of the bank.

Sec. 73. *1. An insurer who offers or issues a policy of long-term care insurance shall submit to the Commissioner for approval any advertisement concerning the insurance that is requested by the Commissioner before it is used by the insurer.*

2. An insurer who offers a policy of long-term care insurance that is endorsed or sold by a professional, trade or occupational association shall submit to the Commissioner, on or before a date

each year specified by the Commissioner, a certification certifying that the insurer has complied with the requirements concerning disclosure, advertising, compensation arrangements and any other requirements set forth in the applicable provisions of this title and the regulations adopted pursuant thereto.

3. It constitutes an unfair method of competition or an unfair or deceptive act or practice in the business of insurance for an insurer to violate the provisions of:

(a) This section; or

(b) NRS 686B.070 or 687B.120, with respect to a policy of long-term care insurance.

Sec. 74. *It constitutes an unfair method of competition or an unfair or deceptive act or practice in the business of insurance for an insurer to violate the provisions of subsection 2 of section 28 of this act.*

Sec. 75. *It constitutes an unfair method of competition or an unfair or deceptive act or practice in the business of insurance for a purchasing group, as defined in NRS 695E.100, to violate the provisions of subsection 1 of NRS 695E.130.*

Sec. 76. *An insurer shall implement antifraud initiatives that are reasonably calculated to detect, prosecute and prevent insurance fraud. Such an initiative may include, without limitation:*

1. The use of fraud investigators, who may be employees or independent contractors of the insurer.

2. A plan to detect, prosecute and prevent insurance fraud submitted by the insurer to the Commissioner. Except as otherwise provided in NRS 239.0115, such a plan must be kept confidential by the Commissioner pursuant to NRS 679B.190.

Sec. 77. *1. Except as otherwise provided in this section, an application for insurance and a claim form, regardless of the form of transmission, must contain a statement in substantially the following form:*

> *Any person who knowingly presents false information in an application for insurance or who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.*

2. The lack of the statement required by subsection 1 on an application for insurance or a claim form does not constitute a defense in any prosecution for insurance fraud.

3. Except as otherwise provided in this section, a policy issued by an unauthorized insurer must contain a statement disclosing

the status of the insurer to do business in this State where the policy is delivered or issued for delivery or the state where the coverage is in force. For a policy subject to the requirements of NRS 685A.090 or 685E.180, compliance with the requirements of those sections satisfies the requirements of this subsection.

4. The requirements of this section do not apply to an application for reinsurance or a claim form for reinsurance.

Sec. 78. NRS 686A.010 is hereby amended to read as follows:

686A.010 ***1.*** The purpose of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress approved March 9, 1945, being c. 20, 59 Stat. 33, also designated as 15 U.S.C. §§ 1011 to 1015, inclusive, and ***the Gramm-Leach-Bliley Act,*** Title V of Public Law 106-102, 15 U.S.C. §§ 6801 et seq. ***, by:***

(a) Defining, or providing for the determination of, all practices in this State that constitute unfair methods of competition or unfair or deceptive acts or practices in the business of insurance; and

(b) Prohibiting the practices defined or determined to constitute unfair methods of competition or unfair or deceptive acts or practices in the business of insurance.

2. Except as otherwise provided in NRS 686A.310, nothing in the provisions of this chapter shall be construed to create or imply a private cause of action against any person for a violation of any provision of this chapter.

Sec. 79. NRS 686A.015 is hereby amended to read as follows:

686A.015 1. Notwithstanding any other provision of law, the Commissioner has exclusive jurisdiction in regulating the subject of trade practices in the business of insurance in this State.

2. The Commissioner shall establish a program within the Division to investigate any act or practice which constitutes an unfair or deceptive trade practice in violation of the provisions of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive ~~[.]~~ ***, and sections 65 to 77, inclusive, of this act.***

3. The powers conferred upon the Commissioner by NRS 686A.010 to 686A.325, inclusive, and sections 65 to 77, inclusive, of this act are in addition to and supplemental to any other powers conferred upon the Commissioner to enforce any penalties, fines or forfeitures authorized by law with respect to any unfair method of competition or any unfair or deceptive act or practice in the business of insurance.

4. The Commissioner may adopt any regulations necessary to carry out the provisions of NRS 686A.010 to 686A.325, inclusive, and sections 65 to 77, inclusive, of this act.

Sec. 80. NRS 686A.020 is hereby amended to read as follows:

686A.020 A person shall not engage in this State in any practice which is defined in NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Sec. 81. NRS 686A.030 is hereby amended to read as follows:

686A.030 A person shall not ~~[make,]~~ ***:***

1. Make, issue, circulate or cause to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation or comparison which:

~~[1.]~~ ***(a)*** Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

~~[2.]~~ ***(b)*** Misrepresents the dividends or share of the surplus to be received on any insurance policy;

~~[3.]~~ ***(c)*** Makes any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;

~~[4.]~~ ***(d)*** Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

~~[5.]~~ ***(e)*** Uses any name or title of any policy or class of insurance policies misrepresenting the true nature thereof;

~~[6.]~~ ***(f)*** Is a misrepresentation ***, including, without limitation, any intentional or unintentional misquote of premium rate,*** for the purpose of inducing or tending to induce the ***purchase,*** lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

~~[7.]~~ ***(g)*** Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; ~~[or~~

~~8.]~~ ***(h)*** Misrepresents any insurance policy as being shares of stock ~~[.]~~ ***; or***

(i) Offers or provides an insurance policy as an inducement to the purchase of another policy or contract or otherwise uses the terms "free" or "no cost" or other terms of similar meaning.

2. As an inducement to purchase an insurance policy, issue or deliver or permit any producer, officer or employee to issue or deliver:

(a) Agency company stock or other capital stock;

(b) Benefit certificates or shares in any common law corporation;

(c) Securities of any special or advisory board contracts; or

(d) Any other contracts promising returns and profits.

Sec. 82. NRS 686A.040 is hereby amended to read as follows:

686A.040 No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, ***through electronic mail or other electronic means, on an Internet website,*** in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter ***,*** ~~[or]~~ poster ~~[,]~~ ***or in any electronic form*** or over any radio or television station, or in any other way, any advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive or misleading.

Sec. 83. NRS 686A.085 is hereby amended to read as follows:

686A.085 ***1.*** A bank ***, affiliate of a bank or other person*** shall not ~~[in any manner extend]~~ ***require as a condition precedent to the lending of money or extension of*** credit, ~~[lease]~~ or ~~[sell property of]~~ any ~~[kind, or furnish any services, or fix or vary]~~ ***renewal thereof, that*** the ~~[consideration for any of them, on the condition]~~ ***person to whom such money is lent or credit is extended,*** or ~~[requirement that the customer purchase insurance from]~~ ***whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through*** a ~~[parent, subsidiary]~~ ***particular insurer*** or ~~[affiliate]~~ ***producer of insurance or group*** of ~~[the bank. For the purposes of this section, the terms "affiliate," "parent" and "subsidiary" have the meanings ascribed to them in NRS 683A.231.]~~ ***producers.***

2. A bank, affiliate of a bank or other person shall not reject a policy of insurance solely because the policy has been issued or underwritten by a person who is not associated with the original bank, affiliate of a bank or other person when insurance is required in connection with a loan or extension of credit.

3. A bank, affiliate of a bank or other person that lends money or extends credit shall not:

(a) As a condition of extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a bank or an affiliate of a bank or a particular insurer or producer of insurance. The provisions of this paragraph do not prohibit a bank, affiliate of a bank or other person from informing a customer or prospective customer that:

(1) Insurance is required in order to obtain a loan or credit;

(2) Loan or credit approval is contingent upon the procurement of acceptable insurance by the customer; and

(3) Insurance is available from the bank, affiliate of a bank or other person.

(b) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or loan. A rejection shall not be deemed unreasonable if the rejection is based on reasonable standards, uniformly applied and relating to the extent of coverage required and the financial soundness of the services of an insurer. The standards must not:

(1) Discriminate against any particular type of insurer; or

(2) Call for the rejection of a policy simply because the policy contains coverage in addition to that required in the credit transaction.

(c) Require that any customer, borrower, mortgagor, purchaser, insurer or producer of insurance pay a separate charge in connection with the handling of any policy required as security for a loan on real estate or to substitute the policy of one insurer for that of another. The provisions of this paragraph do not apply to:

(1) The interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document; or

(2) Charges that would be required when the bank, affiliate of a bank or other person is the licensed producer of insurance providing the insurance.

(d) Require any procedure or condition of a duly licensed producer of insurance or insurer which is not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit.

(e) Use an advertisement or other promotional material relating to insurance that would cause a reasonable person to mistakenly believe that the Federal Government or the State:

(1) Is responsible for the insurance sales activity of, or stands behind the credit of, the bank, affiliate of a bank or other person; or

(2) Guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the bank, affiliate of a bank or other person.

(f) Act as a producer of insurance unless properly licensed in accordance with chapter 683A of NRS.

(g) Pay or receive any commission, brokerage fee or other compensation as a producer of insurance, unless the person holds a valid license as a producer for the applicable class of insurance. This paragraph does not prohibit a person who is not licensed as a producer from making a referral to a licensed producer if the person does not discuss any specific terms and conditions of a policy of insurance. This paragraph does not prohibit a person who is not licensed as a producer from being compensated for a

referral. In the case of a referral of a customer, the compensation must be a fixed dollar amount for each referral that does not depend on whether the customer purchases an insurance product from the licensed producer. Any person who accepts deposits from the public in an area where such transactions are routinely conducted in the bank may not receive more than a one-time, nominal fee of a fixed dollar amount for each referral of a customer that does not depend on whether the referral results in a transaction.

(h) Solicit or sell insurance unless:

(1) Other than credit insurance or flood insurance, the solicitation or sale is completed through documents which are separate from any transaction involving credit;

(2) The insurance sales activities are, to the extent practicable, physically separated from the areas where retail deposits are routinely accepted by banks; and

(3) The bank, affiliate of a bank or other person maintains separate and distinct books and records relating to the transactions involving insurance, including, without limitation, all files relating to and reflecting any complaint of a consumer.

(i) Include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary transaction involving credit without the express written consent of the customer.

4. A bank, affiliate of a bank or other person which lends money or extends credit and which solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to an extension of credit may be purchased from an insurer or producer of insurance that the customer chooses, subject to the right of the lender to reject a given insurer or producer as provided in paragraph (b) of subsection 3. The disclosure must inform the customer that the insurer or producer the customer chooses will not affect the decision to extend credit or terms of credit in any way, except that the bank, affiliate of a bank or other person may impose reasonable requirements concerning the creditworthiness of the insurer and the score of coverage chosen as provided in paragraph (b) of subsection 3.

5. Except as otherwise provided in subsection 6, a bank or any person who solicits, sells, advertises or offers insurance on the premises of a bank or on behalf of a bank shall:

(a) Disclose to the customer in writing, where practicable and in a clear and conspicuous manner, before a sale takes place, that the insurance:

(1) Is not a deposit;

(2) Is not insured by the Federal Deposit Insurance Corporation or any other agency of the Federal Government;

(3) Is not guaranteed by the bank, any affiliate of the bank or any person that is soliciting, selling, advertising or offering insurance; and

(4) If applicable, involves investment risk, including, without limitation, possible loss of value.

(b) Except as otherwise provided in this paragraph, obtain written acknowledgment from the customer of the receipt of the disclosure described in paragraph (a), either at the time of receipt or at the time of the initial purchase of the policy of insurance. If the solicitation is conducted by telephone, the person or bank shall obtain oral acknowledgment from the customer of receipt of the disclosure, maintain sufficient documentation of the oral acknowledgment and make reasonable efforts to obtain a written acknowledgment from the customer. If a customer affirmatively consents to receiving the disclosure by electronic means and the disclosure is provided in a format that the customer may retain or obtain later, the bank or person may provide the disclosure by electronic means and obtain acknowledgment from the customer of receipt of the disclosure by electronic means.

6. The provisions of paragraph (a) of subsection 5 apply:

(a) Only:

(1) When a person purchases, applies to purchase or is solicited to purchase insurance products or annuities primarily for personal, family or household purposes; and

(2) To the extent that the disclosure is accurate.

(b) To an affiliate of a bank only to the extent that it sells, solicits, advertises or offers insurance products or annuities at an office of a bank or on behalf of a bank.

7. For the purposes of subsection 5, a person solicits, sells, advertises or offers insurance on behalf of a bank, whether at an office of the bank or another location, if:

(a) The person represents to the customer that the solicitation, sale, advertisement or offer of the insurance is by or on behalf of the bank;

(b) Documents evidencing the solicitation, sale, advertisement or offer of the insurance identify or refer to the bank; or

(c) The bank:

(1) Refers a customer to the person who sells insurance; and

(2) Has a contractual agreement to receive commissions or fees derived from the sale of insurance resulting from the referral.

8. The Commissioner may examine and investigate the insurance activities of any insurer, bank, affiliate of a bank or

other person that the Commissioner believes may be in violation of this section. The insurer, bank or affiliate of a bank or other person shall make its books and records available to the Commissioner for inspection upon reasonable notice. A person who is affected by a violation or potential violation of this section may submit a complaint or other material pertinent to the enforcement of this section to the Commissioner.

9. Nothing in this section:

(a) Prevents a bank, affiliate of a bank or other person that lends money or extends credit from placing insurance on real or personal property in the event that a mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of a loan or credit document.

(b) Applies to credit-related insurance.

Sec. 84. NRS 686A.095 is hereby amended to read as follows:

686A.095 1. An insurer shall not, without the written consent of the agent ~~[,]~~ ***or producer of insurance,*** cancel a written agreement with an agent ***or a producer*** or reduce or restrict the ~~[agent's]~~ authority ***of the agent or producer*** to transact property or casualty insurance based solely on the loss ratio experience on insurance transacted by that agent ~~[,]~~ ***or producer,*** if the agent ***or producer*** was required to submit the applications for that insurance for underwriting approval, all material information on those applications was fully completed and the agent ***or producer*** did not omit or alter any information provided by the applicants for that insurance.

2. As used in this section, "loss ratio experience" means the amount of money received by the insurer in payment of premiums divided by the amount of money expended by the insurer in payment of claims for a specified period.

Sec. 85. NRS 686A.120 is hereby amended to read as follows:

686A.120 1. Nothing in NRS 686A.100, 686A.105 and 686A.110 shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer and its policyholders.

(b) In the case of life insurance policies issued on the debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(c) Readjusting the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(d) Reducing the premium rate for policies of large amounts, but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plan issued in smaller amounts.

(e) Reducing the premium rates for life or health insurance policies or annuity contracts on salary savings, payroll deduction, preauthorized check, bank draft or similar plans in amounts reasonably commensurate with the savings made by the use of such plans.

(f) Extending credit for the payment of any premium, and for which credit a reasonable rate of interest is charged and collected.

(g) The offering or provision by an insurer or producer of insurance, or by or through an employee, affiliate or third-party representative, of a value-added product or service at no or reduced cost when the product or service is not specified in the policy of insurance if:

(1) The product or service relates to the insurance coverage;

(2) The product or service is primarily designed to:

(I) Provide loss mitigation or control;

(II) Reduce the cost to administer claims or settle claims;

(III) Provide education about risk of liability or risk of loss to persons or property;

(IV) Monitor or assess risk, identify sources of risk or develop strategies to eliminate or reduce risk;

(V) Enhance health;

(VI) Enhance financial wellness, including, without limitation, through education or financial planning services;

(VII) Provide services after a loss;

(VIII) Incentivize changes in behavior to improve the health or reduce the risk of death or disability of a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant; or

(IX) Assist in the administration of employee or retiree benefit insurance coverage;

(3) The cost to the insurer or producer of insurance offering the product or service to a customer is reasonable in comparison to the customer's premiums or insurance coverage for the policy class;

(4) The insurer or producer of insurance is providing the product or service offered, the insurer or producer ensures that the customer is provided with contact information to assist the customer with any question relating to the product or service; and

(5) The availability of the product or service is:

(I) Based on documented objective criteria which must be maintained by the insurer or producer of insurance and made available upon request of the Commissioner; and

(II) Offered in a manner that is not unfairly discriminatory.

(h) Engaging in any activity of the type described in 15 U.S.C. § 6701(d)(2)(B)(viii) that does not violate section 106 of the Bank Holding Company Act Amendment of 1970, 12 U.S.C. § 1972, as interpreted by the Board of Governors of the Federal Reserve System or section 5(q) of the Home Owners' Loan Act, 12 U.S.C. § 1464(q).

2. ***If an insurer or producer of insurance does not have sufficient evidence but has a good faith belief that a product or service described in paragraph (g) of subsection 1 meets the criteria set forth in subparagraph (2) of paragraph (g) of subsection 1, the insurer or producer may provide the product or service as part of a pilot or testing program for not more than 1 year if:***

(a) Not less than 21 days before beginning the pilot or testing program, the insurer or producer notifies the Commissioner of the intent to begin the program;

(b) The Commissioner does not object to the proposed pilot or testing program within 21 days after the date on which notice was given pursuant to paragraph (a); and

(c) The insurer or producer provides the product or service in the pilot or testing program in a manner that is not unfairly discriminatory.

3. Nothing in NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** shall be construed as including within the definition of securities as inducements to purchase insurance the selling or offering for sale, contemporaneously with life insurance, of mutual fund shares or face amount certificates of regulated investment companies under offerings registered with the Securities and Exchange Commission where such shares or such face amount certificates or such insurance may be purchased independently of and not contingent upon purchase of the other, at the same price and upon similar terms and conditions as where purchased independently.

4. The Commissioner may adopt regulations setting forth requirements and restrictions to provide protections for consumers

relating to the practices set forth in this section. Such regulations may include, without limitation, requirements and restrictions to provide protections for the data of consumers and to prevent unfair discrimination and requirements for disclosures that must be made to a consumer.

Sec. 86. NRS 686A.130 is hereby amended to read as follows:

686A.130 1. Except as otherwise provided in subsection 2, no property, casualty, surety or title insurer or underwritten title company or any employee or representative thereof, and no broker, agent ***,*** ~~[or]~~ solicitor ***or producer of insurance*** may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified or provided for in the policy, except to the extent provided for in an applicable filing with the Commissioner.

2. The provisions of subsections 1 and 4 do not prohibit any property, casualty or surety insurer or any employee or representative thereof, or any broker, agent ***,*** ~~[or]~~ solicitor ***or producer of insurance*** from providing to an insured or prospective insured prizes and gifts, goods, wares, merchandise, gift certificates, donations made to charitable organizations, raffle entries, meals, event tickets and other items not to exceed $100 in aggregate value per insured or prospective insured in any 1 calendar year.

3. No title insurer or underwritten title company may:

(a) Pay, directly or indirectly, to the insured or any person acting as agent, representative, attorney or employee of the owner, lessee, mortgagee, existing or prospective, of the real property or interest therein which is the subject matter of title insurance or as to which a service is to be performed, any commission, rebate or part of its fee or charges or other consideration as inducement or compensation for the placing of any order for a title insurance policy or for performance of any escrow or other service by the insurer or underwritten title company with respect thereto; or

(b) Issue any policy or perform any service in connection with which it or any agent ***, producer of insurance*** or other person has paid or contemplates paying any commission, rebate or inducement in violation of this section.

4. Except as otherwise provided in subsection 2, no insured named in a policy or any employee of that insured may knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit or reduction of premium, or any such special favor or advantage or valuable consideration or inducement.

5. No such insurer may make or permit any unfair discrimination between insured or property having like insuring or risk characteristics ~~[, in]~~ ***:***

(a) In the premium or rates charged for insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of insurance.

(b) By refusing to insure, refusing to renew, cancelling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

(c) By refusing to insure, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property therein, solely because of the age of the residential property.

(d) Except as otherwise provided in this paragraph, by refusing to insure, refusing to renew, cancelling or limiting the amount of insurance coverage available to a person on the basis of race, religion, sex, marital status or national origin. The provisions of this paragraph do not:

(1) Prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits; or

(2) Prohibit or limit the operation of fraternal benefit societies authorized to do business in this State pursuant to chapter 695A of NRS.

(e) Except as otherwise provided in this paragraph, by terminating, modifying coverage, refusing to issue or refusing to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired. The provisions of this paragraph do not apply to a policy of accident or health insurance which is sold by a casualty insurer if the termination, modification, refusal to issue or refusal to renew a policy is otherwise permitted by this title.

(f) Except as otherwise provided in this paragraph, by refusing to insure a person solely because another insurer has refused to write a policy, cancelled an existing policy or refused to renew an existing policy in which that person was the named insured. The provisions of this paragraph do not prohibit an insurer from terminating an excess policy of insurance due to the failure of the insured to maintain any required underlying insurance.

6. No casualty insurer may make or permit any unfair discrimination between persons legally qualified to provide a particular service, in the amount of the fee or charge for that service

payable as a benefit under any policy or contract of casualty insurance.

7. The provisions of this section do not prohibit:

(a) The payment of commissions or other compensation to licensed agents, brokers ***,*** ~~[or]~~ solicitors ~~[.]~~ ***or producers of insurance.***

(b) The extension of credit to an insured for the payment of any premium and for which credit a reasonable rate of interest is charged and collected.

(c) Any insurer from allowing or returning to its participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits.

(d) With respect to title insurance, bulk rates or special rates for customers of prescribed classes if the bulk or special rates are provided for in the effective schedule of fees and charges of the title insurer or underwritten title company.

8. The provisions of this section do not apply to wet marine and transportation insurance.

Sec. 87. NRS 686A.140 is hereby amended to read as follows:

686A.140 1. Any person violating the provisions of ***section 69 of this act,*** NRS 686A.110 or 686A.130 is guilty of a misdemeanor.

2. No agent ***,*** ~~[or]~~ broker ***or producer of insurance*** violating any of such provisions shall be entitled to receive any commission for the sale of any policy on which any rebate or inducement prohibited by NRS 686A.110 or 686A.130 has been given or offered, and the full amount of any commission so paid may be recovered by the insurer so paying.

3. The amount of any insurance upon which the insured has knowingly received or accepted, either directly or indirectly, any unlawful rebate of the premium or agent's, solicitor's ***,*** ~~[or]~~ broker's ***or producer's*** commission shall be reduced in such proportion as the amount or value of such rebate, commission or other consideration so received by the insured bears to the total premium on such policy.

4. A title insurer or underwritten title company shall be liable to the State of Nevada for five times the amount of any unlawful commission or rebate paid in violation of NRS 686A.130, which amount may be recovered by the Commissioner in addition to any other penalty imposed by law.

Sec. 88. NRS 686A.150 is hereby amended to read as follows:

686A.150 Except as provided in subsection ~~[2]~~ ***3*** of NRS 686A.120 ***,*** no person shall sell, agree or offer to sell, or give or offer to give, directly or indirectly in any manner whatsoever, as an inducement to insurance or in connection therewith, any stock,

shares, bonds or other securities of any kind, or any advisory board contract or other contract or agreement of any kind offering or promising returns and profits.

Sec. 89. NRS 686A.160 is hereby amended to read as follows:

686A.160 ***1.*** If the Commissioner has cause to believe that any person ***, including, without limitation, an insurer, bank, affiliate of a bank or any other person subject to the provisions of this chapter,*** has been engaged or is engaging, in this State, in any unfair method of competition or any unfair or deceptive act or practice prohibited by NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** and that a proceeding by the Commissioner in respect thereto would be in the interest of the public, the Commissioner may issue and serve upon such person a statement of the charges and a notice of the hearing to be held thereon. The statement of charges and notice of hearing shall comply with the requirements of NRS 679B.320 and shall be served upon such person directly or by certified or registered mail, return receipt requested. ***If the person is a bank, the Commissioner shall provide a copy of the notice to the Commissioner of Financial Institutions or the appropriate federal banking regulatory authority, as applicable.***

2. At the time and place fixed for the hearing the person may appear and show cause why an order should not be made by the Commissioner requiring the person to cease and desist from the acts, methods or practices with which the person is charged. Upon good cause shown, the Commissioner shall permit a person to intervene, appear and be heard at the hearing by counsel or in person.

3. Except as otherwise provided in chapter 233B of NRS and NRS 679B.310 to 679B.370, inclusive, the Commissioner is not bound by formal rules of evidence or pleading.

Sec. 90. NRS 686A.170 is hereby amended to read as follows:

686A.170 1. If the Commissioner believes that any person engaged in the insurance business ***, including, without limitation, a bank or affiliate of a bank,*** is in the conduct of such business engaging in this State in any method of competition or in any act or practice not defined in NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** which is unfair or deceptive and that a proceeding by the Commissioner in respect thereto would be in the public interest, the Commissioner shall, after a hearing of which notice and of the charges against such person are given to the person, make a written report of the findings of fact relative to such charges and serve a copy thereof upon such person and any intervener at the hearing.

2. If such report charges a violation of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** and if such method of competition, act or practice has not been discontinued, the Commissioner may, through the Attorney General, at any time after 20 days after the service of such report cause an action to be instituted in the district court of the county wherein the person resides or has his or her principal place of business to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs or orders as are ancillary to its jurisdiction or necessary in its judgment to prevent injury to the public pendente lite; but the State of Nevada shall not be required to give security before the issuance of any such order or injunction under this section. If a stenographic record of the proceedings in the hearing before the Commissioner was made, a certified transcript thereof including all evidence taken and the report and findings shall be received in evidence in such action.

3. If the court finds that:

(a) The method of competition complained of is unfair or deceptive;

(b) The proceedings by the Commissioner with respect thereto are to the interest of the public; and

(c) The findings of the Commissioner are supported by the weight of the evidence,

➥ it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

4. Either party may appeal from such final judgment or order or decree of court in a like manner as provided for appeals in civil cases.

5. If the Commissioner's report made under subsection 1 or order on hearing made under NRS 679B.360 does not charge a violation of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act,*** then any intervener in the proceedings may appeal therefrom within the time and in the manner provided in this Code for appeals from the Commissioner generally.

6. Upon violation of any injunction issued under this section, the Commissioner, after a hearing thereon, may impose the appropriate penalties provided for in NRS 686A.187.

7. An order issued by the Commissioner or a court pursuant to this section does not relieve any person of any liability existing under any other provision of law.

Sec. 91. NRS 686A.180 is hereby amended to read as follows:

686A.180 1. Service of all process, statements of charges and notices under NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** upon unauthorized insurers shall be made by delivering to and leaving with the Commissioner or some person in apparent charge of the office of the Commissioner ~~[two copies]~~ ***one copy*** thereof, or in the manner provided for by subsection 2 of NRS 685B.050.

2. The Commissioner shall forward all such process, statements of charges and notices to the insurer in the manner provided in subsection 3 of NRS 685B.050.

3. No default shall be taken against any such unauthorized insurer until expiration of 30 days after the date of forwarding by the Commissioner under subsection 2, or date of service of process if under subsection 2 of NRS 685B.050.

4. NRS 685B.050 applies to all process, statements of charges and notices under this section.

Sec. 92. NRS 686A.183 is hereby amended to read as follows:

686A.183 1. After the hearing provided for in NRS 686A.160, the Commissioner shall issue an order on hearing pursuant to NRS 679B.360. If the Commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice in violation of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act,*** the Commissioner shall order the person to cease and desist from engaging in that method of competition, act or practice, and may order one or both of the following:

(a) If the person knew or reasonably should have known that he or she was in violation of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act,*** payment of an administrative fine of not more than ~~[$5,000]~~ ***$10,000*** for each act or violation, except that as to licensed agents, brokers, solicitors and adjusters, the administrative fine must not exceed ~~[$500]~~ ***$1,000*** for each act or violation.

(b) Suspension or revocation of the person's license if the person knew or reasonably should have known that he or she was in violation of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive ~~[.]~~ ***, and sections 65 to 77, inclusive, of this act.***

2. Until the expiration of the time allowed for taking an appeal, pursuant to NRS 679B.370, if no petition for review has been filed within that time, or, if a petition for review has been filed within that time, until the official record in the proceeding has been filed with the court, the Commissioner may, at any time, upon such notice and in such manner as the Commissioner deems proper, modify or set

aside, in whole or in part, any order issued by him or her under this section.

3. After the expiration of the time allowed for taking an appeal, if no petition for review has been filed, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify or set aside, in whole or in part, any order issued by him or her under this section whenever in the opinion of the Commissioner conditions of fact or of law have so changed as to require such action or if the public interest so requires.

4. Before taking an action specified in paragraph (a) or (b) of subsection 1 against a bank, the Commissioner shall, if practicable, provide to the Commissioner of Financial Institutions or the appropriate federal or state banking regulatory authority, as applicable, notice of the intent of the Commissioner to take the action.

Sec. 93. NRS 686A.187 is hereby amended to read as follows:

686A.187 Any person who violates a cease and desist order of the Commissioner issued under NRS 686A.183, except one issued with respect to NRS 686A.170, is subject, in the discretion of the Commissioner, after notice and hearing and upon order of the Commissioner, to one or both of the following:

1. Payment of an administrative fine of not more than ~~[$5,000]~~ ***$10,000*** for each and every violation.

2. Suspension or revocation of the license.

Sec. 94. NRS 686A.200 is hereby amended to read as follows:

686A.200 1. Except as otherwise provided in NRS 616B.710, ~~[no]~~ ***a bank, affiliate of a bank or other*** person shall ~~[require,]~~ ***not:***

(a) Require directly or indirectly, or through any ***producer of insurance,*** trustee, director, officer, agent or employee or affiliate, as a condition, agreement or understanding to selling or furnishing any other person any loan, or extension thereof, credit, sale, goods, property, contract, lease or service, that such other person shall place, continue other than as to life insurance, or renew any policy of insurance of any kind through any particular ***producer of insurance,*** agent, broker or insurer. ~~[No]~~

(b) Fix a price charged for a thing or service described in paragraph (a), or discount from or rebate upon price, on the condition, agreement or understanding that any insurance is to be obtained through a particular insurer or producer of insurance.

(c) If insurance is required in connection with a loan or extension of credit, reject a policy of insurance solely because the policy has been issued or underwritten by a person who is not associated with such bank, affiliate or person.

2. A producer of insurance, agent, broker or insurer shall ***not*** knowingly participate in any ~~[such prohibited]~~ plan or transaction ~~[.~~

~~No person shall fix a price charged for such thing or service, or discount from or rebate upon price, on the condition, agreement or understanding that any insurance is to be obtained through a particular agent, broker or insurer.~~] ***prohibited by paragraph (a) of subsection 1.***

~~[2.]~~ ***3.*** Subsection 1 does not prevent:

(a) The exercise by any such person upon a reasonable basis of any right to approve or disapprove of the insurer and representative to underwrite the insurance. Such basis shall relate only to the adequacy and terms of the coverage with respect to the interest of the vendor, lender, lessor or provider of service to be insured thereunder, the financial standards to be met by the insurer, and the ability of the insurer or representative to service the policy.

(b) The exercise by the vendor, lender, lessor or provider of service of the right to furnish or renew the insurance, and to charge the account of the other person with the costs thereof, if such other person fails to deliver such insurance to the lender, vendor, lessor or provider of service, where otherwise called for and in order, at least 15 days prior to expiration of the existing policy.

Sec. 95. NRS 686A.220 is hereby amended to read as follows:

686A.220 1. Except as otherwise provided in NRS 616B.710, no officer or employee of this State, or of any public agency, public authority or public corporation, except a public corporation or public authority created pursuant to agreement or compact with another state, and no person acting or purporting to act on behalf of such officer or employee, or public agency or public authority or public corporation, shall, with respect to any public building or construction contract which is about to be or which has been competitively bid, require the bidder to make application or furnish financial data to, or to obtain or procure any of the surety bonds or contracts of insurance specified in connection with such contracts or by any law from, a particular insurer or agent ***,*** ~~[or]~~ broker ~~[.]~~ ***or producer of insurance.***

2. Except as otherwise provided in NRS 616B.710, no such officer or employee or any person acting or purporting to act on behalf of such officer or employee shall negotiate, make application for, obtain or procure any of such surety bonds or contracts of insurance, except contracts of insurance for builder's risk or owner's protective liability, which can be obtained or procured by the bidder, contractor or subcontractor.

3. This section does not, however, prevent the exercise by such officer or employee on behalf of the State or such public agency, public authority or public corporation of its right to approve the form, sufficiency or manner of execution of the surety bonds or

contracts of insurance furnished by the insurer selected by the bidder to underwrite such bonds or contracts of insurance.

4. Any provisions in any invitation for bids or in any of the contract documents in conflict with this section are declared to be contrary to the public policy of this State.

5. A violation of this section is subject to the penalties provided by NRS 679A.180.

Sec. 96. NRS 686A.230 is hereby amended to read as follows:

686A.230 1. A person shall not willfully collect any sum as a premium or charge for insurance which is not then provided or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as authorized by this Code.

2. Except as otherwise provided in subsection 3, a person shall not willfully collect as a premium or charge for insurance any sum in excess of the premium or charge applicable to the insurance and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the Commissioner. In cases where classifications, premiums or rates are not required by this Code to be so filed and approved, the premiums and charges must not be in excess of those specified in the policy and as fixed by the insurer. This subsection does not prohibit:

(a) The charging and collection by surplus lines brokers licensed under chapter 685A of NRS of the amount permitted by chapter 685A of NRS and regulations adopted by the Commissioner.

(b) The charging and collection by a life insurer of amounts actually to be expended for the medical examination of any applicant for life insurance or for reinstatement of a life insurance policy.

3. The Commissioner may adopt regulations to allow the charging and collection of a fee by an insurance broker, consultant or financial planner:

(a) In lieu of any other charge or commission for solicitation, negotiation or procurement of a policy of insurance which covers commercial or business risks;

(b) For consultation or any related advice on the insuring of commercial or business risks which does not result in the procurement of a policy of insurance; and

(c) For consultation or related advice on the purchase of individual or group life or health insurance or an individual or group annuity, whether or not it results in the purchase of a policy of insurance or annuity. In such a case, the fee must be set forth in a written contract signed by the client before the consultation begins.

4. An agent ***,*** ~~[or]~~ broker ***or producer of insurance*** who provides consultation or related advice pursuant to this section shall

do so pursuant to a written contract specifying the compensation the agent ***,*** ~~[or]~~ broker ***or producer*** will receive. The compensation may be in addition to or in lieu of a commission and is not a premium as defined in NRS 679A.115.

Sec. 97. NRS 686A.240 is hereby amended to read as follows:

686A.240 1. No form or plan of insurance covering any group or combination of persons or risks shall be written or delivered within or outside this State to cover persons or risks in this State at any preferred rate or on any form other than as offered to persons not in such group or combination and to the public generally, unless such form, plan of insurance, and the rates or premiums to be charged therefor have been submitted to and approved by the Commissioner.

2. Any such plan of insurance described in subsection 1 shall not be approved by the Commissioner unless it is made available to all individuals of the group who seek to be insured. No insurer ***,*** ~~[or]~~ agent ***or producer of insurance*** shall deny coverage to any individual of such group who seeks the type of insurance which is being made available to other members of the group.

3. This section does not apply to life insurance, health insurance, annuity contracts or wet marine and transportation insurance.

Sec. 98. NRS 686A.260 is hereby amended to read as follows:

686A.260 The Commissioner may revoke or suspend the license of any person domiciled or resident in Nevada and licensed to transact insurance in Nevada as insurer, agent, broker ***, producer of insurance*** or otherwise, upon a hearing and proof that such person, as the result of a hearing before the commissioner, director or superintendent of insurance or insurance department of another state, or in a judicial proceeding in another state, has been found to have violated the insurance laws of that state relating to unfair methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance, and as a result thereof either has had his or her license revoked or suspended in that state or has been found guilty of failing to comply with any order, decree or judgment issued pursuant to such hearing or judicial proceeding in that state.

Sec. 99. NRS 686A.270 is hereby amended to read as follows:

686A.270 No insurer shall be held guilty of having committed any of the acts prohibited by NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** by reason of the act of any agent, solicitor or employee not an officer, director or department head thereof, unless an officer, director or department head of the insurer has knowingly permitted such act or has had prior knowledge thereof.

Sec. 100. NRS 686A.281 is hereby amended to read as follows:

686A.281 As used in NRS 686A.281 to 686A.295, inclusive, ***and section 76 of this act*** unless the context otherwise requires, the words and terms defined in NRS 686A.2815, 686A.282 and 686A.2825 have the meanings ascribed to them in those sections.

Sec. 101. NRS 686A.2815 is hereby amended to read as follows:

686A.2815 1. "Insurance fraud" means knowingly and willfully:

(a) Presenting or causing to be presented any statement to an insurer, a reinsurer, a producer, a broker or any agent thereof, if the person who presents or causes the presentation of the statement knows that the statement conceals or omits facts, or contains false or misleading information concerning any fact material to an application for the issuance of a policy of insurance.

(b) Presenting or causing to be presented any statement as a part of, or in support of, a claim for payment or other benefits under a policy of insurance, if the person who presents or causes the presentation of the statement knows that the statement conceals or omits facts, or contains false or misleading information concerning any fact material to that claim.

(c) Assisting, abetting, soliciting or conspiring with another person to present or cause to be presented any statement to an insurer, a reinsurer, a producer, a broker or any agent thereof, if the person who assists, abets, solicits or conspires knows that the statement conceals or omits facts, or contains false or misleading information concerning any fact material to an application for the issuance of a policy of insurance or a claim for payment or other benefits under such a policy.

(d) Acting or failing to act with the intent of defrauding or deceiving an insurer, a reinsurer, a producer, a broker or any agent thereof, to obtain a policy of insurance or any proceeds or other benefits under such a policy.

(e) As a practitioner, an insurer or any agent ***or producer of insurance*** thereof, acting to assist, conspire with or urge another person to commit any act or omission specified in this section through deceit, misrepresentation or other fraudulent means.

(f) Accepting any proceeds or other benefits under a policy of insurance, if the person who accepts the proceeds or other benefits knows that the proceeds or other benefits are derived from any act or omission specified in this section.

(g) Employing a person to procure clients, patients or other persons who obtain services or benefits under a policy of insurance for the purpose of engaging in any act or omission specified in this

section, except that such insurance fraud does not include contact or communication by an insurer or an agent ***, producer of insurance*** or representative of the insurer with a client, patient or other person if the contact or communication is made for a lawful purpose, including, without limitation, communication by an insurer with a holder of a policy of insurance issued by the insurer or with a claimant concerning the settlement of any claims against the policy.

(h) Participating in, aiding, abetting, conspiring to commit, soliciting another person to commit, or permitting an employee ***,*** ~~[or]~~ agent ***or producer of insurance*** to commit any act or omission specified in this section.

2. As used in this section, "policy of insurance" means:

(a) Any policy issued in this State by an authorized insurer; and

(b) Any policy issued outside this State by an authorized insurer which relates to property that:

(1) Is located in this State when any act or omission specified in this section occurs; or

(2) Was located in this State when the incident that gave rise to the act or omission specified in this section occurred.

Sec. 102. NRS 686A.310 is hereby amended to read as follows:

686A.310 1. ***An insurer engages in an unfair practice if the insurer engages in any activity specified in subsection 2 and the activity is engaged in:***

(a) Flagrantly and in conscious disregard for the provisions of this section and any regulations adopted pursuant thereto; or

(b) With such frequency so as to indicate that it is a general business practice for the insurer to engage in the activity.

2. Engaging in any of the following activities ***under the circumstances specified in subsection 1*** is considered to be an unfair practice:

(a) Misrepresenting to insureds or claimants pertinent facts or insurance policy provisions relating to any coverage at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(d) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(e) Failing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear.

(f) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(g) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(h) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, or the representative, agent ***,*** ~~[or]~~ broker ***or producer of insurance*** of the insured.

(i) Failing, upon payment of a claim, to inform insureds or beneficiaries of the coverage under which payment is made.

(j) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(k) Delaying the investigation or payment of claims by requiring an insured or a claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(l) Failing to settle claims promptly, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(m) Failing to comply with the provisions of NRS 687B.310 to 687B.390, inclusive, or 687B.410.

(n) Failing to provide promptly to an insured a reasonable explanation of the basis in the insurance policy, with respect to the facts of the insured's claim and the applicable law, for the denial of the claim or for an offer to settle or compromise the claim.

(o) Advising an insured or claimant not to seek legal counsel.

(p) Misleading an insured or claimant concerning any applicable statute of limitations.

(q) Refusing to pay claims without conducting a reasonable investigation.

(r) Failing to provide any forms necessary to present a claim, accompanied by a reasonable explanation regarding their use, within 15 days after the receipt of a request for such forms.

(s) Failing to adopt and implement reasonable standards to assure that any repairs made by a repairer who is owned by or

required to be used by the insurer are performed in a workmanlike manner.

~~[2.]~~ ***3.*** In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection ~~[1]~~ ***2*** as an unfair practice.

4. The purpose of this section is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of this State.

5. The provisions of this section do not apply to claims involving industrial insurance, surety insurance or boiler and machinery insurance.

Sec. 103. NRS 686A.490 is hereby amended to read as follows:

686A.490 1. No agreement may contain a provision allowing a company recourse against the agent ***or producer of insurance*** who submitted the agreement based upon the insured's default in payments.

2. A company, ***producer of insurance,*** broker or an agent of a company shall not offer to any person as an inducement to enter an agreement any gift, rebate or other consideration unless the consideration is an article of less than $2 in value which includes an advertisement of the company. This subsection does not prohibit a company from providing to a ***producer of insurance,*** broker or an agent who submits the agreement to the company any supplies or equipment necessary to submit the agreement to the company. Any such supplies or equipment which is not disposable remains the property of the company.

3. A company ~~[or an]~~ ***, producer of insurance,*** agent or broker submitting an agreement shall not:

(a) Induce or attempt to induce an insured to become obligated under more than one agreement to obtain more than one initial charge for entering the agreement.

(b) Write any insurance in connection with the agreement, including life or health insurance limited to the amount advanced on behalf of the insured.

Sec. 104. NRS 686A.500 is hereby amended to read as follows:

686A.500 1. Any licensed resident or nonresident agent ***,*** ~~[or]~~ broker ***or producer of insurance*** who has any financial interest in a company, other than in submitting agreements through the company, shall disclose to the insured, in the manner prescribed by the Commissioner, his or her interest in the company.

2. A licensed resident or nonresident agent ***,*** ~~[or]~~ broker ***or producer of insurance*** who submits any agreement shall not accept

any compensation for arranging, directing or performing services in connection with the agreement. A company shall not pay or offer to pay any compensation to a licensed resident or nonresident agent ***,*** ~~[or]~~ broker ***or producer of insurance*** who submits an agreement to the company.

Sec. 105. NRS 686A.510 is hereby amended to read as follows:

686A.510 1. A person who violates the provisions of NRS 686A.340 shall be punished by a fine of not more than $200 per day or $500 per agreement per day for every day the violation continues, whichever is greater.

2. A person who violates any other provision of NRS 686A.330 to 686A.520, inclusive, shall be punished by a fine of not more than ~~[$1,000.]~~ ***$10,000.***

3. A person who fails or refuses to comply with an order issued by the Commissioner pursuant to NRS 686A.330 to 686A.520, inclusive, shall be punished by a fine of not more than ~~[$1,000.]~~ ***$10,000.***

Sec. 106. NRS 686A.520 is hereby amended to read as follows:

686A.520 1. The provisions of NRS 683A.341, 683A.451, 683A.461 and 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** apply to companies.

2. For the purposes of subsection 1, unless the context requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "company."

Sec. 107. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

"Provider of health care" has the meaning ascribed to it in NRS 695G.070.

Sec. 108. NRS 687B.011 is hereby amended to read as follows:

687B.011 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 687B.015 and 687B.018 ***and section 107 of this act*** have the meanings ascribed to them in those sections.

Sec. 109. NRS 687B.120 is hereby amended to read as follows:

687B.120 1. Except as otherwise provided in subsection 2:

(a) No life or health insurance policy or contract, annuity contract form, policy form, health care plan or plan for dental care, whether individual, group or blanket, including those to be issued by a health maintenance organization, organization for dental care or prepaid limited health service organization, or application form where a written application is required and is to be made a part of

the policy or contract, or printed rider or endorsement form or form of renewal certificate, or form of individual certificate or statement of coverage to be issued under group or blanket contracts, or by a health maintenance organization, organization for dental care or prepaid limited health service organization, may be delivered or issued for delivery in this State, unless the form has been filed with and approved by the Commissioner.

(b) As to individual policies pursuant to paragraph (d) of subsection 2 of NRS 679B.220 or group insurance policies effectuated and delivered outside this State but covering persons resident in this State, the certificates to be delivered or issued for delivery in this State must be filed, for informational purposes only, with the Commissioner at the request of the Commissioner.

2. As to group insurance policies to be issued to a group approved pursuant to NRS 688B.030 or 689B.026, no policies of group insurance may be marketed to a resident or employer of this State unless the policy and any form or certificate to be issued pursuant to the policy has been filed with and approved by the Commissioner.

3. ***Each filing of a form or certificate pursuant to subsection 1 or 2 concerning a policy of long-term care insurance must be accompanied by a corresponding outline of the coverage of the policy.***

4. Every filing made pursuant to the provisions of subsection 1 or 2 must be made not less than 45 days in advance of any delivery pursuant to subsection 1 or marketing pursuant to subsection 2. At the expiration of 45 days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the Commissioner. Approval of any such form by the Commissioner constitutes a waiver of any unexpired portion of such waiting period. The Commissioner may extend by not more than an additional 30 days the period within which the Commissioner may so affirmatively approve or disapprove any such form, by giving notice to the insurer of the extension before expiration of the initial 45-day period. At the expiration of any such period as so extended, and in the absence of prior affirmative approval or disapproval, any such form shall be deemed approved. The Commissioner may at any time, after notice and for cause shown, withdraw any such approval.

~~[4.]~~ ***5.*** Any order of the Commissioner disapproving any such form or withdrawing a previous approval must state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer thereof. Any such withdrawal of a previously approved form is effective at the expiration of such a period, not less

than 30 days after the giving of notice of withdrawal, as the Commissioner in such notice prescribes.

~~[5.]~~ ***6.*** The Commissioner may, by order, exempt from the requirements of this section for so long as the Commissioner deems proper any insurance document or form or type thereof specified in the order, to which, in the opinion of the Commissioner, this section may not practicably be applied, or the filing and approval of which are, in the opinion of the Commissioner, not desirable or necessary for the protection of the public.

~~[6.]~~ ***7.*** Appeals from orders of the Commissioner disapproving any such form or withdrawing a previous approval may be taken as provided in NRS 679B.310 to 679B.370, inclusive.

Sec. 110. NRS 687B.404 is hereby amended to read as follows:

687B.404 1. An insurer or other organization providing health coverage pursuant to chapter 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of NRS, including, without limitation, a health maintenance organization or managed care organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid, shall adhere to the applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, Division C, Title V, Subtitle B, and any federal regulations issued pursuant thereto.

2. On or before ~~[July]~~ ***April*** 1 of each year, the Commissioner shall prescribe and provide to each insurer or other organization providing health coverage subject to the provisions of subsection 1 a data request that solicits information necessary to evaluate the compliance of an insurer or other organization with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, Division C, Title V, Subtitle B, including, without limitation, the comparative analyses specified in 42 U.S.C. § 300gg-26(a).

3. On or before ~~[October]~~ ***June*** 1 of each year, each insurer or other organization providing health coverage subject to the provisions of subsection 1 shall:

(a) Complete and submit to the Commissioner, in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners, the data request prescribed pursuant to subsection 2; or

(b) Submit to the Commissioner, in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners, a copy of a report submitted by the insurer or other organization to the Federal

Government demonstrating compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, Division C, Title V, Subtitle B, including, without limitation, the comparative analyses specified in 42 U.S.C. § 300gg-26(a). The Commissioner may request from an insurer or other organization who submits a copy of such a report any supplemental information necessary to determine whether the insurer or other organization is in compliance with that federal law.

4. Any information provided by an insurer or other organization to the Commissioner pursuant to subsection 3 is a public record except that the following information is confidential:

(a) Personally identifiable information of a consumer.

(b) Any information determined by the Commissioner to constitute a trade secret. In determining whether information provided pursuant to subsection 3, including, without limitation, information concerning mental health parity in the adequacy of the networks of insurers and other organizations, reimbursement rates for providers of health care, in-network and out-of-network utilization rates and the number and percentage of denials of claims, constitutes a trade secret pursuant to this paragraph:

(1) The Commissioner shall not make a determination that the information constitutes a trade secret solely because the information reflects whether an insurer is in compliance with the provisions of this section; and

(2) Any doubt or uncertainty regarding whether the information constitutes a trade secret must be resolved in favor of a determination that the information does not constitute a trade secret.

5. On or before December 31 of each year, the Commissioner shall compile a report summarizing the information submitted to the Commissioner pursuant to this section and submit the report to:

(a) The Patient Protection Commission created by NRS 439.908;

(b) The Governor; and

(c) The Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the next regular session of the Legislature; and

(2) In odd-numbered years, the Joint Interim Standing Committee on Health and Human Services.

6. The Commissioner may adopt any regulations necessary to carry out the provisions of this section.

7. As used in this section, “trade secret” has the meaning ascribed to it in NRS 600A.030.

Sec. 111. NRS 687B.409 is hereby amended to read as follows:

687B.409 1. Every payment made pursuant to a policy of health insurance to pay for treatment relating solely to mental health or an alcohol or substance use disorder must be made directly to the provider of health care that provides the treatment if the provider:

(a) Is an out-of-network provider; and

(b) Has obtained and delivered to the insurer or an authorized representative of the insurer, including, without limitation, a third-party administrator, a written assignment of benefits pursuant to which the insured has assigned to the provider the insured's benefits under the policy of health insurance with regard to the treatment.

2. An out-of-network provider that receives payment pursuant to subsection 1:

(a) Shall, if a person paid the provider directly for the treatment described in subsection 1, refund to the person the amount that the person paid directly to the provider for the treatment, less any applicable deductible, copayment or coinsurance, not later than 45 days after the provider receives payment pursuant to subsection 1; and

(b) Must indemnify and hold harmless the insurer against any claim made against the insurer by the person who receives the treatment described in subsection 1 for any amount paid by the insurer to the provider in compliance with this section.

3. An assignment of benefits described in paragraph (b) of subsection 1 is irrevocable for the period:

(a) Beginning on the date the insured gives to the out-of-network provider the assignment of benefits; and

(b) Ending on the later of:

(1) The date on which the out-of-network provider receives from the insurer the final payment for the treatment; or

(2) The date of the final resolution, including, without limitation, by settlement or trial, of all claims relating to all payments which relate to the treatment.

4. Nothing in this section shall be construed to require an insurer to make a payment to an out-of-network provider:

(a) Who is not authorized by law to provide the treatment;

(b) Who provides the treatment in violation of any law; or

(c) In an amount which exceeds the amount required by the policy of health insurance to be paid for out-of-network treatment.

5. As used in this section:

(a) "Health care services" ~~[means services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease.]~~ ***has the meaning ascribed to it in NRS 695G.022.***

(b) "Insured" means a person who receives benefits pursuant to a policy of health insurance.

(c) "Insurer" means a person, including, without limitation, a governmental entity, who issues or otherwise provides a policy of health insurance.

(d) "Network plan" has the meaning ascribed to it in NRS ~~[689B.570.]~~ ***687B.645.***

(e) "Out-of-network provider" means a provider of health care who:

(1) Provides health care services;

(2) Is paid, pursuant to a policy of health insurance, for providing the health care services; and

(3) Is not under contract to provide the health care services as part of any network plan associated with the policy of health insurance.

(f) "Policy of health insurance" includes, without limitation, a policy, contract, certificate, plan or agreement, as applicable, issued pursuant to or otherwise governed by NRS 287.0402 to 287.049, inclusive, or chapter 608, 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of NRS for the provision of, delivery of, arrangement for, payment for or reimbursement for any of the costs of health care services.

~~[(g) "Provider of health care" has the meaning ascribed to it in NRS 695G.070.]~~

Sec. 112. NRS 687B.490 is hereby amended to read as follows:

687B.490 1. A carrier that offers coverage in the small employer group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements described in subsection 2.

2. The Commissioner shall determine, within 90 days after receipt of the application required pursuant to subsection 1, if the carrier, with respect to the network plan:

(a) Has demonstrated the willingness and ability to ensure that health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities in a manner that enhances availability, accessibility and continuity of service;

(b) Has organizational arrangements established in accordance with regulations promulgated by the Commissioner; and

(c) Has a procedure established in accordance with regulations promulgated by the Commissioner to develop, compile, evaluate

and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner.

3. The Commissioner may certify that the carrier and the network plan meet the requirements of subsection 2, or may determine that the carrier and the network plan do not meet such requirements. Upon a determination that the carrier and the network plan do not meet the requirements of subsection 2, the Commissioner shall specify in what respects the carrier and the network plan are deficient.

4. A carrier approved to issue a network plan pursuant to this section must file annually with the Commissioner a summary of information compiled pursuant to subsection 2 in a manner determined by the Commissioner.

5. The Commissioner shall, not less than once each year, or more often if deemed necessary by the Commissioner for the protection of the interests of the people of this State, make a determination concerning the availability and accessibility of the health care services of any network plan approved pursuant to this section.

6. The expense of any determination made by the Commissioner pursuant to this section must be assessed against the carrier and remitted to the Commissioner.

7. When making any determination concerning the availability and accessibility of the services of any network plan or proposed network plan pursuant to this section, the Commissioner shall consider services that may be provided through telehealth, as defined in NRS 629.515, pursuant to the network plan or proposed network plan to be available services.

8. As used in this section:

(a) "Network plan" has the meaning ascribed to it in NRS ~~[689B.570.]~~ ***687B.645.***

(b) "Small employer" has the meaning ascribed to it in NRS 689C.095.

Sec. 113. NRS 687B.860 is hereby amended to read as follows:

687B.860 As used in NRS 687B.860 to 687B.884, inclusive, unless the context otherwise requires, the words and terms defined in NRS 687B.862 to ~~[687B.876,]~~ ***687B.874,*** inclusive, have the meanings ascribed to them in those sections.

Sec. 114. NRS 687B.866 is hereby amended to read as follows:

687B.866 "Health care services" has the meaning ascribed to it in NRS ~~[687B.620.]~~ ***695G.022.***

Sec. 115. NRS 688A.010 is hereby amended to read as follows:

688A.010 This chapter, with the exception of NRS 688A.390 ~~[,]~~ ***and 688A.430,*** applies only to contracts of life insurance, endowment and annuities, other than reinsurance, group life insurance and group annuities.

Sec. 116. NRS 688C.175 is hereby amended to read as follows:

688C.175 1. Persons engaged in the business of viatical settlements are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

(a) NRS 679B.230 to 679B.300, inclusive, concerning examinations of insurers.

(b) NRS 679B.310 to 679B.370, inclusive, concerning hearings regarding insurers and employees of insurers.

(c) Chapter 680A of NRS.

(d) Chapter 683A of NRS.

(e) NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** concerning trade practices and frauds.

2. Nothing in this chapter or elsewhere in this title preempts or otherwise limits the provisions of chapter 90 of NRS, or of any rules, regulations or orders issued by or through the Administrator of the Securities Division of the Office of the Secretary of State or the Administrator's designee acting pursuant to the authority granted by chapter 90 of NRS.

3. Compliance with the provisions of this chapter does not constitute compliance with any applicable provisions of chapter 90 of NRS or with any rule, regulation or order adopted or issued thereunder.

Sec. 117. NRS 688D.050 is hereby amended to read as follows:

688D.050 1. "Policy of life insurance" means any policy, contract or certificate of life insurance that provides a death benefit.

2. The term does not include:

(a) A policy or certificate of life insurance that is used to fund a ~~[preneed]~~ ***prepaid*** contract or sales agreement for funeral or burial services pursuant to chapter 689 of NRS;

(b) A policy or certificate of credit life insurance or credit accident and health insurance pursuant to chapter 690A of NRS; or

(c) A policy or certificate of accidental death insurance.

Sec. 118. NRS 689.160 is hereby amended to read as follows:

689.160 1. The provisions of NRS 683A.341, 683A.451, 683A.461 and 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** apply to agents and sellers.

2. For the purposes of subsection 1, unless the context requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "agent" and "seller."

3. The provisions of NRS 679B.230 to 679B.300, inclusive, apply to sellers. Unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "seller."

4. The provisions of NRS 683A.301 apply to applicants for and holders of a seller's certificate of authority. Unless the context requires that a provision apply only to an applicant for or holder of a license as a producer of insurance, any reference in that section to:

(a) An "applicant for a license as a producer of insurance" must be replaced by a reference to an "applicant for a seller's certificate of authority"; and

(b) A "licensee" must be replaced by a reference to a "holder of a seller's certificate of authority."

Sec. 119. NRS 689.215 is hereby amended to read as follows:

689.215 1. After giving written notice of charges to the seller ~~[, not less than 30 days in advance of]~~ ***and the opportunity for*** a hearing, the Commissioner may ~~[, after the hearing,]~~ revoke the seller's certificate of authority if the seller:

(a) Obtained the certificate of authority through misrepresentation or concealment of a material fact;

(b) Is no longer qualified for such a certificate of authority; or

(c) Knowingly violates any provision of NRS 689.150 to 689.375, inclusive, or any lawful order or regulation of the Commissioner.

2. If a seller is found to be in violation of paragraph (c) of subsection 1, the Commissioner may, in lieu of revocation, suspend the seller's certificate of authority for a period not to exceed 90 days.

Sec. 120. NRS 689.345 is hereby amended to read as follows:

689.345 The net purchase price of the ~~[preneed]~~ ***prepaid*** contract shall be available to the buyer or the estate or heirs of the buyer at any time prior to performing the service described in the ~~[preneed]~~ ***prepaid*** contract upon written notice to the seller and trustee of the intent of the buyer or the estate or heirs of the buyer to terminate the ~~[preneed]~~ ***prepaid*** contract and withdraw trust funds attributable to the buyer.

Sec. 121. NRS 689.455 is hereby amended to read as follows:

689.455 "Burial merchandise" means those items normally supplied by a cemetery authority under a ~~[preneed]~~ ***prepaid*** sales agreement, including urns, memorials, scrolls, vases, foundations, bases and other similar merchandise, but does not include the sale of space for interment, entombment or inurnment.

Sec. 122. NRS 689.460 is hereby amended to read as follows:

689.460 "Burial services" means those services normally performed by a cemetery authority under a ~~[preneed]~~ ***prepaid*** sales agreement for the opening and closing of graves, crypts and niches, and other services in relation thereto.

Sec. 123. NRS 689.510 is hereby amended to read as follows:

689.510 1. After giving written notice of charges to the seller ~~[, not less than 30 days in advance of]~~ ***and an opportunity for*** a hearing, the Commissioner may ~~[, after the hearing,]~~ revoke the seller's permit if the seller:

(a) Obtained the permit through misrepresentation or concealment of a material fact;

(b) Is no longer qualified for such a permit; or

(c) Violates any provision of NRS 689.450 to 689.595, inclusive, or any lawful order or regulation of the Commissioner.

2. If a seller is found to be in violation of paragraph (c) of subsection 1, the Commissioner may, in lieu of revocation, suspend the seller's permit for a period not to exceed 90 days.

Sec. 124. NRS 689.595 is hereby amended to read as follows:

689.595 1. The provisions of NRS 683A.341, 683A.451, 683A.461 and 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** apply to agents and sellers.

2. For the purposes of subsection 1, unless the context requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "agent" and "seller."

3. The provisions of NRS 679B.230 to 679B.300, inclusive, apply to sellers. Unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "seller."

4. The provisions of NRS 683A.301 apply to applicants for and holders of a seller's permit. Unless the context requires that a provision apply only to an applicant for or a holder of a license as a producer of insurance, any reference in that section to:

(a) An "applicant for a license as a producer of insurance" must be replaced by a reference to an "applicant for a seller's permit"; and

(b) A "licensee" must be replaced by a reference to a "holder of a seller's permit."

Sec. 125. NRS 689.715 is hereby amended to read as follows:

689.715 1. A funeral director, funeral arranger or cemetery authority that enters into a ~~[preneed]~~ ***prepaid*** sales agreement shall, upon the death of the buyer, provide a copy of the agreement to each person entitled to custody of the remains.

2. The Commissioner may impose upon any person who knowingly violates the provisions of subsection 1 an administrative

fine of three times the amount of the ~~[preneed]~~ ***prepaid*** sales agreement.

Sec. 126. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 127 to 132, inclusive, of this act.

Sec. 127. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 128 to 132, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 128. ***"Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.***

Sec. 129. ***"Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.***

Sec. 130. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 131. ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

Sec. 132. ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 133. NRS 689A.035 is hereby amended to read as follows:

689A.035 1. An insurer shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider 45 days' written notice of the modification of the insurer's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within

the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments, including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 134. NRS 689A.04033 is hereby amended to read as follows:

689A.04033 1. A policy of health insurance must provide coverage for medical treatment which a policyholder or subscriber receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The policyholder or subscriber has signed, before participating in the clinical trial or study, a statement of consent indicating that the policyholder or subscriber has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the policyholder or subscriber.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the policy of health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of health insurance for a policyholder or subscriber participating in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the policyholder or subscriber is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the policyholder or subscriber during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the policyholder or subscriber during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 689A.04036, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay

the provider the rate of reimbursement that is paid to other providers with whom the insurer has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to a policyholder or subscriber is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the policyholder or subscriber.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the policyholder's or subscriber's policy of health insurance, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the policyholder or subscriber during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the policyholder or subscriber.

(h) Any costs for the management of research relating to the clinical trial or study.

5. An insurer who delivers or issues for delivery a policy of health insurance specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the policyholder or subscriber, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. An insurer who delivers or issues for delivery a policy specified in subsection 1 shall:

(a) Include in any disclosure of the coverage provided by the policy notice to each policyholder and subscriber under the policy of the availability of the benefits required by this section.

(b) Provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

7. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with this section is void.

8. An insurer who delivers or issues for delivery a policy specified in subsection 1 is immune from liability for:

(a) Any injury to a policyholder or subscriber caused by:

(1) Any medical treatment provided to the policyholder or subscriber in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the policyholder or subscriber in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of a policyholder's or subscriber's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the "Policies and Guidelines Relating to the Cancer Center Support Grant" published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

~~[(c) "Provider of health care" means:~~

~~(1) A hospital; or~~

~~(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.]~~

Sec. 135. NRS 689A.04043 is hereby amended to read as follows:

689A.04043 1. When developing a step therapy protocol, an insurer shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. An insurer that offers or issues a policy of health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the insurer concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the insurer; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the insurer shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. An insurer shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The insurer shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of health insurance at the time the attending practitioner selected the drug.

4. If an insurer does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the insurer shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689A.04041 apply.

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

~~(a) "Attending]~~ ***, "attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.]~~

Sec. 136. NRS 689A.04048 is hereby amended to read as follows:

689A.04048 1. A policy of health insurance which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the insurer is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section ~~[~~**:**

~~(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.~~

~~(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care is 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) "Step~~**]** **, "*step*** therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or

her policy of health insurance provides coverage for the recommended drug.

Sec. 137. NRS 689A.04049 is hereby amended to read as follows:

689A.04049 1. An insurer that issues a policy of health insurance shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. 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.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

~~[4. As used in this section:~~

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

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

Sec. 138. NRS 689A.0405 is hereby amended to read as follows:

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

(a) A mammogram to screen for breast cancer annually for insureds who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

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

(a) Except as otherwise provided in subsection 6, require an insured to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

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

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

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

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

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

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified policy of health insurance with respect to the deductible of such a policy of health insurance after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall

apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

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

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

~~(d) "Qualified"~~ ***, "qualified*** policy of health insurance" means a policy of health insurance that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 139. NRS 689A.0412 is hereby amended to read as follows:

689A.0412 1. An insurer that issues a policy of health insurance shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the insured by a provider of health care, facility or medical laboratory that participates in the network plan of the insurer; and

(b) Without prior authorization.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

4. As used in this section ~~[~~:

~~(a) "Medical"~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

~~[(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers~~

~~under contract with the insurer. The term does not include an arrangement for the financing of premiums.~~

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

Sec. 140. NRS 689A.0413 is hereby amended to read as follows:

689A.0413 1. A policy of health insurance must include a provision authorizing a woman covered by the policy to:

(a) Obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

(b) Designate as her primary care physician an obstetrician or gynecologist who:

(1) Participates in the network plan of the insurer;

(2) Satisfies the criteria established by the insurer for designation as a primary care provider under the policy of health insurance; and

(3) Agrees to abide by all terms and conditions imposed by the insurer on other primary care physicians generally.

2. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

3. As used in this section ~~[~~:

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

~~(b) "Primary~~] ***, "primary*** care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 141. NRS 689A.0415 is hereby amended to read as follows:

689A.0415 1. An insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for any type of hormone replacement therapy which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

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

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

other condition for coverage for a prescription for hormone replacement therapy;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future 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.

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

Sec. 142. NRS 689A.0417 is hereby amended to read as follows:

689A.0417 1. An insurer that offers or issues a policy of health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to hormone replacement therapy.

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

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to hormone replacement therapy;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future 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. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 143. NRS 689A.0418 is hereby amended to read as follows:

689A.0418 1. Except as otherwise provided in subsection 8, an insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. An insurer shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same

extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

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

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.

5. Except as otherwise provided in subsections 9, 10 and 12, an insurer that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

7. Except as otherwise provided in subsection 8, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision

of the policy or the renewal which is in conflict with this section is void.

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

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

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug Administration, a policy of health insurance must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the insurer charges a copayment or coinsurance for a drug for contraception, the insurer may only require an insured to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

13. An insurer shall not:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an insured gives birth.

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

15. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with an insurer to provide services to insureds through a network plan offered or issued by the insurer.

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

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

~~(d)]~~ "Provider network contract" means a contract between an insurer and a provider of health care or pharmacy specifying the rights and responsibilities of the insurer and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 144. NRS 689A.0419 is hereby amended to read as follows:

689A.0419 1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

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

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

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

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

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

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

(g) Screening for depression;

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

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

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and

Prevention of the United States Department of Health and Human Services or its successor organization; and

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

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

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

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

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

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

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

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

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

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

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

~~[6. As used in this section~~

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

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

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

Sec. 145. NRS 689A.04195 is hereby amended to read as follows:

689A.04195 1. Except as otherwise provided in subsection 4, an insurer that issues a policy of health insurance shall include in the policy coverage for 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 is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, 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 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 health insurance that is subject to the requirements of subsection 1 and before the renewal of such a policy, provide to the insured or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

5. A policy of health insurance 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.

~~[6. As used in this section:~~

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

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

Sec. 146. NRS 689A.0428 is hereby amended to read as follows:

689A.0428 1. An insurer that issues a policy of health insurance shall include in the policy coverage for:

(a) Necessary case management services for an insured diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an insured who has been diagnosed with sickle cell disease and its variants.

2. An insurer that issues a policy of health insurance which provides coverage for prescription drugs shall include in the policy coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

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

4. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~(c)]~~ "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

~~[(d)]~~ *(c)* "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 147. NRS 689A.0432 is hereby amended to read as follows:

689A.0432 1. Except as otherwise provided in this section, an insurer that issues a policy of health insurance shall include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a policy of health insurance to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. An insurer that issues a policy of health insurance shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the policy provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. An insurer that issues a policy of health insurance may prescribe requirements that must be satisfied before the insurer covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;

(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;

(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, an insurer must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. An insurer shall make a reasonable effort to 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. If, after a reasonable effort, the insurer is unable to make such benefits available through such a provider of health care, the insurer may treat the treatment that the insurer is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the insurer.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the insurer must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, 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.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

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

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

Sec. 148. NRS 689A.0434 is hereby amended to read as follows:

689A.0434 1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for insureds who are less than 26 years of age.

2. An insurer shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

~~(c)]~~ "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)]~~ ***(c)*** "Rehabilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 149. NRS 689A.0435 is hereby amended to read as follows:

689A.0435 1. A health benefit plan must provide ~~[an option of]~~ coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders for persons covered by the policy under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years. For the purposes of such coverage, an insurer shall accept as dispositive any diagnosis of an autism spectrum disorder that is rendered in

accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders through the age of 21 years prescribed pursuant to NRS 427A.872.

2. ~~[Optional coverage]~~ ***Coverage*** provided pursuant to this section must be subject to:

(a) A maximum benefit of not less than the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusions or limitations of a policy of health insurance to the same extent as other medical services or prescription drugs covered by the policy.

3. A health benefit plan that offers or issues a policy of health insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for optional coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the policy; or

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

4. Except as otherwise provided in subsections 1 and 2, an insurer who offers optional coverage pursuant to subsection 1 shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice.

➥ An insurer may request a copy of and review a treatment plan created pursuant to this subsection.

6. Nothing in this section shall be construed as requiring an insurer to provide reimbursement to a school for services delivered through school services.

7. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without

limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorder" has the meaning ascribed to it in NRS 427A.875.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(d) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(e) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(f) "Licensed assistant behavior analyst" has the meaning ascribed to the term "assistant behavior analyst" in NRS 641D.020.

(g) "Licensed behavior analyst" has the meaning ascribed to the term "behavior analyst" in NRS 641D.030.

(h) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

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

~~(j)]~~ "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

~~[(k)]~~ ***(j)*** "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

~~[(l)]~~ ***(k)*** "Registered behavior technician" has the meaning ascribed to it in NRS 641D.100.

~~[(m)]~~ ***(l)*** "Screening for ***and diagnosis of*** autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

~~[(n)]~~ ***(m)*** "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

~~[(o)]~~ ***(n)*** "Treatment plan" means a plan to treat an autism spectrum disorder that is developed by a provider of health care

acting within his or her scope of practice after he or she has assessed the person for whom the treatment plan is developed.

Sec. 150. NRS 689A.0437 is hereby amended to read as follows:

689A.0437 1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the insurer;

(b) Laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the insurer.

2. An insurer that offers or issues a policy of health insurance shall reimburse:

(a) A pharmacist who participates in the network plan of the insurer for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the insurer for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. An insurer shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. 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.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 151. NRS 689A.044 is hereby amended to read as follows:

689A.044 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for:

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

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

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

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

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

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

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

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

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

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

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

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

6. As used in this section ~~[~~:

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

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

~~(c) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers~~

~~under contract with the insurer. The term does not include an arrangement for the financing of premiums.~~

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

Sec. 152. NRS 689A.0446 is hereby amended to read as follows:

689A.0446 1. Subject to the limitations prescribed by subsection 4, an insurer that issues a policy of health insurance shall include in the policy coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. An insurer shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the insurer.

3. If an insurer requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the insurer shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require an insurer to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the insurer; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

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

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

Sec. 153. NRS 689A.0459 is hereby amended to read as follows:

689A.0459 1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the insurer. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. An insurer that offers or issues a policy of health insurance shall reimburse a pharmacist or pharmacy that participates in the network plan of the insurer for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. An insurer shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of whether the drug is included in the formulary of the insurer.

4. Except as otherwise provided in this subsection, an insurer shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step therapy. An insurer may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. An insurer shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. 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.

7. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

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

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 154. NRS 689A.0463 is hereby amended to read as follows:

689A.0463 1. A policy of health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A policy of health insurance must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. An insurer shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A policy of health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A policy of health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 155. NRS 689A.080 is hereby amended to read as follows:

689A.080 1. There shall be a provision as follows:

> Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however,

that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed herein or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

2. The last sentence of subsection 1 may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(a) Until at least age 50; or

(b) In the case of a policy issued after age 44, for at least 5 years from its date of issue.

3. Pursuant to the last sentence in subsection 1, the insurer shall apply the premium accepted in such manner as to place the policy currently in force, exclusive of any applicable grace period, but not in any event to any period more than 60 days prior to the date of reinstatement.

4. The provisions of this section do not apply to a health benefit plan as defined in NRS 687B.470.

Sec. 156. NRS 689A.135 is hereby amended to read as follows:

689A.135 1. A person insured under a policy of health insurance may assign his or her right to benefits to the provider of health care who provided the services covered by the policy. The insurer shall pay all or the part of the benefits assigned by the insured to the person designated by the insured. A payment made pursuant to this subsection discharges the insurer's obligation to pay those benefits.

2. If the insured makes an assignment under this section, but the insurer after receiving a copy of the assignment pays the benefits to the insured, the insurer shall also pay those benefits to the

provider of health care who received the assignment as soon as the insurer receives notice of the incorrect payment.

~~[3. For the purpose of this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 157. NRS 689A.635 is hereby amended to read as follows:

689A.635 ~~[1.]~~ An individual carrier that offers coverage through a network plan is not required pursuant to NRS 689A.630 to offer coverage to or accept an application from a person if the person does not reside or work in the geographic service area or in a geographic rating area, provided that the coverage is refused or terminated uniformly without regard to any health status-related factor of any eligible person.

~~[2. As used in this section, "network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.]~~

Sec. 158. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 159 to 164, inclusive, of this act.

Sec. 159. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 160 to 164, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 160. ***"Medical management technique" has the meaning ascribed to it in section 128 of this act.***

Sec. 161. ***"Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.***

Sec. 162. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 163. ***"Primary care" has the meaning ascribed to it in section 131 of this act.***

Sec. 164. ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 165. NRS 689B.015 is hereby amended to read as follows:

689B.015 1. An insurer that issues a policy of group health insurance shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant

to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider 45 days' written notice of the modification of the insurer's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments, including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 166. NRS 689B.0306 is hereby amended to read as follows:

689B.0306 1. A policy of group health insurance must provide coverage for medical treatment which a person insured under the group policy receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The insured has signed, before participating in the clinical trial or study, a statement of consent indicating that the insured has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured person.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the policy of group health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of group health insurance for an insured participating in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the insured is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the insured during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the insured during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 689B.0303, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay the provider the rate of reimbursement that is paid to other providers with whom the insurer has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to a person insured under the group policy is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the group policy.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the insured's policy of group health insurance, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study, including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the insured during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured.

(h) Any costs for the management of research relating to the clinical trial or study.

5. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the insured, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 shall:

(a) Include in any disclosure of the coverage provided by the policy notice to each group policyholder of the availability of the benefits required by this section.

(b) Provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

7. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with this section is void.

8. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 is immune from liability for:

(a) Any injury to the insured caused by:

(1) Any medical treatment provided to the insured in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the insured in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an insured's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the "Policies and Guidelines Relating to the Cancer Center Support Grant" published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

~~[(c) "Provider of health care" means:~~

~~(1) A hospital; or~~

~~(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.]~~

Sec. 167. NRS 689B.0307 is hereby amended to read as follows:

689B.0307 1. When developing a step therapy protocol, an insurer shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. An insurer that offers or issues a policy of group health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the insurer concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the insurer; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not

later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the insurer shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. An insurer shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The insurer shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of group health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of group health insurance at the time the attending practitioner selected the drug.

4. If an insurer does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the insurer shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage

required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to:

(a) Any prescription drug to which the provisions of NRS 689B.0305 apply.

(b) Any policy of group health insurance purchased or provided pursuant to NRS 287.010.

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

~~(a) "Attending]~~ ***,*** ***"attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.]~~

Sec. 168. NRS 689B.031 is hereby amended to read as follows:

689B.031 1. A policy of group health insurance must include a provision authorizing a woman covered by the policy to:

(a) Obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

(b) Designate as her primary care physician an obstetrician or gynecologist who:

(1) Participates in the network plan of the insurer;

(2) Satisfies the criteria established by the insurer for designation as a primary care provider under the policy of group health insurance; and

(3) Agrees to abide by all terms and conditions imposed by the insurer on other primary care physicians generally.

2. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

3. As used in this section ~~[:~~

~~(a) "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.~~

~~(b) "Primary]~~ ***,*** ***"primary*** care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 169. NRS 689B.0312 is hereby amended to read as follows:

689B.0312 1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the insurer;

(b) Laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the insurer.

2. An insurer that offers or issues a policy of group health insurance shall reimburse:

(a) A pharmacist who participates in the network plan of the insurer for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the insurer for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. An insurer shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. 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.

5. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 170. NRS 689B.0313 is hereby amended to read as follows:

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

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

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

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

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

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

other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

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

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

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

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

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

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

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

6. As used in this section ~~[~~:

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

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

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

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

Sec. 171. NRS 689B.0314 is hereby amended to read as follows:

689B.0314 1. An insurer that issues a policy of group health insurance shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. 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.

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

~~[4. As used in this section:~~

~~(a) "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.~~

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

Sec. 172. NRS 689B.0315 is hereby amended to read as follows:

689B.0315 1. An insurer that issues a policy of group health insurance shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the insured by a provider of health care, facility or medical laboratory that participates in the network plan of the insurer; and

(b) Without prior authorization.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

4. As used in this section ~~[:~~

~~(a) "Medical"~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

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

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

Sec. 173. NRS 689B.0319 is hereby amended to read as follows:

689B.0319 1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the insurer. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. An insurer that offers or issues a policy of group health insurance shall reimburse a pharmacist or pharmacy that participates in the network plan of the insurer for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. An insurer shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of whether the drug is included in the formulary of the insurer.

4. Except as otherwise provided in this subsection, an insurer shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step

therapy. An insurer may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. An insurer shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. 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.

7. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

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

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 174. NRS 689B.0334 is hereby amended to read as follows:

689B.0334 1. Except as otherwise provided in this section, an insurer that issues a policy of group health insurance shall include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;

(b) Pediatric endocrinologists;
(c) Social workers;
(d) Psychiatrists;
(e) Psychologists;
(f) Gynecologists;
(g) Speech-language pathologists;
(h) Primary care physicians;
(i) Advanced practice registered nurses;
(j) Physician assistants; and
(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a policy of group health insurance to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. An insurer that issues a policy of group health insurance shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the policy provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. An insurer that issues a policy of group health insurance may prescribe requirements that must be satisfied before the insurer covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;
(b) The treatment must be recommended by a physician;
(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;
(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and
(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, an insurer must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. An insurer shall make a reasonable effort to 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. If, after a reasonable effort, the insurer is unable

to make such benefits available through such a provider of health care, the insurer may treat the treatment that the insurer is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the insurer.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the insurer must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

~~[(d) "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.~~

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

Sec. 175. NRS 689B.03345 is hereby amended to read as follows:

689B.03345 1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for insureds who are less than 26 years of age.

2. An insurer shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

~~(c)]~~ "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)]~~ *(c)* "Rehabilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 176. NRS 689B.0335 is hereby amended to read as follows:

689B.0335 1. A health benefit plan must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the policy of group health insurance under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years. For the purposes of such coverage, an insurer shall accept as dispositive any diagnosis of an autism spectrum disorder that is rendered in accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders through the age of 21 years prescribed pursuant to NRS 427A.872.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a policy of group health insurance to the same extent as other medical services or prescription drugs covered by the policy.

3. A health benefit plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for

outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the policy; or

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1.

4. Except as otherwise provided in subsections 1 and 2, an insurer shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice.

➥ An insurer may request a copy of and review a treatment plan created pursuant to this subsection.

6. A policy subject to the provisions of this chapter that 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 which is in conflict with subsection 1 or 2 is void.

7. Nothing in this section shall be construed as requiring an insurer to provide reimbursement to a school for services delivered through school services.

8. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorder" has the meaning ascribed to it in NRS 427A.875.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior

provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(d) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(e) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(f) "Licensed assistant behavior analyst" has the meaning ascribed to the term "assistant behavior analyst" in NRS 641D.020.

(g) "Licensed behavior analyst" has the meaning ascribed to the term "behavior analyst" in NRS 641D.030.

(h) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

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

~~(j)]~~ "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

~~[(k)]~~ ***(j)*** "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

~~[(l)]~~ ***(k)*** "Registered behavior technician" has the meaning ascribed to it in NRS 641D.100.

~~[(m)]~~ ***(l)*** "Screening for ***and diagnosis of*** autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

~~[(n)]~~ ***(m)*** "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

~~[(o)]~~ ***(n)*** "Treatment plan" means a plan to treat an autism spectrum disorder that is developed by a provider of health care acting within his or her scope of practice after he or she has assessed the person for whom the treatment plan is developed.

Sec. 177. NRS 689B.034 is hereby amended to read as follows:

689B.034 1. Every policy of group health insurance must contain a provision which reduces the insurer's liability because of benefits under other valid group coverage. To the extent authorized by the Commissioner, such a provision may include subrogation.

2. A provision for subrogation may include a lien upon any recovery by an insured from a third person for the cost of medical benefits paid by the insurer for injuries incurred as a result of the actions of the third person. The lien may not exceed the amount paid by the insurer.

3. ***A provision required by this section must contain a definition of "other valid group coverage" that is approved by the Commissioner. The definition:***

(a) May include, without limitation, hospital, surgical, medical or major medical benefits provided by individual or family-type coverage, governmental programs or workers' compensation.

(b) Must not include any health benefits payable by an automobile plan, franchise plan or third-party coverage.

4. The insurer may require, as part of the proof of the claim, any information necessary to administer a provision required by this section.

5. An insurer may not deny payment for services because of the inclusion of a provision required by this section.

Sec. 178. NRS 689B.0358 is hereby amended to read as follows:

689B.0358 1. An insurer that issues a policy of group health insurance shall include in the policy coverage for:

(a) Necessary case management services for an insured who has been diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an insured who has been diagnosed with sickle cell disease and its variants.

2. An insurer that issues a policy of group health insurance which provides coverage for prescription drugs shall include in the policy coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

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

4. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~authorization or categorizing drugs and devices based on cost, type or method of administration.~~

~~(c)~~] "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

~~[(d)]~~ *(c)* "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 179. NRS 689B.0361 is hereby amended to read as follows:

689B.0361 1. Subject to the limitations prescribed by subsection 4, an insurer that issues a policy of group health insurance shall include in the policy coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. An insurer shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the insurer.

3. If an insurer requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the insurer shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require an insurer to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the insurer; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

~~[(f) "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.~~

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

Sec. 180. NRS 689B.0369 is hereby amended to read as follows:

689B.0369 1. A policy of group or blanket health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A policy of group or blanket health insurance must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. An insurer shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or

reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A policy of group or blanket health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for that service when provided in person. A policy of group or blanket health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.

6. A policy of group or blanket health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 181. NRS 689B.0374 is hereby amended to read as follows:

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

(a) A mammogram to screen for breast cancer annually for insureds who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

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

(a) Except as otherwise provided in subsection 6, require an insured to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

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

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

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

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

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

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified policy of group health insurance with respect to the deductible of such a policy of group health insurance after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

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

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

~~(d) "Qualified~~**]** **,** ***"qualified*** policy of group health insurance" means a policy of group health insurance that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 182. 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.

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

Sec. 183. NRS 689B.03765 is hereby amended to read as follows:

689B.03765 1. A policy of group health insurance which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the

insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the insurer is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) ~~[~~"Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care is 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)~~] "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her policy of group health insurance provides coverage for the recommended drug.

Sec. 184. NRS 689B.0377 is hereby amended to read as follows:

689B.0377 1. An insurer that offers or issues a policy of group health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to hormone replacement therapy.

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

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to 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. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 185. NRS 689B.0378 is hereby amended to read as follows:

689B.0378 1. Except as otherwise provided in subsection 8, an insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 12; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 12;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. An insurer shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable ***provider*** network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

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

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.

5. Except as otherwise provided in subsections 10, 11 and 13, an insurer that offers or issues a policy of group health insurance shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

7. Except as otherwise provided in subsection 8, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

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

9. If an insurer refuses, pursuant to subsection 8, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

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

11. For each of the 18 methods of contraception listed in subsection 12 that have been approved by the Food and Drug Administration, a policy of group health insurance must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the insurer charges a copayment or coinsurance for a drug for contraception, the insurer may only require an insured to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;
(b) Surgical sterilization implants for women;
(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
(r) Ulipristal acetate for emergency contraception.

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

14. An insurer shall not:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 12 at a hospital immediately after an insured gives birth.

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

16. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with an insurer to provide services to insureds through a network plan offered or issued by the insurer.

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

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

~~(d)]~~ "Provider network contract" means a contract between an insurer and a provider of health care or pharmacy specifying the rights and responsibilities of the insurer and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 186. NRS 689B.03785 is hereby amended to read as follows:

689B.03785 1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

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

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

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

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

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

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

(g) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[6. As used in this section:~~

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

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

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

Sec. 187. NRS 689B.080 is hereby amended to read as follows:

689B.080 Any insurer authorized to write health insurance in this State, including a nonprofit corporation for hospital, medical or dental services that has a certificate of authority issued pursuant to chapter 695B of NRS, may issue blanket accident and health insurance. No blanket policy, except as provided in subsection ~~[5]~~ ***6*** of NRS 687B.120, may be issued or delivered in this State unless a copy of the form thereof has been filed in accordance with NRS 687B.120. Every blanket policy must contain provisions which in the opinion of the Commissioner are not less favorable to the policyholder and the individual insured than the following:

1. A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured constitutes the entire contract between the parties, and that any statement made by the policyholder or by a person insured is in the absence of fraud a representation and not a warranty, and that no such statements may be used in defense to a claim under the policy, unless contained in a written application. The insured or the beneficiary or assignee of the insured has the right to make a written

request to the insurer for a copy of an application, and the insurer shall, within 15 days after the receipt of a request at its home office or any branch office of the insurer, deliver or mail to the person making the request a copy of the application. If a copy is not so delivered or mailed, the insurer is precluded from introducing the application as evidence in any action based upon or involving any statements contained therein.

2. A provision that written notice of sickness or of injury must be given to the insurer within 20 days after the date when the sickness or injury occurred. Failure to give notice within that time does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible.

3. A provision that the insurer will furnish to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of 15 days after giving written notice of sickness or injury, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

4. A provision that in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within 90 days after the date of the loss. Failure to furnish such proof within that time does not invalidate or reduce any claim if it is shown that it was not reasonably possible to furnish proof and that the proof was furnished as soon as was reasonably possible.

5. A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of written proof of loss, and that, subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of that period will be paid immediately upon receipt of proof.

6. A provision that the insurer at its own expense has the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim

under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

7. A provision, if applicable, setting forth the provisions of NRS 689B.035.

8. A provision for benefits for expense arising from care at home or health supportive services if that care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.

9. A provision that no action at law or in equity may be brought to recover under the policy before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Sec. 188. NRS 689B.570 is hereby amended to read as follows:

689B.570 ~~[1.]~~ A carrier that offers coverage through a network plan is not required to offer coverage to or accept an application from an employer that does not employ or no longer employs any enrollees who reside or work in the geographic service area of the carrier, provided that such coverage is refused or terminated uniformly without regard to any health status-related factor for any employee of the employer.

~~[2. As used in this section, "network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.]~~

Sec. 189. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 190 to 193, inclusive, of this act.

Sec. 190. ***"Medical management technique" has the meaning ascribed to it in section 128 of this act.***

Sec. 191. ***"Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.***

Sec. 192. ***"Primary care" has the meaning ascribed to it in section 131 of this act.***

Sec. 193. ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 194. NRS 689C.015 is hereby amended to read as follows:

689C.015 Except as otherwise provided in this chapter, as used in this chapter, unless the context otherwise requires, the words and

terms defined in NRS 689C.017 to 689C.106, inclusive, ***and sections 190 to 193, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 195. NRS 689C.077 is hereby amended to read as follows:

689C.077 "Network plan" ~~[means a health benefit plan offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.]~~ ***has the meaning ascribed to it in NRS 687B.645.***

Sec. 196. NRS 689C.131 is hereby amended to read as follows:

689C.131 1. A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the carrier to its insureds.

2. A carrier specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the carrier uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a carrier specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the carrier upon giving to the provider 45 days' written notice of the modification of the carrier's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the 45 day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 45 day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a carrier specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the carrier shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments,

including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 197. NRS 689C.1565 is hereby amended to read as follows:

689C.1565 1. A carrier is not required to provide coverage to small employers pursuant to NRS 689C.156:

(a) During any period in which the Commissioner determines that requiring the carrier to provide such coverage would place the carrier in a financially impaired condition.

(b) If the carrier elects not to offer any new coverage to any small employers in this State. A carrier that elects not to offer new coverage in accordance with this paragraph may maintain its existing policies issued to small employers in this State, subject to the requirements of NRS 689C.310 . ~~[and 689C.320.]~~

2. A carrier that elects not to offer new coverage pursuant to paragraph (b) of subsection 1 shall notify the Commissioner forthwith of that election and shall not thereafter write any new business to small employers in this State for 5 years after the date of the notification.

Sec. 198. NRS 689C.1652 is hereby amended to read as follows:

689C.1652 1. Except as otherwise provided in this section, a carrier that issues a health benefit plan shall include in the health benefit plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;
(b) Pediatric endocrinologists;
(c) Social workers;
(d) Psychiatrists;
(e) Psychologists;
(f) Gynecologists;
(g) Speech-language pathologists;
(h) Primary care physicians;
(i) Advanced practice registered nurses;
(j) Physician assistants; and
(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a health benefit plan to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A carrier that issues a health benefit plan shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the plan provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A carrier that issues a health benefit plan may prescribe requirements that must be satisfied before the carrier covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;

(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;

(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a carrier must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. A carrier shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier. If, after a reasonable effort, the carrier is unable to make such benefits available through such a provider of health care, the carrier may treat the treatment that the carrier is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the carrier.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the carrier must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

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

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

Sec. 199. NRS 689C.1654 is hereby amended to read as follows:

689C.1654 1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for insureds who are less than 26 years of age.

2. A carrier shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A health benefit plan subject to the provisions of this chapter that 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 that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

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

~~(c)~~] "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)]~~ *(c)* "Rehabilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 200. NRS 689C.1655 is hereby amended to read as follows:

689C.1655 1. A health benefit plan must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health benefit plan under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years. For the purposes of such coverage, a carrier shall accept as dispositive any diagnosis of an autism spectrum disorder that is rendered in accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders through the age of 21 years prescribed pursuant to NRS 427A.872.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a health benefit plan to the same extent as other medical services or prescription drugs covered by the plan.

3. A health benefit plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan; or

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1.

4. Except as otherwise provided in subsections 1 and 2, a carrier shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or

rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice.

➥ A carrier may request a copy of and review a treatment plan created pursuant to this subsection.

6. A health benefit plan subject to the provisions of this chapter that 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 which is in conflict with subsection 1 or 2 is void.

7. Nothing in this section shall be construed as requiring a carrier to provide reimbursement to a school for services delivered through school services.

8. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorder" has the meaning ascribed to it in NRS 427A.875.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(d) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(e) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(f) "Licensed assistant behavior analyst" has the meaning ascribed to the term "assistant behavior analyst" in NRS 641D.020.

(g) "Licensed behavior analyst" has the meaning ascribed to the term "behavior analyst" in NRS 641D.030.

(h) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

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

~~(j)]~~ "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

~~[(k)]~~ ***(j)*** "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

~~[(l)]~~ ***(k)*** "Registered behavior technician" has the meaning ascribed to it in NRS 641D.100.

~~[(m)]~~ ***(l)*** "Screening for ***and diagnosis of*** autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

~~[(n)]~~ ***(m)*** "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

~~[(o)]~~ ***(n)*** "Treatment plan" means a plan to treat an autism spectrum disorder that is developed by a provider of health care acting within his or her scope of practice after he or she has assessed the person for whom the treatment plan is developed.

Sec. 201. NRS 689C.1665 is hereby amended to read as follows:

689C.1665 1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the carrier. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A carrier that offers or issues a health benefit plan shall reimburse a pharmacist or pharmacy that participates in the network plan of the carrier for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A carrier shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of whether the drug is included in the formulary of the carrier.

4. Except as otherwise provided in this subsection, a carrier shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step therapy. A carrier may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. A carrier shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. A carrier 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 carrier.

7. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

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

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

~~(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract~~

~~with the carrier. The term does not include an arrangement for the financing of premiums.~~

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 202. NRS 689C.1671 is hereby amended to read as follows:

689C.1671 1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the carrier;

(b) Laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the health benefit plan of the carrier.

2. A carrier that offers or issues a health benefit plan shall reimburse:

(a) A pharmacist who participates in the health benefit plan of the carrier for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the carrier for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A carrier shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. A carrier 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 carrier.

5. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 203. NRS 689C.1672 is hereby amended to read as follows:

689C.1672 1. A health benefit plan must provide coverage for benefits payable for expenses incurred for:

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

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention

of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

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

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

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

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

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

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

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

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

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

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

6. As used in this section ~~[~~:

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

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

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

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

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

Sec. 204. NRS 689C.1673 is hereby amended to read as follows:

689C.1673 1. A carrier that issues a health benefit plan shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. A carrier 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 carrier.

3. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

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

Sec. 205. NRS 689C.1674 is hereby amended to read as follows:

689C.1674 1. A health benefit plan must provide coverage for benefits payable for expenses incurred for:

(a) A mammogram to screen for breast cancer annually for insureds who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

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

(a) Except as otherwise provided in subsection 6, require an insured to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

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

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

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

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

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

4. A plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified health benefit plan with respect to the deductible of such a health benefit plan after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply

regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

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

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

~~(d) "Qualified"~~ ***, "qualified*** health benefit plan" means a health benefit plan that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 206. NRS 689C.1675 is hereby amended to read as follows:

689C.1675 1. A carrier that issues a health benefit plan shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the insured by a provider of health care, facility or medical laboratory that participates in the network plan of the carrier; and

(b) Without prior authorization.

3. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

4. As used in this section ~~[~~:

~~(a) "Medical"~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

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

Sec. 207. NRS 689C.1676 is hereby amended to read as follows:

689C.1676 1. Except as otherwise provided in subsection 8, a carrier that offers or issues a health benefit plan shall include in the plan coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. A carrier shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

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

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the carrier.

5. Except as otherwise provided in subsections 9, 10 and 12, a carrier that offers or issues a health benefit plan shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

7. Except as otherwise provided in subsection 8, a health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

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

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

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug

Administration, a health benefit plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the carrier may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the carrier charges a copayment or coinsurance for a drug for contraception, the carrier may only require an insured to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

13. A carrier shall not:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an insured gives birth.

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

15. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with a carrier to provide services to insureds through a network plan offered or issued by the carrier.

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

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

~~(d)]~~ "Provider network contract" means a contract between a carrier and a provider of health care or pharmacy specifying the rights and responsibilities of the carrier and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 208. NRS 689C.1677 is hereby amended to read as follows:

689C.1677 1. Except as otherwise provided in subsection 4, a carrier that issues a health benefit plan shall include in the plan coverage for 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 is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, 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 carrier 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 carrier.

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

5. A health benefit plan 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.

~~[6. As used in this section:~~

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

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

Sec. 209. NRS 689C.1678 is hereby amended to read as follows:

689C.1678 1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:

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

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

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

(d) Hormone replacement therapy;

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

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

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

(h) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[6. As used in this section:~~

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

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

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

Sec. 210. NRS 689C.1681 is hereby amended to read as follows:

689C.1681 1. When developing a step therapy protocol, a carrier shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A carrier that offers or issues a health benefit plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the carrier concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the carrier; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the carrier shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A carrier shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the carrier a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The carrier shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current health benefit plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his

or her current health benefit plan at the time the attending practitioner selected the drug.

4. If a carrier does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the carrier shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689C.1684 apply.

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

~~(a) "Attending]~~ ***, "attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.]~~

Sec. 211. NRS 689C.1682 is hereby amended to read as follows:

689C.1682 1. A health benefit plan which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the health carrier is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section ~~[~~:

~~(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.~~

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

~~(c) "Step~~**]** ***, "step*** therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her health benefit plan provides coverage for the recommended drug.

Sec. 212. NRS 689C.1687 is hereby amended to read as follows:

689C.1687 1. A carrier that issues a health benefit plan shall include in the plan coverage for:

(a) Necessary case management services for an insured who has been diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an insured who has been diagnosed with sickle cell disease and its variants.

2. A carrier that issues a health benefit plan which provides coverage for prescription drugs shall include in the plan coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

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

4. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~(c)]~~ "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

~~[(d)]~~ ***(c)*** "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 213. NRS 689C.1688 is hereby amended to read as follows:

689C.1688 1. Subject to the limitations prescribed by subsection 4, a carrier that issues a health benefit plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. A carrier shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the carrier.

3. If a carrier requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the carrier shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require a carrier to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that is not in the applicable network plan of the carrier; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

~~[(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 214. NRS 689C.195 is hereby amended to read as follows:

689C.195 1. A health benefit plan must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A health benefit plan must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic;

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A carrier shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A health benefit plan must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A health benefit plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require a carrier to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the carrier is not otherwise required by law to do so.

6. A plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 215. NRS 689C.325 is hereby amended to read as follows:

689C.325 A carrier that offers coverage through a network plan is not required to offer coverage to or accept any applications for coverage from the eligible employees of a small employer pursuant to NRS 689C.310 ~~[and 689C.320]~~ if:

1. The eligible employees do not reside or work in the geographic service area of the network plan.

2. For a small employer whose eligible employees reside or work in the geographic service area of the network plan, the carrier demonstrates to the satisfaction of the Commissioner that the carrier does not have the capacity to deliver adequate service to additional small employers and eligible employees because of the existing obligations of the carrier. If a carrier is authorized by the Commissioner not to offer coverage pursuant to this subsection, the carrier shall not thereafter offer coverage to additional small employers and eligible employees within that geographic service area until the carrier demonstrates to the satisfaction of the Commissioner that it has regained the capacity to deliver adequate service to additional small employers and eligible employees within that service area.

Sec. 216. NRS 689C.360 is hereby amended to read as follows:

689C.360 As used in NRS 689C.360 to 689C.600, inclusive, ~~[unless the context otherwise requires, the words and terms defined in NRS 689C.380 and 689C.390 have the meanings ascribed to them in those sections.]~~ ***"contract":***

1. Means a policy or certificate for hospital or medical expenses, a contract for dental, hospital or medical services, or a health care plan of a health maintenance organization available for use by or offered or sold to a small employer.

2. Does not include coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, coverage for a specified

disease, hospital confinement indemnity or limited-benefit health insurance.

Sec. 217. NRS 690A.085 is hereby amended to read as follows:

690A.085 1. Except as otherwise provided in NRS 690A.087 and 690A.093, all policies, certificates of insurance, applications for insurance, enrollment forms, endorsements and riders delivered or issued for delivery in this State and the schedules of premium rates related thereto must be filed with the Commissioner.

2. An item filed with the Commissioner pursuant to subsection 1 may not be issued or used until 60 days after it is filed with the Commissioner or until the written prior approval of the Commissioner is obtained.

3. The Commissioner shall, not more than 60 days after an item is submitted to the Commissioner pursuant to subsection 1, disapprove the item if the benefits are not reasonable in relation to the premium charged or if the item contains provisions that are unjust, unfair, inequitable, misleading or deceptive or encourage misrepresentation of the coverage or are contrary to any provision of the Code or any regulation adopted pursuant to the Code. If the Commissioner does not disapprove an item filed pursuant to subsection 1 in accordance with this subsection, the item shall be deemed to be approved.

4. If the Commissioner notifies an insurer that an item is disapproved pursuant to subsection 3, the insurer shall not use the item. The notice must include the reason for the disapproval and state that a hearing will be granted not more than 30 days after the insurer submits a written request for a hearing to the Commissioner, unless postponed by mutual consent or by order of the Commissioner.

5. The Commissioner may ~~[hold a hearing to]~~ withdraw approval of an item submitted pursuant to subsection 1 ~~[not less than 20 days]~~ after providing a written notice ~~[of]~~ ***and*** the ***opportunity for a*** hearing to the insurer. The written notice must include one of the reasons described in subsection 3 for the proposed withdrawal of approval of the item. An insurer shall not use an item if approval of the item is withdrawn pursuant to this subsection.

Sec. 218. NRS 690A.280 is hereby amended to read as follows:

690A.280 In addition to any other penalty provided by law, any person who violates any provision of this chapter or a regulation adopted or a final order of the Commissioner issued pursuant to this chapter shall, after notice and ***the opportunity for a*** hearing, pay an administrative penalty:

1. In an amount not to exceed $5,000; or

2. If the violation is willful, in an amount not to exceed $10,000,

➥ and the Commissioner may, after notice and ***the opportunity for*** a hearing, revoke or suspend the license or certificate of authority of that person.

Sec. 219. NRS 690B.024 is hereby amended to read as follows:

690B.024 1. A claimant or any attorney representing the claimant may provide to the party against whom a claim is asserted for compensation or damages for any mental or physical injury under a policy of motor vehicle insurance or any attorney of the party and to the insurer of the party a written authorization to receive all medical reports, records, films and bills related to the claim from the providers of health care. An authorization so provided may not be revoked without cause.

2. If a written authorization is provided pursuant to subsection 1, the insurer of the party shall, within 5 business days after receiving the written authorization, disclose to the claimant or any attorney representing the claimant a copy of the declarations page of the policy of motor vehicle insurance. The insurer of the party may redact personal information from the declarations page of the policy, except that the name of the party and the policy limits must not be redacted.

3. At the written request of the claimant or the attorney of the claimant, copies of all medical reports, records, films and bills obtained by a written authorization pursuant to subsection 1 must be provided to the claimant or the attorney of the claimant within 30 days after the date they are received by the party, any attorney of the party or the insurer of the party. If the claimant or the attorney of the claimant makes a written request for the medical reports, records, films and bills, the claimant or the attorney of the claimant shall pay for the reasonable costs of copying the medical reports, records, films and bills.

4. As used in this section, "provider of health care" has the meaning ascribed to it in NRS ~~[629.031.]~~ ***695G.070.***

Sec. 220. NRS 690C.120 is hereby amended to read as follows:

690C.120 1. Except as otherwise provided in this chapter, the marketing, issuance, sale, offering for sale, making, proposing to make and administration of service contracts are not subject to the provisions of this title, except, when applicable, the provisions of:

(a) NRS 679B.020 to ~~[679B.152,]~~ ***679B.300,*** inclusive ~~[.]~~ ***, and sections 3 and 4 of this act;***

(b) ~~[NRS 679B.159 to 679B.300, inclusive;~~

~~(c)~~ NRS 679B.310 to 679B.370, inclusive;

~~(d)~~ *(c)* NRS 679B.600 to 679B.690, inclusive;

~~(e)~~ *(d)* NRS 685B.090 to 685B.190, inclusive;

~~(f)~~ *(e)* NRS 686A.010 to 686A.095, inclusive;

~~(g)~~ *(f)* NRS 686A.160 to 686A.187, inclusive; ~~and~~

~~(h)~~ *(g) Sections 65 to 77, inclusive, of this act; and*

(h) NRS 686A.260, 686A.270, 686A.280, 686A.300 and 686A.310.

2. A provider, person who sells service contracts, administrator or any other person is not required to obtain a certificate of authority from the Commissioner pursuant to chapter 680A of NRS to issue, sell, offer for sale or administer service contracts.

Sec. 221. NRS 690C.150 is hereby amended to read as follows:

690C.150 A ~~provider~~ ***person*** shall not issue, sell or offer for sale service contracts in this State unless the ~~provider~~ ***person*** has been issued a certificate of registration pursuant to the provisions of this chapter.

Sec. 222. NRS 690C.160 is hereby amended to read as follows:

690C.160 1. A ~~provider~~ ***person*** who wishes to issue, sell or offer for sale service contracts in this State must submit to the Commissioner:

(a) A registration application on a form prescribed by the Commissioner;

(b) Proof that the ~~provider~~ ***person*** has complied with the requirements for financial security set forth in NRS 690C.170;

(c) A copy of each type of service contract the ~~provider~~ ***person*** proposes to issue, sell or offer for sale;

(d) The name, address and telephone number of each administrator with whom the ~~provider~~ ***person*** intends to contract;

(e) A fee of ~~$2,000~~ ***$1,000*** and all applicable fees required pursuant to NRS 680C.110 to be paid at the time of application; and

(f) The following information for each controlling person:

(1) Whether the person, in the last 10 years, has been:

(I) Convicted of a felony or misdemeanor of which an essential element is fraud;

(II) Insolvent or adjudged bankrupt;

(III) Refused a license or registration as a service contract provider or had an existing license or registration as a service contract provider suspended or revoked by any state or governmental agency or authority; or

(IV) Fined by any state or governmental agency or authority in any matter regarding service contracts; and

(2) Whether there are any pending criminal actions against the person other than moving traffic violations.

2. In addition to the fee required by subsection 1, a ~~[provider]~~ ***person*** must pay a fee of $25 for each type of service contract the ~~[provider]~~ ***person*** files with the Commissioner.

3. Each year, not later than the anniversary date of his or her certificate of registration, a provider must pay the annual fee required pursuant to NRS 680C.110 in addition to any other fee required pursuant to this section.

4. A certificate of registration is valid for ~~[2 years]~~ ***1 year*** after the date the Commissioner issues the certificate to the provider. A provider may renew his or her certificate of registration if, not later than 60 days before the certificate expires, the provider submits to the Commissioner:

(a) An application on a form prescribed by the Commissioner;

(b) A fee of ~~[$2,000]~~ ***$1,000*** and, in addition to any other fee or charge, all applicable fees required pursuant to subsection 3; and

(c) The information required by paragraph (f) of subsection 1:

(1) If an existing controlling person has had a change in any of the information previously submitted to the Commissioner; or

(2) For a controlling person who has not previously submitted the information required by paragraph (f) of subsection 1 to the Commissioner.

5. All fees paid pursuant to this section are nonrefundable.

6. Each application submitted pursuant to this section, including, without limitation, an application for renewal, must:

(a) Be signed by an executive officer, if any, of the ~~[provider]~~ ***applicant*** or, if the ~~[provider]~~ ***applicant*** does not have an executive officer, by a controlling person of the ~~[provider;]~~ ***applicant;*** and

(b) Have attached to it an affidavit signed by the person described in paragraph (a) which meets the requirements of subsection 7.

7. Before signing the application described in subsection 6, the person who signs the application shall verify that the information provided is accurate to the best of his or her knowledge.

Sec. 223. NRS 690C.170 is hereby amended to read as follows:

690C.170 1. To be issued a certificate of registration, a provider must comply with one of the following to provide for financial security:

(a) Purchase a contractual liability insurance policy which insures the obligations of each service contract the provider issues, sells or offers for sale. The contractual liability insurance policy must:

(1) Be issued by an insurer which is licensed, registered or otherwise authorized to transact insurance in this State or pursuant to the provisions of chapter 685A of NRS.

(2) Contain a provision prohibiting the insurer from terminating the policy until a notice of termination has been mailed or delivered to the Commissioner at least 60 days prior to the termination of the policy. Any such termination shall not reduce the responsibility of the insurer for service contracts issued by the provider prior to the effective date of termination.

(b) ~~[Maintain a reserve account in this State and deposit with the Commissioner security as provided in this subsection. The reserve account must contain at all times an amount of money equal to at least 40 percent of the unearned gross consideration received by the provider for any unexpired service contracts. The reserve account must be kept separate from the operating accounts of the provider and must be clearly identified as the "(Provider's Name) Nevada Service Contracts Funded Reserve Account." The Commissioner may examine the reserve account at any time. The provider shall also deposit with the Commissioner security in an amount that is equal to $25,000 or 10 percent of the unearned gross consideration received by the provider for any unexpired service contracts, whichever is greater. The security must be:~~

~~(1) A surety bond issued by a surety company authorized to do business in this State;~~

~~(2) Securities of the type eligible for deposit pursuant to NRS 682B.030;~~

~~(3) Cash;~~

~~(4) An irrevocable letter of credit issued by a financial institution approved by the Commissioner; or~~

~~(5) In any other form prescribed by the Commissioner.~~

~~(c)]~~ Maintain, or be a subsidiary of a parent company that maintains, a net worth or stockholders' equity of at least $100,000,000. Upon request, a provider shall provide to the Commissioner a copy of the most recent Form 10-K report or Form 20-F report filed by the provider or parent company of the provider with the Securities and Exchange Commission within the previous year. If the provider or parent company is not required to file those reports with the Securities and Exchange Commission, the provider shall provide to the Commissioner a copy of the most recently audited financial statements of the provider or parent company. If the net worth or stockholders' equity of the parent company of the provider is used to comply with the requirements of this subsection, the parent company must guarantee to carry out the duties of the provider under any service contract issued or sold by the provider.

2. ~~[A provider shall not use any money in a reserve account described in paragraph (b) of subsection 1 for any purpose other than to pay an obligation of the provider under an unexpired service contract.~~

~~3.]~~ A provider shall maintain the financial security required by subsection 1 until:

(a) The provider ceases doing business in this State; and

(b) The provider has performed or otherwise satisfied all liabilities and obligations under all unexpired service contracts issued by the provider.

~~[4.]~~ ***3.*** If the certificate of registration of a provider has not expired and the provider fails to maintain the financial security required by subsection 1, including, without limitation, if the financial security is cancelled or lapses, the provider shall not issue or sell a service contract on or after the effective date of such failure until the provider submits to the Commissioner proof satisfactory to the Commissioner that the provider is in compliance with subsection 1.

Sec. 224. NRS 690C.260 is hereby amended to read as follows:

690C.260 1. A service contract must:

(a) Be written in language that is understandable and printed in a typeface that is easy to read.

(b) Indicate that it is insured by a contractual liability insurance policy if it is so insured, and include the name and address of the issuer of the policy or that it is backed by the full faith and credit of the provider if the service contract is not insured by a contractual liability insurance policy.

(c) Include the amount of any deductible that the holder is required to pay.

(d) Include the name and address of the provider and ***:*** ~~[, if applicable:]~~

(1) The name and address of the administrator ~~[:]~~ ***, if applicable;*** and

(2) The name of the holder ***.*** ~~[, if provided by the holder.]~~

➥ The names and addresses of such persons are not required to be preprinted on the service contract and may be added to the service contract at the time of the sale.

(e) Include the purchase price of the service contract. The purchase price must be determined pursuant to a schedule of fees established by the provider. The purchase price is not required to be preprinted on the service contract and may be negotiated with the holder and added to the service contract at the time of sale.

(f) Include a description of the goods covered by the service contract.

(g) Specify the duties of the provider and any limitations, exceptions or exclusions.

(h) If the service contract covers a motor vehicle, indicate whether replacement parts that are not made for or by the original manufacturer of the motor vehicle may be used to comply with the terms of the service contract.

(i) Include any restrictions on transferring or renewing the service contract.

(j) Include the terms, restrictions or conditions for cancelling the service contract before it expires and the procedure for cancelling the service contract. The conditions for cancelling the service contract must include, without limitation, the provisions of NRS 690C.270.

(k) Include the duties of the holder under the contract, including, without limitation, the duty to protect against damage to the goods covered by the service contract or to comply with any instructions included in the owner's manual for the goods.

(l) Indicate whether the service contract authorizes the holder to recover consequential damages.

(m) Indicate whether any defect in the goods covered by the service contract existing on the date the contract is purchased is not covered under the service contract.

2. A provider shall not allow, make or cause to be made a false or misleading statement in any of the service contracts of the provider or intentionally omit a material statement that causes a service contract to be misleading. The Commissioner may require the provider to amend any service contract that the Commissioner determines is false or misleading.

Sec. 225. NRS 690C.310 is hereby amended to read as follows:

690C.310 1. A provider shall maintain records of the transactions governed by this chapter. The records of a provider must include:

(a) A copy of each type of service contract that the provider issues, sells or offers for sale;

(b) The name and address of each holder who possesses a service contract under which the provider has a duty to perform ***;*** ~~[,~~ ~~to the extent that the provider knows the name and address of each holder;]~~

(c) A list that includes each location where the provider issues, sells or offers for sale service contracts; and

(d) The date and a description of each claim made by a holder under a service contract.

2. Except as otherwise provided in this subsection, a provider shall retain all records relating to a service contract for at least ~~[1~~

~~year]~~ ***3 years*** after the contract has expired. A provider who intends to discontinue doing business in this State shall provide the Commissioner with satisfactory proof that the provider has discharged his or her duties to the holders in this State and shall not destroy his or her records without the prior approval of the Commissioner.

3. The records required to be maintained pursuant to this section may be stored on a computer disc or other storage device for a computer from which the records can be readily printed.

Sec. 226. NRS 690C.325 is hereby amended to read as follows:

690C.325 1. The Commissioner may refuse to renew or may suspend, limit or revoke a provider's certificate of registration if the Commissioner finds after ***the opportunity for*** a hearing thereon, or upon waiver of hearing by the provider, that the provider has:

(a) Violated or failed to comply with any lawful order of the Commissioner;

(b) Conducted business in an unsuitable manner;

(c) Willfully violated or willfully failed to comply with any lawful regulation of the Commissioner; or

(d) Violated any provision of this chapter.

➥ In lieu of such a suspension or revocation, the Commissioner may levy upon the provider, and the provider shall pay forthwith, an administrative fine of not more than $1,000 for each act or violation.

2. The Commissioner shall suspend or revoke a provider's certificate of registration on any of the following grounds if the Commissioner finds after ***the opportunity for*** a hearing thereon that the provider:

(a) Is in unsound condition, is being fraudulently conducted, or is in such a condition or is using such methods and practices in the conduct of its business as to render its further transaction of service contracts in this State currently or prospectively injurious to service contract holders or to the public.

(b) Refuses to be examined, or its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its books, papers, records, contracts, correspondence or other documents for examination by the Commissioner when required, or refuse to perform any legal obligation relative to the examination.

(c) Has failed to pay any final judgment rendered against it in this State upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within 30 days after the judgment became final or within 30 days after dismissal of an appeal before final determination, whichever date is the later.

3. The Commissioner may, without advance notice or a hearing thereon, immediately suspend the certificate of registration of any provider that has filed for bankruptcy or otherwise been deemed insolvent.

Sec. 227. NRS 690C.330 is hereby amended to read as follows:

690C.330 A person who violates any provision of this chapter or an order or regulation of the Commissioner issued or adopted pursuant thereto may be assessed a civil penalty by the Commissioner of not more than $500 for each act or violation **.** ~~[, not to exceed an aggregate amount of $10,000 for violations of a similar nature. For the purposes of this section, violations shall be deemed to be of a similar nature if the violations consist of the same or similar conduct, regardless of the number of times the conduct occurred.]~~

Sec. 228. NRS 691C.320 is hereby amended to read as follows:

691C.320 1. Except as otherwise provided in NRS 691C.330 and 691C.340, all policies, certificates of insurance, applications for insurance, enrollment forms, endorsements and riders delivered or issued for delivery in this State and the schedules of premium rates related thereto must be filed with the Commissioner.

2. An item filed with the Commissioner pursuant to subsection 1 may not be issued until 60 days after it is filed with the Commissioner or until the written prior approval of the Commissioner is obtained.

3. The Commissioner shall, not more than 60 days after an item is submitted to the Commissioner pursuant to subsection 1, disapprove the item if the benefits are not reasonable in relation to the premium charged or if the item contains provisions that are unjust, unfair, inequitable, misleading or deceptive or encourage misrepresentation of the coverage or are contrary to any provision of the Code or any regulation adopted pursuant to the Code. If the Commissioner does not disapprove an item filed pursuant to subsection 1 in accordance with this subsection, the item shall be deemed to be approved.

4. If the Commissioner notifies an insurer that an item is disapproved pursuant to subsection 3, the insurer shall not use the item. The notice must include the reason for the disapproval and state that a hearing will be granted not more than ~~[30]~~ ***60*** days after the insurer submits a written request for a hearing to the Commissioner, unless postponed by mutual consent or by order of the Commissioner.

5. The Commissioner may ~~[hold a hearing to]~~ withdraw approval of an item submitted pursuant to subsection 1 ~~[not less~~

~~than 20 days~~] after providing a written notice ~~[of]~~ ***and*** the ***opportunity for a*** hearing to the insurer. The written notice must include one of the reasons described in subsection 3 for the proposed withdrawal of approval of the item. An insurer shall not use an item if approval of the item is withdrawn pursuant to this subsection.

Sec. 229. NRS 691C.440 is hereby amended to read as follows:

691C.440 In addition to any other penalty provided by law, a person who violates a provision of this chapter or a final order of or a regulation adopted by the Commissioner pursuant to this chapter, after notice and ***the opportunity for*** a hearing, upon order of the Commissioner is subject to:

1. The imposition of an administrative fine not to exceed $5,000 per violation, or $10,000 per violation if the Commissioner determines that the violation was willful; and

2. Revocation, suspension or limitation of the license or certificate of authority held by the person.

Sec. 230. NRS 692A.100 is hereby amended to read as follows:

692A.100 1. The Commissioner shall provide by regulation for the licensing of title agents, their branch offices, direct writing title insurers and escrow officers.

2. Each title agent shall maintain his or her books of account and record and his or her vouchers pertaining to title insurance business in a manner which permits the Commissioner or a representative of the Commissioner to ascertain readily whether the agent has complied with the provisions of this chapter.

3. A title agent or escrow officer may engage in the business of handling escrows, settlements and closings if the title agent or escrow officer maintains a separate record of all receipts and disbursements of money held in escrow and does not commingle that money with his or her own.

4. For the purpose of determining its financial condition, fulfillment of its contractual obligations and compliance with law, the Commissioner or a representative of the Commissioner or the Commissioner of ~~[Financial Institutions]~~ ***Mortgage Lending*** of the Department of Business and Industry or a representative of the Commissioner of ~~[Financial Institutions]~~ ***Mortgage Lending*** of the Department of Business and Industry when requested by the Commissioner of Insurance shall each year examine or cause to be examined the affairs, transactions, agreements, assets, records and accounts, including the escrow accounts, of a title agent, title insurer or escrow officer.

5. A title agent or insurer may engage a certified public accountant to perform such an examination in lieu of the Commissioner. In such a case, the examination must be equivalent to the type of examination made by the Commissioner and the expense must be borne by the title agent or insurer being examined.

6. The Commissioner shall determine whether an examination performed by an accountant pursuant to subsection 5 is equivalent to an examination conducted by the Commissioner. The Commissioner may examine any area of the operation of a title agent or insurer if the Commissioner determines that the examination of that area is not equivalent to an examination conducted by the Commissioner.

7. A person shall not become licensed to circumvent the provisions of this chapter or any other law of this State.

Sec. 231. NRS 692A.1045 is hereby amended to read as follows:

692A.1045 1. The Commissioner shall establish by regulation the fees to be paid by title agents and title insurers for their supervision and examination by the Commissioner or a representative of the Commissioner.

2. In establishing the fees pursuant to subsection 1, the Commissioner shall consider:

(a) The complexity of the various examinations to which the fees apply;

(b) The skill required to conduct such examinations;

(c) The expenses associated with conducting such examinations and preparing reports; and

(d) Any other factors the Commissioner deems relevant.

3. The Commissioner shall, with the approval of the Commissioner of ~~[~~Financial Institutions,~~]~~ ***Mortgage Lending,*** adopt regulations prescribing the standards for determining whether a title insurer or title agent has maintained adequate supervision of a title agent or escrow officer pursuant to the provisions of this chapter.

Sec. 232. NRS 692A.105 is hereby amended to read as follows:

692A.105 1. The Commissioner may refuse to license any title agent or escrow officer or may suspend or revoke any license or impose a fine of not more than $500 for each violation by entering an order to that effect, with the Commissioner's findings in respect thereto, if, upon ***the opportunity for*** a hearing, it is determined that the applicant or licensee:

(a) In the case of a title agent, is insolvent or in such a financial condition that the title agent cannot continue in business with safety to his or her customers;

(b) Has violated any provision of this chapter or any regulation adopted pursuant thereto or has aided and abetted another to do so;

(c) Has committed fraud in connection with any transaction governed by this chapter;

(d) Has intentionally or knowingly made any misrepresentation or false statement to, or concealed any essential or material fact known to the applicant or licensee from, any principal or designated agent of the principal in the course of the escrow business;

(e) Has intentionally or knowingly made or caused to be made to the Commissioner any false representation of a material fact or has suppressed or withheld from the Commissioner any information which the applicant or licensee possesses;

(f) Has failed without reasonable cause to furnish to the parties of an escrow their respective statements of the settlement within a reasonable time after the close of escrow;

(g) Has failed without reasonable cause to deliver, within a reasonable time after the close of escrow, to the respective parties of an escrow transaction any money, documents or other properties held in escrow in violation of the provisions of the escrow instructions;

(h) Has refused to permit an examination by the Commissioner of his or her books and affairs or has refused or failed, within a reasonable time, to furnish any information or make any report that may be required by the Commissioner pursuant to the provisions of this chapter;

(i) Has been convicted of a felony relating to the practice of title agents or any misdemeanor of which an essential element is fraud;

(j) In the case of a title agent, has failed to maintain complete and accurate records of all transactions within the last 7 years;

(k) Has commingled the money of other persons with his or her own or converted the money of other persons to his or her own use;

(l) Has failed, before the close of escrow, to obtain written instructions concerning any essential or material fact or intentionally failed to follow the written instructions which have been agreed upon by the parties and accepted by the holder of the escrow;

(m) Has failed to disclose in writing that the applicant or licensee is acting in the dual capacity of escrow agent or agency and undisclosed principal in any transaction;

(n) In the case of an escrow officer, has been convicted of, or entered a plea of guilty, guilty but mentally ill or nolo contendere to, any crime involving moral turpitude; or

(o) Has failed to obtain and maintain a copy of the executed agreement or contract that establishes the conditions for the sale of real property.

2. It is sufficient cause for the imposition of a fine or the refusal, suspension or revocation of the license of a partnership, corporation or any other association if any member of the

partnership or any officer or director of the corporation or association has been guilty of any act or omission directly arising from the business activities of a title agent which would be cause for such action had the applicant or licensee been a natural person.

3. The Commissioner may suspend or revoke the license of a title agent, or impose a fine, if the Commissioner finds that the title agent:

(a) Failed to maintain adequate supervision of an escrow officer or title agent he or she has appointed or employed.

(b) Instructed an escrow officer to commit an act which would be cause for the revocation of the escrow officer's license and the escrow officer committed the act. An escrow officer is not subject to disciplinary action for committing such an act under instruction by the title agent.

4. The Commissioner may refuse to issue a license to any person who, within 10 years before the date of applying for a current license, has had suspended or revoked a license issued pursuant to this chapter or a comparable license issued by any other state, district or territory of the United States or any foreign country.

Sec. 233. NRS 692A.107 is hereby amended to read as follows:

692A.107 1. In addition to the grounds provided in NRS 680A.200 for insurers generally, the Commissioner may refuse to license any title insurer or may suspend any license or impose a fine of not more than $500 for each violation by entering an order to that effect, with findings in respect thereto, if ~~[upon]~~ ***after the opportunity for*** a hearing, it is determined that the applicant or licensee:

(a) Has committed fraud in connection with any transaction governed by this chapter;

(b) Has failed without reasonable cause to furnish to the parties of an escrow their respective statements of the settlement within a reasonable time after the close of escrow;

(c) Has failed without reasonable cause to deliver, within a reasonable time after the close of escrow, to the respective parties of an escrow transaction any money, documents or other properties held in escrow in violation of the provisions of the escrow instructions;

(d) Has commingled the money of others with his or her own or converted the money of others to his or her own use;

(e) Has failed, before the close of escrow, to obtain written instructions concerning any essential or material fact or intentionally failed to follow the written instructions which have been agreed upon by the parties and accepted by the holder of the escrow;

(f) Has failed to disclose in writing that the applicant or licensee is acting in the dual capacity of escrow agent or agency and undisclosed principal in any escrow transaction; or

(g) Has failed to maintain adequate supervision of an escrow officer or title agent whom the applicant or licensee has certified pursuant to subsection 3 of NRS 692A.110.

2. The Commissioner may refuse to issue a license to any person who, within 10 years before the date of applying for a current license, has had suspended or revoked a license issued pursuant to this chapter or a comparable license issued by any other state, district or territory of the United States or any foreign country.

Sec. 234. NRS 693A.190 is hereby amended to read as follows:

693A.190 A domestic mutual insurer after being authorized to transact one kind of insurance may be authorized to transact such additional kinds of insurance as are permitted under NRS 680A.120, if ***the insurer complies with the requirements of paragraphs (a) and (b) of subsection 1 of NRS 680A.120 and*** otherwise ~~[~~complying~~]~~ ***complies*** with this Code ***.*** ~~[and maintaining unimpaired surplus funds in an amount not less than the amount of paid in capital stock and surplus required to be maintained by a domestic stock insurer transacting like kinds of insurance. When first so authorized to transact an additional kind of insurance, the domestic mutual insurer shall be subject to the additional expendable surplus requirements of NRS 680A.120 applicable to a stock insurer.~~]~~

Sec. 235. NRS 693A.250 is hereby amended to read as follows:

693A.250 1. A domestic mutual insurer, by depositing through the Commissioner and thereafter maintaining unimpaired surplus funds not less in amount than the minimum ~~[~~paid in~~]~~ capital stock and surplus required of a domestic stock insurer for authority to transact the same kind or kinds of insurance, may, upon receipt of the Commissioner's order so authorizing, extinguish the contingent liability to assessment of its members as to all its policies in force and, so long as such surplus and deposit are maintained, may omit provisions imposing contingent liability in all policies currently issued. Any deposit of the insurer made through the Commissioner as a prerequisite to its certificate of authority may be included as part of the deposit required under this section.

2. The Commissioner shall not authorize a domestic insurer to extinguish the contingent liability of any of its members or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its members and in all such policies for all kinds of insurance transacted by it.

3. The Commissioner shall revoke the authority of a domestic mutual insurer to issue policies without contingent liability if:

(a) The insurer's assets are less than the sum of its liabilities and the surplus required for such authority and such deficiency is not cured within 30 days after written notice thereof to the insurer by the Commissioner; or

(b) The insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked.

4. During the absence of such authority the insurer shall not issue any policy without providing therein for the contingent liability of the policyholder, or renew any policy which is then in force without endorsing the same to provide for such contingent liability.

5. A foreign mutual insurer may issue nonassessable policies to its members in this State as authorized by its charter and the laws of the state or country of its domicile, if the requirements for issuance of such policies are substantially equal to or higher than those applicable to domestic insurers under this Code.

Sec. 236. NRS 693A.260 is hereby amended to read as follows:

693A.260 1. If at any time ~~[the amount of assets of]~~ a domestic stock or mutual insurer ~~[are less than the sum of its liabilities plus its paid-in capital stock and minimum surplus required to be maintained (in the case of a stock insurer), or the minimum surplus required to be maintained (in the case of a mutual insurer), under this Code for authority to transact the kinds of insurance being transacted,]~~ ***is operating in an impaired financial condition, as defined in section 375 of this act,*** the Commissioner shall at once determine the amount of the deficiency ***of admitted assets*** and give written notice to the insurer of the amount of ~~[impairment]~~ ***deficiency*** and require that the ~~[impairment]~~ ***deficiency*** be cured and proof thereof filed with the Commissioner within such period, not less than 30 days nor more than 90 days from date of the notice, as the Commissioner may designate.

2. If the ~~[impairment]~~ ***deficiency*** of ***admitted*** assets is 10 percent or less of the ~~[combined required paid-in]~~ capital ~~[stock]~~ and surplus ~~[(as to a stock insurer) or surplus (as to a mutual insurer),]~~ ***required to be maintained by the insurer*** and the Commissioner believes that the ~~[impairment]~~ ***deficiency*** might be made good by an extension of time, the Commissioner may extend the time within which the ~~[impairment]~~ ***deficiency*** may be cured by not to exceed an additional 90 days.

3. The Commissioner shall require such restriction of, or arrangements as to, operations of the insurer while the ~~[impairment]~~

deficiency exists as the Commissioner deems advisable for the protection of policyholders, the insurer or the public.

Sec. 237. NRS 693A.270 is hereby amended to read as follows:

693A.270 1. A deficiency referred to in NRS 693A.260 may be made good in whole or in part in cash or in assets eligible under chapter 682A of NRS (investments) for investment of the insurer's funds, or ~~[by amendment of the insurer's certificate of authority to cover only such kind or kinds of insurance thereafter for which the insurer has sufficient paid-in capital stock and surplus (if a stock insurer) or surplus (if a mutual insurer) under this Code, or, if a stock insurer, by reduction of its capital stock to an amount of authorized and unimpaired paid-in capital stock not below the minimum thereof required for the kinds of insurance thereafter to be transacted.]~~ ***in any other manner authorized by the Commissioner.***

2. If the deficiency is not made good and proof thereof filed with the Commissioner within the period required under NRS 693A.260, the insurer shall be deemed insolvent and the Commissioner shall institute delinquency proceedings against it under chapter 696B of NRS.

Sec. 238. NRS 694B.230 is hereby amended to read as follows:

694B.230 1. If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee the Commissioner shall issue a certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this State, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this State for so long as ~~[all such surplus remains unimpaired.]~~ ***the reciprocal insurer operates in a financial condition that is not an impaired financial condition.***

2. ~~[Upon impairment of such surplus,]~~ ***If the reciprocal insurer is operating in an impaired financial condition,*** the Commissioner shall forthwith revoke the certificate. Such revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid; but after such revocation no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

3. The Commissioner shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to

and does extinguish such liability of all its subscribers and in all such policies for all kinds of insurance transacted by it; but if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

4. As used in this section, "impaired financial condition" has the meaning ascribed to it in section 375 of this act.

Sec. 239. NRS 694B.260 is hereby amended to read as follows:

694B.260 1. Subject to the limitation set forth in the power of attorney or policy, if ~~[the assets of]~~ a domestic reciprocal insurer ~~[are]~~ ***is*** at any time ~~[insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus,]~~ ***operating in an impaired financial condition, as defined in section 375 of this act,*** its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency ~~[.]~~ ***of admitted assets.***

2. If the attorney fails to make up such deficiency or to make the assessment within 30 days after the Commissioner orders the attorney to do so, or if the deficiency is not fully made up within 60 days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this Code.

3. If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to the limits provided by this chapter, as the Commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons, but including the reasonable cost of the liquidation.

Sec. 240. Chapter 694C of NRS is hereby amended by adding thereto the provisions set forth as sections 241 and 242 of this act.

Sec. 241. ***1. The Account for Outreach and Promotion of Captive Insurance is hereby created in the State General Fund. All money collected for the use of the Account must be deposited in the Account.***

2. The Commissioner shall administer the Account. The money in the Account must be used for the purposes described in section 242 of this act.

3. The Commissioner may apply for and accept any donation, gift, grant, bequest or other source of money for deposit in the Account.

4. The interest and income earned on money in the Account, after deducting any applicable charges, must be credited to the Account.

5. Except as otherwise provided in subsection 6, any money remaining in the Account at the end of the fiscal year must remain in the Account and does not revert to the State General Fund, and the balance in the Account must be carried forward to the next fiscal year.

6. At the end of each fiscal year, any money in the Account that exceeds $100,000 must be transferred to the State General Fund.

Sec. 242. ***1. The Commissioner may use money in the Account for Outreach and Promotion of Captive Insurance created by section 241 of this act:***

(a) To advertise and promote Nevada as a domicile for new or existing insurance companies seeking to organize under the laws of this State, including, without limitation, for expenses to allow an employee of the State to attend events at which the employee may engage in such advertising or promotion;

(b) For expenses to allow an employee of the State to improve his or her knowledge of captive insurance, industry trends or developments in federal or state laws relating to captive insurance;

(c) To provide funding to a public or private organization to sponsor a specific event or program so long as:

(1) The event is open to the public and insurance regulators and includes educational sessions concerning captive insurance; and

(2) The organization provides to the State, in return for the funding, a benefit in the form of advertising, promotion or enabling employees of the State to attend the event or program;

(d) To provide grants in accordance with subsections 2 and 3; or

(e) To support any other opportunity, program or event for the promotion of or the provision of education concerning insurance or a related industry that includes activities for the promotion of or the provision of education concerning captive insurance, even if the opportunity, program or event is not specifically designated as pertaining to captive insurance.

2. A state agency whose primary purpose is the promotion of programs of business development, tourism or economic development may submit a request for a grant from the Account. The request must include, without limitation:

(a) The amount of money requested, which must not exceed $10,000;

(b) Specific details of how the money will be used to promote captive insurance;

(c) Details concerning the costs that the grant will be used to pay; and

(d) Any other information required by the Commissioner.

3. The Commissioner may provide a grant to a state agency that has submitted a request pursuant to subsection 2 if:

(a) The account contains sufficient surplus over budgeted activities to fulfill the request;

(b) The request would not encumber funds in more than 1 fiscal year; and

(c) The request is approved by the Director of the Department of Business and Industry and the Interim Finance Committee.

Sec. 243. NRS 694C.060 is hereby amended to read as follows:

694C.060 "Captive insurer" means:

1. Any pure captive insurer, association captive insurer, agency captive insurer ~~[, rental captive insurer]~~ and sponsored captive insurer licensed pursuant to this chapter. The term includes a pure captive insurer who, unless otherwise provided by the Commissioner, is a branch captive insurer with respect to operations in this State.

2. Any state-chartered risk retention group.

Sec. 244. NRS 694C.160 hereby amended to read as follows:

694C.160 1. The terms and conditions set forth in chapter 696B of NRS pertaining to insurance reorganization, receiverships and injunctions apply to captive insurers incorporated pursuant to this chapter.

2. The provisions of NRS 679B.285 pertaining to the confidentiality and disclosure of certain records and information relating to an insurer apply to such records and information relating to a captive insurer incorporated pursuant to this chapter.

3. ***The provisions of section 4 of this act governing the issuance of a cease and desist order by the Commissioner apply to a captive insurer incorporated pursuant to this chapter or a person acting as a captive insurer without a license from the Commissioner pursuant to NRS 694C.200.***

4. The provisions of NRS 693A.170 governing the right of a domestic insurer to purchase or acquire shares of its own stock apply to a captive insurer incorporated pursuant to this chapter.

5. An agency captive insurer ~~[, a rental captive insurer]~~ and an association captive insurer are subject to those provisions of chapter 686A of NRS which are applicable to insurers.

~~[4.]~~ ***6.*** A state-chartered risk retention group is subject to the following:

(a) The provisions of NRS 681A.250 to 681A.580, inclusive, regarding intermediaries;

(b) The provisions of NRS 681B.550 regarding risk-based capital;

(c) The provisions of chapter 683A of NRS regarding managing general agents;

(d) The provisions of chapter 686A of NRS which are applicable to insurers; and

(e) The provisions of NRS 693A.110 and any regulations adopted pursuant thereto regarding management and agency contracts of insurers.

Sec. 245. NRS 694C.180 is hereby amended to read as follows:

694C.180 1. Unless otherwise approved by the Commissioner, a pure captive insurer, an agency captive insurer ~~[, a rental captive insurer]~~ or a sponsored captive insurer must be incorporated as a stock insurer.

2. An association captive insurer or a state-chartered risk retention group must be formed as a:

(a) Stock insurer;

(b) Mutual insurer; or

(c) Reciprocal insurer, except that its attorney-in-fact must be a corporation incorporated in this State.

3. A captive insurer shall have not less than three incorporators or organizers, at least one of whom must be a resident of this State.

4. Before the articles of incorporation of a captive insurer may be filed with the Secretary of State, the Commissioner must approve the articles of incorporation. In determining whether to grant that approval, the Commissioner shall consider:

(a) The character, reputation, financial standing and purposes of the incorporators or organizers;

(b) The character, reputation, financial responsibility, experience relating to insurance and business qualifications of the officers and directors of the captive insurer;

(c) The competence of any person who, pursuant to a contract with the captive insurer, will manage the affairs of the captive insurer;

(d) The competence, reputation and experience of the legal counsel of the captive insurer relating to the regulation of insurance;

(e) ~~[If the captive insurer is a rental captive insurer, the competence, reputation and experience of the underwriter of the captive insurer;~~

~~(f)]~~ The business plan of the captive insurer; and

~~[(g)]~~ ***(f)*** Such other aspects of the captive insurer as the Commissioner deems advisable.

5. The capital stock of a captive insurer incorporated as a stock insurer must be issued at not less than par value.

6. At least one member of the board of directors of a captive insurer formed as a corporation, or one member of the subscribers advisory committee or the attorney-in-fact of a captive insurer formed as a reciprocal insurer, must be a resident of this State.

7. A captive insurer formed pursuant to the provisions of this chapter has the privileges of, and is subject to, the provisions of general corporation law set forth in chapter 78 of NRS and, if formed as a nonprofit corporation, the provisions set forth in chapter 82 of NRS, as well as the applicable provisions contained in this chapter. If the provisions of this chapter conflict with the general provisions in chapter 78 or 82 of NRS governing corporations, the provisions of this chapter control. The provisions of chapter 693A of NRS relating to mergers, consolidations, conversions, mutualizations and transfers of domicile to this State apply to determine the procedures to be followed by captive insurers in carrying out any of those transactions in accordance with this chapter.

8. The articles of association, articles of incorporation, charter or bylaws of a captive insurer formed as a corporation must require that a quorum of the board of directors consists of not less than one-third of the number of directors prescribed by the articles of association, articles of incorporation, charter or bylaws.

9. The agreement of the subscribers or other organizing document of a captive insurer formed as a reciprocal insurer must require that a quorum of its subscribers advisory committee consists of not less than one-third of the number of its members.

Sec. 246. NRS 694C.190 is hereby amended to read as follows:

694C.190 A captive insurer shall not use or adopt a name that ~~[is]~~ ***:***

1. Is the same, deceptively similar or likely to be confused with or mistaken for any other existing business name registered in this State.

2. The Commissioner deems to be misleading as to the type or nature of the company.

Sec. 247. NRS 694C.250 is hereby amended to read as follows:

694C.250 1. A captive insurer must not be issued a license, and shall not hold a license, unless the captive insurer has and maintains, in addition to any other capital or surplus required to be maintained pursuant to subsection 3, unimpaired paid-in capital and unencumbered surplus of:

(a) For a pure captive insurer, not less than $200,000;

(b) For an association captive insurer, not less than $500,000;

(c) For an agency captive insurer, not less than $600,000;

(d) ~~[For a rental captive insurer, not less than $800,000;~~

~~(e)]~~ For a sponsored captive insurer, not less than ~~[$500,000;]~~ ***$350,000;*** and

~~[(f)]~~ ***(e)*** For a state-chartered risk retention group, not less than $500,000.

2. Except as otherwise provided by the Commissioner pursuant to subsection 3, the capital and surplus required to be maintained pursuant to this section must be in the form of cash or an irrevocable letter of credit.

3. The Commissioner may prescribe additional requirements relating to capital or surplus based on the type, volume and nature of the insurance business that is transacted by the captive insurer and requirements regarding which capital and surplus, if any, may be in the form of an irrevocable letter of credit.

4. A letter of credit used by a captive insurer as evidence of capital and surplus required pursuant to this section must:

(a) Be issued by a bank chartered by this State or a bank that is a member of the United States Federal Reserve System and has been approved by the Commissioner; and

(b) Include a provision pursuant to which the letter of credit is automatically renewable each year, unless the issuer gives written notice to the Commissioner and the captive insurer at least 90 days before the expiration date.

5. A surplus note used by a captive insurer as evidence of capital and surplus required pursuant to this section must:

(a) Be subject to strict control by the Commissioner and have been approved by the Commissioner as to form and content.

(b) Be subordinate to:

(1) Policyholders;

(2) Claims by claimants and beneficiaries under policies; and

(3) All other classes of creditors pursuant to paragraph (k) of subsection 1 of NRS 696B.420.

(c) Require prior approval of the Commissioner for any:

(1) Payment of interest; and

(2) Repayment of principal.

(d) Be accompanied by proceeds which are received by the captive insurer in the form of:

(1) Cash; or

(2) Other assets that:

(I) Are acceptable to the Commissioner;

(II) Have values that are readily determined; and

(III) Have liquidity that is satisfactory to the Commissioner.

(e) Be accounted for in such a manner that interest shall not be recorded as a liability or an expense until approval for payment of such interest has been granted by the Commissioner.

Sec. 248. NRS 694C.270 is hereby amended to read as follows:

694C.270 1. The Commissioner may suspend or revoke the license of a captive insurer if, after ***the opportunity for*** a hearing, the Commissioner determines that:

(a) The captive insurer:

(1) Is insolvent or has impaired its required capital or surplus;

(2) Has failed to meet a requirement of NRS 694C.250, 694C.320 or 694C.330;

(3) Has refused or failed to submit an annual report, as required by NRS 694C.400, or any other report or statement required by law or by order of the Commissioner;

(4) Has failed to comply with the provisions of its charter or bylaws;

(5) Has failed to submit to an examination required pursuant to NRS 694C.410;

(6) Has refused or failed to pay the cost of an examination required pursuant to NRS 694C.410;

(7) Has used any method in transacting insurance pursuant to this chapter which is detrimental to the operation of the captive insurer or would make its condition unsound with respect to its policyholders or the general public; or

(8) Has failed to pay taxes on premiums as required by NRS 694C.450 or otherwise to comply with the laws of this State; and

(b) The suspension or revocation of the license of the captive insurer is in the best interest of its policyholders or the general public.

2. The provisions of NRS 679B.310 to 679B.370, inclusive, apply to hearings conducted pursuant to this section.

Sec. 249. NRS 694C.300 is hereby amended to read as follows:

694C.300 1. Except as otherwise provided in this section, a captive insurer licensed pursuant to this chapter may transact any form of insurance described in NRS 681A.020 to 681A.080, inclusive.

2. A captive insurer licensed pursuant to this chapter:

(a) Shall not directly provide personal motor vehicle insurance coverage, or any component thereof.

(b) Shall not accept or cede reinsurance, except as otherwise provided in NRS 694C.350.

(c) ~~[May provide]~~ ***Shall not provide workers' compensation insurance, but may:***

(1) Provide excess workers' compensation insurance to its parent and affiliated companies, unless otherwise prohibited by the laws of the state in which the insurance is transacted.

~~[(d) May reinsure]~~

(2) Reinsure workers' compensation insurance provided pursuant to a program of self-funded insurance of its parent and affiliated companies if:

~~[(1)]~~ ***(I)*** The parent or affiliated company which is providing the self-funded insurance is certified as a self-insured employer by the Commissioner, if the insurance is being transacted in this State; or

~~[(2)]~~ ***(II)*** The program of self-funded insurance is otherwise qualified pursuant to, or in compliance with, the laws of the state in which the insurance is transacted.

3. A pure captive insurer shall not insure any risks other than those of its parent and affiliated companies or controlled unaffiliated businesses.

4. Except as otherwise provided in this subsection, an association captive insurer shall not insure any risks other than those of the member organizations of its association and the affiliated companies of the member organizations. An association captive insurer may insure the risks of individual homeowners who combine into an association for the purpose of procuring homeowners' insurance or the risks of individual units' owners in a common-interest community so long as the association captive insurer is owned by the association created by the homeowners or the unit-owners' association of the common-interest community, as applicable.

5. A state-chartered risk retention group shall not insure any risks other than those of the members of its association.

6. An agency captive insurer shall not insure any risks other than those of the policies that are placed by or through the insurance agency or brokerage that owns the captive insurer.

7. ~~[A rental captive insurer shall not insure any risks other than those of the policyholders or associations that have entered into agreements with the rental captive insurer for the insurance of those risks. Such agreements must be in a form which has been approved by the Commissioner.~~

~~8.]~~ A sponsored captive insurer shall not insure any risks other than those of its participants. A sponsored captive insurer may insure the risks of individual homeowners, including, without limitation, units' owners in a common-interest community, who

elect to become a participant of a protected cell of a sponsored captive insurer.

~~[9.]~~ ***8.*** As used in this section:

(a) "Common-interest community" has the meaning ascribed to it in NRS 116.021.

(b) "Excess workers' compensation insurance" means insurance in excess of the specified per-incident or aggregate limit, if any, established by:

(1) The Commissioner, if the insurance is being transacted in this State; or

(2) The chief regulatory officer for insurance in the state in which the insurance is being transacted.

(c) "Unit-owners' association" has the meaning ascribed to it in NRS 116.011.

(d) "Unit's owner" has the meaning ascribed to it in NRS 116.095.

Sec. 250. NRS 694C.340 is hereby amended to read as follows:

694C.340 1. Except as otherwise provided in this section and NRS 694C.382, an association captive insurer, an agency captive insurer, ~~[a rental captive insurer,]~~ a sponsored captive insurer or a state-chartered risk retention group shall comply with the requirements relating to investments set forth in chapter 682A of NRS. Upon the request of the association captive insurer, agency captive insurer, ~~[rental captive insurer,]~~ sponsored captive insurer or state-chartered risk retention group, the Commissioner may approve the use of reliable, alternative methods of valuation and rating.

2. A pure captive insurer is not subject to any restrictions on allowable investments, except that the Commissioner may prohibit or limit any investment that threatens the solvency or liquidity of the pure captive insurer.

3. A pure captive insurer may make a loan to its parent or affiliated company if the loan:

(a) Is first approved in writing by the Commissioner;

(b) Is evidenced by a note that is in a form that is approved by the Commissioner; and

(c) Does not include any money that has been set aside as capital or surplus as required by subsection 1 of NRS 694C.250.

Sec. 251. NRS 694C.388 is hereby amended to read as follows:

694C.388 Before June 30 of each year or, if approved by the Commissioner, not more than ~~[60]~~ ***180*** days after the expiration of the fiscal year of the branch captive insurer, the branch captive insurer shall file with the Commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in

which the alien captive insurer is domiciled. The reports and statements must be verified by oath of two of the executive officers of the alien captive insurer. If the Commissioner is satisfied that the annual report filed by the alien captive insurer in the jurisdiction in which it is domiciled provides adequate information concerning the financial condition of the alien captive insurer, the Commissioner may waive the requirement for completion of the captive annual statement for business written in the alien jurisdiction.

Sec. 252. NRS 694C.400 is hereby amended to read as follows:

694C.400 1. On or before June 30 of each year, a captive insurer, other than a state-chartered risk retention group, shall submit to the Commissioner a report of its financial condition. A captive insurer shall use generally accepted accounting principles and include any useful or necessary modifications or adaptations thereof that have been approved or accepted by the Commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the Commissioner. Except as otherwise provided in this section, each association captive insurer, agency captive insurer ~~[, rental captive insurer]~~ or sponsored captive insurer shall file its report in the time and form required by the Commissioner. Each state-chartered risk retention group shall file its report in the time and form required by NRS 680A.270. The Commissioner shall adopt regulations designating the form in which pure captive insurers must report.

2. Each captive insurer, other than a state-chartered risk retention group, shall submit to the Commissioner, on or before June 30 of each year, an annual audit as of December 31 of the preceding calendar year that is certified by a certified public accountant who is not an employee of the insurer. An annual audit submitted pursuant to this subsection must comply with the requirements set forth in regulations adopted by the Commissioner which govern such an annual audit, including, without limitation, criteria for extensions and exemptions. ***If the results of the annual audit reveal any deficiency in the amount of the tax imposed by NRS 694C.450 that is required to be paid by the captive insurer, the captive insurer shall pay to the Division the amount of the deficiency within 60 days after the date on which the annual audit was submitted to the Division.***

3. Each state-chartered risk retention group shall file a financial statement pursuant to NRS 680A.265.

4. A pure captive insurer may apply, in writing, for authorization to file its annual report based on a fiscal year that is consistent with the fiscal year of the parent company of the pure captive insurer. If an alternative date is granted, the annual report is

due not later than ~~[60]~~ ***180*** days after the end of each such fiscal year.

5. A pure captive insurer shall file on or before March 1 of each year such forms as required by the Commissioner by regulation to provide sufficient detail to support its premium tax return filed pursuant to NRS 694C.450.

6. Any captive insurer failing, without just cause beyond the reasonable control of the captive insurer, to file its annual report of financial condition as required by subsection 1, its annual audit as required by subsection 2 or its financial statement as required by subsection 3 shall pay a penalty of $100 for each day the captive insurer fails to file the report of financial condition, the annual audit or the financial statement, but not to exceed an aggregate amount of $3,000, to be recovered in the name of the State of Nevada by the Attorney General.

7. Any director, officer, agent or employee of a captive insurer who subscribes to, makes or concurs in making or publishing, any annual or other statement required by law, knowing the same to contain any material statement which is false, is guilty of a gross misdemeanor.

Sec. 253. NRS 694C.450 is hereby amended to read as follows:

694C.450 1. Except as otherwise provided in this section, a captive insurer shall pay to the Division, not later than March 1 of each year, a tax at the rate of:

(a) Two-fifths of 1 percent on the first $20,000,000 of its net direct premiums;

(b) One-fifth of 1 percent on the next $20,000,000 of its net direct premiums; and

(c) Seventy-five thousandths of 1 percent on each additional dollar of its net direct premiums.

2. Except as otherwise provided in this section, a captive insurer shall pay to the Division, not later than March 1 of each year, a tax at a rate of:

(a) Two hundred twenty-five thousandths of 1 percent on the first $20,000,000 of revenue from assumed reinsurance premiums;

(b) One hundred fifty thousandths of 1 percent on the next $20,000,000 of revenue from assumed reinsurance premiums; and

(c) Twenty-five thousandths of 1 percent on each additional dollar of revenue from assumed reinsurance premiums.

➥ The tax on reinsurance premiums pursuant to this subsection must not be levied on premiums for risks or portions of risks which are subject to taxation on a direct basis pursuant to subsection 1. A captive insurer is not required to pay any reinsurance premium tax pursuant to this subsection on revenue related to the receipt of assets

by the captive insurer in exchange for the assumption of loss reserves and other liabilities of another insurer that is under common ownership and control with the captive insurer, if the transaction is part of a plan to discontinue the operation of the other insurer and the intent of the parties to the transaction is to renew or maintain such business with the captive insurer.

3. If the sum of the taxes to be paid by a captive insurer calculated pursuant to subsections 1 and 2 is less than $5,000 in any given year, the captive insurer shall pay a tax of $5,000 for that year. The maximum aggregate tax for any year must not exceed ~~[$175,000.]~~ ***$350,000.*** The maximum aggregate tax to be paid by a sponsored captive insurer applies only to each protected cell and does not apply to the sponsored captive insurer as a whole.

4. Two or more captive insurers under common ownership and control must be taxed as if they were a single captive insurer.

5. Notwithstanding any specific statute to the contrary and except as otherwise provided in this subsection, the tax provided for by this section constitutes all the taxes collectible pursuant to the laws of this State from a captive insurer, and no occupation tax or other taxes may be levied or collected from a captive insurer by this State or by any county, city or municipality within this State, except for taxes imposed pursuant to chapter 363A, 363B or 363C of NRS and ad valorem taxes on real or personal property located in this State used in the production of income by the captive insurer.

6. ~~[Twenty-five]~~ ***Twenty-three*** percent of the revenues collected from the tax imposed pursuant to this section must be deposited with the State Treasurer for credit to the Fund for Insurance Administration and Enforcement created by NRS 680C.100. ***Two percent of the revenues collected must be deposited with the State Treasurer for credit to the Account for Outreach and Promotion of Captive Insurance created by section 241 of this act.*** The remaining 75 percent of the revenues collected must be deposited with the State Treasurer for credit to the State General Fund.

7. A captive insurer that is issued a license pursuant to this chapter after July 1, 2003, is entitled to receive a nonrefundable credit of $5,000 applied against the aggregate taxes owed by the captive insurer for the first year in which the captive insurer incurs any liability for the payment of taxes pursuant to this section. A captive insurer is entitled to a nonrefundable credit pursuant to this section not more than once after the captive insurer is initially licensed pursuant to this chapter.

8. ***Except as otherwise provided in subsection 9, if a captive insurer fails to pay the tax imposed by this section by the date specified in subsection 1 or fails to pay a deficiency within the time***

required by subsection 2 of NRS 694C.400, the captive insurer shall pay an administrative penalty of $100 per day until the tax is paid. The Attorney General shall recover the penalty in the name of the State of Nevada.

9. The Commissioner may waive any penalty imposed upon a captive insurer by subsection 8 if the captive insurer:

(a) Submits to the Commissioner a written request for a waiver from a penalty imposed by subsection 8; and

(b) Proves to the satisfaction of the Commissioner that the failure of the captive insurer to pay the tax imposed by this section by the date specified in subsection 1 or the failure to pay the deficiency within the time required by subsection 2 of NRS 694C.400 was the result of circumstances beyond the control of the captive insurer.

10. As used in this section, unless the context otherwise requires:

(a) "Common ownership and control" means:

(1) In the case of a stock insurer, the direct or indirect ownership of 80 percent or more of the outstanding voting stock of two or more corporations by the same member or members.

(2) In the case of a mutual insurer, the direct or indirect ownership of 80 percent or more of the surplus and the voting power of two or more corporations by the same member or members.

(b) "Net direct premiums" means the ***total premiums derived from*** direct premiums ~~[collected or contracted for]~~ on policies or contracts of insurance ~~[written]~~ ***issued*** by a captive insurer during the preceding calendar year, less the amounts paid to policyholders as return premiums ***.*** ~~[, including dividends on unabsorbed premiums or premium deposits returned or credited to policyholders.]~~

Sec. 254. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 255 to 260, inclusive, of this act.

Sec. 255. ***"Medical management technique" has the meaning ascribed to it in section 128 of this act.***

Sec. 256. ***"Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.***

Sec. 257. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 258. ***"Primary care" has the meaning ascribed to it in section 131 of this act.***

Sec. 259. ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 260. ***The provisions of section 4 of this act governing the issuance of a cease and desist order by the Commissioner apply to a fraternal benefit society.***

Sec. 261. NRS 695A.001 is hereby amended to read as follows:

695A.001 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695A.003 to 695A.044, inclusive, ***and sections 255 to 259, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 262. NRS 695A.095 is hereby amended to read as follows:

695A.095 1. A society shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the society to its insureds.

2. A society shall not contract with a provider of health care to provide health care to an insured unless the society uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a society and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the society upon giving to the provider 45 days' written notice of the modification of the society's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a society contracts with a provider of health care to provide health care to an insured, the society shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments, including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 263. NRS 695A.1843 is hereby amended to read as follows:

695A.1843 1. A society that offers or issues a benefit contract shall include in the benefit coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the society;

(b) Laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the society.

2. A society that offers or issues a benefit contract shall reimburse:

(a) A pharmacist who participates in the network plan of the society for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the society for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A society shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. A society 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 society.

5. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 264. NRS 695A.18445 is hereby amended to read as follows:

695A.18445 1. A society that offers or issues a benefit contract shall include in the contract a provision authorizing a woman covered by the plan to:

(a) Obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

(b) Designate as her primary care physician an obstetrician or gynecologist who:

(1) Participates in the network plan of the society;

(2) Satisfies the criteria established by the society for designation as a primary care provider under the benefit contract; and

(3) Agrees to abide by all terms and conditions imposed by the society on other primary care physicians generally.

2. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by this section, and any provision of the benefit contract or

renewal of the benefit contract which is in conflict with this section is void.

~~[3. As used in this section:~~

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

~~(b) "Primary care physician" has the meaning ascribed to it in NRS 695G.060.]~~

Sec. 265. NRS 695A.1845 is hereby amended to read as follows:

695A.1845 1. A benefit contract must provide coverage for benefits payable for expenses incurred for:

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

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

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

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

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

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

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

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

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

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

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

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

6. As used in this section ~~[:~~

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

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

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

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

Sec. 266. NRS 695A.1853 is hereby amended to read as follows:

695A.1853 1. A society that issues a benefit contract shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. A society 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 society.

3. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage

required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[4. As used in this section:~~

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

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

Sec. 267. NRS 695A.1855 is hereby amended to read as follows:

695A.1855 1. A benefit contract must provide coverage for benefits payable for expenses incurred for:

(a) A mammogram to screen for breast cancer annually for insureds who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

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

(a) Except as otherwise provided in subsection 6, require an insured to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition for coverage to obtain any benefit provided in a benefit contract pursuant to subsection 1;

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

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

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

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

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

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified benefit contract with respect to the deductible of such a benefit contract after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

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

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

~~(d) "Qualified]~~ ***, "qualified*** benefit contract" means a benefit contract that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 268. NRS 695A.1856 is hereby amended to read as follows:

695A.1856 1. A society that issues a benefit contract shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the insured by a provider of health care, facility or medical laboratory that participates in the network plan of the society; and

(b) Without prior authorization.

3. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the contract that conflicts with the provisions of this section is void.

4. As used in this section ~~[:~~

~~(a) "Medical]~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

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

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

Sec. 269. NRS 695A.1859 is hereby amended to read as follows:

695A.1859 1. Subject to the limitations prescribed by subsection 4, a society that issues a benefit contract shall include in the contract coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. A society shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the society.

3. If a society requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the society shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require a society to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the society; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the benefit contract or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological

process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A gene mutation or characteristic; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

~~[(f) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care,~~

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

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

Sec. 270. NRS 695A.1865 is hereby amended to read as follows:

695A.1865 1. Except as otherwise provided in subsection 8, a society that offers or issues a benefit contract which provides coverage for prescription drugs or devices shall include in the contract coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

(d) The insertion of a device for contraception or the removal of such a device if the device was inserted while the insured was covered by the same benefit contract;

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. A society shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

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

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the society.

5. Except as otherwise provided in subsections 9, 10 and 12, a society that offers or issues a benefit contract shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

7. Except as otherwise provided in subsection 8, a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

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

prospective insured written notice of the coverage that the society refuses to provide pursuant to this subsection.

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

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug Administration, a benefit contract must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the society may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the society charges a copayment or coinsurance for a drug for contraception, the society may only require an insured to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

13. A society shall not:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an insured gives birth.

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

15. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with a society to provide services to insureds through a network plan offered or issued by the society.

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

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

~~(d)]~~ "Provider network contract" means a contract between a society and a provider of health care or pharmacy specifying the rights and responsibilities of the society and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 271. NRS 695A.1866 is hereby amended to read as follows:

695A.1866 1. Except as otherwise provided in subsection 4, a society that issues a benefit contract shall include in the contract coverage for 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 is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, 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 society 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 society.

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

5. A benefit contract 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 contract or the renewal that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

~~(a) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including~~

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

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

Sec. 272. NRS 695A.1867 is hereby amended to read as follows:

695A.1867 1. Except as otherwise provided in this section, a society that issues a benefit contract shall include in the benefit contract coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a benefit contract to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A society that issues a benefit contract shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the contract provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A society that issues a benefit contract may prescribe requirements that must be satisfied before the society covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;

(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;

(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a society must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. A society shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society. If, after a reasonable effort, the society is unable to make such benefits available through such a provider of health care, the society may treat the treatment that the society is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the society.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the society must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked

difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

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

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

Sec. 273. NRS 695A.1873 is hereby amended to read as follows:

695A.1873 1. A society that issues a benefit contract shall include in the benefit contract coverage for:

(a) Necessary case management services for an insured who has been diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an insured who has been diagnosed with sickle cell disease and its variants.

2. A society that issues a benefit contract which provides coverage for prescription drugs shall include in the benefit contract coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

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

4. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~(c)]~~ "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

~~[(d)]~~ ***(c)*** "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 274. NRS 695A.18735 is hereby amended to read as follows:

695A.18735 1. A society that offers or issues a benefit contract shall include in the contract coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for insureds who are less than 26 years of age.

2. A society shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A benefit contract subject to the provisions of this chapter that 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 contract that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

~~(c)]~~ "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)]~~ *(c)* "Rehabilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 275. NRS 695A.1874 is hereby amended to read as follows:

695A.1874 1. A society that offers or issues a benefit contract shall include in the contract coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the society. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A society that offers or issues a benefit contract shall reimburse a pharmacist or pharmacy that participates in the network plan of the society for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A society shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of whether the drug is included in the formulary of the society.

4. Except as otherwise provided in this subsection, a society shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step therapy. A society may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. A society shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. A society 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 society.

7. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the contract that conflicts with the provisions of this section is void.

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

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

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

~~(c) "Primary"~~ ***, "primary*** care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 276. NRS 695A.1875 is hereby amended to read as follows:

695A.1875 1. A society that offers or issues a benefit contract shall include in the contract coverage for:

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

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

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

(d) Hormone replacement therapy;

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

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

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

(h) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[6. As used in this section:~~

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

~~(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the~~

~~society. The term does not include an arrangement for the financing of premiums.~~

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

Sec. 277. NRS 695A.256 is hereby amended to read as follows:

695A.256 1. A benefit contract which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the society is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section ~~[~~:

~~(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.~~

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

~~(c) "Step~~] ***, "step*** therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of

prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her benefit contract provides coverage for the recommended drug.

Sec. 278. NRS 695A.258 is hereby amended to read as follows:

695A.258 1. When developing a step therapy protocol, a society shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A society that offers or issues a benefit contract which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the society concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the society; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the society shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A society shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the society a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The society shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current benefit contract at the time, and was discontinued due to lack of efficacy or effectiveness,

diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current benefit contract at the time the attending practitioner selected the drug.

4. If a society does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the society shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695A.259 apply.

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

~~(a) "Attending]~~ ***, "attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.]~~

Sec. 279. NRS 695A.265 is hereby amended to read as follows:

695A.265 1. A benefit contract must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A benefit contract must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A society shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A benefit contract must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A benefit contract may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require a society to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the society is not otherwise required by law to do so.

6. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1,

2023, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 280. NRS 695B.030 is hereby amended to read as follows:

695B.030 As used in this chapter:

1. "Dental services" means general and special dental services ordinarily provided by dentists licensed under the provisions of chapter 631 of NRS to practice in the State of Nevada in accordance with the generally accepted practices of the community at the time the service is rendered, and the furnishing of necessary appliances, drugs, medicines and supplies, prosthetic appliances, orthodontic appliances, metal, ceramic and other restorations.

2. "Hospital services" means the furnishing or providing of any or all of the following:

(a) Maintenance and care in the hospital, including but not limited to, nursing care, drugs, medicines, supplies, physiotherapy, transportation and use of facilities and appliances.

(b) Reimbursement of the beneficiary or subscriber for, but without requiring that the beneficiary or subscriber first pay, expenses incurred for any of the items included in paragraph (a).

(c) Reimbursement, at a uniform rate, of the beneficiary or subscriber for, but without requiring that the beneficiary or subscriber first pay, the costs and expenses incurred for medical supplies.

(d) Reimbursement for expenses incurred outside of the hospital for continued care and treatment following the subscriber's discharge from the hospital, for nursing service, necessary appliances, drugs, medicines, supplies and any other services which would have been available in the hospital (excluding physicians' services), whether or not provided through a hospital.

(e) Reimbursement for ambulance service expenses.

3. ***"Medical management technique" has the meaning ascribed to it in section 128 of this act.***

4. "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

5. "Medical services" means the furnishing or providing of any or all of the following:

(a) Medical or surgical services, in or out of a hospital, by a physician licensed to practice under the laws of Nevada.

(b) Reimbursement for expenses incurred for nursing services, necessary appliances, drugs, medicines, supplies and any other health care services.

6. "Network plan" has the meaning ascribed to it in NRS 687B.645.

7. "Primary care" has the meaning ascribed to it in section 131 of this act.

8. "Provider of health care" has the meaning ascribed to it in NRS 695G.070.

Sec. 281. NRS 695B.035 is hereby amended to read as follows:

695B.035 1. A corporation subject to the provisions of this chapter shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the corporation to its insureds.

2. A corporation specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the corporation uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a corporation specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the corporation upon giving to the provider 45 days' written notice of the modification of the corporation's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a corporation specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the corporation shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments, including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 282. NRS 695B.185 is hereby amended to read as follows:

695B.185 A group contract for hospital, medical or dental services which offers a difference of payment between preferred providers of health care and providers of health care who are not preferred:

1. ~~[May not require a deductible of more than $600 difference per admission to a facility for inpatient treatment which is not a preferred provider of health care.~~

~~2. May not require a deductible of more than $500 difference per treatment, other than inpatient treatment at a hospital, by a provider which is not preferred.~~

~~3.]~~ May not require an insured, another insurer who issues policies of group health insurance, a nonprofit medical service corporation or a health maintenance organization to pay any amount in excess of the deductible or coinsurance due from the insured based on the rates agreed upon with a provider.

~~[4. May not provide for a difference in percentage rates of payment for coinsurance of more than 30 percentage points between the copayment required to be paid by the insured to a preferred provider of health care and the copayment required to be paid by the insured to a provider of health care who is not preferred.~~

~~5.]~~ ***2.*** Must require that the deductible and payment for coinsurance paid by the insured to a preferred provider of health care be applied to the negotiated reduced rates of that provider.

~~[6.]~~ ***3.*** Must provide that if there is a particular service which a preferred provider of health care does not provide and the provider of health care who is treating the insured determines that the use of the service is necessary for the health of the insured, the service shall be deemed to be provided by the preferred provider of health care.

~~[7.]~~ ***4.*** Must require the corporation to process a claim of a provider of health care who is not preferred not later than 30 working days after the date on which proof of the claim is received.

Sec. 283. NRS 695B.1903 is hereby amended to read as follows:

695B.1903 1. A policy of health insurance issued by a medical services corporation must provide coverage for medical treatment which a person insured under the policy receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The insured has signed, before participating in the clinical trial or study, a statement of consent indicating that the insured has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured person.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the policy of health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of health insurance for an insured participating in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the insured is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the insured during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the insured during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 695B.1901, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the medical services corporation has contracted for such services. If the medical services corporation has not contracted for the provision of such services, the medical services corporation shall pay the provider the rate of reimbursement that is paid to other providers with whom the medical services corporation has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to a person insured under the policy is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the policy.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the insured's policy of health insurance, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study, including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the insured during the trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured.

(h) Any costs for the management of research relating to the clinical trial or study.

5. A medical services corporation that delivers or issues for delivery a policy of health insurance specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the insured, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. A medical services corporation that delivers or issues for delivery a policy of health insurance specified in subsection 1 shall:

(a) Include in any disclosure of the coverage provided by the policy notice to each person insured under the policy of the availability of the benefits required by this section.

(b) Provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

7. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with this section is void.

8. A medical services corporation that delivers or issues for delivery a policy of health insurance specified in subsection 1 is immune from liability for:

(a) Any injury to the insured caused by:

(1) Any medical treatment provided to the insured in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the insured in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an insured's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the "Policies and Guidelines Relating to the Cancer Center Support Grant" published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

~~[(c) "Provider of health care" means:~~

~~(1) A hospital; or~~

~~(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.]~~

Sec. 284. NRS 695B.1904 is hereby amended to read as follows:

695B.1904 1. A contract for hospital, medical or dental services subject to the provisions of this chapter must include services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A contract for hospital, medical or dental services must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A medical services corporation that issues contracts for hospital, medical or dental services shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A contract for hospital, medical or dental services must not require an insured to obtain prior authorization for any service

provided through telehealth that is not required for the service when provided in person. A contract for hospital, medical or dental services may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require a medical services corporation that issues contracts for hospital, medical or dental services to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the medical services corporation is not otherwise required by law to do so.

6. A contract for hospital, medical or dental services subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 285. NRS 695B.19046 is hereby amended to read as follows:

695B.19046 1. A policy of health insurance offered or issued by a hospital or medical services corporation which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the hospital or medical services corporation is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section ~~[~~:

~~(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.~~

~~(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 is 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) "Step~~~~]~~ ***, "step*** therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her policy of health insurance offered or issued by a hospital or medical services corporation provides coverage for the recommended drug.

Sec. 286. NRS 695B.19047 is hereby amended to read as follows:

695B.19047 1. When developing a step therapy protocol, a hospital or medical services corporation shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A hospital or medical services corporation that offers or issues a policy of health insurance which includes coverage for a

prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the hospital or medical services corporation concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the hospital or medical services corporation; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the hospital or medical services corporation shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A hospital or medical services corporation shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the hospital or medical services corporation a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The hospital or medical services corporation shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his

or her current policy of health insurance at the time the attending practitioner selected the drug.

4. If a hospital or medical services corporation does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the hospital or medical services corporation shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695B.19085 apply.

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

~~(a) "Attending]~~ ***, "attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.]~~

Sec. 287. NRS 695B.19087 is hereby amended to read as follows:

695B.19087 1. Subject to the limitations prescribed by subsection 4, a hospital or medical service corporation that issues a policy of health insurance shall include in the policy coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. A hospital or medical service corporation shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the hospital or medical service corporation.

3. If a hospital or medical service corporation requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the hospital or medical service corporation shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require a hospital or medical service corporation to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the hospital or medical service corporation; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

~~[(f) "Network plan" means a policy of health insurance offered by a hospital or medical service 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 service corporation. The term does not include an arrangement for the financing of premiums.~~

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

Sec. 288. NRS 695B.1911 is hereby amended to read as follows:

695B.1911 1. A hospital or medical services corporation that issues a policy of health insurance shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. 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.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

~~[4. As used in this section:~~

~~(a) "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.~~

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

Sec. 289. NRS 695B.1912 is hereby amended to read as follows:

695B.1912 1. An insurer that offers or issues a contract for hospital or medical service must provide coverage for benefits payable for expenses incurred for:

(a) A mammogram to screen for breast cancer annually for insureds who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

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

(a) Except as otherwise provided in subsection 6, require an insured to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition to obtain any benefit provided in a contract for hospital or medical service pursuant to subsection 1;

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

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

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

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

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

4. A contract for hospital or medical service subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified contract for hospital or medical service with respect to the deductible of such a contract for hospital or medical service after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

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

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

~~(d) "Qualified"~~ ***, "qualified*** contract for hospital or medical service" means a contract for hospital or medical service that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 290. NRS 695B.1913 is hereby amended to read as follows:

695B.1913 1. A hospital or medical services corporation that issues a policy of health insurance shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the insured by a provider of health care, facility or medical laboratory that participates in the network plan of the hospital or medical services corporation; and

(b) Without prior authorization.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after

July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

4. As used in this section ~~[:~~

~~(a) "Medical]~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

~~[(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.]~~

Sec. 291. NRS 695B.1914 is hereby amended to read as follows:

695B.1914 1. A contract for hospital or medical service must include a provision authorizing a woman covered by the contract to:

(a) Obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

(b) Designate as her primary care physician an obstetrician or gynecologist who:

(1) Participates in the network plan of the hospital or medical services corporation;

(2) Satisfies the criteria established by the hospital or medical services corporation for designation as a primary care provider under the contract; and

(3) Agrees to abide by all terms and conditions imposed by the hospital or medical services corporation on other primary care physicians generally.

2. A contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

3. As used in this section ~~[:~~

~~(a) "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.~~

~~(b) "Primary~~ ***, "primary*** care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 292. NRS 695B.1915 is hereby amended to read as follows:

695B.1915 1. Except as otherwise provided in this section, a hospital or medical services corporation that issues a policy of health insurance shall include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a policy of health insurance to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A hospital or medical services corporation that issues a policy of health insurance shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the policy provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A hospital or medical services corporation that issues a policy of health insurance may prescribe requirements that must be satisfied before the hospital or medical services corporation covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;

(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;

(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a hospital or medical services corporation must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. A hospital or medical services corporation shall make a reasonable effort to 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. If, after a reasonable effort, the hospital or medical services corporation is unable to make such benefits available through such a provider of health care, the hospital or medical services corporation may treat the treatment that the hospital or medical services corporation is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the hospital or medical services corporation.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the hospital or medical services corporation must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

~~[(d) "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.~~

~~(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.~~**]**

Sec. 293. NRS 695B.19155 is hereby amended to read as follows:

695B.19155 1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for insureds who are less than 26 years of age.

2. A hospital or medical services corporation shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

~~(c)~~**]** "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)]~~ ***(c)*** "Rehabilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 294. 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.

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

Sec. 295. NRS 695B.1918 is hereby amended to read as follows:

695B.1918 1. An insurer that offers or issues a contract for hospital or medical service which provides coverage for outpatient care shall include in the contract coverage for any health care service related to hormone replacement therapy.

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

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

other condition for coverage for outpatient care related to 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. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 296. NRS 695B.1919 is hereby amended to read as follows:

695B.1919 1. Except as otherwise provided in subsection 8, an insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 12; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 12;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. An insurer shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

3. An insurer that offers or issues a contract for hospital or medical services must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.

5. Except as otherwise provided in subsections 10, 11 and 13, an insurer that offers or issues a contract for hospital or medical service shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

7. Except as otherwise provided in subsection 8, a contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

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

9. If an insurer refuses, pursuant to subsection 8, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

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

11. For each of the 18 methods of contraception listed in subsection 12 that have been approved by the Food and Drug Administration, a contract for hospital or medical service must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the insurer charges a copayment or coinsurance for a drug for contraception, the insurer may only require an insured to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;
(b) Surgical sterilization implants for women;
(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
(r) Ulipristal acetate for emergency contraception.

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

14. An insurer shall not:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 12 at a hospital immediately after an insured gives birth.

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

16. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with an insurer to provide services to insureds through a network plan offered or issued by the insurer.

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

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

~~(d)]~~ "Provider network contract" means a contract between an insurer and a provider of health care or pharmacy specifying the rights and responsibilities of the insurer and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 297. NRS 695B.19192 is hereby amended to read as follows:

695B.19192 1. Except as otherwise provided in subsection 4, a hospital or medical services corporation that issues a policy of health insurance shall include in the policy coverage for 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 is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, 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 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 health insurance that is subject to the requirements of subsection 1 and before the renewal of such a policy, provide to the insured or prospective insured, as applicable, written notice of the coverage that the hospital or medical services corporation refuses to provide pursuant to this subsection.

5. A policy of health insurance 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.

~~[6. As used in this section:~~

~~(a) "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.~~

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

Sec. 298. NRS 695B.19195 is hereby amended to read as follows:

695B.19195 1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:

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

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

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

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

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

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

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

(g) Screening for depression;

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

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

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

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

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

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

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

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the

person applying for or covered by the contract uses or may use any such benefit;

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

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

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

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

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

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

~~[6. As used in this section:~~

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

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

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

Sec. 299. NRS 695B.19197 is hereby amended to read as follows:

695B.19197 1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the hospital or medical services corporation. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A hospital or medical services corporation that offers or issues a policy of health insurance shall reimburse a pharmacist or pharmacy that participates in the network plan of the hospital or medical services corporation for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A hospital or medical services corporation shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of whether the drug is included in the formulary of the hospital or medical services corporation.

4. Except as otherwise provided in this subsection, a hospital or medical services corporation shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step therapy. A hospital or medical services corporation may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. A hospital or medical services corporation shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. 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.

7. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

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

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

~~(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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 300. NRS 695B.1924 is hereby amended to read as follows:

695B.1924 1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the hospital or medical services organization;

(b) Laboratory testing that is necessary for therapy using a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the hospital or medical services corporation.

2. A hospital or medical services corporation that offers or issues a policy of health insurance shall reimburse:

(a) A pharmacist who participates in the network plan of the hospital or medical services corporation for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the hospital or medical services corporation for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A hospital or medical services corporation shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. 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.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

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

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

~~(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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 301. NRS 695B.1925 is hereby amended to read as follows:

695B.1925 1. An insurer that offers or issues a contract for hospital or medical service must provide coverage for benefits payable for expenses incurred for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 302. NRS 695B.1929 is hereby amended to read as follows:

695B.1929 1. A hospital or medical service corporation that issues a policy of health insurance shall include in the policy coverage for:

(a) Necessary case management services for an insured who has been diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an insured who has been diagnosed with sickle cell disease and its variants.

2. A hospital or medical service corporation that issues a policy of health insurance which provides coverage for prescription drugs shall include in the policy coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

3. A hospital or medical service corporation may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

4. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~(c)]~~ "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

~~[(d)]~~ ***(c)*** "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 303. NRS 695B.1997 is hereby amended to read as follows:

695B.1997 1. A person insured under a contract for hospital, medical or dental services may assign his or her right to benefits to the provider of health care who provided the services covered by the contract. The nonprofit hospital, medical or dental service corporation shall pay all the benefits or the part of the benefits assigned by the insured to the person designated by the insured. A payment made pursuant to this subsection discharges the obligation of the corporation to pay those benefits.

2. If the insured makes an assignment under this section, but the corporation after receiving a copy of the assignment pays the benefits to the insured, the corporation shall also pay those benefits to the provider of health care who received the assignment as soon as the corporation receives notice of the incorrect payment.

~~[3. For the purpose of this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 304. NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 681B of NRS, NRS 686A.010 to ~~[686A.315,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act,*** 686B.010 to 686B.175, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, 687B.500, 687B.900 to 687B.990, inclusive, and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term "insurer."

Sec. 305. NRS 695C.030 is hereby amended to read as follows:

695C.030 As used in this chapter, unless the context otherwise requires:

1. "Comprehensive health care services" means medical services, dentistry, drugs, psychiatric and optometric and all other care necessary for the delivery of services to the consumer.

2. "Enrollee" means a natural person who has been voluntarily enrolled in a health care plan.

3. "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

4. "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for or reimburse any part of the cost of any health care services and at least part of the arrangement consists of arranging for or the provision of health care services paid for by or on behalf of the enrollee on a periodic prepaid basis.

5. "Health care services" ~~[means any services included in the furnishing to any natural person of medical or dental care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing or healing human illness or injury.]~~ ***has the meaning ascribed to it in NRS 695G.022.***

6. "Health maintenance organization" means any person which provides or arranges for provision of a health care service or services and is responsible for the availability and accessibility of such service or services to its enrollees, which services are paid for or on behalf of the enrollees on a periodic prepaid basis without regard to the dates health services are rendered and without regard to the extent of services actually furnished to the enrollees, except that supplementing the fixed prepayments by nominal additional payments for services in accordance with regulations adopted by the Commissioner shall not be deemed to render the arrangement not to be on a prepaid basis. A health maintenance organization, in addition to offering health care services, may offer indemnity or service benefits provided through insurers or otherwise.

7. ***"Medical management technique" has the meaning ascribed to it in section 128 of this act.***

8. "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

9. "Network plan" has the meaning ascribed to it in NRS 687B.645.

10. "Primary care" has the meaning ascribed to it in section 131 of this act.

11. "Provider ~~[" means any physician, hospital or other person who is licensed or otherwise authorized in this state to furnish health care services.]~~ ***of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 306. NRS 695C.070 is hereby amended to read as follows:

695C.070 Each application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be in a form prescribed by the Commissioner, and must set forth or be accompanied by the following:

1. A copy of the basic organizational document, if any, of the applicant, and all amendments thereto;

2. A copy of the bylaws, rules or regulations, or a similar document, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses and official positions of the persons who will be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers in the case of a corporation, and the partners or members in the case of a partnership or association;

4. A copy of any contract made or to be made between any providers or persons listed in subsection 3 and the applicant;

5. A statement generally describing the health maintenance organization, its health care plan or plans, the location of facilities at which health care services will be regularly available to enrollees and the type of health care personnel who will provide the health care services;

6. A copy of the form of evidence of coverage to be issued to the enrollees;

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

8. Certified financial statements showing the applicant's assets, liabilities and sources of financial support;

9. The proposed method of marketing the plan, a financial plan which includes a 3-year projection of the initial operating results anticipated and the sources of ~~[working]~~ capital ***and surplus*** and any other sources of funding;

10. A power of attorney, executed by the applicant, appointing the Commissioner and the authorized deputies of the Commissioner as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

11. A statement reasonably describing the geographic area to be served;

12. A description of the procedures for resolving complaints and procedures for external reviews to be used as required under NRS 695C.260;

13. A description of the procedures and programs to be implemented to meet the quality of health care requirements in NRS 695C.080;

14. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of program content under subsection 2 of NRS 695C.110; and

15. Such other information as the Commissioner may require to make the determinations required in NRS 695C.080.

Sec. 307. NRS 695C.090 is hereby amended to read as follows:

695C.090 The Commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to NRS 695C.060 within 90 days after certification. Issuance of a certificate of authority must be granted upon payment of the fees prescribed in NRS 695C.230 if the Commissioner is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations.

2. The Commissioner certifies, in accordance with NRS 695C.080, that the health maintenance organization's proposed plan of operation meets the requirements of subsection 1 of NRS 695C.080.

3. The health care plan furnishes comprehensive health care services.

4. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commissioner may consider:

(a) The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of ~~[working]~~ capital ~~[,]~~ ***and surplus;***

(c) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services;

(d) Any agreement with providers for the provision of health care services; and

(e) Any surety bond or deposit of cash or securities submitted in accordance with NRS 695C.270 as a guarantee that the obligations will be duly performed.

5. The enrollees will be afforded an opportunity to participate in matters of program content pursuant to NRS 695C.110.

6. Nothing in the proposed method of operation, as shown by the information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, or by independent investigation is contrary to the public interest.

Sec. 308. NRS 695C.125 is hereby amended to read as follows:

695C.125 1. A health maintenance organization shall not contract with a provider of health care to provide health care to an insured unless the health maintenance organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a health maintenance organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the health maintenance organization upon giving to the provider 45 days' written notice of the modification of the health maintenance organization's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider

fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a health maintenance organization contracts with a provider of health care to provide health care to an enrollee, the health maintenance organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments, including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[4. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 309. NRS 695C.145 is hereby amended to read as follows:

695C.145 1. A health maintenance organization shall use accounting principles that are recognized by the laws of this State or approved by the Commissioner for:

(a) All financial reports;

(b) The accounting of investments and deposits; and

(c) Transactions between affiliates and holding companies.

2. A health maintenance organization is subject to the requirements for insurers for:

(a) Administrators, agents, brokers and solicitors, pursuant to chapter 683A of NRS;

(b) Borrowing, pursuant to NRS 693A.180;

(c) ~~[Impairment of capital, surplus or assets,]~~ ***Operating in an impaired financial condition*** pursuant to NRS 693A.260, 693A.270 and 693A.280;

(d) Management and agency contracts executed on or after January 1, 1992; and

(e) Officers, pursuant to NRS 693A.120 and 693A.130.

3. A domestic health maintenance organization is subject to the requirements for insurers for corporations pursuant to NRS 693A.040 to 693A.070, inclusive.

Sec. 310. NRS 695C.1693 is hereby amended to read as follows:

695C.1693 1. Except as otherwise provided in NRS 695C.050, a health care plan issued by a health maintenance

organization must provide coverage for medical treatment which an enrollee receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The enrollee has signed, before participating in the clinical trial or study, a statement of consent indicating that the enrollee has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the enrollee.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the health care plan.

(c) The cost of any routine health care services that would otherwise be covered under the health care plan for an enrollee in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the enrollee is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the enrollee during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the enrollee during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 695C.1691, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the health maintenance organization has contracted for such services. If the health maintenance organization has not contracted for the provision of such services, the health maintenance organization shall pay the provider the rate of reimbursement that is paid to other providers with whom the health maintenance organization has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to an enrollee is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the enrollee.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the enrollee's health care plan, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study, including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the enrollee during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the enrollee.

(h) Any costs for the management of research relating to the clinical trial or study.

5. A health maintenance organization that delivers or issues for delivery a health care plan specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the enrollee, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. A health maintenance organization that delivers or issues for delivery a health care plan specified in subsection 1 shall provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the plan.

7. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the plan that conflicts with this section is void.

8. A health maintenance organization that delivers or issues for delivery a health care plan specified in subsection 1 is immune from liability for:

(a) Any injury to an enrollee caused by:

(1) Any medical treatment provided to the enrollee in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the enrollee in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an enrollee's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the "Policies and Guidelines Relating to the Cancer Center Support Grant" published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

~~[(c) "Provider of health care" means:~~

~~(1) A hospital; or~~

~~(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.]~~

Sec. 311. NRS 695C.16932 is hereby amended to read as follows:

695C.16932 1. Subject to the limitations prescribed by subsection 4, a health maintenance organization that issues a health care plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. A health maintenance organization shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an enrollee or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the health maintenance organization.

3. If a health maintenance organization requires an enrollee to obtain prior authorization for a biomarker test described in subsection 1, the health maintenance organization shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require a health maintenance organization to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the health maintenance organization; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of

medical professionals that has established a policy to avoid conflicts of interest.

~~[(f) "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.~~

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

Sec. 312. NRS 695C.16934 is hereby amended to read as follows:

695C.16934 1. Except as otherwise provided in this section, a health maintenance organization that issues a health care plan shall include in the health care plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;
(b) Pediatric endocrinologists;
(c) Social workers;
(d) Psychiatrists;
(e) Psychologists;
(f) Gynecologists;
(g) Speech-language pathologists;
(h) Primary care physicians;
(i) Advanced practice registered nurses;
(j) Physician assistants; and
(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a health care plan to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A health maintenance organization that issues a health care plan shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the plan provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A health maintenance organization that issues a health care plan may prescribe requirements that must be satisfied before the health maintenance organization covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for

an enrollee who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;

(c) The enrollee must provide a written expression of the desire of the enrollee to undergo the treatment;

(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and

(e) Parental consent is provided for the enrollee unless the enrollee is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a health maintenance organization must consider the most recent Standards of Care prescribed by the World Professional Association for Transgender Health, or its successor organization.

6. A health maintenance organization shall make a reasonable effort to 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. If, after a reasonable effort, the health maintenance organization is unable to make such benefits available through such a provider of health care, the health maintenance organization may treat the treatment that the health maintenance organization is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the health maintenance organization.

7. If an enrollee appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the enrollee is not medically necessary, the health maintenance organization must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the enrollee when considering the appeal.

8. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

~~[(d) "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.~~

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

Sec. 313. 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.

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

Sec. 314. NRS 695C.16947 is hereby amended to read as follows:

695C.16947 1. A health care plan which provides coverage for prescription drugs must not require an enrollee to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the enrollee, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the enrollee or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an enrollee in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the health maintenance organization is located 60 miles or more from the residence of the enrollee; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the enrollee, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section ~~[:~~

~~(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.~~

~~(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care is 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) "Step]~~ ***, "step*** therapy protocol" means a procedure that requires an enrollee to use a prescription drug or sequence of

prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the enrollee before his or her health care plan provides coverage for the recommended drug.

Sec. 315. NRS 695C.1695 is hereby amended to read as follows:

695C.1695 1. A health maintenance organization that offers or issues a health care plan which provides coverage for outpatient care shall include in the plan coverage for any health care service related to hormone replacement therapy.

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

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to 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. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 316. NRS 695C.1696 is hereby amended to read as follows:

695C.1696 1. Except as otherwise provided in subsection 8, a health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 12; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 12;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. A health maintenance organization shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

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

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the health maintenance organization.

5. Except as otherwise provided in subsections 10, 11 and 13, a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an enrollee must be the same as for the enrollee.

7. Except as otherwise provided in subsection 8, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

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

9. If a health maintenance organization refuses, pursuant to subsection 8, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

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

11. For each of the 18 methods of contraception listed in subsection 12 that have been approved by the Food and Drug Administration, a health care plan must include at least one drug or

device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the enrollee, but the health maintenance organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the health maintenance organization charges a copayment or coinsurance for a drug for contraception, the health maintenance organization may only require an enrollee to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

14. A health maintenance organization shall not:

(a) Use medical management techniques to require an enrollee to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an enrollee to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 12 at a hospital immediately after an enrollee gives birth.

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

16. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with a health maintenance organization to provide services to enrollees through a network plan offered or issued by the health maintenance organization.

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

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

~~(d)]~~ "Provider network contract" means a contract between a health maintenance organization and a provider of health care or pharmacy specifying the rights and responsibilities of the health maintenance organization and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 317. NRS 695C.1698 is hereby amended to read as follows:

695C.1698 1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

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

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

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

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

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

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

(g) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[6. As used in this section:~~

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

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

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

Sec. 318. NRS 695C.1699 is hereby amended to read as follows:

695C.1699 1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the health maintenance organization. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A health maintenance organization that offers or issues a health care plan shall reimburse a pharmacist or pharmacy that participates in the network plan of the health maintenance organization for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A health maintenance organization shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of whether the drug is included in the formulary of the health maintenance organization.

4. Except as otherwise provided in this subsection, a health maintenance organization shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step therapy. A health maintenance organization may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. A health maintenance organization shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. 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.

7. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

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

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 319. NRS 695C.1708 is hereby amended to read as follows:

695C.1708 1. A health care plan of a health maintenance organization must include coverage for services provided to an enrollee through telehealth to the same extent as though provided in person or by other means.

2. A health care plan of a health maintenance organization must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A health maintenance organization shall not:

(a) Require an enrollee to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an enrollee through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an enrollee receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A health care plan of a health maintenance organization must not require an enrollee to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. A health maintenance organization that provides medical 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 Medicaid Division of the Nevada Health Authority shall provide referrals to providers of dental services who provide services through teledentistry.

6. A health maintenance organization that provides dental 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 Medicaid Division of the Nevada Health Authority shall:

(a) Maintain a list of providers of dental services included in the network of the health maintenance organization who offer services through teledentistry;

(b) At least quarterly, update the list and submit a copy of the updated list to the emergency department of each hospital located in this State; and

(c) Allow such providers of dental services to include on claim forms codes for teledentistry services provided through both real-time interactions and asynchronous transmissions of medical and dental information.

7. The provisions of this section do not require a health maintenance organization to:

(a) Ensure that covered services are available to an enrollee through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the health maintenance organization is not otherwise required by law to do so.

8. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

9. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Teledentistry" has the meaning ascribed to it in NRS 631.107.

~~[(g)]~~ ***(f)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 320. NRS 695C.17095 is hereby amended to read as follows:

695C.17095 1. When developing a step therapy protocol, a health maintenance organization shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A health maintenance organization that offers or issues a health care plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an enrollee and his or her attending practitioner may:

(1) Request an exemption for the enrollee from the step therapy protocol; and

(2) Appeal a decision made by the health maintenance organization concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the health maintenance organization; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the health maintenance organization shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A health maintenance organization shall grant a request to exempt an enrollee from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the enrollee submits to the health maintenance organization a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The health maintenance organization shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the enrollee;

(2) Is expected to be ineffective based on the known clinical characteristics of the enrollee and the known characteristics of the required prescription drug;

(3) Has been tried by the enrollee, regardless of whether the enrollee was covered by the current health care plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the enrollee, based on medical necessity; or

(b) The enrollee is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the enrollee was covered by his or her current health care plan at the time the attending practitioner selected the drug.

4. If a health maintenance organization does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the health maintenance organization shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the enrollee.

6. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695C.17333 apply.

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

~~(a) "Attending]~~ ***, "attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695C.053.]~~

Sec. 321. NRS 695C.1713 is hereby amended to read as follows:

695C.1713 1. A health care plan must include a provision authorizing a woman covered by the plan to:

(a) Obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

(b) Designate as her primary care physician an obstetrician or gynecologist who:

(1) Participates in the network plan of the health maintenance organization;

(2) Satisfies the criteria established by the health maintenance organization for designation as a primary care provider under the health care plan; and

(3) Agrees to abide by all terms and conditions imposed by the health maintenance organization on other primary care physicians generally.

2. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

3. As used in this section ~~[~~:

~~(a) "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.~~

~~(b) "Primary]~~ ***, "primary*** care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 322. NRS 695C.1715 is hereby amended to read as follows:

695C.1715 1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for enrollees who are less than 26 years of age.

2. A health maintenance organization shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A health care plan subject to the provisions of this chapter that 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 that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

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

~~(c)~~] "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)~~] *(c)* "Rehabilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 323. NRS 695C.1717 is hereby amended to read as follows:

695C.1717 1. A health care plan issued by a health maintenance organization must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health care plan under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years. For the purposes of such coverage, a health maintenance organization shall accept as dispositive any diagnosis of an autism spectrum disorder that is rendered in accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders through the age of 21 years prescribed pursuant to NRS 427A.872.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a health care plan to the same extent as other medical services or prescription drugs covered by the plan.

3. A health care plan issued by a health maintenance organization that provides coverage for outpatient care shall not:

(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan; or

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1.

4. Except as otherwise provided in subsections 1 and 2, a health maintenance organization shall not limit the number of visits an enrollee may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice.

➥ A health maintenance organization may request a copy of and review a treatment plan created pursuant to this subsection.

6. Evidence of coverage subject to the provisions of this chapter that 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 evidence of coverage or the renewal which is in conflict with subsection 1 or 2 is void.

7. Nothing in this section shall be construed as requiring a health maintenance organization to provide reimbursement to a school for services delivered through school services.

8. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorder" has the meaning ascribed to it in NRS 427A.875.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(d) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(e) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(f) "Licensed assistant behavior analyst" has the meaning ascribed to the term "assistant behavior analyst" in NRS 641D.020.

(g) "Licensed behavior analyst" has the meaning ascribed to the term "behavior analyst" in NRS 641D.030.

(h) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

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

~~(j)]~~ "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

~~[(k)]~~ ***(j)*** "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

~~[(l)]~~ ***(k)*** "Registered behavior technician" has the meaning ascribed to it in NRS 641D.100.

~~[(m)]~~ ***(l)*** "Screening for ***and diagnosis of*** autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

~~[(n)]~~ ***(m)*** "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

~~[(o)]~~ ***(n)*** "Treatment plan" means a plan to treat an autism spectrum disorder that is developed by a provider of health care acting within his or her scope of practice after he or she has assessed the person for whom the treatment plan is developed.

Sec. 324. NRS 695C.1721 is hereby amended to read as follows:

695C.1721 1. Except as otherwise provided in subsection 4, a health maintenance organization that issues a health care plan shall include in the plan coverage for 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 is medically necessary to preserve fertility because the enrollee has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The enrollee is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, 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 that 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 health care plan that is subject to the requirements of subsection 1 and before the renewal of such a plan, provide to the enrollee or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.

5. A health care plan 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.

~~[6. As used in this section:~~

~~(a) "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.~~

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

Sec. 325. NRS 695C.1728 is hereby amended to read as follows:

695C.1728 1. A health maintenance organization that issues a health care plan shall include in the plan coverage for:

(a) Necessary case management services for an enrollee who has been diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an enrollee who has been diagnosed with sickle cell disease and its variants.

2. A health maintenance organization that issues a health care plan which provides coverage for prescription drugs shall include in the plan coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

3. A health maintenance organization shall establish a plan for each enrollee under 18 years of age who has been diagnosed with sickle cell disease and its variants to transition the enrollee from pediatric care to adult care when the enrollee reaches 18 years of age.

4. A health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

5. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~(c)]~~ "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

~~[(d)]~~ ***(c)*** "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 326. NRS 695C.17347 is hereby amended to read as follows:

695C.17347 1. A health maintenance organization that issues a health care plan shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. 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.

3. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[4. As used in this section:~~

~~(a) "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.~~

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

Sec. 327. NRS 695C.1735 is hereby amended to read as follows:

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

(a) A mammogram to screen for breast cancer annually for enrollees who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the enrollee's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the enrollee.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the enrollee's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

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

(a) Except as otherwise provided in subsection 6, require an enrollee to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

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

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

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

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

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

4. A health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an enrollee pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified health care plan with respect to the deductible of such a health care plan after the enrollee has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

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

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

~~(d) "Qualified~~**,** ***"qualified*** health care plan" means a health care plan of a health maintenance organization that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 328. NRS 695C.1737 is hereby amended to read as follows:

695C.1737 1. A health maintenance organization that issues a health care plan shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the enrollee by a provider of health care, facility or medical laboratory that participates in the network plan of the health maintenance organization; and

(b) Without prior authorization.

3. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

4. As used in this section ~~[:~~

~~(a) "Medical]~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

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

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

Sec. 329. NRS 695C.1743 is hereby amended to read as follows:

695C.1743 1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the health maintenance organization;

(b) Laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of

primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the health maintenance organization.

2. A health maintenance organization that offers or issues a health care plan shall reimburse:

(a) A pharmacist who participates in the network plan of the health maintenance organization for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the health maintenance organization for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A health maintenance organization shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the enrollee is diagnosed.

4. 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.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

~~(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription~~

~~drugs. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.~~

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 330. NRS 695C.1745 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

6. As used in this section ~~[~~:

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

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

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

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

Sec. 331. NRS 695C.1798 is hereby amended to read as follows:

695C.1798 1. A person insured under a health care plan may assign his or her right to benefits to the provider of health care who provided the services covered by the plan. The health maintenance organization shall pay all the benefits or the part of the benefits assigned by the insured to the person designated by the insured. A

payment made pursuant to this subsection discharges the obligation of the health maintenance organization to pay those benefits.

2. If the insured makes an assignment under this section, but the health maintenance organization after receiving a copy of the assignment pays the benefits to the insured, the health maintenance organization shall also pay those benefits to the provider of health care who received the assignment as soon as the insurer receives notice of the incorrect payment.

~~[3. For the purpose of this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.]~~

Sec. 332. NRS 695C.300 is hereby amended to read as follows:

695C.300 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading or any form of evidence of coverage which is deceptive. For purposes of this chapter:

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

(b) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

(c) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format as well as language, shall be such as to cause a reasonable person not possessing special knowledge regarding health care plans and evidences of coverage therefor to expect benefits, services, charges or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

2. NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the nature of health

maintenance organizations, health care plans and evidences of coverage render the sections therein clearly inappropriate.

3. An enrollee may not be cancelled or not renewed except for the failure to pay the charge for such coverage or for cause as determined in the master contract.

4. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

5. No person not certificated under this chapter shall use in its name, contracts or literature the phrase "health maintenance organization" or the initials "HMO."

Sec. 333. NRS 695C.340 is hereby amended to read as follows:

695C.340 1. When the Commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, the Commissioner shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension or revocation and ~~[fixing a time at least 30 days thereafter for a hearing on the matter.]~~ ***provide a reasonable opportunity to appear and be heard pursuant to NRS 679B.310 to 679B.370, inclusive.***

2. After the ***opportunity for a*** hearing, ~~[or upon the failure of the health maintenance organization to appear at the hearing,]~~ the Commissioner shall take action as is deemed advisable on written findings which must be mailed to the health maintenance organization. The action of the Commissioner is subject to review by the First Judicial District Court of the State of Nevada in and for Carson City. The court may, in disposing of the issue before it, modify, affirm or reverse the order of the Commissioner in whole or in part.

Sec. 334. NRS 695D.216 is hereby amended to read as follows:

695D.216 1. A plan for dental care must include coverage for services provided to a member through telehealth to the same extent as though provided in person or by other means.

2. A plan for dental care must provide reimbursement for services described in subsection 1 in the same amount as though provided in person or by other means if the services:

(a) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(b) Are not provided through audio-only interaction.

3. An organization for dental care shall not:

(a) Require a member to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to a member through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which a member receives services through telehealth; or

(2) The technology used to provide the services:

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A plan for dental care must not require a member to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A plan for dental care may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. The provisions of this section do not require an organization for dental care to:

(a) Ensure that covered services are available to a member through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the organization for dental care is not otherwise required by law to do so.

6. A plan for dental care subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

7. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) "Provider of health care" has the meaning ascribed to it in NRS ~~[439.820.]~~ ***695G.070.***

(e) "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 335. NRS 695D.290 is hereby amended to read as follows:

695D.290 The provisions of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** relating to trade practices and frauds apply to organizations for dental care.

Sec. 336. NRS 695D.310 is hereby amended to read as follows:

695D.310 1. If the Commissioner believes that grounds for denying a certificate of authority or for suspending or revoking a certificate exist, the Commissioner shall notify the organization for dental care in writing, specifying the grounds for the denial, suspension or revocation and ~~[fix a time for a hearing on the matter within 30 days after the notice.]~~ ***provide a reasonable opportunity to appear and be heard pursuant to NRS 679B.310 to 679B.370, inclusive.***

2. After the ***opportunity for a*** hearing ***,*** ~~[or upon the failure of the organization to appear at the hearing,]~~ the Commissioner shall enter a written order of the decision of the Commissioner which must be mailed by certified mail to the organization.

Sec. 337. NRS 695E.170 is hereby amended to read as follows:

695E.170 1. A risk retention group and its agents and representatives are subject to the provisions of:

(a) NRS 680A.205 and any regulations adopted pursuant thereto, including, without limitation, regulations relating to the standards which may be used by the Commissioner in determining whether a risk retention group is in a hazardous financial condition.

(b) NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive ~~[.]~~ ***, and sections 65 to 77, inclusive, of this act.*** Any injunction obtained pursuant to those sections must be obtained from a court of competent jurisdiction.

2. All premiums paid for coverages within this State to a risk retention group are subject to the provisions of chapter 680B of NRS. Each risk retention group shall report all premiums paid to it

and shall pay the taxes on premiums and any related fines or penalties for risks resident, located or to be performed in the state.

3. Any person acting as an agent or a broker for a risk retention group pursuant to NRS 695E.210 shall:

(a) Report to the Commissioner each premium for direct business for risks resident, located or to be performed in this State which the person has placed with or on behalf of a risk retention group that is not chartered in this State.

(b) Maintain a complete and separate record of each policy obtained from each risk retention group. Each record maintained pursuant to this subsection must be made available upon request by the Commissioner for examination pursuant to NRS 679B.240, and must include, for each policy and each kind of insurance provided therein:

(1) The limit of liability;

(2) The period covered;

(3) The effective date;

(4) The name of the risk retention group which issued the policy;

(5) The gross annual premium charged; and

(6) The amount of return premiums, if any.

4. As used in this section, "premiums for direct business" means any premium written in this State for a policy of insurance. The term does not include any premium for reinsurance or for a contract between members of a risk retention group.

Sec. 338. NRS 695F.090 is hereby amended to read as follows:

695F.090 1. Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

(a) NRS 686B.010 to 686B.175, inclusive, concerning rates and essential insurance.

(b) NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

(c) NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

(d) The requirements of NRS 679B.152.

(e) The fees imposed pursuant to NRS 449.465.

(f) NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 65 to 77, inclusive, of this act*** concerning trade practices and frauds.

(g) The assessment imposed pursuant to NRS 679B.700.

(h) Chapter 683A of NRS.

(i) To the extent applicable, the provisions of NRS 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

(j) NRS 689A.035, 689A.0463, 689A.410, 689A.413 and 689A.415.

(k) NRS 680B.025 to 680B.060, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this paragraph, unless the context otherwise requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "prepaid limited health service organization."

(l) Chapter 692C of NRS, concerning holding companies.

(m) NRS 689A.637, concerning health centers.

(n) Chapter 681B of NRS, concerning assets and liabilities.

(o) NRS 682A.400 to 682A.468, inclusive, concerning investments.

2. For the purposes of this section and the provisions set forth in subsection 1, a prepaid limited health service organization is included in the meaning of the term "insurer."

Sec. 339. NRS 695F.140 is hereby amended to read as follows:

695F.140 1. If the Commissioner denies an application for a certificate of authority of a person who files an application pursuant to NRS 695F.120 or 695F.130, the Commissioner shall send a written notice to the applicant. The notice must include the reason for the denial of the certificate.

2. The applicant may, within ~~[30]~~ ***60*** days after it receives the notice, submit to the Commissioner a written request for a hearing on the matter. The Commissioner shall hold a hearing within ~~[30]~~ ***60*** days after the Commissioner receives the request.

3. The hearing must be held in the manner set forth in NRS 679B.310 to 679B.370, inclusive. The decision of the Commissioner is a final decision for the purpose of judicial review.

Sec. 340. NRS 695F.159 is hereby amended to read as follows:

695F.159 1. Evidence of coverage which provides coverage for prescription drugs must not require an enrollee to use a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the enrollee, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the enrollee or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an enrollee in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the prepaid limited health service organization is located 60 miles or more from the residence of the enrollee; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the enrollee, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of an evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" ~~[means evidence of coverage offered by a prepaid limited health service organization under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the prepaid limited health service organization. The term does not include an arrangement for the financing of premiums.]~~ ***has the meaning ascribed to it in NRS 687B.645.***

(c) "Step therapy protocol" means a procedure that requires an enrollee to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the enrollee before his or her evidence of coverage provides coverage for the recommended drug.

Sec. 341. NRS 695F.350 is hereby amended to read as follows:

695F.350 1. The Commissioner may suspend or revoke the certificate of authority of a prepaid limited health service organization issued pursuant to this chapter if the Commissioner determines that:

(a) The prepaid limited health service organization is operating substantially in violation of its basic organizational document or in a manner contrary to the manner described in and reasonably inferred

from any other information submitted pursuant to NRS 695F.110 unless any amendment to its basic organization document or other information has been filed with and approved by the Commissioner;

(b) The prepaid limited health service organization issued an evidence of coverage or used rates or charges which do not comply with the requirements of NRS 695F.150 and 695F.160;

(c) The prepaid limited health service organization is not able to carry out its obligations to provide its limited health service;

(d) The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to carry out its obligations to enrollees or prospective enrollees;

(e) The capital of the prepaid limited health service organization is less than the amount required by NRS 695F.200 or the organization has failed to correct any deficiency concerning its capital as required by the Commissioner;

(f) The prepaid limited health service organization has failed to establish and maintain in a reasonable manner the complaint system required by NRS 695F.230;

(g) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(h) The prepaid limited health service organization has failed to comply with any other provision of this chapter.

2. If the Commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority of a prepaid limited health service organization exist, the Commissioner shall send written notice to the organization. The notice must include the reason for the suspension or revocation and ~~[a time not more than 30 days thereafter]~~ ***the opportunity*** for a hearing on the matter. The hearing must be held in the manner set forth in NRS 695F.140.

3. If the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs. The organization shall not:

(a) Conduct any further business unless it is essential for the orderly conclusion of its affairs; and

(b) Engage in any further advertising or solicitation.

4. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner considers necessary to enable the enrollees to obtain limited health services from another organization or provider.

Sec. 342. NRS 695F.360 is hereby amended to read as follows:

695F.360 If the Commissioner, after ***the opportunity for*** a hearing held pursuant to NRS 695F.140, finds that a prepaid limited

health service organization or other person subject to this chapter has violated a provision of this chapter, the Commissioner may:

1. Issue and cause to be served upon the organization or any other person charged with a violation of this chapter, a copy of the findings of the Commissioner and an order directing the organization or person to cease and desist from engaging in the act or practice which constitutes the violation; and

2. Impose a fine of not more than $1,000 for each violation, not to exceed a total amount of $10,000.

Sec. 343. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 344, 345 and 346 of this act.

Sec. 344. ***"Medical management technique" has the meaning ascribed to it in section 128 of this act.***

Sec. 345. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 346. ***"Primary care" has the meaning ascribed to it in section 131 of this act.***

Sec. 347. NRS 695G.010 is hereby amended to read as follows:

695G.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695G.012 to 695G.085, inclusive, ***and sections 344, 345 and 346 of this act*** have the meanings ascribed to them in those sections.

Sec. 348. NRS 695G.019 is hereby amended to read as follows:

695G.019 "Health benefit plan" ~~[means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.]~~ ***has the meaning ascribed to it in NRS 687B.470.***

Sec. 349. NRS 695G.024 is hereby amended to read as follows:

695G.024 "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, ***an organization for dental care,*** a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation ***, a utilization review organization while acting in its capacity as a utilization review organization for a health carrier*** or any other entity providing a plan of health insurance, health benefits or health care services.

Sec. 350. NRS 695G.127 is hereby amended to read as follows:

695G.127 1. A managed care organization shall not contract with a provider of health care to provide health care to an insured unless the managed care organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a managed care organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the managed care organization upon giving to the provider 45 days' written notice of the modification of the managed care organization's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a managed care organization contracts with a provider of health care to provide health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS, the managed care organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments, including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

~~[4. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.]~~

Sec. 351. NRS 695G.162 is hereby amended to read as follows:

695G.162 1. A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A health care plan issued by a managed care organization for group coverage must provide reimbursement for services described

in subsection 1 in the same amount as though provided in person or by other means:

(a) If the services:

(1) Are received at an originating site described in 42 U.S.C. § 1395m(m)(4)(C) or furnished by a federally-qualified health center or a rural health clinic; and

(2) Except for services described in paragraph (b), are not provided through audio-only interaction; or

(b) For counseling or treatment relating to a mental health condition or a substance use disorder, including, without limitation, when such counseling or treatment is provided through audio-only interaction.

3. A managed care organization shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1 or the reimbursement described in subsection 2;

(c) Refuse to provide the coverage described in subsection 1 or the reimbursement described in subsection 2 because of:

(1) The distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(2) The technology used to provide the services;

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services; or

(e) Categorize a service provided through telehealth differently for purposes relating to coverage or reimbursement than if the service had been provided in person or through other means.

4. A health care plan of a managed care organization must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

5. A managed care organization that provides medical 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 Medicaid Division of the Nevada Health Authority shall provide referrals to providers of dental services who provide services through teledentistry.

6. A managed care organization that provides dental 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 Medicaid Division of the Nevada Health Authority shall:

(a) Maintain a list of providers of dental services included in the network of the managed care organization who offer services through teledentistry;

(b) At least quarterly, update the list and submit a copy of the updated list to the emergency department of each hospital located in this State; and

(c) Allow such providers of dental services to include on claim forms codes for teledentistry services provided through both real-time interactions and asynchronous transmissions of medical and dental information.

7. The provisions of this section do not require a managed care organization to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.

8. Evidence of coverage that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

9. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(c) "Originating site" has the meaning ascribed to it in NRS 629.515.

(d) ~~[~~"Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~(e)]~~ "Rural health clinic" has the meaning ascribed to it in 42 U.S.C. § 1395x(aa)(2).

~~[(f)]~~ ***(e)*** "Teledentistry" has the meaning ascribed to it in NRS 631.107.

~~[(g)]~~ ***(f)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 352. NRS 695G.1639 is hereby amended to read as follows:

695G.1639 1. When developing a step therapy protocol, a managed care organization shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A managed care organization that offers or issues a health care plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the managed care organization concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the managed care organization; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the managed care organization shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A managed care organization shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the managed care organization a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The managed care organization shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current health care plan at the time, and was discontinued due to lack of efficacy or effectiveness,

diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current health care plan at the time the attending practitioner selected the drug.

4. If a managed care organization does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the managed care organization shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695G.1675 apply.

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

~~(a) "Attending]~~ ***, "attending*** practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

~~[(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.]~~

Sec. 353. NRS 695G.1643 is hereby amended to read as follows:

695G.1643 1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for habilitative speech-language pathology and rehabilitative speech-language pathology as a treatment for stuttering for insureds who are less than 26 years of age.

2. A managed care organization shall not:

(a) Set a maximum annual limit on the benefits described in subsection 1, including, without limitation, a limit on the number of annual visits to a speech-language pathologist;

(b) Limit the benefits described in subsection 1 based on the cause of the stuttering; or

(c) Subject the benefits described in subsection 1 to medical management techniques.

3. A health care plan subject to the provisions of this chapter that 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 that conflicts with the provisions of this section is void.

4. As used in this section:

(a) "Habilitative speech-language pathology" means services that constitute the practice of speech-language pathology which help a person keep, learn or improve skills and functioning for daily living.

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

~~(c)]~~ "Practice of speech-language pathology" has the meaning ascribed to it in NRS 637B.060.

~~[(d)]~~ *(c)* "Rehabilitative speech-language pathology" means services that constitute the practice of speech language pathology which help a person restore or improve skills and functioning for daily living that have been lost or impaired.

Sec. 354. NRS 695G.1645 is hereby amended to read as follows:

695G.1645 1. A health care plan issued by a managed care organization for group coverage must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health care plan under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years. For the purposes of such coverage, a managed care organization shall accept as dispositive any diagnosis of an autism spectrum disorder that is rendered in accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders through the age of 21 years prescribed pursuant to NRS 427A.872.

2. A health care plan issued by a managed care organization for individual coverage must provide an option for coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health care plan under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years. For the purposes of that coverage, the managed care organization shall

accept as dispositive any diagnosis of an autism spectrum disorder that is rendered in accordance with the statewide standard for measuring outcomes and assessing persons with autism spectrum disorders through the age of 21 years prescribed pursuant to NRS 427A.872.

3. Coverage provided under this section is subject to:

(a) A maximum benefit of the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a health care plan to the same extent as other medical services or prescription drugs covered by the plan.

4. A managed care organization that offers or issues a health care plan which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan; or

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1.

5. Except as otherwise provided in subsections 1, 2 and 3, a managed care organization shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

6. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a provider of health care acting within his or her scope of practice.

➥ A managed care organization may request a copy of and review a treatment plan created pursuant to this subsection.

7. An evidence of coverage subject to the provisions of this chapter that 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 evidence of coverage or the renewal which is in conflict with subsection 1 or 3 is void.

8. Nothing in this section shall be construed as requiring a managed care organization to provide reimbursement to a school for services delivered through school services.

9. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorder" has the meaning ascribed to it in NRS 427A.875.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(d) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(e) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(f) "Licensed assistant behavior analyst" has the meaning ascribed to the term "assistant behavior analyst" in NRS 641D.020.

(g) "Licensed behavior analyst" has the meaning ascribed to the term "behavior analyst" in NRS 641D.030.

(h) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

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

~~(j)]~~ "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

~~[(k)]~~ ***(j)*** "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

~~[(l)]~~ ***(k)*** "Registered behavior technician" has the meaning ascribed to it in NRS 641D.100.

~~[(m)]~~ ***(l)*** "Screening for ***and diagnosis of*** autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

~~[(n)]~~ ***(m)*** "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

~~[(o)]~~ ***(n)*** "Treatment plan" means a plan to treat an autism spectrum disorder that is developed by a provider of health care acting within his or her scope of practice after he or she has assessed the person for whom the treatment plan is developed.

Sec. 355. NRS 695G.1702 is hereby amended to read as follows:

695G.1702 1. A health care plan which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the managed care organization is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section ~~[:~~

~~(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.~~

~~(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care is 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) "Step~~ ***, "step*** therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her health care plan provides coverage for the recommended drug.

Sec. 356. NRS 695G.1703 is hereby amended to read as follows:

695G.1703 1. Subject to the limitations prescribed by subsection 4, a managed care organization that issues a health care plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

(c) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(d) Nationally recognized clinical practice guidelines or consensus statements.

2. A managed care organization shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens;

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the managed care organization.

3. If a managed care organization requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the managed care organization shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. The provisions of this section do not require a managed care organization to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the managed care organization; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

6. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(d) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Not primarily provided for the convenience of the patient or provider of health care; and

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the risks and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

~~[(f) "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.~~

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

Sec. 357. NRS 695G.1705 is hereby amended to read as follows:

695G.1705 1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

(a) All drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the managed care organization;

(b) Laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus;

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

(d) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the managed care organization.

2. A managed care organization that offers or issues a health care plan shall reimburse:

(a) A pharmacist who participates in the network plan of the managed care organization for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the managed care organization for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A managed care organization shall not:

(a) Subject the benefits required by subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. 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.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage

required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[6. As used in this section:~~

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 358. NRS 695G.1709 is hereby amended to read as follows:

695G.1709 1. A managed care organization that offers or issues a health care plan shall include in the plan a provision authorizing a woman covered by the plan to:

(a) Obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

(b) Designate as her primary care physician an obstetrician or gynecologist who:

(1) Participates in the network plan of the managed care organization;

(2) Satisfies the criteria established by the managed care organization for designation as a primary care provider under the health care plan; and

(3) Agrees to abide by all terms and conditions imposed by the managed care organization on other primary care physicians generally.

2. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by this section, and any provision of the plan or renewal of the plan which is in conflict with this section is void.

~~[3. As used in this section, "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.~~]

Sec. 359. NRS 695G.171 is hereby amended to read as follows:

695G.171 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for:

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

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

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

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:

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

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

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

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

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

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

4. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or

renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with this section is void.

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

6. As used in this section ~~[~~:

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

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

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

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

Sec. 360. NRS 695G.1712 is hereby amended to read as follows:

695G.1712 1. A managed care organization that issues a health care plan shall provide coverage for screening, genetic counseling and testing for harmful mutations in the BRCA gene for women under circumstances where such screening, genetic counseling or testing, as applicable, is required by NRS 457.301.

2. 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.

3. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage

required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~[4. As used in this section:~~

~~(a) "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.~~

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

Sec. 361. NRS 695G.1713 is hereby amended to read as follows:

695G.1713 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for:

(a) A mammogram to screen for breast cancer annually for insureds who are 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:

(a) Except as otherwise provided in subsection 6, require an insured to pay a deductible, copayment, coinsurance or any other form of cost-sharing or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

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

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

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

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

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

4. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

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

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified health care plan with respect to the deductible of such a health care plan after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

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

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

~~(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical~~

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

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

~~(d) "Qualified"~~ ***, "qualified*** health care plan" means a health care plan issued by a managed care organization that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 362. NRS 695G.1714 is hereby amended to read as follows:

695G.1714 1. A managed care organization that issues a health care plan shall provide coverage for the examination of a person who is pregnant for the discovery of:

(a) Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

(b) Syphilis in accordance with NRS 442.010.

2. The coverage required by this section must be provided:

(a) Regardless of whether the benefits are provided to the insured by a provider of health care, facility or medical laboratory that participates in the network plan of the managed care organization; and

(b) Without prior authorization.

3. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

4. As used in this section ~~[~~:

~~(a) "Medical"~~ ***, "medical*** laboratory" has the meaning ascribed to it in NRS 652.060.

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

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

Sec. 363. NRS 695G.1715 is hereby amended to read as follows:

695G.1715 1. Except as otherwise provided in subsection 8, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

(d) The insertion of a device for contraception or the removal of such a device if the device was inserted while the insured was covered by the same health care plan;

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

(f) The management of side effects relating to contraception; and

(g) Voluntary sterilization for women.

2. A managed care organization shall provide coverage for any services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. The terms of the policy must not limit:

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

3. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a

provider of health care who participates in the network plan of the managed care organization.

4. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the managed care organization.

5. Except as otherwise provided in subsections 9, 10 and 12, a managed care organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

7. Except as otherwise provided in subsection 8, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

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

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

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the managed care organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. If the managed care organization charges a copayment or coinsurance for a drug for contraception, the managed care organization may only require an enrollee to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

13. A managed care organization shall not:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care;

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1; or

(c) Refuse to cover a contraceptive injection or the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an insured gives birth.

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

15. As used in this section:

(a) "In-network pharmacy" means a pharmacy that has entered into a contract with a managed care organization to provide services to insureds through a network plan offered or issued by the managed care organization.

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

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

~~(d)]~~ "Provider network contract" means a contract between a managed care organization and a provider of health care or pharmacy specifying the rights and responsibilities of the managed care organization and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.

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

~~(f)]~~ ***(c)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 364. NRS 695G.17165 is hereby amended to read as follows:

695G.17165 1. Except as otherwise provided in subsection 4, a managed care organization that issues a health care plan shall include in the plan coverage for 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 is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, 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 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 health care plan that is subject to the requirements of subsection 1 and before the renewal of such a plan, provide to the insured or prospective insured, as applicable, written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

5. A health care plan 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.

~~[6. As used in this section:~~

~~(a) "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.~~

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

Sec. 365. NRS 695G.1717 is hereby amended to read as follows:

695G.1717 1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

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

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

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

(d) Hormone replacement therapy;

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

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

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

(h) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[6. As used in this section:~~

~~(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or~~

~~prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.~~

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

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

Sec. 366. NRS 695G.1718 is hereby amended to read as follows:

695G.1718 1. Except as otherwise provided in this section, a managed care organization that issues a health care plan shall include in the health care plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a health care plan to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A managed care organization that issues a health care plan shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the plan provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A managed care organization that issues a health care plan may prescribe requirements that must be satisfied before the managed care organization covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured

who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;

(b) The treatment must be recommended by a physician;

(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;

(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a managed care organization must consider the most recent Standards of Care prescribed by the World Professional Association for Transgender Health, or its successor organization.

6. A managed care organization shall make a reasonable effort to 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. If, after a reasonable effort, the managed care organization is unable to make such benefits available through such a provider of health care, the managed care organization may treat the treatment that the managed care organization is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the managed care organization.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the managed care organization must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

(b) "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.

(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.

(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.

(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.

(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not provided primarily for the convenience of the patient or provider of health care;

(4) Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

➥ A provider of health care prescribing, ordering, recommending or approving a health care service or product does not, by itself, make that health care service or product medically necessary.

~~[(d) "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.~~

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

Sec. 367. NRS 695G.1719 is hereby amended to read as follows:

695G.1719 1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

(a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) All drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(c) The services described in NRS 639.28079 when provided by a pharmacist or pharmacy that participates in the network plan of the managed care organization. The Commissioner shall adopt regulations governing the provision of reimbursement for such services.

(d) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A managed care organization that offers or issues a health care plan shall reimburse a pharmacist or pharmacy that participates in the network plan of the managed care organization for the services described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A managed care organization shall provide the coverage required by paragraphs (a) and (b) of subsection 1 regardless of

whether the drug is included in the formulary of the managed care organization.

4. Except as otherwise provided in this subsection, a managed care organization shall not subject the benefits required by paragraphs (a), (b) and (c) of subsection 1 to medical management techniques, other than step therapy. A managed care organization may subject the benefits required by paragraphs (b) and (c) of subsection 1 to other reasonable medical management techniques when the benefits are provided by a pharmacist in accordance with NRS 639.28079.

5. A managed care organization shall not:

(a) Limit the covered amount of a drug described in paragraph (a) or (b) of subsection 1; or

(b) Refuse to cover a drug described in paragraph (a) or (b) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

6. 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.

7. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

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

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

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

~~(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.~~

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

Sec. 368. NRS 695G.173 is hereby amended to read as follows:

695G.173 1. A health care plan issued by a managed care organization must provide coverage for medical treatment which a person insured under the plan receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The insured has signed, before participating in the clinical trial or study, a statement of consent indicating that the insured has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the health care plan.

(c) The cost of any routine health care services that would otherwise be covered under the health care plan for an insured in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the insured is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the insured during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the insured during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 695G.164, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the managed care organization has contracted for such services. If the managed care organization has not contracted for the provision of such services, the managed care organization shall pay the provider the rate of reimbursement that is paid to other providers with whom the managed care organization has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to a person insured under the plan is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the plan.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the insured's health care plan, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study, including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the insured during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured.

(h) Any costs for the management of research relating to the clinical trial or study.

5. A managed care organization that delivers or issues for delivery a health care plan specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the insured, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. A managed care organization that delivers or issues for delivery a health care plan specified in subsection 1 shall provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the plan.

7. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the plan that conflicts with this section is void.

8. A managed care organization that delivers or issues for delivery a health care plan specified in subsection 1 is immune from liability for:

(a) Any injury to an insured caused by:

(1) Any medical treatment provided to the insured in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical

treatment to the insured in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an insured's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the "Policies and Guidelines Relating to the Cancer Center Support Grant" published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

~~[(c) "Provider of health care" means:~~

~~(1) A hospital; or~~

~~(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.]~~

Sec. 369. NRS 695G.174 is hereby amended to read as follows:

695G.174 1. A managed care organization that issues a health care plan shall include in the plan coverage for:

(a) Necessary case management services for an insured diagnosed with sickle cell disease and its variants; and

(b) Medically necessary care for an insured who has been diagnosed with sickle cell disease and its variants.

2. A managed care organization that issues a health care plan which provides coverage for prescription drugs shall include in the plan coverage for medically necessary prescription drugs to treat sickle cell disease and its variants.

3. A managed care organization shall establish a plan for each insured under 18 years of age who has been diagnosed with sickle cell disease and its variants to transition the insured from pediatric care to adult care when the insured reaches 18 years of age.

4. A managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

5. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

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

~~(c)]~~ "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

Sec. 370. NRS 695H.060 is hereby amended to read as follows:

695H.060 "Provider of health care" has the meaning ascribed to it in NRS ~~[~~629.031.~~]~~ ***695G.070.***

Sec. 371. NRS 695K.220 is hereby amended to read as follows:

695K.220 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers or other qualified persons or entities to administer the Public Option. If a statewide Medicaid managed care program is established pursuant to subsection 1 of NRS 422.273, the

competitive bidding process must coincide with the statewide procurement process for that Medicaid managed care program.

2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in any Medicaid managed care program established in this State, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of NRS 695K.200.

4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:

(a) Demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care, where applicable;

(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of this chapter.

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of NRS 695K.200 and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

(a) Filing rates and supporting information with the Commissioner of Insurance as required by NRS 686B.010 to 686B.1799, inclusive; and

(b) Obtaining certification as a qualified health plan pursuant to 42 U.S.C. § 18031.

7. The Director shall deposit into the Trust Fund any money received from:

(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or

(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

8. As used in this section:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Health carrier" ~~[means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.]~~ ***has the meaning ascribed to it in NRS 695G.024.***

Sec. 372. NRS 696A.160 is hereby amended to read as follows:

696A.160 1. The Commissioner shall revoke or suspend the certificate of authority of a motor club whenever, after ***the opportunity for*** a hearing, the Commissioner finds in accordance with the procedure provided in NRS 679B.310 to 679B.370, inclusive, that any of the following circumstances exist:

(a) The club has violated any provision of this chapter.

(b) It is insolvent.

(c) Its assets are less than its liabilities.

(d) It or its officers refuse to submit to an examination.

(e) It is transacting business fraudulently.

2. The Commissioner shall give notice of such revocation or suspension to the public in such manner as the Commissioner deems proper.

Sec. 373. NRS 696A.360 is hereby amended to read as follows:

696A.360 Motor clubs are also subject, in the same manner as insurers, to the following provisions of this Code to the extent reasonably applicable:

1. Chapter 679A of NRS (scope and definitions);

2. Chapter 679B of NRS (Commissioner of Insurance);

3. NRS 683A.400 (fiduciary funds);

4. Chapter 685B of NRS (unauthorized insurers);

5. NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive ***, and sections 65 to 77, inclusive, of this act*** (trade practices and frauds); and

6. Chapter 696B of NRS (delinquent insurers).

Sec. 374. Chapter 696B of NRS is hereby amended by adding thereto the provisions set forth as sections 375 and 376 of this act.

Sec. 375. ***"Impaired financial condition" means that an insurer does not have admitted assets at least equal to all its liabilities and the minimum capital and surplus required to maintain the certificate of authority of the insurer pursuant to the applicable provisions of this title and the regulations adopted pursuant thereto, including, without limitation, the regulations adopted pursuant to subsection 6 of NRS 680A.120 or NRS 681B.550, as applicable.***

Sec. 376. ***1. If an applicable law, order or agreement fixes a period within which an insurer may commence an action, and the period has not expired before the date on which the initial petition is filed in a delinquency proceeding, the receiver may commence the action on or before the later of:***

(a) The end of the period fixed in the applicable law, order or agreement, including, without limitation, any suspension of the period that occurs on or after the filing of the initial petition in the delinquency proceeding; or

(b) Four years after the entry of the most recent receivership order.

2. Except as otherwise provided in subsection 1, if an applicable law, order or agreement fixes a period within which an insurer may file a pleading, demand, notice or proof of claim or loss, cure a default in a case or proceeding or perform any other similar act and the period has not expired before the date of the filing of the initial petition in the delinquency proceedings, the receiver may file, cure or perform, as applicable, on or before the later of:

(a) The end of the period fixed in the applicable law, order or agreement, including, without limitation, any suspension of the period that occurs on or after the filing of the initial petition in the delinquency proceeding; or

(b) Sixty days after the entry of the most recent receivership order.

3. If an applicable law, order or agreement fixes a period for commencing or continuing a civil action against the insurer in a court other than the receivership court and the period has not expired before the date of the filing of the initial petition in the

delinquency proceedings, the period does not expire until the later of:

(a) The end of the period fixed in the applicable law, order or agreement, including, without limitation, any suspension of the period that occurs on or after the filing of the initial petition in the delinquency proceeding; or

(b) Thirty days after the termination or expiration of any stay issued with respect to the claim, if applicable.

Sec. 377. NRS 696B.030 is hereby amended to read as follows:

696B.030 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 696B.040 to 696B.180, inclusive, ~~[shall]~~ ***and section 375 of this act*** have the meanings ascribed to them in ~~[NRS 696B.040 to 696B.180, inclusive.]~~ ***those sections.***

Sec. 378. NRS 696B.110 is hereby amended to read as follows:

696B.110 "Insolvency" exists:

1. When ~~[the]~~ ***:***

(a) One of the following conditions is met:

(1) The insurer fails to meet its obligations as they mature;

~~[2. When a stock insurer's]~~

(2) The insurer does not have admitted assets ~~[are less than the sum of]~~ ***at least equal to all*** its liabilities ***;*** ~~[and its paid-in capital stock account;~~

~~3. When a mutual insurer's assets are less than the sum of its liabilities and the minimum basic surplus required to be maintained by the insurer under this Code for authority to transact the kinds of insurance transacted;]~~ or

~~[4.]~~ ***(3) The capital and surplus of the insurer is less than an amount specified by the Commissioner by regulation; and***

(b) The Commissioner has ordered the insurer to make good the applicable deficiency and file proof thereof with the Commissioner and the insurer has failed to do so within the time required by the order; or

2. As otherwise expressly provided in this Code.

Sec. 379. NRS 696B.190 is hereby amended to read as follows:

696B.190 1. The district court has original jurisdiction of delinquency proceedings under NRS 696B.010 to 696B.565, inclusive, ***and sections 375 and 376 of this act*** and any court with jurisdiction may make all necessary or proper orders to carry out the purposes of those sections. The Nevada Rules of Civil Procedure do not govern the commencement of a delinquency proceeding pursuant to NRS 696B.250 and the filing of a petition by the

Commissioner or the issuance by the court of an order to show cause pursuant to that section.

2. The venue of delinquency proceedings against a domestic insurer must be in the county in this State of the insurer's principal place of business or, if the principal place of business is located in another state, in any county in this State selected by the Commissioner for the purpose. The venue of proceedings against foreign insurers must be in any county in this State selected by the Commissioner for the purpose.

3. At any time after commencement of a proceeding, the Commissioner or any other party may apply to the court for an order changing the venue of, and removing, the proceeding to any other county of this State in which the proceeding may most conveniently, economically and efficiently be conducted.

4. No court has jurisdiction to entertain, hear or determine any petition or complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer, or for an injunction or restraining order or other relief preliminary, incidental or relating to such proceedings, other than in accordance with NRS 696B.010 to 696B.565, inclusive ~~[.]~~ ***, and sections 375 and 376 of this act.***

5. An appeal to the appellate court of competent jurisdiction pursuant to the rules fixed by the Supreme Court pursuant to Section 4 of Article 6 of the Nevada Constitution may be taken from any court granting or refusing rehabilitation, liquidation, conservation or receivership, and from every order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

Sec. 380. NRS 696B.220 is hereby amended to read as follows:

696B.220 The Commissioner may apply to the court for an order appointing the Commissioner as receiver, if his or her appointment as receiver is not then in effect, and directing the Commissioner to liquidate the business of a domestic insurer or of the United States branch of an alien insurer having trusteed assets in this State, whether or not there has been a prior order directing the Commissioner to conserve or rehabilitate the insurer, upon any one or more of the following grounds:

1. That the insurer has failed to cure ~~[an impairment]~~ ***a deficiency*** of surplus, or capital, or assets within the time allowed therefor by any lawful order of the Commissioner.

2. That the insurer is insolvent, or has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute or is the object, in this State or elsewhere, of any action or proceeding to liquidate its business or affairs, or to dissolve its corporate

charter, or to procure the appointment of a receiver, trustee, custodian or sequestrator under any law except this Code. This subsection does not apply to the conversion of a stock insurer to an ordinary business corporation as authorized under NRS 693A.300, or to voluntary dissolution of the insurer pursuant to NRS 692B.250.

3. That the insurer has ceased for a period of 1 year to transact insurance business.

4. If a proposed insurer has not completed its organization and obtained a certificate of authority as an insurer within the time allowed therefor under any applicable solicitation permit issued by the Commissioner.

5. That efforts to rehabilitate the insurer and remove the causes or adverse effects thereof for which rehabilitation was instituted have failed despite all reasonable efforts by the Commissioner, or cannot be continued without material increase of risk of loss to the insurer's creditors or policyholders.

6. If the insurer has requested or consented to liquidation by a vote or written authorization of a majority of its directors, or stockholders, or members, if a mutual insurer.

Sec. 381. NRS 696B.230 is hereby amended to read as follows:

696B.230 The Commissioner may apply to the court for an order appointing the Commissioner as receiver or ancillary receiver, and directing the Commissioner to conserve the assets within this State, of a foreign or alien insurer:

1. Upon any of the applicable grounds specified in NRS 696B.210 or 696B.220;

2. Upon the ground that the insurer's property has been sequestrated in its domiciliary sovereignty or in any other sovereignty; or

3. In the case of an alien insurer, upon the ground that the insurer has failed to make good ~~[an impairment]~~ ***a deficiency in the amount*** of its trusteed funds ***as required by NRS 682B.130*** within the time required therefor by order of the Commissioner.

Sec. 382. NRS 696B.500 is hereby amended to read as follows:

696B.500 1. If the Commissioner determines after a hearing that any insurer has committed or engaged in, or is committing or engaging in, or is about to commit or engage in any act, practice or transaction that would subject it to formal delinquency proceedings under this chapter, the Commissioner may make and serve upon the insurer and other persons involved, such orders, other than seizure orders under NRS 696B.530 and 696B.540, as the Commissioner deems reasonably necessary to correct, eliminate or remedy such conduct, condition or ground. Orders to cure ~~[impairment of capital~~

~~or surplus~~] ***a deficiency*** of a domestic insurer ***operating in an impaired financial condition*** are subject to NRS 693A.260 and 693A.270.

2. If the Commissioner believes that irreparable harm to the insurer, or its policyholders, creditors or the public may occur unless an order of the Commissioner is issued with immediate effect, the Commissioner may make and serve an order without notice and before hearing, and shall simultaneously therewith serve upon the insurer and other persons involved the notice of hearing as required under subsection 3.

3. The Commissioner's order and notice of hearing shall be served by personal service in any manner provided by the Nevada Rules of Civil Procedure.

Sec. 383. Chapter 697 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Any person who employs, hires, contracts with, engages or otherwise uses the services of a person who does not hold an appropriate license issued pursuant to this chapter to perform any function, duty or power prescribed for a bail agent, general agent, bail enforcement agent or bail solicitor in this chapter is jointly and severally liable for any damages, injuries or losses arising out of or resulting from the acts or omissions of the unlicensed person while performing such a function, duty or power.

2. Any person who suffers any damages, injuries or losses arising out of or resulting from any act or omission described in subsection 1 may bring an action against the unlicensed person and the person who employed, hired, contracted with, engaged or otherwise used the services of the unlicensed person to recover actual damages and reasonable attorney's fees and costs.

3. The liability imposed by this section is in addition to any other administrative, civil or criminal liability imposed by law.

Sec. 384. NRS 697.360 is hereby amended to read as follows:

697.360 Licensed bail agents, bail solicitors and bail enforcement agents, and general agents are also subject to the following provisions of this Code, to the extent reasonably applicable:

1. Chapter 679A of NRS.
2. Chapter 679B of NRS.
3. NRS 683A.261.
4. NRS 683A.301.
5. NRS 683A.311.
6. NRS 683A.331.
7. NRS 683A.341.
8. NRS 683A.361.
9. NRS 683A.400.

10. NRS 683A.451.
11. NRS 683A.461.
12. NRS 683A.500.
13. NRS 683A.520.
14. NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive ~~[.]~~ ***, and sections 65 to 77, inclusive, of this act.***

Sec. 385. NRS 7.107 is hereby amended to read as follows:

7.107 1. An attorney licensed in this State who performs the functions of a real estate broker in a real estate transaction shall comply with the standards of business ethics that apply to a real estate broker pursuant to chapter 645 of NRS, including, without limitation, such standards set forth in NRS 645.635 **.** ~~[and 645.645.]~~

2. An attorney who performs the functions of a real estate broker and who does not comply with the standards of business ethics that apply to a real estate broker as required pursuant to subsection 1 may be disciplined by the State Bar of Nevada pursuant to the rules of the Supreme Court.

3. The provisions of this section do not require an attorney who performs the functions of a real estate broker in a real estate transaction to obtain a license to practice as a real estate broker pursuant to chapter 645 of NRS.

Sec. 386. NRS 40.607 is hereby amended to read as follows:

40.607 "Builder's warranty" means a warranty issued or purchased by or on behalf of a contractor for the protection of a claimant. The term:

1. Includes a warranty contract issued by or on behalf of a contractor whose liability pursuant to the warranty contract is subsequently insured by a risk retention group that operates in compliance with chapter 695E of NRS and insures all or any part of the liability of a contractor for the cost to repair a constructional defect in a residence.

2. Does not include ~~[a policy of insurance for home protection as defined in NRS 690B.100 or]~~ a service contract as defined in NRS 690C.080.

Sec. 387. NRS 41.100 is hereby amended to read as follows:

41.100 1. Except as otherwise provided in this section, no cause of action is lost by reason of the death of any person, but may be maintained by or against the person's executor or administrator.

2. In an action against an executor or administrator, any damages may be awarded which would have been recovered against the decedent if the decedent had lived, except damages awardable under NRS 42.005 or 42.010 or other damages imposed primarily for the sake of example or to punish the defendant.

3. Except as otherwise provided in this subsection, when a person who has a cause of action dies before judgment, the damages

recoverable by the decedent's executor or administrator include all losses or damages which the decedent incurred or sustained before the decedent's death, including any penalties or punitive and exemplary damages which the decedent would have recovered if the decedent had lived, and damages for pain, suffering or disfigurement and loss of probable support, companionship, society, comfort and consortium. This subsection does not apply to the cause of action of a decedent brought by the decedent's personal representatives for the decedent's wrongful death.

4. The executor or administrator of the estate of a person insured under a policy of life insurance may recover on behalf of the estate any loss, including, without limitation, consequential damages and attorney's fees, arising out of the commission of an act that constitutes an unfair practice pursuant to subsection ~~[1]~~ *2* of NRS 686A.310.

5. This section does not prevent subrogation suits under the terms and conditions of an uninsured motorists' provision of an insurance policy.

Sec. 388. NRS 118A.290 is hereby amended to read as follows:

118A.290 1. The landlord shall at all times during the tenancy maintain the dwelling unit in a habitable condition. A dwelling unit is not habitable if it violates provisions of housing or health codes concerning the health, safety, sanitation or fitness for habitation of the dwelling unit or if it substantially lacks:

(a) Effective waterproofing and weather protection of the roof and exterior walls, including windows and doors.

(b) Plumbing facilities which conformed to applicable law when installed and which are maintained in good working order.

(c) A water supply approved under applicable law, which is:

(1) Under the control of the tenant or landlord and is capable of producing hot and cold running water;

(2) Furnished to appropriate fixtures; and

(3) Connected to a sewage disposal system approved under applicable law and maintained in good working order to the extent that the system can be controlled by the landlord.

(d) Adequate heating facilities which conformed to applicable law when installed and are maintained in good working order.

(e) Electrical lighting, outlets, wiring and electrical equipment which conformed to applicable law when installed and are maintained in good working order.

(f) An adequate number of appropriate receptacles for garbage and rubbish in clean condition and good repair at the commencement of the tenancy. The landlord shall arrange for the

removal of garbage and rubbish from the premises unless the parties by written agreement provide otherwise.

(g) Building, grounds, appurtenances and all other areas under the landlord's control at the time of the commencement of the tenancy in every part clean, sanitary and reasonably free from all accumulations of debris, filth, rubbish, garbage, rodents, insects and vermin.

(h) Floors, walls, ceilings, stairways and railings maintained in good repair.

(i) Ventilating, air-conditioning and other facilities and appliances, including elevators, maintained in good repair if supplied or required to be supplied by the landlord.

2. The landlord and tenant may agree that the tenant is to perform specified repairs, maintenance tasks and minor remodeling only if:

(a) The agreement of the parties is entered into in good faith; and

(b) The agreement does not diminish the obligations of the landlord to other tenants in the premises.

3. An agreement pursuant to subsection 2 is not entered into in good faith if the landlord has a duty under subsection 1 to perform the specified repairs, maintenance tasks or minor remodeling and the tenant enters into the agreement because the landlord or his or her agent has refused to perform them.

4. Except as otherwise provided in subsection 5, the landlord shall not require a tenant to pay any fee or other charge for the performance of any repairs, maintenance tasks or other work for which the landlord has a duty under subsection 1 to perform, including, without limitation, any fee or other charge to cover the costs of any deductible or copayment under a ~~[~~policy of insurance for home protection or~~]~~ service contract for the performance of any such repairs, maintenance tasks or other work.

5. The landlord may require a tenant to pay any fee or other charge for the performance of any repairs, maintenance tasks or other work necessary for a condition caused by the tenant's own deliberate or negligent act or omission or that of a member of his or her household or other person on the premises with his or her consent.

6. As used in this section ~~[~~:

~~(a) "Insurance for home protection" has the meaning ascribed to it in NRS 690B.100.~~

~~(b) "Service"~~] , ***"service*** contract" has the meaning ascribed to it in NRS 690C.080.

Sec. 389. NRS 171.085 is hereby amended to read as follows:

171.085 Except as otherwise provided in NRS 171.080 to 171.084, inclusive, and 171.095, an indictment for:

1. Theft, robbery, burglary, forgery, arson, a violation of NRS 90.570, a violation punishable pursuant to paragraphs (a) to (d), inclusive, of subsection 3 of NRS 598.0999 or a violation of NRS 205.377 must be found, or an information or complaint filed, within 4 years after the commission of the offense.

2. Sexual assault must be found, or an information or complaint filed, within 20 years after the commission of the offense.

3. Sex trafficking must be found, or an information or complaint filed, within 6 years after the commission of the offense.

4. ***Insurance fraud must be found, or an information or complaint filed, within 7 years after the commission of the offense.***

5. Any felony other than the felonies listed in subsections 1 ~~[, 2 and 3]~~ ***to 4, inclusive,*** must be found, or an information or complaint filed, within 3 years after the commission of the offense.

Sec. 390. NRS 179A.075 is hereby amended to read as follows:

179A.075 1. The Central Repository for Nevada Records of Criminal History is hereby created within the Records, Communications and Compliance Division of the Department.

2. Each agency of criminal justice and any other agency dealing with crime shall:

(a) Collect and maintain records, reports and compilations of statistical data required by the Department; and

(b) Submit the information collected to the Central Repository:

(1) In the manner approved by the Director of the Department; and

(2) Through the use of the National Incident-Based Reporting System.

3. Each agency of criminal justice shall submit the information relating to records of criminal history that it creates, issues or collects, and any information in its possession relating to the DNA profile of a person from whom a biological specimen is obtained pursuant to NRS 176.09123 or 176.0913, to the Division. The information must be submitted to the Division:

(a) Through an electronic network;

(b) On a medium of magnetic storage; or

(c) In the manner prescribed by the Director of the Department,

➥ within 60 days after the date of the disposition of the case. If an agency has submitted a record regarding the arrest of a person who is later determined by the agency not to be the person who committed the particular crime, the agency shall, immediately upon making that determination, so notify the Division. The Division

shall delete all references in the Central Repository relating to that particular arrest.

4. Each state and local law enforcement agency shall submit Uniform Crime Reports to the Central Repository:

(a) In the manner prescribed by the Director of the Department;

(b) Through the use of the National Incident-Based Reporting System; and

(c) Within the time prescribed by the Director of the Department.

5. The Division shall, in the manner prescribed by the Director of the Department:

(a) Collect, maintain and arrange all information submitted to it relating to:

(1) Records of criminal history; and

(2) The DNA profile of a person from whom a biological specimen is obtained pursuant to NRS 176.09123 or 176.0913.

(b) When practicable, use a record of the personal identifying information of a subject as the basis for any records maintained regarding him or her.

(c) Upon request, provide, in paper or electronic form, the information that is contained in the Central Repository to the Committee on Domestic Violence and Sexual Assault appointed pursuant to NRS 228.470 when, pursuant to NRS 228.495, the Committee is reviewing the death of the victim of a crime that constitutes domestic violence pursuant to NRS 33.018.

(d) Upon request, provide, in paper or electronic form, the information that is contained in the Central Repository to the Commissioner of Insurance when the Commissioner is carrying out his or her duties pursuant to NRS 679B.600 to 679B.700, inclusive.

6. The Division may:

(a) Disseminate any information which is contained in the Central Repository to any other agency of criminal justice;

(b) Enter into cooperative agreements with repositories of the United States and other states to facilitate exchanges of information that may be disseminated pursuant to paragraph (a); and

(c) Request of and receive from the Federal Bureau of Investigation information on the background and personal history of any person whose record of fingerprints or other biometric identifier the Central Repository submits to the Federal Bureau of Investigation and:

(1) Who has applied to any agency of the State of Nevada or any political subdivision thereof for a license which it has the power to grant or deny;

(2) With whom any agency of the State of Nevada or any political subdivision thereof intends to enter into a relationship of employment or a contract for personal services;

(3) Who has applied to any agency of the State of Nevada or any political subdivision thereof to attend an academy for training peace officers approved by the Peace Officers' Standards and Training Commission;

(4) For whom such information is required or authorized to be obtained pursuant to NRS 62B.270, 62G.223, 62G.353, 127A.340, 424.031, 432A.170, 432B.198, 433B.183, 449.123, 449B.310 and 449B.710; or

(5) About whom any agency of the State of Nevada or any political subdivision thereof is authorized by law to have accurate personal information for the protection of the agency or the persons within its jurisdiction.

7. To request and receive information from the Federal Bureau of Investigation concerning a person pursuant to subsection 6, the Central Repository must receive:

(a) The person's complete set of fingerprints for the purposes of:

(1) Booking the person into a city or county jail or detention facility;

(2) Employment;

(3) Contractual services; or

(4) Services related to occupational licensing;

(b) One or more of the person's fingerprints for the purposes of mobile identification by an agency of criminal justice; or

(c) Any other biometric identifier of the person as it may require for the purposes of:

(1) Arrest; or

(2) Criminal investigation,

➥ from the agency of criminal justice or agency of the State of Nevada or any political subdivision thereof and submit the received data to the Federal Bureau of Investigation for its report.

8. The Central Repository shall:

(a) Collect and maintain records, reports and compilations of statistical data submitted by any agency pursuant to subsection 2.

(b) Tabulate and analyze all records, reports and compilations of statistical data received pursuant to this section.

(c) Disseminate to federal agencies engaged in the collection of statistical data relating to crime information which is contained in the Central Repository.

(d) Investigate the criminal history of any person who:

(1) Has applied to the Superintendent of Public Instruction for the issuance or renewal of a license;

(2) Has applied to a county school district, charter school or private school for employment or to serve as a volunteer; or

(3) Is employed by or volunteers for a county school district, charter school or private school,

➥ and immediately notify the superintendent of each county school district, the governing body of each charter school and the Superintendent of Public Instruction, or the administrator of each private school, as appropriate, if the investigation of the Central Repository indicates that the person has been convicted of a violation of NRS 200.508, 201.230, 453.3385, 453.3387 or 453.339, or convicted of a felony or any offense involving moral turpitude.

(e) Upon discovery, immediately notify the superintendent of each county school district, the governing body of each charter school or the administrator of each private school, as appropriate, by providing the superintendent, governing body or administrator with a list of all persons:

(1) Investigated pursuant to paragraph (d); or

(2) Employed by or volunteering for a county school district, charter school or private school whose fingerprints were sent previously to the Central Repository for investigation,

➥ who the Central Repository's records indicate have been convicted of a violation of NRS 200.508, 201.230, 453.3385, 453.3387 or 453.339, or convicted of a felony or any offense involving moral turpitude since the Central Repository's initial investigation. The superintendent of each county school district, the governing body of a charter school or the administrator of each private school, as applicable, shall determine whether further investigation or action by the district, charter school or private school, as applicable, is appropriate.

(f) Investigate the criminal history of each person who submits one or more fingerprints or other biometric identifier or has such data submitted pursuant to NRS 62B.270, 62G.223, 62G.353, 127A.340, 424.031, 432A.170, 432B.198, 433B.183, 449.122, 449.123, 449B.300, 449B.310, 449B.700 or 449B.710.

(g) Provide an electronic means to access on the Central Repository's Internet website statistical data relating to crime.

(h) Provide an electronic means to access on the Central Repository's Internet website statistical data about domestic violence in this State.

(i) Identify and review the collection and processing of statistical data relating to criminal justice by any agency identified in subsection 2 and make recommendations for any necessary changes in the manner of collecting and processing statistical data by any such agency.

(j) Adopt regulations governing biometric identifiers and the information and data derived from biometric identifiers, including, without limitation:

(1) Their collection, use, safeguarding, handling, retention, storage, dissemination and destruction; and

(2) The methods by which a person may request the removal of his or her biometric identifiers from the Central Repository and any other agency where his or her biometric identifiers have been stored.

9. The Central Repository may:

(a) In the manner prescribed by the Director of the Department, disseminate compilations of statistical data and publish statistical reports relating to crime.

(b) Charge a reasonable fee for any publication or special report it distributes relating to data collected pursuant to this section. The Central Repository may not collect such a fee from an agency of criminal justice or any other agency dealing with crime which is required to submit information pursuant to subsection 2. All money collected pursuant to this paragraph must be used to pay for the cost of operating the Central Repository or for any other purpose authorized by the Legislature, and any balance of the money remaining at the end of a fiscal year reverts to the State General Fund.

(c) In the manner prescribed by the Director of the Department, use electronic means to receive and disseminate information contained in the Central Repository that it is authorized to disseminate pursuant to the provisions of this chapter.

10. As used in this section:

(a) "Mobile identification" means the collection, storage, transmission, reception, search, access or processing of a biometric identifier using a handheld device.

(b) "Personal identifying information" means any information designed, commonly used or capable of being used, alone or in conjunction with any other information, to identify a person, including, without limitation:

(1) The name, driver's license number, social security number, date of birth and photograph or computer-generated image of a person; and

(2) A biometric identifier of a person.

(c) "Private school" has the meaning ascribed to it in NRS 394.103.

Sec. 391. NRS 179A.100 is hereby amended to read as follows:

179A.100 1. The following records of criminal history may be disseminated by an agency of criminal justice without any restriction pursuant to this chapter:

(a) Any which reflect records of conviction only; and

(b) Any which pertain to an incident for which a person is currently within the system of criminal justice, including parole or probation.

2. Without any restriction pursuant to this chapter, a record of criminal history or the absence of such a record may be:

(a) Disclosed among agencies which maintain a system for the mutual exchange of criminal records.

(b) Furnished by one agency to another to administer the system of criminal justice, including the furnishing of information by a police department to a district attorney.

(c) Reported to the Central Repository.

3. An agency of criminal justice shall disseminate to a prospective employer, upon request, records of criminal history concerning a prospective employee or volunteer which are the result of a name-based inquiry and which:

(a) Reflect convictions only; or

(b) Pertain to an incident for which the prospective employee or volunteer is currently within the system of criminal justice, including parole or probation.

4. Records of criminal history must be disseminated by an agency of criminal justice, upon request, to the following persons or governmental entities:

(a) The person who is the subject of the record of criminal history for the purposes of NRS 179A.150.

(b) The person who is the subject of the record of criminal history when the subject is a party in a judicial, administrative, licensing, disciplinary or other proceeding to which the information is relevant.

(c) The Nevada Gaming Control Board.

(d) The State Board of Nursing.

(e) The Private Investigator's Licensing Board to investigate an applicant for a license.

(f) A public administrator or a person employed or contracted with pursuant to NRS 253.125, as applicable, to carry out the duties as prescribed in chapter 253 of NRS.

(g) A public guardian to investigate a protected person or proposed protected person or persons who may have knowledge of assets belonging to a protected person or proposed protected person.

(h) Any agency of criminal justice of the United States or of another state or the District of Columbia.

(i) Any public utility subject to the jurisdiction of the Public Utilities Commission of Nevada when the information is necessary to conduct a security investigation of an employee or prospective employee or to protect the public health, safety or welfare.

(j) Persons and agencies authorized by statute, ordinance, executive order, court rule, court decision or court order as construed by appropriate state or local officers or agencies.

(k) Any person or governmental entity which has entered into a contract to provide services to an agency of criminal justice relating to the administration of criminal justice, if authorized by the contract, and if the contract also specifies that the information will be used only for stated purposes and that it will be otherwise confidential in accordance with state and federal law and regulation.

(l) Any reporter or editorial employee who is employed or affiliated with a newspaper, press association or commercially operated, federally licensed radio or television station who requests a record of a named person or aggregate information for statistical purposes, excluding any personal identifying information, in a professional capacity for communication to the public.

(m) Prospective employers if the person who is the subject of the information has given written consent to the release of that information by the agency which maintains it.

(n) For the express purpose of research, evaluative or statistical programs pursuant to an agreement with an agency of criminal justice.

(o) An agency which provides child welfare services, as defined in NRS 432B.030.

(p) The Division of Social Services of the Department of Human Services or its designated representative, as needed to ensure the safety of investigators and caseworkers.

(q) The Aging and Disability Services Division of the Department of Human Services or its designated representative, as needed to ensure the safety of investigators and caseworkers.

(r) An agency of this or any other state or the Federal Government that is conducting activities pursuant to Part D of Subchapter IV of Chapter 7 of Title 42 of the Social Security Act, 42 U.S.C. §§ 651 et seq.

(s) The Commissioner of Insurance ~~[.]~~ ***to carry out his or her duties, including, without limitation, the duties set forth in NRS 679B.600 to 679B.700, inclusive.***

(t) The Board of Medical Examiners.

(u) The State Board of Osteopathic Medicine.

(v) The Board of Massage Therapy and its Executive Director.

(w) The Board of Examiners for Social Workers.

(x) The State Board of Cosmetology and its Executive Director.

(y) The Committee on Domestic Violence and Sexual Assault appointed pursuant to NRS 228.470 when, pursuant to NRS 228.495, the Committee is reviewing the death of the victim of a crime that constitutes domestic violence pursuant to NRS 33.018.

(z) A county coroner or medical examiner, as needed to conduct an investigation of the death of a person.

5. Agencies of criminal justice in this State which receive information from sources outside this State concerning transactions involving criminal justice which occur outside Nevada shall treat the information as confidentially as is required by the provisions of this chapter.

Sec. 392. NRS 232.825 is hereby amended to read as follows:

232.825 The Commissioner:

1. May appoint ~~[three]~~ ***four*** deputies. The deputies are in the unclassified service of the State. Except as otherwise provided in NRS 284.143, each deputy shall devote his or her entire time and attention to the business of his or her office and shall not pursue any other business or occupation or hold any other office of profit.

2. Is responsible for the administration of the provisions of title 57 of NRS, and all other provisions of law relating to the functions of the Division.

3. May employ such staff as is necessary for the performance of the Commissioner's duties.

4. Has such other powers and duties as are provided by law.

Sec. 393. NRS 616B.027 is hereby amended to read as follows:

616B.027 1. Every insurer shall:

(a) Provide an office in this State operated by the insurer, its third-party administrator or a legal representative of the insurer or third-party administrator in which:

(1) A complete file, or a reproduction of the complete file, of each claim is accessible, in accordance with the provisions of NRS 616B.021;

(2) Persons authorized to act for the insurer and, if necessary, licensed pursuant to chapter 683A of NRS, may receive information related to a claim and provide the services to an employer and the employees of the employer required by chapters 616A to 617, inclusive, of NRS; and

(3) An employee, a representative of an employee or his or her employer, upon request, is provided with information related to a claim filed by the employee or a copy or other reproduction of the information from the file for that claim, in accordance with the provisions of NRS 616B.021. Any information which is provided

pursuant to this subparagraph may be provided as an electronic copy or in an electronic format that produces an accurate reproduction of the original.

(b) Provide statewide toll-free telephone service to the office maintained pursuant to paragraph (a).

2. Each private carrier shall provide:

(a) Adequate services to its insured employers in controlling losses; and

(b) Adequate information on the prevention of industrial accidents and occupational diseases.

3. Except as otherwise provided in subsection 4, an employee of a private carrier who is licensed as ~~[a company]~~ ***an*** adjuster pursuant to chapter 684A of NRS or a person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a private carrier who administers a claim arising under chapters 616A to 616D, inclusive, or chapter 617 of NRS from a location outside of this State pursuant to subsection 1 of NRS 616B.0275 shall be available to communicate live and in real time with the claimant or a representative of the claimant Monday through Friday, 9 a.m. to 5 p.m. local time in this State, excluding any day declared to be a legal holiday pursuant to NRS 236.015.

4. The provisions of subsection 3 do not apply to an employee of a private carrier described in subsection 3 or a person who acts as a third-party administrator for a private carrier described in subsection 3 if the private carrier or third-party administrator, as applicable, operates an office in this State.

Sec. 394. NRS 616B.0275 is hereby amended to read as follows:

616B.0275 1. An employee of a private carrier who is licensed as ~~[a company]~~ ***an*** adjuster pursuant to chapter 684A of NRS or a person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a private carrier may administer claims arising under chapters 616A to 616D, inclusive, or chapter 617 of NRS from a location in or outside of this State. All records concerning a claim administered pursuant to this subsection must be maintained at one or more offices located in this State or by computer in a microphotographic, electronic or other similar format that produces an accurate reproduction of the original.

2. Except as otherwise provided in subsection 3, an employee of a private carrier who is not licensed as ~~[a company]~~ ***an*** adjuster pursuant to chapter 684A of NRS or a person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a self-insured employer or an association of self-insured public or private employers may administer claims

arising under chapters 616A to 616D, inclusive, or chapter 617 of NRS only from one or more offices located in this State.

3. A ***person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a*** self-insured private employer or its parent ~~[, a subsidiary of its parent or an affiliate of the self-insured private employer]~~ may administer claims arising under chapters 616A to 616D, inclusive, or chapter 617 of NRS from a location in or outside of this State if ***the Commissioner has approved such administration and*** the total aggregate number of employees of the self-insured private employer ~~[, its parent, any subsidiary of its parent]~~ and any affiliate of the employer employed in this State is 30,000 or more, as reported to the Department of Employment, Training and Rehabilitation for the most recent calendar quarter.

4. The Commissioner may:

(a) Under exceptional circumstances, waive the requirements of subsections 1, 2 and 3; and

(b) Adopt regulations to carry out the provisions of this section.

5. As used in this section, "affiliate" has the meaning ascribed to it in NRS 78.412.

Sec. 395. NRS 616B.300 is hereby amended to read as follows:

616B.300 1. An employer may qualify and remain qualified as a self-insured employer by establishing to the satisfaction of the Commissioner that the employer has sufficient administrative and financial resources to make certain the prompt payment of all compensation under chapters 616A to 616D, inclusive, or chapter 617 of NRS. For the purposes of this subsection, an employer has sufficient financial resources if:

(a) At the time of initial qualification and ~~[until the employer has operated successfully as a qualified self-insured employer for 3 years, as]~~ ***each year thereafter, on or before a date*** determined by the Commissioner, the employer has a tangible net worth of not less than $2,500,000, as evidenced by a statement of tangible net worth provided to the Division of Insurance of the Department of Business and Industry by an independent certified public accountant; or

(b) After 3 years of successful operation as a qualified self-insured employer, ~~[as determined by the Commissioner,]~~ the employer has net cash flows from operating activities plus net cash flows from financing activities of five times the average of claims paid for each of the last 3 years or $7,500,000, whichever is less ~~[.]~~ ***and the Commissioner authorizes the sufficiency of the financial resources of the employer to be determined in accordance with this paragraph.***

2. A self-insured employer must, in addition to establishing financial ability to pay, deposit with the Commissioner a bond executed by the employer as principal, and by a corporation qualified under the laws of this State as surety, payable to the State of Nevada, and conditioned upon the payment of compensation for injuries and occupational diseases to employees. The bond must be in an amount reasonably sufficient to ensure payment of compensation, but in no event may it be less than 105 percent of the employer's expected annual incurred cost of claims, or less than $100,000. In arriving at an amount for the expected annual cost of claims, due consideration must be given to the past and prospective experience of the employer with losses and expenses within this State, to the hazard of catastrophic loss, to other contingencies, and to trends within the State. In arriving at the amount of the deposit required, the Commissioner may consider the nature of the employer's business, the financial ability of the employer to pay compensation and the employer's probable continuity of operation.

3. In lieu of a bond, the employer may deposit with the Commissioner a like amount of lawful money of the United States or any other form of security authorized by NRS 100.065. If security is provided in the form of a savings certificate, certificate of deposit or investment certificate, the certificate must state that the amount is unavailable for withdrawal except upon order of the Commissioner.

4. The required deposit may be increased or decreased by the Commissioner in accordance with chapter 681B of NRS and the Commissioner's regulations for loss reserves in casualty insurance. If the Commissioner requires an employer to increase his or her deposit, the Commissioner may specify the form of the additional security. The employer shall comply with such a requirement within 60 days after receiving notice from the Commissioner.

5. The Commissioner shall require the self-insured employer to submit evidence of excess insurance to provide protection against a catastrophic loss. The excess insurance must be written by an insurer authorized to do business in this State. The Commissioner shall consider the excess insurance coverage as a basis for a reduction in the deposit required of an employer.

6. The Account for Self-Insured Employers is hereby created in the State Agency Fund for Bonds. All money received by the Commissioner pursuant to this section must be deposited with the State Treasurer to the credit of the Account for Self-Insured Employers. All claims against this Account must be paid as other claims against the State are paid.

Sec. 396. NRS 616B.306 is hereby amended to read as follows:

616B.306 If a self-insured employer becomes insolvent, institutes any voluntary proceeding under the Bankruptcy Act or is named in any involuntary proceeding thereunder, makes a general or special assignment for the benefit of creditors or fails to pay compensation under chapters 616A to 616D, inclusive, or chapter 617 of NRS after an order for payment of any claim becomes final, the Commissioner may, after giving at least 10 days' notice to the employer and any insurer or guarantor, use money or interest on securities, sell securities or institute legal proceedings on surety bonds deposited or filed with the Commissioner pursuant to NRS ~~[679B.175]~~ ***616B.300*** to the extent necessary to make those payments. Until the Commissioner gives a 10-day notice pursuant to this section, the employer is entitled to all interest and dividends on bonds or securities on deposit pursuant to NRS ~~[679B.175]~~ ***616B.300*** and to exercise all voting rights, stock options and other similar incidents of ownership thereof.

Sec. 397. NRS 616B.624 is hereby amended to read as follows:

616B.624 1. If a quasi-public or private corporation or a limited-liability company is required to be insured pursuant to chapters 616A to 616D, inclusive, of NRS, an officer of the corporation or a manager of the company who:

(a) Receives pay for services performed as an officer, manager or employee of the corporation or company shall be deemed for the purposes of those chapters to receive a minimum pay of $6,000 per policy year and a maximum pay ~~[of $36,000]~~ per policy year ~~[.]~~ ***in an amount calculated in the manner described in NRS 616B.222.***

(b) Does not receive pay for services performed as an officer, manager or employee of the corporation or company shall be deemed for the purposes of those chapters to receive a minimum pay of $500 per month or $6,000 per policy year.

2. An officer or manager who does not receive pay for services performed as an officer, manager or employee of the corporation or company may elect to reject coverage for himself or herself by filing written notice thereof with the corporation or company and the insurer. The rejection is effective upon receipt of the notice by the insurer.

3. An officer or manager of such a corporation or company who:

(a) Owns the corporation or company; and

(b) Receives pay for the services performed,

↦ may elect to reject coverage for himself or herself by filing written notice thereof with the insurer. The rejection is effective upon receipt of the notice by the insurer.

4. An officer or manager who has rejected coverage may rescind that rejection by filing written notice thereof with the corporation or company and the insurer. The rescission is effective upon receipt of the notice by the insurer. Except as otherwise provided in subsection 3, if an officer or manager who has rejected coverage receives pay for services performed as an officer, manager or employee of the corporation or company, the officer or manager shall be deemed to have rescinded that rejection.

5. A nonprofit corporation whose officers do not receive pay for services performed as officers or employees of the corporation may elect to reject coverage for its current officers and all future officers who do not receive such pay by filing written notice thereof with the corporation and the insurer. The rejection is effective upon receipt of the notice by the insurer.

6. A nonprofit corporation which has rejected coverage for its officers who do not receive pay for services performed as officers or employees of the corporation may rescind that rejection by filing written notice thereof with the corporation and the insurer. The rescission is effective upon receipt of the notice by the insurer. If an officer of a nonprofit corporation which has rejected coverage receives pay for services performed as an officer or employee of the corporation, the corporation shall be deemed to have rescinded that rejection.

Sec. 398. NRS 629.095 is hereby amended to read as follows:

629.095 1. Except as otherwise provided in subsection 2, the Commissioner of Insurance shall develop, prescribe for use and make available a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations, managed care organizations, hospitals, medical facilities and other facilities that provide health care in obtaining any information related to the credentials of a provider of health care.

2. The provisions of subsection 1 do not prohibit the Commissioner of Insurance from developing, prescribing for use and making available:

(a) Appropriate variations of the form described in that subsection for use in different geographical regions of this State.

(b) Addenda or supplements to the form described in that subsection to address, until such time as a new form may be developed, prescribed for use and made available, any requirements newly imposed by the Federal Government, the State or one of its agencies, or a body that accredits hospitals, medical facilities or health care plans.

3. With respect to the form described in subsection 1, the Commissioner of Insurance shall:

(a) Hold public hearings to seek input regarding the development of the form;

(b) Develop the form in consideration of the input received pursuant to paragraph (a);

(c) Ensure that the form is developed in such a manner as to accommodate and reflect the different types of credentials applicable to different classes of providers of health care;

(d) Ensure that the form is developed in such a manner as to reflect standards of accreditation adopted by national organizations which accredit hospitals, medical facilities and health care plans; and

(e) Ensure that the form is developed to be used efficiently and is developed to be neither unduly long nor unduly voluminous.

4. As used in this section:

(a) "Carrier" has the meaning ascribed to it in NRS 689C.025.

(b) "Corporation" means a corporation operating pursuant to the provisions of chapter 695B of NRS.

(c) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(d) "Insurer" means:

(1) An insurer that issues policies of individual health insurance in accordance with chapter 689A of NRS; and

(2) An insurer that issues policies of group health insurance in accordance with chapter 689B of NRS.

(e) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(f) "Provider of health care" ~~[means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of]~~ ***has the meaning ascribed to it in*** NRS ~~[.]~~ ***695G.070.***

(g) "Society" has the meaning ascribed to it in NRS 695A.044.

Sec. 399. The amendatory provisions of section 389 of this act apply to an offense committed:

1. Before July 1, 2027, if the applicable statute of limitations has commenced but has not expired on July 1, 2027.

2. On or after July 1, 2027.

Sec. 400. The amendatory provisions of sections 21 and 222 of this act apply only to a certificate of registration as a provider, as defined in NRS 690C.070, that is issued or renewed on or after July 1, 2027.

Sec. 401. The Legislative Counsel shall, in preparing supplements to the Nevada Administrative Code, appropriately change any references to an officer, agency or other entity whose name is changed or whose responsibilities are transferred pursuant

to the provisions of this act to refer to the appropriate officer, agency or other entity.

Sec. 402. 1. Any administrative regulations adopted by an officer or an agency whose name has been changed or whose responsibilities have been transferred pursuant to the provisions of this act to another officer or agency remain in force until amended by the officer or agency to which the responsibility for the adoption of the regulations has been transferred.

2. Any contracts or other agreements entered into by an officer or agency whose name has been changed or whose responsibilities have been transferred pursuant to the provisions of this act to another officer or agency are binding upon the officer or agency to which the responsibility for the administration of the provisions of the contract or other agreement has been transferred. Such contracts and other agreements may be enforced by the officer or agency to which the responsibility for the enforcement of the provisions of the contract or other agreement has been transferred.

3. Any action taken by an officer or agency whose name has been changed or whose responsibilities have been transferred pursuant to the provisions of this act to another officer or agency remains in effect as if taken by the officer or agency to which the responsibility for the enforcement of such actions has been transferred.

Sec. 403. NRS 645.645, 687B.660, 687B.876, 689C.320, 689C.380, 689C.390, 690B.100, 690B.110, 690B.120, 690B.130, 690B.140, 690B.150, 690B.155, 690B.160, 690B.170, 690B.175, 690B.180, 690C.130, 694C.140 and 696B.100 are hereby repealed.

Sec. 404. This act becomes effective on July 1, 2027.

LEADLINES OF REPEALED SECTIONS

645.645 Additional grounds for disciplinary action: Unprofessional and improper conduct relating to sale of insurance for home protection.

687B.660 "Provider of health care" defined.

687B.876 "Provider of health care" defined.

689C.320 Required notification when carrier discontinues transacting insurance in this State or particular geographic service area of state; restrictions on carrier that discontinues transacting insurance.

689C.380 "Contract" defined.

689C.390 "Dependent" defined.

690B.100 Definitions.

690B.110 Applicability of other provisions.

690B.120 Exemption of person selling insurance from licensing requirements as agent, broker or solicitor.

690B.130 Deposit of securities or surety bond; maintenance of capital stock or surplus, premium reserves and losses and loss expense reserves.

690B.140 Investments in tangible personal property: Limitation; waiver.

690B.150 Filing of annual and quarterly statements.

690B.155 Provision requiring binding arbitration authorized; procedures for arbitration.

690B.160 Contracts: Specifications; cancellation; renewal.

690B.170 Contracts: Regulations on content.

690B.175 Regulations regarding administrative expenses for insurers and accounting standards.

690B.180 Prohibited acts.

690C.130 Annual report by Commissioner concerning service contract industry.

694C.140 "Rental captive insurer" defined.

696B.100 "Impairment" defined.