SUMMARY—Revises provisions relating to insurance. (BDR 57-256)

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: Yes.

AN ACT relating to insurance; making various changes to the Nevada Insurance Code; revising provisions governing examinations of insurers and other persons subject to regulation under the Code; revising certain powers and duties of the Commissioner of Insurance; revising various requirements and restrictions imposed on insurers and other persons subject to regulation under the Code; revising provisions relating to service contracts, providers of service contracts and administrators of service contracts; repealing provisions governing insurance for home protection; revising provisions relating to administrators; standardizing the definitions of certain words and terms; revising provisions relating to adjustors; revising provisions relating to certain trade practices and frauds; removing certain obsolete and duplicative provisions; transferring certain duties from the Commissioner of Financial Institutions to the Commissioner of Mortgage Lending; revising provisions relating to certain accounts and funds relevant to the regulation of certain insurers and insurance administration; designating certain employees of the Division of Insurance of the Department of Business and Industry as

category II peace officers; providing penalties; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Commissioner of Insurance to regulate insurance in this State and enforce the provisions of the Nevada Insurance Code. (NRS 679B.120) Existing law sets forth various requirements relating to examinations of insurers, which are conducted by the Commissioner. (NRS 679B.230-679B.300) **Section 354** of this bill repeals those provisions of existing law relating to examinations of insurers. **Sections 1-41** of this bill reenact, reorganize and revise those provisions into a new chapter of the Nevada Revised Statutes governing examinations of insurers and other persons subject to regulation under the Nevada Insurance Code. **Sections 3-12 and 27-41** additionally enact provisions that are modeled, in general, after the Market Conduct Surveillance Model Law adopted by the National Association of Insurance Commissioners and which: (1) require the Commissioner to collect and analyze information concerning the market practices of insurers; and (2) authorize the Commissioner to take certain actions, including, without limitation, the conducting of certain examinations, based on the results of that analysis. **Sections 43, 54, 65, 111, 113, 114, 124-127, 197, 203, 210, 213, 216-218, 221, 223, 229, 251, 253, 269, 289-291, 293, 294, 297, 318, 319, 336, 340 and 342** of this bill make conforming changes to replace references in existing law to the sections which were repealed and reenacted in **sections 2-41**.

Section 42 of this bill authorizes the Commissioner, during a state of emergency or declaration of disaster, to issue a temporary order to address certain matters relating to policies issued in this State. **Section 42** requires each such order to be approved by the Governor and meet certain other requirements. **Section 333** of this bill exempts any order issued by the Commissioner pursuant to **section 42** from the requirements of the Nevada Administrative Procedure Act. (NRS 233B.039)

Section 44 of this bill expands the applicability of a provision of existing law requiring the Secretary of State to nullify the charter or certificate of certain insurers who are prohibited from transacting insurance in this State to include any person who is prohibited from transacting insurance in this State. **Section 45** of this bill revises requirements imposed on the Commissioner concerning the publication of a guide to rates for policies of insurance for motor vehicles. **Section 46** of this bill revises provisions governing oversight by the Commissioner of certain usual and customary fees or reimbursement methodologies. **Section 47** of this bill authorizes an attorney employed by the Division of Insurance of the Department of Business and Industry to act as legal counsel to the Division and the Commissioner in certain matters, instead of the Attorney General. **Section 48** of this bill: (1) authorizes the Commissioner to enter into contracts with the National Association of Insurance Commissioners for goods and services related to the regulation of insurance; and (2) exempts such a contract from the provisions of existing law governing purchasing for the State. **Section 116** of this bill makes a conforming change to update an internal reference changed by **section 48**. **Section 51** of this bill authorizes the Commissioner to limit, in addition to suspending, the certificate of authority of an insurer under certain circumstances.

Existing law provides for the registration and regulation of administrators by the Commissioner. (NRS 683A.0805-683A.0893) **Section 55** of this bill requires an administrator to report to the Commissioner certain information concerning administrative actions and criminal prosecutions against the administrator. **Section 57** of this bill applies certain definitions in existing law relating to administrators to **section 55**. **Sections 58-60** of this bill revise provisions relating to certain: (1) documents which are required as part of an application for registration as an administrator; (2) bonds which are required to be filed by an administrator; and (3) recordkeeping requirements for administrators. **Section 61** of this bill authorizes an administrator to use accounts in a financial institution not located in this State to hold certain money in a fiduciary capacity. **Section 62** of this bill authorizes the Commissioner to revoke the registration of an administrator without further notice if the registration has already been suspended and the administrator becomes nonresponsive.

Existing law provides for the registration and regulation of providers of service contracts by the Commissioner. (Chapter 690C of NRS) **Sections 52 and 205** 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 202, 207 and 209** of this bill revise provisions relating to certain duties and requirements for the registration of a service contract provider. **Section 206** of this bill revises provisions relating to the financial security which is required of a service contract provider. **Section 208** of this bill requires a service contract to include the name of the holder of the service contract. **Sections 56, 199, 201 and 204** of this bill: (1) require a person who administers a service contract to obtain a certificate of registration as an administrator issued by the Commissioner; (2)

subject such an administrator to the provisions of existing law governing administrators; and (3) set forth certain requirements for the operation of such an administrator. **Sections 200 and 211** of this bill authorize the Commissioner to: (1) issue a cease and desist order under certain circumstances; and (2) suspend, without advance notice or a hearing, the registration of a service contract provider if the provider violates a cease and desist order from the Commissioner. **Section 212** of this bill increases the maximum fines the Commissioner may assess for certain violations of existing law relating to service contracts.

Section 64 of this bill: (1) removes a provision requiring certain hearings to be held within 30 days of a written application under certain circumstances, thus making existing law applicable which provides a 60-day timeline for such hearings under those circumstances; and (2) authorizes the Commissioner, after notice and the opportunity for a hearing, to take certain actions against the license of a business organization. (NRS 679B.310)

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 67** 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 66, 68-70, 73-76, 343 and 344** of this bill make conforming changes to reflect that consolidation.

Existing law generally exempts a person who is licensed as an adjuster in another state from the requirement to take and pass an examination to obtain a nonresident license as an adjuster under certain circumstances. **Sections 71 and 72** 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 77 of this bill revises requirements for licensing as a surplus lines broker. **Section 78** of this bill revises provisions relating to the Commissioner accepting service of process on behalf of unauthorized insurers in 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 80-83, 97, 99, 101, 102 and 110** of this bill revise and add to the provisions of existing law governing trade practices and frauds for the purpose of conforming more closely to the Unfair Trade Practices Act adopted by the National Association of Insurance Commissioners. **Section 80** prohibits an insurer from taking certain discriminatory actions. **Section 81** imposes certain requirements on an insurer relating to recordkeeping. **Section 82** prohibits a person from making certain false or fraudulent statements or representations. **Section 83** requires a property and casualty insurer to provide to a primary insured certain loss information upon request. **Section 97** prohibits an insurer from providing certain inducements to purchase insurance. **Section 99** sets forth certain restrictions upon a person, bank or affiliate relating to insurance. **Section 101** sets forth certain actions relating to value-added products or services that do not constitute prohibited discrimination or rebates. **Section 102** sets forth certain actions that constitute prohibited unfair discrimination. **Section 110** sets forth certain recordkeeping requirements for a person who generates leads for an insurer or producer of insurance relating to health insurance products and services.

Existing law prohibits certain health insurers from denying a claim, refusing to issue or cancelling a policy of health insurance solely because the claim involves an act of domestic violence or the person applying for or covered by the policy was the victim of such an act of domestic violence. (NRS 689A.413, 689B.068, 689C.196, 695A.195, 695B.316, 695C.203, 695D.217) **Section 354** repeals those provisions. **Sections 84-93** of this bill instead set forth restrictions concerning discrimination based on domestic violence which are modeled, in general, after several model acts adopted by the National Association of Insurance Commissioners relating to unfair discrimination against subjects of abuse. **Sections 83-92** prohibit insurers, insurance professionals and other persons from engaging in various discriminatory actions relating to domestic violence, including, among other actions: (1) denying, refusing to issue or renew, cancelling or otherwise terminating a policy of insurance on the basis of the domestic violence status of a person; and (2) with certain exceptions, denying benefits on a policy of insurance on the basis of domestic violence status, including, without limitation, denying a claim under a policy of health insurance solely because the claim involves an act that constitutes domestic violence. **Section 93** requires an insurer or insurance professional to explain to an applicant or insured, and demonstrate to the Commissioner, certain matters relating to certain actions involving medical conditions relating to domestic violence.

Section 109 of this bill sets forth certain unfair trade practices relating to the handling of claims that are modeled, in general, after provisions set forth in the Unfair Claims Settlement Practices Act adopted by the National Association of Insurance Commissioners.

Section 115 of this bill limits deductions for depreciation in the settlement of certain property insurance claims to the cost of physical goods being repaired or replaced.

Section 117 of this bill reduces the time within which an insurer is required to respond to a request for prior authorization, from within 20 days after the insurer received the request to: (1) within 2 business days after the date of submission of the request, if the request involves urgent health care services; and (2) within 5 business days after the date of submission of the request, if the request does not involve urgent health care services.

Existing law prohibits an insurer from taking certain adverse actions against a policy of motor vehicle insurance as a result of the filing of certain claims or the making of certain inquiries. (NRS 687B.385) **Section 118** of this bill expands that prohibition to prohibit an insurer from taking certain adverse actions against a policy of property or casualty insurance as a result of the filing of certain claims or the making of certain inquiries.

Section 119 of this bill revises the dates on which the Commissioner is required to request and an insurer is required to provide certain annual information relating to compliance with certain federal laws.

Sections 128-134, 153-159, 175-181, 197, 232-237, 252, 270, 298-302, 304 and 305 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," "network plan," "provider network contract," "provider of health care" and "therapeutic equivalent" 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 63, 120-123, 136-149, 151, 152, 160-174, 183-194, 238-250, 255-268, 274-287, 296, 303, 306-317, 328, 337, 338 and 349** of this bill make conforming changes to eliminate duplicative references in provisions of existing law to which those reorganized definitions apply.

Section 135 of this bill removes certain obsolete references to a program for reinsurance. **Section 150** of this bill exempts certain health benefit plans from a requirement to include certain provisions relating to reinstatement.

Sections 214 and 215 of this bill transfer certain duties of the Commissioner of Financial Institutions to the Commissioner of Mortgage Lending. **Sections 219, 321, 322 and 345** of this bill revise the conditions under which certain insurers are considered impaired or insolvent for the purpose of conforming more closely to the Insurer Receivership Model Act adopted by the National Association of Insurance Commissioners.

Sections 220 and 334 of this bill provide for the confidentiality of certain information relating to captive insurers. **Section 222** of this bill authorizes the Commissioner to exempt a pure captive insurer that only insures risks of its parent and affiliated companies or controlled unaffiliated businesses from certain provisions of existing law applicable to captive insurers generally. For a captive insurer who is not currently transacting the business of insurance and has been issued a certificate of dormancy by the Commissioner, **section 224** of this bill: (1) revises the amount of capital and surplus required of a dormant captive insurer; and (2) requires a dormant captive insurer to comply with any applicable responsibilities of the insurer which accrued before the date on

which the certificate of dormancy was issued. **Section 230** of this bill specifies the minimum amount of the annual premium tax that is required to be paid by a captive insurer in any year in which the captive insurer was not a dormant captive insurer and wrote no direct premiums or assumed no reinsurance premiums. **Section 225** of this bill eliminates a requirement for the Commissioner to adopt administrative regulations relating to the competence of an attorney with whom a captive insurer enters into a contract. **Section 226** of this bill authorizes the calculation of what constitutes an extraordinary dividend or extraordinary distribution based on the fiscal year of a captive insurer rather than a calendar year. **Sections 227 and 228** of this bill revise provisions relating to certain reporting requirements applicable to certain captive insurers for consistency in existing law among different types of captive insurers.

Sections 230 and 231 of this bill: (1) eliminate the Account for the Regulation and Supervision of Captive Insurers; and (2) redirect all fees, assessments, taxes and other sources of funds which are credited to the Account into the Fund for Insurance Administration and Enforcement.

Section 254 of this bill revises provisions relating to certain deductibles and coinsurance payments which are applicable to group contracts for hospital, medical or dental services.

Section 271 of this bill clarifies the applicability to health maintenance organizations of certain existing laws relating to network plans. **Sections 272 and 273** of this bill revise certain terminology relating to the capital and surplus of a health maintenance organization.

Sections 323-327 of this bill authorize the Commissioner to appoint a person who is not an employee of the Division of Insurance to serve as the administrative supervisor of an insurer which has been placed under administrative supervision by the Commissioner.

Section 335 of this bill designates investigators and administrators of the Division who perform certain duties relating to insurance fraud as category II peace officers, thus requiring them to meet certain training and educational requirements applicable to those officers.

Sections 339 and 341 of this bill authorize the Commissioner to adopt administrative regulations relating to cemeteries and crematories for pets.

Sections 347 and 348 of this bill: (1) require an association of self-insured public or private employers to file a corrective action plan with the Commissioner relating to certain deficiencies; and (2) authorize the Commissioner to withdraw the certificate of an association if the association fails to notify the Commissioner of such a deficiency.

Section 354 repeals provisions of existing law relating to insurance for home protection. (NRS 645.645, 690B.100-690B.180) **Section 354** also repeals a provision applicable to health insurance for small employers which is duplicative of existing law applicable to all group and blanket health insurance. (NRS 689C.320) **Sections 53, 182, 195 and 330-332** of this bill make conforming changes by removing and replacing references in existing law to provisions repealed by **section 354**.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN

SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 41, inclusive, of this act.

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 to 12, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Desk examination" means a targeted examination that is conducted at a location other than the office of the insurer or the location at which the records under review are stored.***

Sec. 4. ***"Market analysis" means the process required by sections 27 and 28 of this act whereby the Commissioner and market conduct surveillance personnel collect and analyze information to develop a baseline understanding of the marketplace and to identify patterns or practices of insurers that deviate significantly from the norm or that may pose a potential risk to a consumer of insurance.***

Sec. 5. ***1. "Market conduct action" means any action that the Commissioner may initiate to assess and address the market practices of an insurer, including, without limitation, market analysis, a targeted examination and any other action described in section 30 of this act.***

2. The term does not include any action by the Commissioner to resolve any individual complaint of a consumer or other report or a specific instance of misconduct.

Sec. 6. ***"Market conduct surveillance personnel" means any person employed by or contracted with by the Commissioner to collect, analyze, review or act on information in the insurance marketplace that identifies patterns or practices of insurers.***

Sec. 7. ***"Market conduct uniform examination procedures" means the most recent set of guidelines, developed and adopted by the National Association of Insurance Commissioners, to be used by market conduct surveillance personnel in conducting an examination.***

Sec. 8. ***"Market Regulation Handbook" means the most recent handbook, developed and adopted by the National Association of Insurance Commissioners, which:***

1. Outlines the elements and objectives of market analysis and the process by which states can establish and implement programs of market analysis; and

2. Sets forth guidelines which document established practices to be used by market conduct surveillance personnel in developing and executing an examination.

Sec. 9. ***"On-site examination" means a targeted examination that is conducted at the office of the insurer or the location at which the records under review are stored.***

Sec. 10. ***"Standardized Data Request" means the most recent set of field names and descriptions, developed and adopted by the National Association of Insurance Commissioners, for use by market conduct surveillance personnel during an examination.***

Sec. 11. ***"Targeted examination" means a focused examination based on the results of market analysis to review specific lines of business or specific business practices of an insurer as described in section 13 of this act.***

Sec. 12. *"Third-party model or product" means a model or product used by an insurer that was provided to the insurer by a person not under direct or indirect corporate control of the insurer.*

Sec. 13. *The specific lines of business or specific business practices of an insurer that may be the subject of a targeted examination include, without limitation:*

1. Underwriting and rating;

2. Marketing and sales;

3. Complaint handling operations or management;

4. Advertising materials;

5. Licensing;

6. Policyholder services;

7. Nonforfeitures;

8. Claims handling; or

9. Policy forms and filings.

Sec. 14. *If a change is made to any procedures, guidelines, handbook or other work product of the National Association of Insurance Commissioners referenced in this chapter that would materially change the manner in which a market conduct action is conducted, the Commissioner shall give notice and provide interested parties with the opportunity for a hearing to be held pursuant to NRS 679B.310 on the matter if:*

1. The change cannot be implemented without an amendment to an existing statute or regulation; or

2. The Commissioner chooses not to follow the change or otherwise deviate from the most recent version of the procedures, guidelines, handbook or other work product.

Sec. 15. *1. For the purpose of determining financial condition, fulfillment of contractual obligations and compliance with the law, the Commissioner shall, as often as he or she deems advisable, examine the affairs, transactions, accounts, records and assets of each person subject to regulation under this Code and of any person as to any matter relevant to the financial affairs of the person subject to regulation under this Code or to the examination. Except as otherwise expressly provided in this Code, the Commissioner shall so examine each authorized insurer not less frequently than every 5 years. In scheduling and determining the nature, scope and frequency of examinations, the Commissioner shall consider:*

(a) The results of any analysis or any applicable financial statement;

(b) Any change in management or ownership of the person subject to regulation under this Code;

(c) Any applicable actuarial opinion or summary;

(d) Any applicable report of an independent certified public accountant; and

(e) Any other applicable criteria set forth in the Market Regulation Handbook and most recent edition of the Financial Condition Examiners Handbook, published by the National Association of Insurance Commissioners that is in effect when the Commissioner exercises his or her discretion pursuant to this section.

2. In performing an examination pursuant to this section of a person subject to regulation under this Code, the Commissioner may examine or investigate any person, or the business of

any person, if the examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the person subject to regulation under this Code.

3. The examination of an alien insurer must be limited to its insurance transactions, assets, trust deposits and affairs in the United States, except as otherwise required by the Commissioner.

4. The Commissioner shall in like manner examine each insurer applying for an initial certificate of authority to transact insurance in this State.

5. In lieu of an examination under this chapter, the Commissioner may accept a report of the examination of a foreign or alien insurer prepared by the Division for a foreign insurer's state of domicile or an alien insurer's state of entry into the United States.

6. As far as practicable, the examination of a foreign or alien insurer must be made in cooperation with the supervisory officers of insurance of other states in which the insurer transacts business.

Sec. 16. *To ascertain compliance with law, or relationships and transactions between any person and any person subject to regulation under this Code, the Commissioner may, as often as he or she deems advisable, examine the accounts, records, documents and transactions relating to such compliance or relationships of:*

1. Any producer of insurance, solicitor, surplus lines broker, general agent, adjuster, insurer representative, bail agent, motor club agent or any other licensee or any other person the Commissioner has reason to believe may be holding himself or herself out as any of the foregoing.

2. Any person having a contract under which the person enjoys in fact the exclusive or dominant right to manage or control an insurer.

3. Any insurance holding company or other person holding the shares of voting stock or the proxies of policyholders of a domestic insurer, to control the management thereof, as voting trustee or otherwise.

4. Any subsidiary of the person subject to regulation under this Code.

5. Any person engaged in this State in, or proposing to engage in this State in, or holding himself or herself out in this State as so engaging or proposing, or in this State assisting in, the promotion, formation or financing of an insurer or insurance holding corporation, or corporation or other group to finance an insurer or the production of its business.

6. Any independent review organization, as defined in NRS 695G.026.

Sec. 17. *1. When the Commissioner determines to examine the affairs of any person, the Commissioner shall designate one or more examiners and instruct the examiner or examiners as to the scope of the 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 and the officers, attorneys, employees, agents and representatives of the person 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 which are in his or her possession or control and 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, the Commissioner may employ experts to reconstruct, rewrite, post or balance the accounts or records at the expense of the person being examined if that person has failed to maintain, complete or correct the accounts or records 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 account, record, document, file or other property of the person being examined from the offices or place of the person being examined except with the written consent of the person before removal or pursuant to an order of a court duly obtained. This provision does not affect the making and removal of copies or abstracts of any such account, record, document, file or other property.

7. Any person who refuses without just cause to be examined under oath or who willfully obstructs or interferes with an examiner in the exercise of his or her 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. 18. *1. No cause of action arises, nor may any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or any authorized representative or examiner of the Commissioner pursuant to an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent, the intent to deceive or gross negligence.*

2. The Commissioner, his or her authorized representative or any examiner appointed by the Commissioner is entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For the purposes of this subsection, an action is substantially justified if the action had a reasonable basis in law or fact at the time it was brought.

Sec. 19. *1. Except as otherwise provided in subsection 2:*

(a) The cost of an examination of an insurer, or of any person described in subsection 1, 2, 5 or 6 of section 16 of this act, must be borne by the person examined. Such costs include only the reasonable compensation and per diem allowance of the examiners of the Commissioner, including expert assistance, and incidental expenses as necessarily incurred in the examination. As to the costs incurred in any such examination, the Commissioner shall give due consideration

to scales and limitations recommended by the National Association of Insurance Commissioners and outlined in the examination manual sponsored by the Association.

(b) The person examined shall promptly pay the costs of the examination upon presentation by the Commissioner of a reasonably detailed written statement thereof.

2. The Commissioner may bill a person subject to regulation under this Code for the examination of any person referred to in subsection 1 of section 16 of this act and shall adopt regulations governing such billings.

Sec. 20. *1. All money received by the Commissioner pursuant to section 19 of this act must be deposited in the Fund for Insurance Administration and Enforcement created by NRS 680C.100.*

2. Money for travel, per diem, compensation and other necessary and authorized expenses incurred by an examiner or other representative of the Division in the examination of any person required to pay, and making payment of, the expense of examination pursuant to section 19 of this act must be paid out of the Fund for Insurance Administration and Enforcement as other claims against the State are paid.

Sec. 21. *The provisions of sections 22 to 26, inclusive, of this act apply to an examination conducted by the Commissioner other than a targeted examination.*

Sec. 22. *1. If the Commissioner deems it necessary to value any asset involved in an examination, the Commissioner may submit a written request to the person being examined to appoint one or more appraisers who by reason of education, experience or special training, and disinterest, are competent to appraise the asset. Selection of any such appraiser must be subject*

to the written approval of the Commissioner. If no such appointment is made within 10 days after the request was delivered to the person, the Commissioner may appoint the appraiser or appraisers.

2. Any such appraisal must be expeditiously made, and a copy of the appraisal furnished to the Commissioner and to the person being examined.

3. The reasonable costs of the appraisal must be borne by the person being examined.

Sec. 23. *1. Not later than 60 days after the completion of an examination, the examiner designated by the Commissioner shall file a verified report of examination, in writing, which must be comprised only of facts appearing upon the books, records or other documents of the person subject to regulation under this Code, the agents of the person or other persons examined concerning the affairs of the person, or as ascertained from the testimony of the officers or agents of the person or other persons examined concerning the affairs of the person, and such conclusions and recommendations as the examiner finds reasonably warranted from the facts. The report of examination must be verified by the oath of the examiner making the report.*

2. The report of examination of a person subject to regulation under this Code verified pursuant to subsection 1 is prima facie evidence in any action or proceeding for the receivership, conservation or liquidation of the person brought in the name of the State against the person, or the officers or agents of the person, upon the facts stated therein.

Sec. 24. *1. Upon receipt of the verified report of examination pursuant to section 23 of this act, the Commissioner shall deliver a copy of the report to the person examined with a notice affording the person 10 days or such additional reasonable period as the Commissioner for good*

cause may allow within which to review the report and make a written submission or rebuttal with respect to recommended changes or any matters contained in the report.

2. Within 30 days after the end of the period allowed for the receipt of written submissions or rebuttals, the Commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's working papers and enter an order:

(a) Adopting the report as filed or with modification or corrections;

(b) Rejecting the report with directions to the examiner to reopen the examination for purposes of obtaining additional data, documentation or information, and requiring the refiling of the report pursuant to subsection 1 of section 23 of this act; or

(c) For an investigatory hearing for purposes of obtaining additional documentation, data, information and testimony.

3. If the report reveals that a person subject to regulation under this Code is operating in violation of any law, regulation or previous order of the Commissioner, the Commissioner may order the person to take any action the Commissioner considers necessary or appropriate to cure the violation.

Sec. 25. *1. If requested by the person examined, within the period allowed under subsection 1 of section 24 of this act, or if ordered pursuant to subsection 2 of that section, the Commissioner shall hold a hearing relative to the report and shall not file the report in the Division for public inspection until after the hearing and the order of the Commissioner thereon.*

2. If no hearing has been requested or ordered, the report of examination, with modifications, if any, as the Commissioner deems proper, must be filed in the Division for public inspection within 30 days after the expiration of the period allowed for review by the person examined. Otherwise the report must be so filed within 30 days after final hearing thereon, except that the Commissioner may withhold from public inspection any report for so long as the Commissioner deems such withholding to be necessary for the protection of the person examined against unwarranted injury or to be in the public interest.

3. The Commissioner shall forward to the person examined a copy of the report of examination as filed, together with any recommendations or statements relating thereto which the Commissioner deems proper.

4. If the report concerns the examination of a domestic insurer, a copy of the report, or a summary thereof approved by the Commissioner must be presented by the insurer's chief executive officer to the insurer's board of directors or similar governing body at its next regular board meeting. A copy of the report must also be furnished by the secretary of the insurer, if incorporated, or by the attorney-in-fact if a reciprocal insurer, within 30 days after receipt of the report in final form by the insurer, to each member of the insurer's board of directors or similar governing body, and the certificate of the secretary or attorney-in-fact that a copy of the report of examination has been so furnished shall be deemed to constitute knowledge of the contents of the report by each such member.

Sec. 26. *1. The Commissioner may disclose the content of a report of examination, 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 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, NRS 239.0115 and subsection 4 of section 25 of this act. 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 person to which it pertains has been obtained.

Sec. 27. *For the purpose of conducting the analysis required by section 28 of this act, the Commissioner and market conduct surveillance personnel shall collect information from:*

1. Data currently available to the Division;

2. Surveys and required reporting requirements;

3. Information collected by the National Association of Insurance Commissioners;

4. Other sources in public and private sectors; and

5. Other sources from within and outside the insurance industry.

Sec. 28. *1. The Commissioner and market conduct surveillance personnel shall analyze the information collected pursuant to section 27 of this act to develop a baseline understanding of the marketplace and to identify for further review any insurer or pattern or practice of an insurer that deviates significantly from the norm or that may pose a potential risk to a consumer of insurance.*

2. The Commissioner and market conduct surveillance personnel shall use the Market Regulation Handbook as one resource in performing the analysis required by subsection 1.

Sec. 29. *Except as otherwise provided by law, every insurer or other person from whom information is sought in connection with a market conduct action, including the officers, directors and agents of the insurer or other person, shall provide the Commissioner or market conduct surveillance personnel convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the insurer. The officers, directors, employees, producers of insurance and agents of the insurer or other person shall facilitate market conduct actions and aid in market conduct actions so far as it is in their power to do so.*

Sec. 30. *1. If the Commissioner determines, as the result of market analysis, that further inquiry into an insurer or a pattern or practice of an insurer is needed, the Commissioner may, subject to section 32 of this act, initiate an on-site examination or, before initiating an on-site examination, initiate one or more other market conduct actions, including, without limitation:*

(a) Correspondence with the insurer.

(b) An interview with the insurer.

(c) Information gathering.

(d) Policy and procedure reviews.

(e) Interrogatories.

(f) A review of any self-evaluation or compliance program of the insurer, including, without limitation, membership in a best practices organization.

(g) A desk examination.

(h) Any other investigation, review or other action the Commissioner deems appropriate to assess the market practices of the insurer.

2. Any market conduct action initiated by the Commissioner must:

(a) Be cost effective for the Division and the insurer;

(b) Provide for the protection of consumers of insurance; and

(c) Focus on the general business practices and compliance activities of the insurer rather than on identifying infrequent or unintentional errors that do not cause significant harm to consumers of insurance.

3. Before initiating a market conduct action, the Commissioner may provide the insurer an opportunity to resolve any concerns of the Commissioner raised by market analysis to the satisfaction of the Commissioner.

4. The Commissioner shall notify an insurer in writing if the Commissioner initiates a market conduct action which requires a response or other participation from the insurer.

5. The Commissioner shall take reasonable steps to eliminate duplicative inquiries and coordinate market conduct actions and findings with other states.

Sec. 31. ***1. The Commissioner may determine the frequency and timing of market conduct actions. In determining the frequency and timing of market conduct actions, the Commissioner shall consider:***

(a) The specific market conduct action to be initiated; and

(b) Whether extraordinary circumstances indicating a risk to consumers warrant immediate action.

2. If the Commissioner has reason to believe that more than one insurer is engaged in common practices that constitute grounds for initiating a market conduct action, the Commissioner may schedule and coordinate more than one market conduct action simultaneously.

3. The Commissioner shall conduct any targeted examination in accordance with the Market Regulation Handbook and the market conduct uniform examination procedures.

4. To the greatest extent possible, the Division shall use the Standardized Data Request during a targeted examination. The Division may adopt by regulation a successor product to the Standardized Data Request if the Commissioner determines the successor product is substantially similar.

5. In lieu of a targeted examination of a foreign or alien insurer licensed in this State, the Commissioner may accept an examination report of another state if the Commissioner determines that the state has a market surveillance system that is comparable to the provisions of this chapter.

Sec. 32. *1. To the greatest extent possible, the Commissioner shall consider initiating a desk examination or other market conduct action described in section 30 of this act before initiating an on-site examination.*

2. If the Commissioner determines that other market conduct actions identified in section 30 of this act are not appropriate or if the Commissioner has already conducted another market conduct action but determines that further inquiry into an insurer or the pattern or practices of an insurer is warranted, the Commissioner may initiate and conduct an on-site examination.

3. If the Commissioner schedules an on-site examination, the Commissioner shall post notice of that fact, in accordance with the requirements set forth in section 34 of this act, on the system for tracking examinations maintained by the National Association of Insurance Commissioners or its successor product or organization, as determined by the Commissioner.

Sec. 33. *Before conducting an on-site examination, market conduct surveillance personnel shall prepare a work plan for the examination that must include, without limitation:*

1. The name and address of the insurer to be examined;

2. The name and contact information of a lead examiner who will oversee the examination;

3. Notice of any personnel from outside the Division who will assist in the examination;

4. The justification for the on-site examination;

5. The scope of the on-site examination;

6. The date on which the on-site examination is scheduled to begin;

7. An estimate of the length of time that the on-site examination will take;

8. A budget for the on-site examination; and

9. The factors which will be included in the billing for the on-site examination.

Sec. 34. *1. Except as otherwise provided in subsection 3, not later than 60 days before the date on which an on-site examination is scheduled to begin, the Commissioner shall:*

(a) Send to the insurer:

(1) Notice in writing of that fact;

(2) The work plan prepared pursuant to section 33 of this act; and

(3) A request for the insurer to name an examination coordinator and to provide the name and contact information of that person to the Commissioner.

(b) Post notice of that fact on the system for tracking examinations maintained by the National Association of Insurance Commissioners or its successor product or organization, as determined by the Commissioner.

2. Except as otherwise provided in subsection 3, not later than 30 days before the date on which an on-site examination is scheduled to begin, the Commissioner shall conduct a pre-examination conference with the examination coordinator named by the insurer pursuant to paragraph (a) of subsection 1 and any other key personnel, as determined by the Commissioner or examination coordinator, as applicable.

3. If the on-site examination is initiated in response to extraordinary circumstances pursuant to paragraph (b) of subsection 1 of section 31 of this act, the Commissioner shall comply with the provisions of this section as soon as is practicable.

4. Before completing an on-site examination, the lead examiner named in the work plan prepared pursuant to section 33 of this act shall conduct an exit conference with the insurer.

5. As soon as is practicable after completing the examination, the Commissioner shall send notice in writing to the insurer confirming the date on which the on-site examination was completed.

Sec. 35. *1. Except by mutual agreement in writing between the Commissioner and the insurer to modify the following timeline:*

(a) Not later than 60 days after the date on which an on-site examination is confirmed as complete pursuant to subsection 5 of section 34 of this act, the Commissioner shall send a draft report of examination results to the insurer.

(b) Not later than 30 days after the date on which the insurer receives the draft report of examination results described in paragraph (a), the insurer may send any written comments related to the draft report to the Commissioner. The insurer is not required by this paragraph to submit written comments. If the insurer submits written comments pursuant to this paragraph, the comments must not include the name of any person involved in any aspect of the examination, except that the name of a person may be included to acknowledge the involvement of the person in the examination.

(c) Not later than 30 days after the date on which the Commissioner receives any written comments from the insurer pursuant to paragraph (b), or not later than 60 days after the date on which the Commissioner sent the draft report pursuant to paragraph (a) if the insurer does not submit any written comments, the Commissioner shall send a final report of examination results to the insurer in compliance with the requirements of subsections 2 and 3.

(d) Not later than 30 days after the date on which the insurer receives the final report of examination results, the insurer shall be deemed to accept the final report and the findings of the final report unless the insurer:

(1) Makes a written application for a hearing pursuant to NRS 679B.310; or

(2) Makes a written request for a one-time extension from the Commissioner of 30 additional days. The Commissioner may grant a request for extension submitted pursuant to this subparagraph if the Commissioner determines it is appropriate.

2. The Commissioner may make revisions or corrections to the report of examination results at any time after sending a draft report to the insurer pursuant to paragraph (a) of subsection 1 and before sending a final report to the insurer pursuant to paragraph (c) of subsection 1. If the insurer submits any written comments related to the draft report pursuant to paragraph (b) of subsection 1, the Commissioner:

(a) Shall make a good faith effort to informally resolve any issues raised in the written comments; and

(b) Except as otherwise provided in subsection 3, shall include the written comments in the final report of examination results, either in the body of the report or as an appendix.

3. The final report of examination results must not include the name of any person involved in any aspect of the examination, except that the name of a person may be included to acknowledge the involvement of the person in the examination. If the insurer submits written comments pursuant to paragraph (b) of subsection 1 in violation of the requirements of that

paragraph, the Commissioner shall redact the written comments in compliance with the requirements of this subsection before including the written comments in the final report.

Sec. 36. *1. Except as otherwise provided in this section, the Commissioner shall keep confidential the final report of examination results created pursuant to section 35 of this act for not less than 30 days after:*

(a) The date on which the insurer accepts the report or is deemed to accept the report; or

(b) The date on which any proceedings related to a hearing requested by the insurer pursuant to NRS 679B.310 have concluded.

2. So long as a court of competent jurisdiction has not stayed the publication of the final report of examination results created pursuant to section 35 of this act, the Commissioner shall make the final report open for public inspection after the period of confidentiality described in subsection 1 has expired.

3. Nothing in this chapter shall be construed to prevent the Commissioner from disclosing to the insurance regulatory body of any other state or agency of the Federal Government, at any time, any information discovered in the course of or the results of targeted examination or any matter relating thereto, including, without limitation, any draft report or final report of examination results, if the state, agency or office receiving the information, results or report agrees to hold the information, results or report confidential in accordance with the provisions of this chapter.

Sec. 37. *1. Except as otherwise provided by law, in the course of any market conduct action, market conduct surveillance personnel shall have free and full access to all books and*

records, employees, officers and directors, as practicable, of an insurer during regular business hours.

2. An insurer utilizing a third-party model or product for any of the activities which are the subject of a market conduct action shall, upon the request of market conduct surveillance personnel, make the details of the third-party model or product available.

3. All documents created, produced, disclosed to or obtained by the Commissioner, the National Association of Insurance Commissioners or any other person in the course of market analysis or any other market conduct action shall be confidential and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. For the purposes of this subsection, the term "documents" includes, without limitation, working papers, third-party models or products, complaint logs and any copies of the foregoing.

4. Disclosure from an insurer to the Commissioner of any documents, materials or other information subject to the provisions of this section shall not be construed as a waiver of any applicable privilege or claim of confidentiality.

Sec. 38. *Notwithstanding the provisions of section 37 of this act, the Commissioner may, in order to assist in the performance of his or her duties:*

1. Share documents, materials and other information, including confidential and privileged documents, materials and other information, with an agency of any other state or country that regulates insurance, law enforcement officers of this or any other state, an agency of the Federal Government or the National Association of Insurance Commissioners and its

affiliates and subsidiaries, if the recipient of the information has the legal authority to and agrees to maintain the confidential and privileged status of the information;

2. Receive documents, materials and other information, including confidential and privileged documents, materials and other information, from an agency of any other state or country that regulates insurance, law enforcement officers of this or any other state, an agency of the Federal Government or the National Association of Insurance Commissioners and its affiliates and subsidiaries, if the Commissioner maintains the confidential and privileged status of any information received with notice of or the understanding that it is confidential or privileged under the laws of the jurisdiction where the document, material or other information originated; and

3. Enter into agreements governing the sharing and use of documents, materials and other information consistent with this chapter.

Sec. 39. *1. Market conduct surveillance personnel must be qualified by education, experience and, where applicable, professional designations. The Commissioner may contract with qualified outside market conduct surveillance personnel to supplement existing market conduct surveillance personnel if the Commissioner determines assistance is necessary.*

2. Except as otherwise provided in subsection 3, market conduct surveillance personnel have a conflict of interest in a market conduct action pursuant to the provisions of this chapter if the market conduct surveillance personnel directly or indirectly:

(a) Are affiliated with the management of the insurer subject to the market conduct action;

(b) Have been employed by the insurer subject to the market conduct action; or

(c) Own a pecuniary interest in the insurer subject to the market conduct action.

3. Nothing in the provisions of subsection 2 shall be construed to automatically preclude a person from being:

(a) A policyholder or claimant under a policy of insurance;

(b) A grantee of a mortgage or similar instrument on the residence of the person from a regulated entity, if under customary terms and in the ordinary course of business;

(c) An owner of an investment in shares of regulated diversified investment companies; or

(d) A settlor or beneficiary of a blind trust into which any otherwise permissible holding has been placed.

Sec. 40. *1. Any fine or other penalty levied as the result of a market conduct action must be consistent, reasonable and justified.*

2. In determining whether a fine or penalty is consistent, reasonable and justified, the Commissioner shall consider:

(a) Any actions taken by the insurer to maintain membership in and comply with the standards of any best practices organizations that promote high ethical standards of conduct in the marketplace; and

(b) The extent to which the insurer maintains any program of regulatory compliance to assess, report and remediate any problems detected by the insurer.

Sec. 41. *1. The Commissioner shall report data which is collected during market analysis to the market information systems which are used by the National Association of Insurance Commissioners, or successor products as determined by the Commissioner, including, without*

limitation, the Complaints Database System, the Examination Tracking System and the Regulatory Information Retrieval System.

2. The Division shall compile and maintain data and other information in a manner that meets the requirements of the National Association of Insurance Commissioners.

3. The Commissioner shall share information and coordinate the market analysis and examination efforts of the Division with other states through the National Association of Insurance Commissioners.

Sec. 42. Chapter 679B of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the Governor or the Legislature proclaims the existence of a state of emergency or issues a declaration of disaster pursuant to NRS 414.070, the Commissioner may issue an order that addresses any or all of the following matters related to policies issued in this State:

(a) Reporting requirements for claims;

(b) Grace periods for payment of insurance premiums and performance of other duties by an insured; or

(c) Temporary postponement of cancellations and nonrenewals.

2. An order issued pursuant to subsection 1:

(a) Must be approved by the Governor;

(b) Is effective for not more than 30 days unless the Commissioner, with the approval of the Governor, extends the order for an additional period of not more than 30 days or any subsequent additional period of not more than 30 days.

(c) Must specify, by line of insurance:

(1) The geographic areas in which the order applies, which must be:

(I) Within, but may be less extensive than, the geographic area specified in the proclamation of the existence of a state of emergency or declaration of disaster; and

(II) Specified by an appropriate means of delineation which may include, without limitation, delineation by zip code; and

(2) The date on which the order becomes effective and the date on which the order terminates.

3. The Commissioner shall adopt regulations that establish general criteria for an order issued pursuant to subsection 1.

4. Nothing in this section prohibits the Commissioner from adopting an emergency regulation in accordance with chapter 233B of NRS relating to a specific proclamation of a state of emergency or declaration of disaster or otherwise limits or affects the regulatory authority of the Commissioner as provided by law.

Sec. 43. NRS 679B.139 is hereby amended to read as follows:

679B.139 1. The Commissioner may adopt regulations governing plans for providing welfare benefits to employees of more than one employer. The regulations must provide standards requiring the maintenance of specified levels of reserves and specified levels of contributions which any such plan, or any trust established under such a plan, must meet. If a plan does not meet the standards, no benefits may be paid under the plan.

2. The Commissioner may conduct an examination of any insurer which administers a plan for providing welfare benefits to employees of more than one employer to determine whether the insurer is complying with the Commissioner's regulations. The cost of the examination must be borne by the insurer in the manner provided in ~~[NRS 679B.290.]~~ ***section 19 of this act.*** If the Commissioner determines that the insurer is not complying with the Commissioner's regulations, the Commissioner shall require the insurer not to pay benefits under the plan.

3. As used in this section, the term "plan for providing welfare benefits for employees of more than one employer" is intended to be equivalent to the term "employee welfare benefit plan which is a multiple employer welfare arrangement" as used in federal statutes and regulations.

Sec. 44. 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. 45. NRS 679B.145 is hereby amended to read as follows:

679B.145 The Commissioner shall:

1. Publish a guide to rates for policies of insurance for motor vehicles which contains:

(a) An explanation of the various types of coverage available.

(b) A list of all insurers which offer insurance for motor vehicles in Nevada.

(c) ~~[Comparisons of the cost for each type of insurance when purchased from the five insurers who offer it at the highest price and the five insurers who offer it at the lowest price, using one or more hypothetical examples developed by the Commissioner.~~

~~(d)]~~ Any other information which the Commissioner deems appropriate and useful to the public.

2. Maintain the guide by republishing it with revised information ~~[at least once each year.]~~ ***if the Commissioner determines market conditions have changed enough to warrant an update.***

3. Distribute the guide and the information contained in the guide in any manner the Commissioner deems appropriate.

Sec. 46. NRS 679B.152 is hereby amended to read as follows:

679B.152 1. Every insurer or organization for dental care which pays claims on the basis of ***usual and customary*** fees ~~[for medical]~~ or ~~[dental care which are "usual and customary"]~~ ***other reimbursement methodology*** shall submit to the Commissioner a complete description of the method it uses to determine those fees ~~[.]~~ ***or of the other methodology, as applicable.*** Except as otherwise provided in NRS 239.0115, this information must be kept confidential by the Commissioner. The fees ~~[determined]~~ ***or methodology submitted*** by the insurer or organization ~~[to be the usual and customary fees]~~ for ~~[that]~~ ***dental*** care are subject to the approval of the

Commissioner as being the usual and customary fees ***or an appropriate reimbursement methodology*** in that locality. ~~[The]~~ ***Except as otherwise provided in subsection 3, the*** provisions of this subsection apply to medical or dental care provided to a claimant under any contract of insurance.

2. Any contract for group, blanket or individual health insurance and any contract issued by a nonprofit hospital, medical or dental service corporation or organization for dental care, which provides a plan for dental care to its insureds or members which limits their choice of a dentist, under the plan to those in a preselected group, must offer its insureds or members the option of selecting a plan of benefits which does not restrict the choice of a dentist. The selection of that option does not entitle the insured or member to any increase in contributions by his or her employer or other organization toward the premium or cost of the optional plan over that contributed under the restricted plan.

3. The provisions of subsection 1 do not apply to fees or reimbursement methodologies used to reimburse a participating provider of health care under a network plan issued pursuant to NRS 687B.600 to 687B.850, inclusive.

Sec. 47. 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, ***an attorney employed by the Division or*** the Attorney General shall act as legal counsel to the Division and the Commissioner in all matters pertaining to the administration and enforcement of this Code.

Sec. 48. NRS 679B.220 is hereby amended to read as follows:

679B.220 1. The Commissioner shall communicate on request of the regulatory officer for insurance in any state, province or country any information which it is the duty of the Commissioner by law to ascertain respecting authorized insurers.

2. The Commissioner may:

(a) Be a member of the National Association of Insurance Commissioners or any successor organization **.** ~~[,]~~

(b) Exchange with the ~~[association]~~ ***Association*** or any successor organization any information, not otherwise confidential, relating to applicants and licensees under this title **.** ~~[;]~~

(c) Communicate with the ~~[association]~~ ***Association*** or any successor organization concerning the business of insurance generally **.** ~~[;]~~

(d) ***Enter into contracts with or through the Association or any successor organization for goods and services related to the regulation of insurance. Any contract entered into pursuant to this paragraph is not subject to the provisions of chapter 333 of NRS.***

(e) Enter into compacts with the regulatory officers in other states to:

(1) Further the uniform treatment of insurers throughout the United States;

(2) Ensure market stability; or

(3) Ensure essential insurance is made available to Nevada residents ***.*** ~~[; and~~

~~(e)]~~ ***(f)*** Participate in and support other cooperative activities of public officers having supervision of the business of insurance.

Sec. 49. 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 80 to 93, inclusive, of this act;*** or

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

Sec. 50. NRS 680A.120 is hereby amended to read as follows:

680A.120 1. Except as ***otherwise*** provided in ~~[subsections 2 and 5,]~~ ***subsection 4,*** 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 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 surplus, and when first so authorized shall possess 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]~~ ***2,000,000***	500,000	~~[1,000,000]~~ ***2,000,000***	N/A	N/A
Health, Property, Casualty, Surety, Marine & Transportation Multiple line	500,000	~~[1,000,000]~~ ***2,000,000***	500,000	~~[1,000,000]~~ ***2,000,000***	500,000	~~[1,000,000]~~ ***2,000,000***
Title	500,000	~~[750,000]~~ ***1,500,000***	N/A	N/A	N/A	N/A

Financial

~~[Guarantee]~~

Guaranty.....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.]~~ ***3.*** 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.]~~ ***4.*** 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.

Sec. 51. 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 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 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 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 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 ***limit or*** 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. 52. 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

(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. 53. 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) 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. 54. NRS 681B.400 is hereby amended to read as follows:

681B.400 1. The following types of information shall qualify as confidential information:

(a) A memorandum in support of an opinion submitted pursuant to NRS 681B.200 to 681B.260, inclusive, or 681B.350 and any other documents, materials and other information, including, without limitation, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such memorandum;

(b) All documents, materials and other information, including, without limitation, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in the course of an examination authorized by subsection 4 of ~~[NRS 679B.230]~~ ***section 15 of this act*** or subsection 7 of NRS 681B.300, provided that if an examination report or other material prepared in connection with an examination authorized by ~~[NRS 679B.230 to~~

~~679B.300,~~] ***sections 2 to 41,*** inclusive, ***of this act,*** is not held as private and confidential information in accordance with the provisions of ~~[NRS 679B.230 to 679B.300,~~] ***sections 2 to 41,*** inclusive, ***of this act,*** an adopted examination report created in accordance with the provisions of subsection 4 of ~~[NRS 679B.230]~~ ***section 15 of this act*** or subsection 7 of NRS 681B.300 shall not be deemed confidential information;

(c) Any reports, documents, materials and other information developed by an applicable company in support of, or in connection with, an annual certification by the applicable company in accordance with the provisions of paragraph (b) of subsection 1 of NRS 681B.360 evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation, and any other documents, materials and other information, including, without limitation, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such reports, documents, materials and other information;

(d) Any principle-based valuation report developed in accordance with paragraph (c) of subsection 1 of NRS 681B.360, and any other documents, materials and other information, including, without limitation, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such report; and

(e) Any experience data and experience materials, and any other documents, materials, data and other information, including, without limitation, all working papers, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in connection with such data and materials.

2. As used in this section:

(a) "Experience data" means all documents, materials, data and other information submitted by an applicable company to the Commissioner, a designated experience reporting agent or other such person authorized to act on behalf of the Commissioner pursuant to NRS 681B.500 and 681B.510.

(b) "Experience materials" means all documents, materials, data and other information, including, without limitation, all working papers, and copies thereof, created or produced in connection with experience data including, without limitation, any potentially company-identifying or personally identifiable information, that is provided to or obtained by the Commissioner, a designated experience reporting agent or other such person authorized to act on behalf of the Commissioner pursuant to NRS 681B.500 and 681B.510.

Sec. 55. Chapter 683A of NRS is hereby amended by adding thereto a new section to read as follows:

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, not later than 30 days after the date of the final disposition of the matter. The report must include, without limitation, 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, not later than 30 days after the date of the initial pretrial hearing. The report must include, without limitation, a

copy of the complaint filed, any order issued after the pretrial hearing and any other relevant legal documents.

Sec. 56. 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 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) ***Administers a service contract, as defined in NRS 690C.080; or***

(h) 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),]~~ ***(g),*** 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)]~~ ***(h)*** 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. 57. NRS 683A.0805 is hereby amended to read as follows:

683A.0805 As used in NRS 683A.0805 to 683A.0893, inclusive, ***and section 55 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. 58. 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 accepted accounting principles ~~[.]~~ ***, statutory accounting principles or other recognized financial standards as the Commissioner may allow;*** 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.

(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]~~ ***resident*** in this State, a copy of the license, certificate or other authorization issued by the state in which the applicant is ~~[domiciled]~~ ***resident*** which authorizes the applicant to act as an administrator in that state, if any.

12. Any other information required by the Commissioner.

Sec. 59. 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. 60. 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]~~ ***return*** the books and records ~~[from the State, store their contents on microfilm 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,]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.***

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. 61. NRS 683A.0877 is hereby amended to read as follows:

683A.0877 1. All insurance charges and premiums collected by an administrator on behalf of an insurer and return premiums received from an insurer are held by the administrator in a fiduciary capacity.

2. Money must be remitted within 15 days to the person or persons entitled to it, or be deposited within 15 days in one or more fiduciary accounts established and maintained by the administrator in a bank, credit union or other financial institution . ~~[in this state.]~~ The fiduciary accounts must be separate from the personal or business accounts of the administrator.

3. If charges or premiums deposited in an account have been collected for or on behalf of more than one insurer, the administrator shall cause the bank, credit union or other financial institution where the fiduciary account is maintained to record clearly the deposits and withdrawals from the account on behalf of each insurer.

4. The administrator shall promptly obtain and keep copies of the records of each fiduciary account and shall furnish any insurer with copies of the records which pertain to him or her upon demand of the insurer.

5. The administrator shall not pay any claim by withdrawing money from his or her fiduciary account in which premiums or charges are deposited.

6. Withdrawals must be made as provided in the agreement between the insurer and the administrator for:

(a) Remittance to the insurer.

(b) Deposit in an account maintained in the name of the insurer.

(c) Transfer to and deposit in an account for the payment of claims.

(d) Payment to a group policyholder for remittance to the insurer entitled to the money.

(e) Payment to the administrator of the commission, fees or charges of the administrator.

(f) Remittance of return premiums to persons entitled to them.

7. The administrator shall maintain copies of all records relating to deposits or withdrawals and, upon the request of an insurer, provide the insurer with copies of those records.

Sec. 62. 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 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 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 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 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:***

(1) The Commissioner suspends the certificate of registration of the administrator pursuant to paragraph (d); and

(2) The administrator or a responsible person has not responded to the notice required by paragraph (d) 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. 63. 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]~~ ***has*** the ~~[financing and delivery of medical care is provided, in whole or]~~ ***meaning ascribed to it*** 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.]~~ ***NRS 687B.645.***

Sec. 64. 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 ***notice and 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 nor more than $500 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. 65. NRS 683C.018 is hereby amended to read as follows:

683C.018 The provisions of chapters 679A and 679B of NRS ***, sections 2 to 41, inclusive, of this act,*** and NRS 683A.301, 683A.341 and 683A.351 apply to an insurance consultant.

Sec. 66. 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. 67. 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. 68. 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 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. 69. 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 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. 70. 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. 71. 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]~~ ***Except as otherwise provided in paragraph (d) of subsection 1 of NRS 684A.115, 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; 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. 72. 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. 73. 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) 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. 74. 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. 75. 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. 76. 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. 77. 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,]~~ ***property and casualty insurance,*** 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:

(a) Application for a license and payment of all applicable fees for a license;

(b) Submitting the statement required pursuant to NRS 685A.127; and

(c) Passing 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. 78. 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 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. 79. Chapter 686A of NRS is hereby amended by adding thereto the provisions set forth as sections 80 to 93, inclusive, of this act.

Sec. 80. ***1. Except as otherwise provided in subsection 2 or 3, an insurer shall not refuse to insure, refuse to continue to insure or limit the amount of coverage available to a person on the basis of race, religion, sex, marital status or national origin.***

2. The provisions of this section do not prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits.

3. The provisions of this section do not prohibit or limit the operation of fraternal benefit societies authorized to do business in this State pursuant to chapter 695A of NRS.

Sec. 81. *1. An insurer shall maintain its books, documents and other business records, including, without limitation, recordings:*

(a) In such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the Commissioner; and

(b) For a period of not less than 5 years after the date on which the book, document or other business record was created.

2. An insurer shall maintain a complete record of all complaints received since the date of the most recent examination conducted pursuant to sections 2 to 41, inclusive, of this act, which must include, without limitation:

(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 for the insurer to process each complaint.

3. As used in this section, "complaint" means any communication made in writing, by telephone or by electronic mail which primarily expresses a grievance.

Sec. 82. *A person shall not make false or fraudulent statements or representations on or relating to an application for a policy for the purpose of obtaining a fee, commission, money or other benefit.*

Sec. 83. *1. Except as otherwise provided in subsection 3 or 4, an insurer that issues policies of property and casualty insurance shall provide to a primary insured, within 30 days*

after the date on which the primary insured makes a written request for such information, the following loss information for the 3 policy years immediately preceding the date of the request:

(a) For all claims, the date and description of the claim and the total amount of payments; and

(b) For any other occurrence not described in paragraph (a), the date and description of the occurrence.

2. If a prospective insurer requests that a primary insured provide detailed loss information which is beyond the scope of the information described in subsection 1, the primary insured may submit to the insurer, by mail, electronic mail or other means, a written request for the additional information. A prospective insurer shall not request more detailed loss information than is reasonably required to underwrite the same line or class of insurance.

3. Except as otherwise provided in subsection 4, an insurer that receives a written request from a primary insured pursuant to subsection 2 shall provide the information to the insured as soon as practicable, but in no event later than 20 days after the date on which the insurer receives the written request.

4. The provisions of this section do not require an insurer to provide loss reserve information. A prospective insurer shall not refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

Sec. 84. *As used in sections 84 to 93, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 85 to 88, inclusive, of this act have the meanings ascribed to them in those sections.*

Sec. 85. *"Domestic violence" has the meaning ascribed to it in NRS 33.018.*

Sec. 86. *"Domestic violence related medical condition" means a medical condition sustained by a subject of domestic violence which arises in whole or in part from an act or pattern of domestic violence.*

Sec. 87. *"Domestic violence status" means the fact or perception that a person is, has been or may be a subject of domestic violence, without regard to whether the person has sustained a domestic violence related medical condition.*

Sec. 88. *"Insurance professional" means a producer of insurance, adjuster or administrator licensed pursuant to the provisions of this title.*

Sec. 89. *"Subject of domestic violence" means a person:*

1. Against whom an act of domestic violence has been directed;

2. Who has a past or current injury, illness or disorder that resulted from domestic violence or other domestic violence related medical condition; or

3. Who seeks, may have sought or had reason to seek:

(1) Medical or psychological treatment for domestic violence; or

(2) Protection or shelter from domestic violence, including, without limitation, a temporary or extended order for protection issued by a court.

Sec. 90. *1. Except as otherwise provided in subsection 2, a person shall not:*

(a) Deny, refuse to issue, refuse to renew or reissue, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to a policy of insurance for an applicant or insured on the basis of the domestic violence status of the applicant or insured; or

(b) Except as otherwise permitted or required by the laws of this State relating to acts of domestic violence committed by an insurance beneficiary, exclude, limit or deny benefits on a policy of insurance on the basis of the domestic violence status of an insured, including, without limitation, denying a claim solely because the claim involves an act that constitutes domestic violence.

2. The provisions of this section do not prohibit an insurer or insurance professional from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy, and:

(a) The applicant or prospective owner of the policy lacks an insurable interest in the insured;

(b) The applicant or prospective owner of the policy is known, on the basis of medical, law enforcement or court records, to have committed an act of domestic violence against the proposed insured; or

(c) The insured or prospective insured:

(1) Is a subject of domestic violence; and

(2) Has objected to, or a person who has assumed the care of the insured or prospective insured if a minor or incapacitated person has objected to, the policy on the grounds that the policy would be issued to or for the direct or indirect benefit of the perpetrator of domestic violence.

Sec. 91. ***1. A person shall not engage in any conduct that is unfairly discriminatory pursuant to this section.***

2. If an insurer or insurance professional has information in its possession that clearly indicates that an insured or applicant is a subject of domestic violence, it is unfairly discriminatory for a person employed by or contracting with the insurer or insurance professional to disclose or transfer confidential domestic violence information for any purpose or to any person, except where the disclosure or transfer is made:

(a) To the insured or applicant who is a subject of domestic violence or a person who is designated in writing by the insured or applicant. Nothing in this section shall be construed to preclude a subject of domestic violence from obtaining his or her insurance records.

(b) To a provider of health care:

(1) For the direct provision of health care services; or

(2) Who is designated in writing by the insured or applicant who is a subject of domestic violence.

(c) Pursuant to an order of the Commissioner or a court of competent jurisdiction or otherwise required by law.

(d) When necessary for a valid business purpose to transfer information that contains confidential domestic violence information which cannot reasonably be segregated, without undue hardship. Confidential domestic violence information may be disclosed pursuant to this paragraph only:

(1) If the recipient of the information executes a written agreement to be bound by the prohibitions of this section in all respects and to be subject to the jurisdiction of the courts of this State for enforcement of this section for the benefit of the applicant or insured; and

(2) To the following persons:

(I) A reinsurer that indemnifies or seeks to indemnify all or any part of a policy covering a subject of domestic violence and that cannot underwrite or satisfy its obligations under the reinsurance agreement without the disclosure of the information;

(II) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(III) Medical or claims personnel contracting with the insurer or insurance professional, only if necessary to process an application, to perform the duties of the insurer or insurance professional under the policy or to protect the safety or privacy of a subject of domestic violence; or

(IV) If the confidential domestic violence information is an address or telephone number, to persons or entities with whom the insurer or insurance professional transacts business only where the business cannot be transacted without the address or telephone number.

(e) To an attorney who needs the information to represent the insurer or insurance professional effectively, if the insurer or insurance professional:

(1) Notifies the attorney of obligations of the insurer or insurance professional under this section; and

(2) Requests that the attorney exercise due diligence to protect the confidential domestic violence information consistent with the obligation of the attorney to represent the insurer or insurance professional.

(f) To the owner of the policy or assignee, in the course of delivering the policy, if the policy contains information about domestic violence status.

(g) To any other person or entity deemed appropriate by the Commissioner.

3. Except as otherwise provided in subsection 4, it is unfairly discriminatory to:

(a) Request information about acts of domestic violence or domestic violence status or make use of that information, however obtained, except where the request for or use of information is for the purpose of complying with a legal obligation or to verify a claim that a person is a subject of domestic violence.

(b) Except as otherwise provided in this paragraph, terminate coverage under a policy of group health insurance for a subject of domestic violence because coverage was originally issued in the name of the perpetrator of domestic violence, and the perpetrator has divorced, separated from or lost custody of the subject of domestic violence or the coverage of the perpetrator has been terminated voluntarily or involuntarily. The provisions of this paragraph do not prohibit an insurer or insurance professional from requiring the subject of domestic violence to pay the full premium for coverage under the policy of group health insurance or from requiring, as a condition of coverage, that the subject of domestic violence reside or work within the geographic service area of the insurer or insurance professional. If the insurer or insurance professional offers conversion to an equivalent individual plan, the insurer or insurance professional may terminate the coverage under a policy of group health insurance after the continuation coverage required by this paragraph has been in force for 18 months. The continuation coverage required by this paragraph:

(1) Shall be satisfied by coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 which is provided to a subject of domestic violence; and

(2) Is not intended to be in addition to coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985.

4. For a policy of life insurance, to the extent otherwise permitted by sections 84 to 93, inclusive, of this act and any other applicable law, the provisions of subsection 3 do not prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite a policy or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is related to domestic violence.

5. As used in this section "confidential domestic violence information" means information concerning:

(a) An act of domestic violence;

(b) The domestic violence status of a subject of domestic violence; or

(c) The status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of domestic violence.

Sec. 92. *1. A person shall not engage in any conduct that is unfairly discriminatory pursuant to this section.*

2. Except as otherwise provided in subsection 3, for a policy of property or casualty insurance it is unfairly discriminatory to:

(a) Exclude or limit payment for a covered loss or deny a covered claim incurred as a result of domestic violence by a person other than a co-insured;

(b) Fail to pay losses arising out of domestic violence to an innocent insured who makes a first-party claim, to the extent of the legal interest of the first-party claimant in the covered property, if the loss is caused by the intentional act of an insured; or

(c) Use exclusions or limitations on coverage which the Commissioner has determined unreasonably restrict the ability of a subject of domestic violence to be indemnified for losses.

3. The provisions of subsection 2:

(a) Do not require payment in excess of the loss or policy limits; and

(b) Do not prohibit an insurer or insurance professional from applying reasonable standards to proof of claims.

Sec. 93. *An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is related to domestic violence:*

1. Shall explain the reason for its action to the applicant or insured in writing; and

2. At the request of the Commissioner, must be able to demonstrate that the action and any applicable policy provisions:

(a) Do not have the purpose or effect of treating domestic violence status as a medical condition or underwriting criteria;

(b) Are not based on any actual or perceived correlation between a medical condition and domestic violence;

(c) Are otherwise permitted by law and applied in the same manner and to the same extent to all applicants and insureds with a similar medical condition, without regard to whether the condition or claim is related to domestic violence; and

(d) Except for claims actions, are based on a determination, made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

Sec. 94. NRS 686A.010 is hereby amended to read as follows:

686A.010 The purpose of NRS 686A.010 to ~~[686A.310,]~~ ***686A.325,*** inclusive, ***and sections 80 to 93, 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 Title V of Public Law 106-102, 15 U.S.C. §§ 6801 et seq.

Sec. 95. 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 80 to 93, inclusive, of this act.***

3. The powers conferred upon the Commissioner by NRS 686A.010 to 686A.325, inclusive, and sections 80 to 93, 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.

Sec. 96. 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 80 to 93, 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. 97. 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 misrepresentation of a 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," "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. 98. 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. 99. NRS 686A.085 is hereby amended to read as follows:

686A.085 ***1.*** A ***person,*** bank ***or affiliate*** 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]~~ ***producers.***

2. A person, bank or affiliate 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 person, bank or affiliate when insurance is required in connection with a loan or extension of credit.

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

(a) As a condition for 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 or a particular insurer or producer of insurance. The provisions of this paragraph do not prohibit a person, bank or affiliate 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; or

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

(b) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if the rejection is based on reasonable standards, uniformly applied, 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 person, bank or affiliate 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 person, bank or affiliate; or

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

(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 person, bank or affiliate 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 person, bank or affiliate that lends money or extends credit and that 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 agent 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 person, bank or affiliate may impose reasonable requirements concerning the creditworthiness of the insurer and the scope 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 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 person or bank 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 person, insurer, bank or affiliate that the Commissioner believes may be in violation of this section. The person, insurer, bank or affiliate 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. Any examination undertaken pursuant to this subsection must be conducted in accordance with sections 2 to 41, inclusive, of this act.

9. Nothing in this section:

(a) Prevents a person, bank or affiliate 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.

10. As used in this section, the terms ~~[“affiliate,” “parent”]~~ ***“affiliate”*** and ~~[“subsidiary”]~~ ***“bank”*** have the meanings ascribed to them in NRS 683A.231.

Sec. 100. NRS 686A.095 is hereby amended to read as follows:

686A.095 1. An insurer shall not, without the written consent of the ~~[agent,]~~ ***producer of insurance,*** cancel a written agreement with ~~[an agent]~~ ***a producer*** or reduce or restrict the ~~[agent's]~~ authority ***of the producer*** to transact property or casualty insurance based solely on the loss ratio experience on insurance transacted by that ~~[agent,]~~ ***producer,*** if the ~~[agent]~~ ***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]~~ ***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. 101. 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) If 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.

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 80 to 93, 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.

Sec. 102. 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]~~ ***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]~~ ***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 the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(d) 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.

(e) 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.]~~ ***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. 103. NRS 686A.150 is hereby amended to read as follows:

686A.150 Except as provided in subsection ~~[2]~~ ***3*** of NRS 686A.120 (contemporaneous sales of life insurance and mutual fund shares), 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. 104. NRS 686A.160 is hereby amended to read as follows:

686A.160 If the Commissioner has cause to believe that any person 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 80 to 93, 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.

Sec. 105. 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 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 80 to 93, 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 80 to 93, 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 80 to 93, 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.

Sec. 106. 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 80 to 93, 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 (service of process).

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. 107. 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 80 to 93, 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 80 to 93, inclusive, of this act,***

payment of an administrative fine of not more than $5,000 for each act or violation, except that as to licensed agents, brokers, solicitors and adjusters, the administrative fine must not exceed $500 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 80 to 93, 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.

Sec. 108. 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 80 to 93, 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. 109. NRS 686A.310 is hereby amended to read as follows:

686A.310 1. Engaging in any of the following activities 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 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 a claim without conducting a reasonable investigation.

(r) Failing to provide forms necessary to present a claim and a reasonable explanation concerning the use of the forms within 15 days after the date on which a request for the forms is made.

2. 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 as an unfair practice.

Sec. 110. NRS 686A.400 is hereby amended to read as follows:

686A.400 1. A company shall maintain records of each transaction for 3 years after making the final entry with respect to the transaction. The records may be preserved in photographic form, ***electronic form,*** on microfilm or microfiche or in a form approved by the Commissioner.

2. ***A person who generates leads or other information relating to potential customers of health insurance products and services for any insurer or producer of insurance shall maintain any books, documents and other business records:***

(a) In such an order that data regarding complaints and marketing are accessible and retrievable for examination by the Commissioner; and

(b) For 3 years after the date on which the book, document or other record was created.

3. The records ***, books, documents and other business records maintained pursuant to this section*** must be open to the Commissioner at all times. The Commissioner may require a company to furnish to the Commissioner in any form the Commissioner requires any information maintained in the company's records.

Sec. 111. NRS 686A.410 is hereby amended to read as follows:

686A.410 The Commissioner may conduct an examination of a company at any time in accordance with ~~[NRS 679B.250 to 679B.287,]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.*** The expense of the examination must be borne by the company in accordance with ~~[NRS 679B.290]~~ ***section 19 of this act*** as if the company were an insurer.

Sec. 112. 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 80 to 93, 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. 113. NRS 686B.125 is hereby amended to read as follows:

686B.125 1. Except as otherwise provided in this section, no insurer, organization or person licensed pursuant to this title may sell or offer to sell any contract providing coverage for dental care at a rate which is excessive for the benefits offered to the insured or member. For the purpose of this section, a ratio of losses to premiums collected which is less than 75 percent is presumed to show an excessive rate.

2. The provisions of subsection 1 do not apply to a contract providing coverage for dental care that is sold to a small employer pursuant to the provisions of chapter 689C of NRS. As used in this subsection, "small employer" has the meaning ascribed to it in NRS 689C.095.

3. Each year, every insurer, organization or person licensed pursuant to this title who provides coverage for dental care in this State shall, in accordance with requirements established by regulation of the Commissioner, file with the Commissioner a report of the losses and premiums collected for that insurer, organization or person, as applicable, for the calendar year.

4. For the purposes of subsection 3, the values of losses and premiums collected must be determined at the end of each calendar year for the entire calendar year.

5. The Commissioner may, pursuant to ~~[NRS 679B.240,]~~ ***section 16 of this act,*** examine the accounts, records, documents and transactions of any insurer, organization or person licensed pursuant to this title who sells or offers to sell any contract providing coverage for dental care in this State to ascertain compliance with the provisions of this section.

Sec. 114. NRS 686B.1784 is hereby amended to read as follows:

686B.1784 1. The Commissioner may examine any insurer, advisory organization or plan for apportioned risks whenever the Commissioner determines that such an examination is necessary.

2. The reasonable cost of an examination must be paid by the insurer or other person examined upon presentation by the Commissioner of an accounting of those costs pursuant to ~~[NRS 679B.290.]~~ ***section 19 of this act.***

3. In lieu of an examination, the Commissioner may accept the report of an examination made by the agency of another state that regulates insurance.

Sec. 115. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

1. In any settlement for the payment of a claim pertaining to a policy or coverage of property insurance, if the contract of insurance provides for a settlement on the basis of actual cash value or another term which is similarly defined, only the cost of the physical goods being repaired or replaced may be subject to a deduction for depreciation.

2. The following types of payments, if separately itemized by the provider of repairs or replacement or by any governmental entity, must be paid or reimbursed by the insurer in full and may not be subject to a deduction for depreciation:

(a) The cost of services provided, including, without limitation, labor;

(b) Any expenses incurred by the provider of repairs or replacement, including, without limitation, overhead expenses which do not pertain to the repair or replacement of physical goods;

(c) Any profits earned by the provider of repairs or replacement;

(d) Any taxes paid by the governmental entity in connection with the repair or replacement;

(e) Any fees or charges, by any name called, required to be paid by the governmental entity which are not part of the price of the physical goods being repaired or replaced.

3. Any cost not separately itemized shall be deemed to be part of the cost of physical goods being repaired or replaced, unless otherwise stated by the provider of repairs or replacement or the governmental entity.

4. As used in this section, "actual cash value" means replacement cost minus a deduction for depreciation.

Sec. 116. 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)]~~ ***(e)*** 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. 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. 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. 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. 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. 117. NRS 687B.225 is hereby amended to read as follows:

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

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

(b) Unless a shorter time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703, ~~[respond to any]~~ ***approve a*** request for ~~[approval by]~~ ***prior authorization or respond to*** the insured ***,*** ~~[or]~~ member ***or provider of health care*** ~~[pursuant to this section]~~ ***with a request for additional information:***

(1) If the request for prior authorization involves urgent health care services, within ~~[20]~~ ***2 business*** days after ~~[it receives]~~ the ***date on which the*** request ~~[.]~~ ***for prior authorization was submitted; or***

(2) If the request for prior authorization does not involve urgent health care services, within 5 business days after the date on which the request for prior authorization was submitted.

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

Sec. 118. NRS 687B.385 is hereby amended to read as follows:

687B.385 ***1.*** An insurer shall not refuse to issue, cancel, refuse to renew or increase the premium for renewal of a policy of motor vehicle insurance covering private passenger cars or commercial vehicles as a result of any ~~[:~~

~~1. Claims]~~ ***claims*** made under any policy of insurance with respect to which the insured was not at fault ***.*** ~~[;]~~

2. ***An insurer shall not refuse to issue, set a higher premium when issuing, cancel, refuse to renew or increase the premium for renewal of a policy of property or casualty insurance as a result of any:***

(a) Claims made under any policy of insurance for which the insurer has not made any payment or for which the insurer recovered the entirety of the insurer's payment on the claim by means of salvage, subrogation or another mechanism; or

~~[3.]~~ ***(b)*** Inquiries made regarding an actual or potential claim under any policy of insurance regarding:

~~[(a)]~~ ***(1)*** The existence of insurance coverage for any matter; or

~~[(b)]~~ ***(2)*** Any hypothetical or informational matter pertaining to insurance.

Sec. 119. 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)(8).

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 the data request prescribed pursuant to subsection 2; or

(b) Submit to the Commissioner 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)(8). 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 confidential.

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.

Sec. 120. 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.

(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.]~~ ***629.031.***

Sec. 121. 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. 122. NRS 687B.615 is hereby amended to read as follows:

687B.615 "Health benefit plan" has the meaning ascribed to it in NRS ~~[695G.019.]~~ ***687B.470.***

Sec. 123. NRS 687B.660 is hereby amended to read as follows:

687B.660 "Provider of health care" has the meaning ascribed to it in NRS ~~[695G.070.]~~ ***629.031.***

Sec. 124. 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,]~~ ***Sections 2 to 41,*** inclusive, ***of this act*** 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 80 to 93, 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. 125. NRS 688C.180 is hereby amended to read as follows:

688C.180 The Commissioner may examine or investigate a licensee under this chapter as often as the Commissioner considers appropriate. An examination will be conducted in the manner provided in ~~[NRS 679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.*** The Commissioner may also examine or investigate any other person or business insofar as the Commissioner considers necessary or material to the examination or investigation of the licensee. Instead of an examination or investigation under this chapter of a foreign or alien person licensed under this chapter, the Commissioner may accept a report on examination or investigation of the licensee by the equivalent authority of the licensee's state of domicile or port of entry.

Sec. 126. 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 80 to 93, 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,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** 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. 127. 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 80 to 93, 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,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** 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. 128. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 129 to 134, inclusive, of this act.

Sec. 129. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 130 to 134, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 130. ***"Medical management technique" has the meaning ascribed to it in section 299 of this act.***

Sec. 131. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 132. ***"Provider network contract" has the meaning ascribed to it in NRS 687B.658.***

Sec. 133. ***"Provider of health care" has the meaning ascribed to it in NRS 629.031.***

Sec. 134. ***"Therapeutic equivalent" has the meaning ascribed to it in section 302 of this act.***

Sec. 135. NRS 689A.020 is hereby amended to read as follows:

689A.020 Nothing in this chapter applies to or affects:

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein.

2. Any group or blanket policy.

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance **.** ~~[, except as otherwise provided in NRS 689A.470 to 689A.740, inclusive, and 689C.610 to 689C.940, inclusive, relating to the program of reinsurance.]~~

5. Any policy of insurance offered on the Silver State Health Insurance Exchange in accordance with NRS 695I.505.

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

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

(f) 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]~~ ***includes*** 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) "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. 143. 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. 144. 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. 145. 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. 146. 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~~**]** ***, "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. 147. 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. 148. 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. 149. 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~~ ***, "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. 150. NRS 689A.080 is hereby amended to read as follows:

689A.080 1. ~~[There]~~ ***Except as otherwise provided in subsection 4, 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 689A.540.

Sec. 151. 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. 152. 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. 153. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 154 to 159, inclusive, of this act.

Sec. 154. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 155 to 159, inclusive, of this act, have the meanings ascribed to them in those sections.***

Sec. 155. ***"Medical management technique" has the meaning ascribed to it in section 299 of this act.***

Sec. 156. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 157. ***"Provider network contract" has the meaning ascribed to it in NRS 687B.658.***

Sec. 158. ***"Provider of health care" has the meaning ascribed to it in NRS 629.031.***

Sec. 159. ***"Therapeutic equivalent" has the meaning ascribed to it in section 302 of this act.***

Sec. 160. 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~~**]** ***, "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. 161. 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. 162. 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. 163. 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. 164. 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~~**]** **,** ***"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. 165. 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. 166. 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. 167. 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. 168. 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. 169. 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. 170. 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. 171. 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. 172.** 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) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same policy of group health insurance;

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

(f) 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 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]~~ ***includes*** 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) “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. 173. 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. 174. 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. 175. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 176 to 179, inclusive, of this act.

Sec. 176. ***"Medical management technique" has the meaning ascribed to it in section 299 of this act.***

Sec. 177. ***"Provider network contract" has the meaning ascribed to it in NRS 687B.658.***

Sec. 178. ***"Provider of health care" has the meaning ascribed to it in NRS 629.031.***

Sec. 179. ***"Therapeutic equivalent" has the meaning ascribed to it in section 302 of this act.***

Sec. 180. 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 176 to 179, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 181. 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]~~ ***has*** 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.]~~ ***meaning ascribed to it in NRS 687B.645.***

Sec. 182. 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 ***689B.560 and*** 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. 183. 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. 184. 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~~**]** **,** ***"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. 185. 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]~~ ***, "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. 186. 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. 187. 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. 188. 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. 189. 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. 190. 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) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same health benefit plan;

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

(f) 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]~~ ***includes*** 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) "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. 191. 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. 192. 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 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. 193. 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. 194. 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. 195. 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 ***689B.560 and*** 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. 196. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 176 to 179, inclusive, of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 197. NRS 690A.260 is hereby amended to read as follows:

690A.260 1. Except as otherwise provided in subsection 2, an authorized insurer issuing consumer credit insurance may not enter into any agreement whereby the authorized insurer transfers, by reinsurance or otherwise, to an unauthorized insurer, as they relate to consumer credit insurance written or issued in this State:

(a) A substantial portion of the risk of loss under the consumer credit insurance written by the authorized insurer in this State;

(b) All of one or more kinds, lines, types or classes of consumer credit insurance;

(c) All of the consumer credit insurance produced through one or more agents, agencies or creditors;

(d) All of the consumer credit insurance written or issued in a designated geographical area; or

(e) All of the consumer credit insurance under a policy of group insurance.

2. An authorized insurer may make the transfers listed in subsection 1 to an unauthorized insurer if the unauthorized insurer:

(a) Maintains security on deposit with the Commissioner in an amount which when added to the actual capital and surplus of the insurer is equal to the capital and surplus required of an

authorized stock insurer pursuant to NRS 680A.120. The security may consist only of the following:

(1) Cash.

(2) General obligations of, or obligations guaranteed by, the Federal Government, this State or any of its political subdivisions. These obligations must be valued at the lower of market value or par value.

(3) Any other type of security that would be acceptable if posted by a domestic or foreign insurer.

(b) Files an annual statement with the Commissioner pursuant to NRS 680A.270.

(c) Maintains reserves on its consumer credit insurance business pursuant to NRS 681B.050.

(d) Values its assets and liabilities pursuant to NRS 681B.010 to 681B.040, inclusive.

(e) Agrees to examinations conducted by the Commissioner pursuant to ~~[NRS 679B.230.]~~ ***section 15 of this act.***

(f) Complies with the standards adopted by the Commissioner pursuant to NRS 679A.150.

(g) Does not hold, issue or have an arrangement for holding or issuing any of its stock for which dividends are paid based on:

(1) The experience of a specific risk of all of one or more kinds, lines, types or classes of insurance;

(2) All of the business produced through one or more agents, agencies or creditors;

(3) All of the business written in a designated geographical area; or

(4) All of the business written for one or more forms of insurance.

Sec. 198. Chapter 690C of NRS is hereby amended by adding thereto the provisions set forth as sections 199 and 200 of this act.

Sec. 199. ***1. A person who wishes to act as an administrator for a provider must obtain a certificate of registration issued by the Commissioner pursuant to NRS 683A.08524.***

2. A person who acts as an administrator pursuant to this chapter shall:

(a) Administer from one or more offices located in this State all of the claims arising under each service contract that the person administers;

(b) Maintain in the offices described in paragraph (a) all of the records concerning the claims described in paragraph (a);

(c) Administer each service contract directly without subcontracting with another administrator or person;

(d) If the contract between the administrator and the provider is terminated, transfer all of the records in possession of the administrator concerning any claim arising under a service contract to any other administrator that is chosen by the provider; and

(e) Comply with the requirements of chapter 683A of NRS and all other relevant provisions of this title for administrators.

Sec. 200. ***The Commissioner may order any person to cease and desist any conduct that violates any provision of this chapter.***

Sec. 201. NRS 690C.020 is hereby amended to read as follows:

690C.020 "Administrator" means a person who ~~[is responsible for administering]~~ ***administers*** a service contract that is issued, sold or offered for sale by a provider.

Sec. 202. NRS 690C.070 is hereby amended to read as follows:

690C.070 "Provider" means a person who ~~[is obligated to a holder pursuant]~~ ***:***

1. Issues, sells or offers for sale service contracts; or

2. Pursuant to the terms of a service contract ~~[to repair, replace]~~ ***, repairs, replaces*** or ~~[perform]~~ ***performs*** maintenance on, or ~~[to indemnify]~~ ***indemnifies*** the holder for the costs of repairing, replacing or performing maintenance on, goods.

Sec. 203. 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, inclusive;

(b) NRS 679B.159 to ~~[679B.300,]~~ ***679B.228,*** inclusive;

(c) NRS 679B.310 to 679B.370, inclusive;

(d) NRS 679B.600 to 679B.690, inclusive;

(e) ***Sections 2 to 41, inclusive, of this act;***

(f) NRS 685B.090 to 685B.190, inclusive;

~~[(f)]~~ ***(g)*** NRS 686A.010 to 686A.095, inclusive;

~~[(g)]~~ ***(h)*** NRS 686A.160 to 686A.187, inclusive; and

~~[(h)]~~ ***(i)*** 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. 204. NRS 690C.150 is hereby amended to read as follows:

690C.150 ***1.*** A ~~[provider]~~ ***person*** shall not ~~[issue, sell or offer for sale service contracts in this state]~~ ***act or offer to act in the capacity of a provider, perform any of the functions, duties or powers prescribed for a provider or hold himself or herself out to the public as a provider*** unless the ~~[provider]~~ ***person is qualified and*** has been issued a certificate of registration ***as a provider*** pursuant to the provisions of this chapter.

2. A person shall not act or offer to act in the capacity of an administrator, perform any of the functions, duties or powers prescribed for an administrator or hold himself or herself out to the public as an administrator unless the person is qualified and has obtained a certificate of registration issued by the Commissioner pursuant to NRS 683A.08524.

3. The Commissioner may impose an administrative fine of not more than $5,000 for each act or violation of the provisions of subsection 1 or 2.

4. For the protection of the people of this State, the Commissioner shall not issue or renew, or permit to exist, any certificate or registration:

(a) For a provider or administrator except in compliance with the provisions of this chapter and chapter 683A of NRS, as applicable.

(b) For any person found to be untrustworthy or incompetent, or who has not established to the satisfaction of the Commissioner that the person is qualified for a certificate or registration in accordance with this chapter and chapter 683A of NRS, as applicable.

Sec. 205. 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. 206. 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. 207. NRS 690C.200 is hereby amended to read as follows:

690C.200 1. Except as otherwise provided in this section, a provider shall not include in the name of the business of the provider:

(a) The words "insurance," "casualty," "surety," "mutual" or any other word or term that implies that the provider is ~~[engaged in the business of transacting]~~ ***an*** insurance or ~~[is a]~~ surety company; or

(b) A name that is deceptively similar to the name or description of an insurer or surety company or the name of another provider.

2. A provider may include the word "guaranty" or a similar word in the name of the business of the provider.

3. This section does not apply to a provider who, before January 1, 2000, includes in the name of the business of the provider a name that does not comply with the provisions of subsection 1. Such a provider shall include in each service contract the provider issues, sells or offers for sale a statement that the service contract is not a contract of insurance.

Sec. 208. 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. 209. 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. 210. NRS 690C.320 is hereby amended to read as follows:

690C.320 1. Except as otherwise provided in this subsection, the Commissioner may conduct examinations to enforce the provisions of this chapter pursuant to the provisions of ~~[~~NRS ~~679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** at such times as the Commissioner deems necessary. The Commissioner is not required to comply with the requirement in ~~[~~NRS ~~679B.230]~~ ***section 15 of this act*** that insurers be examined not less frequently than every 5 years in the enforcement of this chapter.

2. A provider shall, upon the request of the Commissioner, make available to the Commissioner for inspection any accounts, books and records concerning any service contract issued, sold or offered for sale by the provider which are reasonably necessary to enable the Commissioner to determine whether the provider is in compliance with the provisions of this chapter.

Sec. 211. 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 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 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]~~ ***:***

(a) Violated a cease and desist order of the Commissioner; or

(b) Filed for bankruptcy or otherwise been deemed insolvent.

Sec. 212. NRS 690C.330 is hereby amended to read as follows:

690C.330 ~~[A]~~ ***Except as otherwise provided in NRS 690C.150, 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]~~ ***$1,000*** 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. 213. NRS 691C.380 is hereby amended to read as follows:

691C.380 1. Except as otherwise provided in subsection 2, an authorized insurer issuing credit personal property insurance may not enter into any agreement whereby the authorized insurer transfers, by reinsurance or otherwise, to an unauthorized insurer, as they relate to credit personal property insurance written or issued in this State:

(a) A substantial portion of the risk of loss under the credit personal property insurance written by the authorized insurer in this State;

(b) All of one or more kinds, lines, types or classes of credit personal property insurance;

(c) All of the credit personal property insurance produced through one or more agents, agencies or creditors;

(d) All of the credit personal property insurance written or issued in a designated geographical area; or

(e) All of the credit personal property insurance under a policy of group insurance.

2. An authorized insurer may make the transfers listed in subsection 1 to an unauthorized insurer if the unauthorized insurer:

(a) Maintains security on deposit with the Commissioner in an amount which when added to the actual capital and surplus of the insurer is equal to the capital and surplus required of an authorized stock insurer pursuant to NRS 680A.120. The security may consist only of the following:

(1) Cash.

(2) General obligations of, or obligations guaranteed by, the Federal Government, this State or any of its political subdivisions. These obligations must be valued at the lower of market value or par value.

(3) Any other type of security that would be acceptable if posted by a domestic or foreign insurer.

(b) Files an annual statement with the Commissioner pursuant to NRS 680A.270.

(c) Maintains reserves on its credit personal property insurance business pursuant to NRS 681B.050.

(d) Values its assets and liabilities pursuant to NRS 681B.010 to 681B.040, inclusive.

(e) Agrees to examinations conducted by the Commissioner pursuant to ~~[NRS 679B.230.]~~ ***section 15 of this act.***

(f) Complies with the standards adopted by the Commissioner pursuant to NRS 679A.150.

(g) Does not hold, issue or have an arrangement for holding or issuing any of its stock for which dividends are paid based on:

(1) The experience of a specific risk of all of one or more kinds, lines, types or classes of insurance;

(2) All of the business produced through one or more agents, agencies or creditors;

(3) All of the business written in a designated geographical area; or

(4) All of the business written for one or more forms of insurance.

Sec. 214. 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. 215. 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 of the Department of Business and Industry,*** 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. 216. NRS 692C.290 is hereby amended to read as follows:

692C.290 1. Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on forms provided by the Commissioner within 15 days after the end of the month in which it learns of each such change or addition, and not less often than annually, except that, subject to the provisions of NRS 692C.390, each registered insurer shall report all dividends and other distributions to shareholders within 5 business days following the declaration and 10 days before payment.

2. The principal of a registered insurer shall file an annual report of enterprise risk pursuant to this subsection. If the principal of a registered insurer does not file a report of enterprise risk

with the commissioner of the lead state of the insurance company system, as determined by the most recent edition of the Financial Analysis Handbook, published by the NAIC, in a calendar year, the principal shall file a report of enterprise risk with the Commissioner. The principal shall include in the report the material risks within the insurance holding company system that, to the best of his or her knowledge and belief, may pose enterprise risk to the registered insurer.

3. Except as otherwise provided in this subsection, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report shall be completed in accordance with the Group Capital Calculation Instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the Commissioner in accordance with the procedures within the Financial Analysis Handbook adopted by the NAIC. An insurance holding company system is exempt from filing the group capital calculation if it is:

(a) An insurance holding company system that has only one insurer within its holding company structure, that only writes business and is only licensed in its domestic state and that assumes no business from any other insurer.

(b) Except as otherwise provided in this paragraph, an insurance holding company system that is required to perform a group capital calculation specified by the United States Federal Reserve Board. The lead state commissioner shall request the calculation from the Federal Reserve Board under the terms of information sharing agreements currently in effect. If the Federal Reserve Board

cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing.

(c) An insurance holding company system whose non-United States group-wide supervisor is located within a reciprocal jurisdiction as defined in NRS 681A.062 that recognizes the United States's state regulatory approach to group supervision and group capital.

(d) An insurance holding company system:

(1) That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook; and

(2) Whose non-United States group-wide supervisor that is not in a reciprocal jurisdiction as defined in NRS 681A.062 recognizes and accepts, as specified by the Commissioner in regulation, the group capital calculation as the world-wide group capital assessment for United States insurance groups who operate in that jurisdiction.

4. Notwithstanding the provisions of paragraphs (c) and (d) of subsection 3, a lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

5. Notwithstanding the exemptions from filing the group capital calculation stated in paragraphs (a) to (d), inclusive, of subsection 3, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the Commissioner in regulation.

6. If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under subsection 3, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

7. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year's liquidity stress test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC.

8. For the purposes of subsection 7:

(a) The NAIC Liquidity Stress Test Framework and the included scope criteria applicable to a specific data year, which are reviewed at least annually by the NAIC Financial Stability Task Force or its successor, and any change to the NAIC Liquidity Stress Test Framework or to the data year for which the scope criteria are to be measured, are effective on January 1 of the year following the calendar year when such changes are adopted by the NAIC.

(b) An insurer which meets at least one threshold of the scope criteria is considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the NAIC Liquidity Stress Test Framework for that data year.

(c) An insurer that does not trigger at least one threshold of the scope criteria is not considered scoped into the NAIC Liquidity Stress Test Framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the NAIC Liquidity Stress Test Framework for that data year.

9. The lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, will assess whether an insurer is scoped in or not scoped into the NAIC Liquidity Stress Test Framework as part of the lead state commissioner's determinations pursuant to this section for an insurer.

10. The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC Liquidity Stress Test Framework's instructions and reporting templates for that year and any lead state insurance commissioner's determination, in conjunction with the Financial Stability Task Force or its successor, as provided within the NAIC Liquidity Stress Test Framework.

11. Whenever it appears to the Commissioner that any person has committed a violation of subsection 2 which prevents the full understanding of the enterprise risk to the insurer by affiliates

or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for conducting an examination of the insurer pursuant to ~~[~~NRS 679B.230 to 679B.287,~~]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.***

Sec. 217. NRS 692C.3503 is hereby amended to read as follows:

692C.3503 1. The requirements of NRS 692C.3501 to 692C.3509, inclusive, apply to all insurers domiciled in this State, including, without limitation:

(a) Insurers, as identified in chapter 680A of NRS;

(b) Hospital, medical or dental service corporations, as identified in chapter 695B of NRS;

(c) Health maintenance organizations, as identified in chapter 695C of NRS;

(d) Plans for dental care, as identified in chapter 695D of NRS;

(e) Prepaid limited health service organizations, as identified in chapter 695F of NRS; and

(f) Risk retention groups and state-chartered risk retention groups, as identified in 15 U.S.C. § 3902, 42 U.S.C. § 9673 and chapters 694C and 695E of NRS.

2. Except as otherwise provided in subsection 3, nothing in NRS 692C.3501 to 692C.3509, inclusive, shall be construed to limit the Commissioner's authority, or the rights or obligations of third parties, under ~~[~~NRS 679B.230 to 679B.300,~~]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.***

3. Nothing in NRS 692C.3501 to 692C.3509, inclusive, shall be construed to prescribe or impose corporate governance standards and internal procedures beyond those which are required by the appropriate provisions of title 7 of NRS.

Sec. 218. NRS 692C.410 is hereby amended to read as follows:

692C.410 1. Subject to the limitation contained in this section and in addition to the powers which the Commissioner has under ~~[NRS 679B.230 to 679B.287,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** relating to the examination of insurers, the Commissioner may examine any insurer registered under NRS 692C.260 to 692C.350, inclusive, and any affiliate of the insurer to ascertain the financial condition of the insurer, including, without limitation, the enterprise risk posed to the insurer by a person controlling the insurer, any entity or combination of entities within the insurance holding company system or by the insurance holding company system. The Commissioner may order any insurer registered under NRS 692C.260 to 692C.350, inclusive, to produce any information not in the possession of the insurer if the insurer is able to obtain the information pursuant to any contractual or statutory requirement or any other method. If the insurer is unable to obtain any information requested by the Commissioner pursuant to this section, the insurer shall provide to the Commissioner a statement setting forth the reasons the insurer is unable to obtain the information and the identity of the holder of the information, if known to the insurer. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of $100 for each day the requested information is not produced or may suspend or revoke the license of the insurer. In the event such insurer fails to comply with such order, the Commissioner may examine such affiliates to obtain such information.

2. The Commissioner shall exercise his or her power under subsections 1 and 5 only if the examination of the insurer under ~~[NRS 679B.230 to 679B.287,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** is inadequate or the interests of the policyholders of such insurer may be adversely affected.

3. The Commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist in the conduct of the examination under subsections 1 and 5. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

4. Each insurer producing for examination any information pursuant to subsection 1 or any records, books and papers pursuant to subsection 5 shall be liable for and shall pay the expense of such examination in accordance with ~~[NRS 679B.290.]~~ ***section 19 of this act.***

5. To carry out the provisions of this section and except as otherwise provided in subsection 2, the Commissioner may subpoena witnesses, compel their attendance, administer oaths, examine any person under oath concerning the subject of the examination and require the production of any books, papers, records, correspondence or any other documents which the Commissioner deems relevant to the examination. If any person fails to obey a subpoena or refuses to testify as to any matter relating to the subject of the examination, the Commissioner may file a written report describing the refusal and proof of service of the subpoena in any court of competent jurisdiction in the county in which the examination is being conducted, for such action as the court may determine. Failure by the person to obey an order of the court pursuant to this section is punishable as contempt of court.

6. A person subpoenaed under subsection 5 is entitled to witness fees and mileage as allowed for testimony in a court of record. The insurer or affiliate being examined must pay the witness

fees and mileage, as well as any other expense incurred in securing the attendance of witnesses for the examination in accordance with ~~[NRS 679B.290.]~~ ***section 19 of this act.***

Sec. 219. 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 impaired, as defined in NRS 696B.100,*** the Commissioner shall at once determine the amount of the deficiency and give written notice to the insurer of the amount of impairment and require that the impairment 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 of 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), and the Commissioner believes that the impairment might be made good by an extension of time, the Commissioner may extend the time within which the impairment 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 exists as the Commissioner deems advisable for the protection of policyholders, the insurer or the public.

Sec. 220. Chapter 694C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, all of the following documents and information and any copies thereof which are produced by, obtained by or disclosed to the Commissioner and which are related to an examination conducted pursuant to the provisions of this chapter are confidential, are not subject to subpoena, and may not be made public by the Commissioner, unless the Commissioner obtains the prior written consent of the captive insurance company to which the document or information pertains:

(a) License applications that are designated as confidential by or on behalf of an applicant captive insurance company, if the designation is reasonable;

(b) Examination reports, other than an examination report of any state-chartered risk retention group;

(c) Preliminary examination reports;

(d) Examination working papers; and

(e) Any other recorded information or other documents.

2. The provisions of subsection 1 do not apply to:

(a) A subpoena issued in connection with an administrative, civil or criminal investigation by a governmental agency.

(b) Any document or information disclosed by a captive insurer which is used by the Division in the course of any regulatory proceeding, disciplinary action or hearing. The Commissioner shall disclose to a captive insurance company a copy of any document or information which the Commissioner believes is related to a violation of this title or which justifies any regulatory proceeding, disciplinary action or hearing involving the captive insurance company. A

disclosure made pursuant to this subsection shall not be construed as a waiver of any applicable privilege or claim of confidentiality.

Sec. 221. NRS 694C.160 is 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]~~ ***679B.122*** 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. 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. 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. 222. 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) 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]~~ ***Except as otherwise provided in this subsection, 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. ***The Commissioner may***

approve an exemption from the provisions of chapter 693A for a pure captive insurer if the Commissioner determines the exemption is appropriate.

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. 223. NRS 694C.220 is hereby amended to read as follows:

694C.220 An application by a captive insurer for licensure must include a nonrefundable application fee of $500. The Commissioner may retain legal, financial and examination services from outside the Division to review and make recommendations regarding the qualifying examination of the applicant. The cost of those services must be paid by the applicant. The provisions of ~~[NRS 679B.230 to 679B.287,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** apply to examinations, investigations and processing conducted pursuant to this section.

Sec. 224. NRS 694C.259 is hereby amended to read as follows:

694C.259 1. A captive insurer which is not transacting the business of insurance, including, without limitation, the issuance of insurance policies and the assumption of reinsurance, may apply to the Commissioner for a certificate of dormancy.

2. Upon application by a captive insurer pursuant to subsection 1, the Commissioner may issue a certificate of dormancy to the captive insurer. The Commissioner may issue a certificate of dormancy to a captive insurer even if the captive insurer retains liabilities that are associated with policies that were written or assumed by the captive insurer provided that the captive insurer otherwise is not transacting the business of insurance.

3. A dormant captive insurer shall:

(a) Possess and thereafter maintain unimpaired paid-in capital and surplus ~~[of]~~ ***in an amount the Commissioner determines is sufficient to cover liabilities retained pursuant to subsection 2 but*** not less than $25,000.

(b) Pursuant to NRS 694C.230, pay an annual fee and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110 for the renewal of a license.

(c) Be subject to examination for any year for which the dormant captive insurer is not in compliance with the provisions of this section.

4. A dormant captive insurer may:

(a) At the discretion of the Commissioner, be subject to examination for any year for which the dormant captive insurer is in compliance with the provisions of this section.

(b) Continue to adjudicate and settle insurance claims under any contract of insurance or reinsurance that the captive insurer issued during any period in which the captive insurer was not a dormant captive insurer. The effective date of such a contract of insurance or reinsurance must be before the date on which the Commissioner issued a certificate of dormancy to the captive insurer.

5. ~~[After]~~ ***Except as otherwise provided in subsection 6, after*** being issued a certificate of dormancy, and until the certificate of dormancy expires or is revoked, a dormant captive insurer is not:

(a) Subject to or liable for the payment of any tax pursuant to NRS 694C.450.

(b) Required to:

(1) Prepare audited financial statements;

(2) Obtain actuarial certifications or opinions; or

(3) File annual reports with the Commissioner pursuant to NRS 694C.400.

6. ***The provisions of subsection 5 do not absolve a captive insurer from complying with any applicable responsibilities or requirements of this title which accrued before the date on which the certificate of dormancy was issued to the captive insurer, but are due on or after the date on which the certificate of dormancy was issued, including, without limitation, an annual report or audit based on the preceding calendar or fiscal year.***

7. A certificate of dormancy is subject to renewal after 5 years. If not timely renewed, the certificate of dormancy expires. Immediately upon the expiration of the certificate of dormancy, the captive insurer must be in compliance with all provisions of this chapter applicable to a captive insurer which holds an active license to transact the business of insurance issued pursuant to this chapter.

~~[7.]~~ ***8.*** Except as otherwise provided ~~[by]~~ ***in*** this section, before issuing any insurance policy or otherwise transacting the business of insurance, a dormant captive insurer must apply to the

Commissioner for approval to surrender its certificate of dormancy and resume transacting the business of insurance.

~~[8.]~~ ***9.*** The Commissioner shall revoke the certificate of dormancy of a dormant captive insurer that is not in compliance with the provisions of this section.

~~[9.]~~ ***10.*** The Commissioner may adopt regulations necessary to carry out the provisions of this section.

Sec. 225. NRS 694C.310 is hereby amended to read as follows:

694C.310 1. The board of directors of a captive insurer shall meet at least once each year in this State. The captive insurer shall:

(a) Maintain its principal place of business in this State; and

(b) Appoint a resident of this State as a registered agent to accept service of process and otherwise act on behalf of the captive insurer in this State. If the registered agent cannot be located with reasonable diligence for the purpose of serving a notice or demand on the captive insurer, the notice or demand may be served on the Secretary of State who shall be deemed to be the agent for the captive insurer.

2. A captive insurer shall not transact insurance in this State unless:

(a) The captive insurer has made adequate arrangements with:

(1) A state-chartered bank, a state-chartered credit union or a thrift company licensed pursuant to chapter 677 of NRS that is located in this State; or

(2) A federally chartered bank or federally chartered credit union that has a branch which is located in this State,

➥ that is authorized pursuant to state or federal law to transfer money.

(b) If the captive insurer employs or has entered into a contract with a natural person or business organization to manage the affairs of the captive insurer, the natural person or business organization meets the standards described in paragraph (b) of subsection 4 of NRS 694C.210 to the satisfaction of the Commissioner.

(c) The captive insurer employs or has entered into a contract with a qualified and experienced certified public accountant who is approved by the Commissioner or a firm of certified public accountants that is nationally recognized.

(d) The captive insurer employs or has entered into a contract with qualified, experienced actuaries who are approved by the Commissioner to perform reviews and evaluations of the operations of the captive insurer.

(e) The captive insurer employs or has entered into a contract with an attorney who is licensed to practice law in this State **.** ~~[and who meets the standards of competence and experience in matters concerning the regulation of insurance in this State established by the Commissioner by regulation.]~~

3. The Commissioner may periodically review the qualifications of a natural person or business organization described in paragraph (b) of subsection 2 and, if appropriate:

(a) Disqualify the manager pursuant to the authority of the Commissioner under NRS 679B.125; or

(b) Suspend or revoke the license of the captive insurer pursuant to NRS 694C.270.

Sec. 226. NRS 694C.330 is hereby amended to read as follows:

694C.330 1. Except as otherwise provided in this section, a captive insurer shall pay dividends out of, or make any other distributions from, its capital or surplus, or both, in accordance with the provisions set forth in NRS 692C.370, 693A.140, 693A.150 and 693A.160.

2. A captive insurer other than a state-chartered risk retention group shall not pay extraordinary dividends out of, or make any other extraordinary distribution with respect to, its capital or surplus, or both, in violation of this section unless the captive insurer has obtained the prior approval of the Commissioner to make such a payment or distribution. As used in this subsection, "extraordinary dividend" and "extraordinary distribution" mean any dividend or distribution of cash or other property, the fair market value of which, together with that of other dividends or distributions within the preceding 12 months, exceeds the greater of:

(a) Ten percent of the surplus of the captive insurer as of December 31 ***or the last day of the fiscal year of the captive insurer*** next preceding the date of the dividend or distribution; or

(b) The net income of the captive insurer for the 12-month period ending December 31 ***or the last day of the fiscal year of the captive insurer*** next preceding the date of the dividend or distribution.

3. A state-chartered risk retention group shall not pay any dividend or distribution without prior approval of the Commissioner.

Sec. 227. 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. 228. 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.

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. 229. NRS 694C.410 is hereby amended to read as follows:

694C.410 1. Except as otherwise provided in this section, at least once every 3 years, and at such other times as the Commissioner determines necessary, the Commissioner, or a designee of the Commissioner, shall visit each captive insurer and thoroughly inspect and examine the affairs of the captive insurer to ascertain:

(a) The financial condition of the captive insurer;

(b) The ability of the captive insurer to fulfill its obligations; and

(c) Whether the captive insurer has complied with the provisions of this chapter and the regulations adopted pursuant thereto.

2. Upon the application of a captive insurer, the Commissioner may conduct the visits required pursuant to subsection 1 every 5 years if the captive insurer conducts comprehensive annual audits:

(a) The scope of which is satisfactory to the Commissioner; and

(b) Which are conducted by an independent auditor appointed by the Commissioner.

3. The provisions of subsections 1 and 2 do not apply to a pure captive insurer. The Commissioner may conduct an examination of a pure captive insurer at any reasonable time to ascertain:

(a) The financial condition of the pure captive insurer;

(b) The ability of the pure captive insurer to fulfill its obligations; and

(c) Whether the pure captive insurer has complied with the provisions of this chapter and the regulations adopted pursuant thereto.

4. The Commissioner may contract to obtain legal, financial and examination services from outside the Division to conduct the examination and make recommendations to the Commissioner. The cost of the examination must be paid to the Commissioner by the captive insurer.

5. The provisions of ~~[NRS 679B.230 to 679B.287,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** apply to examinations conducted pursuant to this section.

Sec. 230. 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, ***including, without limitation, a year in which the captive insurer wrote no direct premiums or assumed no reinsurance premiums and was not a dormant captive insurer,*** 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. 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 percent of the revenues collected from the tax imposed pursuant to this section must be deposited with the State Treasurer for credit to the ~~[Account for the Regulation and Supervision of Captive Insurers]~~ ***Fund for Insurance Administration and Enforcement*** created ~~[pursuant to NRS 694C.460.]~~ ***by NRS 680C.100.*** 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. 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 direct premiums collected or contracted for on policies or contracts of insurance written 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. 231. NRS 694C.460 is hereby amended to read as follows:

694C.460 ~~[1. There is hereby created in the Fund for Insurance Administration and Enforcement created by NRS 680C.100 an Account for the Regulation and Supervision of Captive Insurers. Money in the Account must be used only to carry out the provisions of this chapter or for any other purpose authorized by the Legislature.]~~ Except as otherwise provided in NRS ~~[680C.110 and]~~ 694C.450, all fees and assessments received by the Commissioner or Division pursuant to this chapter must be credited to the ~~[Account. Not more than 2 percent of the tax collected and deposited in the Account pursuant to NRS 694C.450, may, upon application by the Division or an agency for economic development to, and with the approval of, the Interim Finance Committee, be transferred to an agency for economic development to be used by that agency to promote the industry of captive insurance in this State.~~

~~2. Except as otherwise provided in this section, all payments from the Account for the maintenance of staff and associated expenses, including contractual services, as necessary, must be disbursed from the State Treasury only upon warrants issued by the State Controller, after receipt of proper documentation of the services rendered and expenses incurred.~~

~~3. At the end of each fiscal year, that portion of the balance in the Account which exceeds $500,000 must be transferred to the State General Fund.~~

~~4. The State Controller may anticipate receipts to the Account and issue warrants based thereon.]~~ ***Fund for Insurance Administration and Enforcement created by NRS 680C.100.***

Sec. 232. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 233 to 237, inclusive, of this act.

Sec. 233. ***"Medical management technique" has the meaning ascribed to it in section 299 of this act.***

Sec. 234. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 235. ***"Provider network contract" has the meaning ascribed to it in NRS 687B.658.***

Sec. 236. ***"Provider of health care" has the meaning ascribed to it in NRS 629.031.***

Sec. 237. ***"Therapeutic equivalent" has the meaning ascribed to it in section 302 of this act.***

Sec. 238. 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 233 to 237, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 239. 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~~ ~~]~~ ***, "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. 240. 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. 241. 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. 242. 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. 243. 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. 244. 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. 245. 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) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same benefit contract;

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

(f) 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]~~ ***includes*** 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) "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. 246. 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. 247. 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. 248. 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. 249. 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. 250. 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 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. 251. NRS 695A.500 is hereby amended to read as follows:

695A.500 The Commissioner, or any person the Commissioner may appoint, may examine any domestic, foreign or alien society which is transacting business or applying for admission to transact business in this state in the same manner as authorized for the examination of domestic, foreign or alien insurers. For the purposes of this section, the provisions of ~~[~~NRS 679B.230 to 679B.300,~~]~~ ***sections 2 to 41,*** inclusive, ***of this act*** are applicable to societies.

Sec. 252. 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 299 of this act.***

4. "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.

5. "Network plan" has the meaning ascribed to it in NRS 687B.645.

6. "Provider network contract" has the meaning ascribed to it in NRS 687B.658.

7. "Provider of health care" has the meaning ascribed to it in NRS 629.031.

8. "Therapeutic equivalent" has the meaning ascribed to it in section 302 of this act.

Sec. 253. NRS 695B.160 is hereby amended to read as follows:

695B.160 1. Every corporation subject to the provisions of this chapter shall annually:

(a) On or before March 1, file in the Office of the Commissioner a statement verified by at least two of the principal officers of the corporation, showing its condition and affairs as of December 31 of the preceding calendar year. The statement must be in the form required by the Commissioner and must contain statements relative to the matters required to be established as a condition precedent to maintaining or operating a nonprofit hospital, medical or dental service plan and to other matters which the Commissioner may prescribe.

(b) Pay all applicable fees for the renewal of a certificate of authority and the fee for the filing of an annual statement.

2. Every corporation subject to the provisions of this chapter shall file a financial statement pursuant to NRS 680A.265, as required pursuant to paragraph (c) of subsection 1 of NRS 680A.265.

3. Every corporation subject to the provisions of this chapter shall file with the Commissioner and the National Association of Insurance Commissioners a quarterly statement in the form most recently adopted by the National Association of Insurance Commissioners for that type of insurer. The quarterly statement must be:

(a) Prepared in accordance with the instructions which are applicable to that form, including, without limitation, the required date of submission for the form; and

(b) Filed by electronic means.

4. The Commissioner may examine, as often as the Commissioner deems it desirable, the affairs of every corporation subject to the provisions of this chapter. The Commissioner shall, if practicable, examine each such corporation at least once in every 3 years, and in any event, at least once in every 5 years, as to its condition, fulfillment of its contractual obligations and compliance with applicable laws. The actual expenses of the examination must be paid by the corporation in accordance with the provisions of ~~[NRS 679B.290.]~~ ***section 19 of this act.*** The Commissioner shall refuse to issue a certificate of authority or shall revoke a certificate of authority issued to any corporation which neglects or refuses to pay such expenses.

Sec. 254. 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. 255. 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 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. 256. 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. 257. 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. 258. 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. 259. 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. 260. 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. 261. 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. 262. 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. 263. 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) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same contract for hospital or medical service;

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

(f) 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]~~ ***includes*** 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.

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

~~(f) "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 classification as a therapeutic equivalent.]~~

Sec. 264. 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. 265. 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~~**]** ***, "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. 266. 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~~**]** ***, "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. 267. 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. 268. 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. 269. 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, ***sections 2 to 41, inclusive, of this act,*** 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 80 to 93, inclusive, of this act, NRS*** 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.402 to*** 687B.430, ***inclusive,*** 687B.500 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. 270. 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.

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 299 of this act.***

8. "Network plan" has the meaning ascribed to it in NRS 687B.645.

9. "Provider" means any physician, hospital or other person who is licensed or otherwise authorized in this state to furnish health care services.

10. "Provider network contract" has the meaning ascribed to it in NRS 687B.658.

11. "Provider of health care" has the meaning ascribed to it in NRS 629.031.

12. "Therapeutic equivalent" has the meaning ascribed to it in section 302 of this act.

Sec. 271. NRS 695C.055 is hereby amended to read as follows:

695C.055 1. The provisions of NRS 449.465, 679A.200, ***679B.152,*** 679B.700, subsections 7 and 8 of NRS 680A.270, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.020 to 680B.060, inclusive, chapters 681B and 686A of NRS, NRS 686B.010 to 686B.175, inclusive, 687B.122 to 687B.128, inclusive, 687B.310 to 687B.420, inclusive, ~~[and]~~ 687B.500 ***and 687B.600 to 687B.850, inclusive,*** and chapters 692C and 695G of NRS apply to a health maintenance organization.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by "health maintenance organization."

Sec. 272. 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. 273. 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. 274. 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. 275. 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. 276. 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. 277. 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 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. 278. 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. 279. 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) Insertion of a device for contraception or removal of such a device if the device was inserted while the enrollee was covered by the same health care plan;

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

(f) 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~~] ***includes*** 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) "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. 280. 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. 281. 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~~**]** **,** ***"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. 282. 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. 283. 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. 284. 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. 285. 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. 286. 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~~**]** **,** ***"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. 287. 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. 288. 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 80 to 93, 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. 289. NRS 695C.310 is hereby amended to read as follows:

695C.310 1. The Commissioner shall make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements

or other arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State, but not less frequently than once every 3 years.

2. The Commissioner shall make an examination concerning any compliance program used by a health maintenance organization and any report, as determined to be appropriate by the Commissioner, regarding the health maintenance organization produced by an organization which examines best practices in the insurance industry. The Commissioner shall make such an examination as often as the Commissioner deems it necessary for the protection of the interests of the people of this State, but not less frequently than once every 3 years.

3. In making an examination pursuant to subsection 1 or 2, the Commissioner:

(a) Shall determine whether the health maintenance organization is in compliance with this Code, including, without limitation, whether any relationship or transaction between the health maintenance organization and any other health maintenance organization is in compliance with this Code; and

(b) May examine any account, record, document or transaction of any health maintenance organization or any provider which relates to:

(1) Compliance with this Code by the health maintenance organization which is the subject of the examination;

(2) Any relationship or transaction between the health maintenance organization which is the subject of the examination and any other health maintenance organization; or

(3) Any relationship or transaction between the health maintenance organization which is the subject of the examination and any provider.

4. Except as otherwise provided in this subsection, for the purposes of an examination pursuant to subsection 1 or 2, each health maintenance organization and provider shall, upon the request of the Commissioner or an examiner designated by the Commissioner, submit its books and records relating to any applicable health care plan to the Commissioner or the examiner, as applicable. Medical records of natural persons and records of physicians providing service pursuant to a contract with a health maintenance organization are not subject to such examination, although the records, except privileged medical information, are subject to subpoena upon a showing of good cause. For the purpose of examinations, the Commissioner may administer oaths to and examine the officers and agents of a health maintenance organization and the principals of providers concerning their business.

5. The expenses of examinations pursuant to this section must be assessed, billed and paid in accordance with the provisions of ~~[NRS 679B.290.]~~ ***section 19 of this act.***

6. In lieu of an examination pursuant to this section, the Commissioner may accept the report of an examination made by the insurance commissioner of another state or an applicable regulatory agency of another state.

Sec. 290. NRS 695C.317 is hereby amended to read as follows:

695C.317 The Commissioner shall use the procedures required by:

1. ~~[NRS 679B.230 to 679B.290,]~~ ***Sections 2 to 41,*** inclusive, ***of this act*** when conducting an examination of a health maintenance organization.

2. NRS 679B.310 to 679B.370, inclusive, when conducting a hearing involving a health maintenance organization.

Sec. 291. NRS 695D.270 is hereby amended to read as follows:

695D.270 1. The Commissioner shall, not less frequently than once every 3 years, conduct an examination of an organization for dental care pursuant to ~~[NRS 679B.250 to 679B.300,]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.***

2. The Commissioner may examine any organization which holds a certificate of authority from this State or another state at any other time the Commissioner deems necessary. For those organizations transacting business in this State which are not organized in this State, the Commissioner may accept a full report of the last examination of the organization certified by the state officer who supervises those organizations in the other state, if that examination is equivalent to an examination conducted by the Commissioner.

3. The Commissioner shall, in like manner, examine all organizations applying for a certificate of authority.

Sec. 292. 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 80 to 93, inclusive, of this act*** relating to trade practices and frauds apply to organizations for dental care.

Sec. 293. 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 80 to 93, 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,]~~ ***section 16 of this act,*** 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. 294. NRS 695E.210 is hereby amended to read as follows:

695E.210 1. The provisions of chapters 683A and 685A of NRS apply to any person acting, or offering to act, as an agent or broker for:

(a) A purchasing group;

(b) A member of a purchasing group under the group policy; or

(c) A risk retention group transacting insurance in this State.

2. Except as otherwise provided in this chapter, the provisions of chapter 679B of NRS ***and sections 2 to 41, inclusive, of this act*** apply to purchasing groups and risk retention groups, and to the provisions of this chapter, to the extent that the provisions of chapter 679B of NRS ***and sections 2 to 41, inclusive, of this act*** are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986.

3. A risk retention group that violates any provision of this chapter is subject to the fines and penalties, including revocation of its right to do business in this state, applicable to licensed insurers under this title.

Sec. 295. 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 80 to 93, 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. 296. 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]~~ ***has*** the ~~[financing and delivery of medical care is provided, in whole or]~~ ***meaning ascribed to it*** 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.]~~ ***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. 297. NRS 695F.310 is hereby amended to read as follows:

695F.310 1. The Commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the residents of this State, but not less frequently than once every 3 years.

2. A prepaid limited health service organization shall make its books and records available for examination and cooperate with the Commissioner to facilitate the examination.

3. In lieu of such an examination, the Commissioner may accept the report of an examination conducted by the commissioner of insurance of another state.

4. An examination conducted pursuant to this section must be conducted in accordance with the provisions of ~~[NRS 679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.***

5. A prepaid limited health service organization may be investigated in accordance with NRS 679B.600 to 679B.700, inclusive.

Sec. 298. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 299 to 302, inclusive, of this act.

Sec. 299. ***"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.***

Sec. 300. ***"Network plan" has the meaning ascribed to it in NRS 687B.645.***

Sec. 301. ***"Provider network contract" has the meaning ascribed to it in NRS 687B.658.***

Sec. 302. ***"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. 303. 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 299 to 302, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 304. 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]~~ ***has*** the ~~[costs of health care services.]~~ ***meaning ascribed to it in NRS 687B.470.***

Sec. 305. NRS 695G.070 is hereby amended to read as follows:

695G.070 "Provider of health care" ~~[means:~~

~~1. A physician or other health care practitioner who is licensed or otherwise authorized]~~ ***has the meaning ascribed to it*** in ~~[this State to furnish any health care service; and~~

~~2. An institution providing health care services or other setting in which health care services are provided, including, without limitation, a hospital, surgical center for ambulatory patients, facility for skilled nursing, residential facility for groups, laboratory and any other such licensed facility.]~~ ***NRS 629.031.***

Sec. 306. 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 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. 307. 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. 308. 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]~~ ***, "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. 309. 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. 310. 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. 311. 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. 312. 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. 313. 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 dispenses by a pharmacist pursuant to NRS 639.28078;

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

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

(f) 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~~]~~ ***includes*** 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) "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. 314. 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. 315. 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. 316. 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]~~ ***, "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. 317. 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. 318. NRS 695H.140 is hereby amended to read as follows:

695H.140 1. Except as otherwise provided in this subsection, the Commissioner may conduct examinations to enforce the provisions of this chapter pursuant to the provisions of ~~[NRS 679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** at such times as the Commissioner deems necessary. For the purposes of this chapter, the Commissioner is not required to comply with the requirement in ~~[NRS 679B.230]~~ ***section 16 of this act*** that insurers be examined not less frequently than every 5 years.

2. A person who is responsible for conducting the business activities of a medical discount plan shall, upon the request of the Commissioner, make available to the Commissioner for inspection any accounts, books and records concerning the medical discount plan which are reasonably necessary to enable the Commissioner to determine whether the medical discount plan is in compliance with the provisions of this chapter.

Sec. 319. NRS 696A.170 is hereby amended to read as follows:

696A.170 1. Every motor club shall be subject to examination by the Commissioner in the manner and under the conditions provided for examination of insurers contained in ~~[NRS 679B.230 to 679B.290,]~~ ***sections 2 to 41,*** inclusive ~~[.]~~ ***, of this act.***

2. The expense of such examination shall be paid by the motor club.

Sec. 320. 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 80 to 93, inclusive, of this act*** (trade practices and frauds); ~~[and]~~

6. Chapter 696B of NRS (delinquent insurers) ~~[.]~~ ***; and***

7. Sections 2 to 41, inclusive, of this act (examinations).

Sec. 321. NRS 696B.100 is hereby amended to read as follows:

696B.100 "Impairment" exists as to:

1. A stock insurer when ~~[the]~~ ***:***

(a) The insurer's ***admitted*** assets do not at least equal the sum of its liabilities, including also its paid-in capital stock account and the minimum surplus required to be maintained under this Code for authority to transact the kinds of insurance transacted ~~[.]~~ ***; or***

(b) The insurer has a total adjusted capital that is less than its authorized control level of risk-based capital required pursuant to NRS 681B.550 and any regulations adopted by the Commissioner pursuant to that section.

2. A mutual insurer when ~~[the]~~ ***:***

(a) The insurer's ***admitted*** assets do not at least equal the sum of the insurer's liabilities and the minimum surplus required under this Code to be maintained for authority to transact the kinds of insurance transacted ~~[.]~~ ***; or***

(b) The insurer has a total adjusted capital that is less than its authorized control level of risk-based capital required pursuant to NRS 681B.550 and any regulations adopted by the Commissioner pursuant to that section.

Sec. 322. NRS 696B.110 is hereby amended to read as follows:

696B.110 "Insolvency" exists:

1. When the insurer fails to meet its obligations as they mature;

2. When ~~[a stock]~~ ***an*** insurer's ***admitted*** assets are less than the sum of its liabilities ***;*** ~~[and its paid-in capital stock account;]~~

3. When ~~[a mutual]~~ ***an*** insurer's ~~[assets are]~~ ***total adjusted capital is*** less than ~~[the sum of]~~ its ~~[liabilities]~~ ***mandatory control level of risk-based capital required pursuant to NRS 681B.550*** and ***any regulations adopted by*** the ~~[minimum basic surplus required]~~ ***Commissioner pursuant*** to ~~[be maintained by the insurer under this Code for authority to transact the kinds of insurance transacted;]~~ ***that section;*** or

4. As otherwise expressly provided in this Code.

Sec. 323. NRS 696C.110 is hereby amended to read as follows:

696C.110 1. During the period an insurer is under administrative supervision pursuant to NRS 696C.100, the Commissioner or an appointee ~~[designated by]~~ ***of*** the Commissioner shall

serve as the administrative supervisor of the insurer. ***A person appointed by the Commissioner pursuant to this subsection is not required to be an employee of the Division.***

2. The Commissioner may identify any one or more actions specified in subsection 3 as actions which the insurer shall not take during the period the insurer remains under administrative supervision pursuant to NRS 696C.100 unless the insurer obtains approval in advance from the administrative supervisor ~~[designated]~~ ***appointed*** pursuant to subsection 1.

3. If identified by the Commissioner pursuant to subsection 2, the insurer shall not, without obtaining approval in advance from the administrative supervisor:

(a) Dispose of, convey or encumber any of its assets or its business in force;

(b) Withdraw money from any of its bank accounts;

(c) Lend any of its money;

(d) Invest any of its money;

(e) Transfer any of its property;

(f) Incur any debt, obligation or liability;

(g) Merge or consolidate with another insurer or any other business entity as defined in NRS 682A.025;

(h) Approve new premiums or renew any policies;

(i) Enter into any new reinsurance contract or treaty;

(j) Terminate, surrender, forfeit, convert or lapse any insurance policy, certificate or contract, except for nonpayment of premiums due;

(k) Release, pay or refund premium deposits, accrued cash or loan values, unearned premiums or other reserves on any insurance policy, certificate or contract;

(l) Make any material change in management; or

(m) Increase any salary or benefit of an officer or director, increase the preferential payment of a bonus or dividend or increase any other payment deemed by the Commissioner to be preferential.

Sec. 324. NRS 696C.130 is hereby amended to read as follows:

696C.130 1. During the period an insurer is under administrative supervision pursuant to NRS 696C.100, the insurer may contest any action taken or proposed to be taken by the administrative supervisor ~~[designated]~~ ***appointed*** pursuant to subsection 1 of NRS 696C.110 on the ground that the action would not result in improving the condition of the insurer. To contest an action taken or proposed to be taken by the administrative supervisor, the insurer must submit a request for reconsideration to the administrative supervisor. If the administrative supervisor, upon reconsideration, denies the insurer's request, the insurer may request a review of the decision of the administrative supervisor pursuant to NRS 679B.310 to 679B.370, inclusive.

2. Any action taken by the Commissioner pursuant to this chapter is subject to:

(a) Review pursuant to NRS 679B.310 to 679B.370, inclusive, and any regulations adopted pursuant thereto; and

(b) Judicial review pursuant to chapter 233B of NRS.

Sec. 325. NRS 696C.150 is hereby amended to read as follows:

696C.150 Notwithstanding any other provision of law, at the time of any proceeding or during the pendency of any proceeding held pursuant to this chapter, the Commissioner may meet with an administrative supervisor ~~[designated]~~ ***appointed*** by the Commissioner pursuant to subsection 1 of NRS 696C.110, and with the attorney or other representative of the administrative supervisor ~~[designated]~~ ***appointed*** pursuant to subsection 1 of NRS 696C.110, without the presence of any other person:

1. To carry out the duties of the Commissioner under this chapter; or

2. To allow the administrative supervisor to carry out his or her duties under this chapter.

Sec. 326. NRS 696C.160 is hereby amended to read as follows:

696C.160 The Commissioner may:

1. Adopt any regulations necessary to carry out the purposes and provisions of this chapter;

2. In addition to an administrative supervisor ~~[designated]~~ ***appointed*** by the Commissioner pursuant to subsection 1 of NRS 696C.110, employ any other counsels, actuaries, clerks and assistants as the Commissioner deems necessary for the administrative supervision of an insurer; and

3. Require an insurer placed under administrative supervision to pay the compensation and expenses of the administrative supervisor ~~[designated]~~ ***appointed*** by the Commissioner pursuant to subsection 1 of NRS 696C.110 and any other counsels, actuaries, clerks and assistants described in subsection 2.

Sec. 327. NRS 696C.170 is hereby amended to read as follows:

696C.170 There shall be no liability on the part of, and no cause of action of any nature against, the Commissioner or any employee or agent of the Commissioner, or an administrative supervisor ~~[designated]~~ ***appointed*** pursuant to subsection 1 of NRS 696C.110, for any action taken by them in the performance of their powers and duties under this chapter.

Sec. 328. NRS 695K.080 is hereby amended to read as follows:

695K.080 "Provider of health care" has the meaning ascribed to it in NRS ~~[695G.070.]~~ ***629.031.***

Sec. 329. 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 80 to 93, inclusive, of this act.***

15. Sections 2 to 41, inclusive, of this act.

Sec. 330. 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. 331. 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. 332. 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. 333. NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in subsection 7 and NRS 209.221 and 209.2473, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.

(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and adjusting the schedule of fees and charges for accident benefits pursuant to subsection 2 of NRS 616C.260.

(l) The Board to Review Claims in adopting resolutions to carry out its duties pursuant to NRS 445C.310.

(m) The Silver State Health Insurance Exchange.

2. Except as otherwise provided in subsection 5 and NRS 391.323, the Department of Education, the Board of the Public Employees' Benefits Program and the Commission on

Professional Standards in Education are subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

3. The special provisions of:

(a) Chapter 612 of NRS for the adoption of an emergency regulation or the distribution of regulations by and the judicial review of decisions of the Employment Security Division of the Department of Employment, Training and Rehabilitation;

(b) Chapters 616A to 617, inclusive, of NRS for the determination of contested claims;

(c) Chapter 91 of NRS for the judicial review of decisions of the Administrator of the Securities Division of the Office of the Secretary of State; and

(d) NRS 90.800 for the use of summary orders in contested cases,

➥ prevail over the general provisions of this chapter.

4. The provisions of NRS 233B.122, 233B.124, 233B.125 and 233B.126 do not apply to the Department of Health and Human Services in the adjudication of contested cases involving the issuance of letters of approval for health facilities and agencies.

5. The provisions of this chapter do not apply to:

(a) Any order for immediate action, including, but not limited to, quarantine and the treatment or cleansing of infected or infested animals, objects or premises, made under the authority of the State Board of Agriculture, the State Board of Health, or any other agency of this State in the discharge of a responsibility for the preservation of human or animal health or for insect or pest control;

(b) An extraordinary regulation of the State Board of Pharmacy adopted pursuant to NRS 453.2184;

(c) A regulation adopted by the State Board of Education pursuant to NRS 388.255 or 394.1694;

(d) The judicial review of decisions of the Public Utilities Commission of Nevada;

(e) The adoption, amendment or repeal of policies by the Rehabilitation Division of the Department of Employment, Training and Rehabilitation pursuant to NRS 426.561 or 615.178;

(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075;

(h) The adoption, amendment or repeal of standards of content and performance for courses of study in public schools by the Council to Establish Academic Standards for Public Schools and the State Board of Education pursuant to NRS 389.520;

(i) The adoption, amendment or repeal of the statewide plan to allocate money from the Fund for a Resilient Nevada created by NRS 433.732 established by the Department of Health and Human Services pursuant to paragraph (b) of subsection 1 of NRS 433.734; ~~[or]~~

(j) The adoption or amendment of a data request by the Commissioner of Insurance pursuant to NRS 687B.404 ~~[.]~~ ***; or***

(k) An order issued by the Commissioner of Insurance pursuant to subsection 1 of section 42 of this act.

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

7. The Department of Corrections is subject to the provisions of this chapter for the purpose of adopting regulations relating to fiscal policy, correspondence with inmates and visitation with inmates of the Department of Corrections.

Sec. 334. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.0397, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119A.677, 119B.370, 119B.382, 120A.640, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 164.041, 172.075, 172.245, 176.01334, 176.01385, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 178.5717, 179.495, 179A.070, 179A.165, 179D.160, 180.600, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3923, 209.3925, 209.419, 209.429, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240,

218G.350, 218G.615, 224.240, 226.462, 226.796, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1285, 231.1473, 232.1369, 233.190, 237.300, 239.0105, 239.0113, 239.014, 239B.026, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 239C.420, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.545, 247.550, 247.560, 250.087, 250.130, 250.140, 250.145, 250.150, 268.095, 268.0978, 268.490, 268.910, 269.174, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 284.4086, 286.110, 286.118, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.5757, 293.870, 293.906, 293.908, 293.909, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 353D.250, 360.240, 360.247, 360.255, 360.755, 361.044, 361.2242, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.0075, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.033, 391.035, 391.0365, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 393.045, 394.167, 394.16975, 394.1698, 394.447, 394.460, 394.465, 396.1415, 396.1425, 396.143, 396.159, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 414.280, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 427A.940, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.4018, 432B.407, 432B.430, 432B.560, 432B.5902, 432C.140, 432C.150, 433.534, 433A.360, 439.4941, 439.4988, 439.5282, 439.840, 439.914, 439A.116,

439A.124, 439B.420, 439B.754, 439B.760, 439B.845, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 442.774, 445A.665, 445B.570, 445B.7773, 449.209, 449.245, 449.4315, 449A.112, 450.140, 450B.188, 450B.805, 453.164, 453.720, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.535, 480.545, 480.935, 480.940, 481.063, 481.091, 481.093, 482.170, 482.368, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484A.469, 484B.830, 484B.833, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 598A.420, 599B.090, 603.070, 603A.210, 604A.303, 604A.710, 604D.500, 604D.600, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.238, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.043, 629.047, 629.069, 630.133, 630.2671, 630.2672, 630.2673, 630.2687, 630.30665, 630.336, 630A.327, 630A.555, 631.332, 631.368, 632.121, 632.125, 632.3415, 632.3423, 632.405, 633.283, 633.301, 633.427, 633.4715, 633.4716, 633.4717, 633.524, 634.055, 634.1303, 634.214, 634A.169, 634A.185, 634B.730, 635.111, 635.158, 636.262, 636.342, 637.085, 637.145, 637B.192, 637B.288, 638.087, 638.089, 639.183, 639.2485, 639.570, 640.075, 640.152, 640A.185, 640A.220, 640B.405, 640B.730, 640C.580, 640C.600, 640C.620, 640C.745, 640C.760, 640D.135, 640D.190, 640E.225, 640E.340, 641.090, 641.221, 641.2215, 641A.191, 641A.217, 641A.262, 641B.170, 641B.281, 641B.282, 641C.455, 641C.760, 641D.260, 641D.320, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.126,

652.228, 653.900, 654.110, 656.105, 657A.510, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 670B.680, 671.365, 671.415, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 678A.470, 678C.710, 678C.800, 679B.122, 679B.124, 679B.152, 679B.159, 679B.190, ~~[679B.285,]~~ 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.060, 687A.115, 687B.404, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117, 692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.325, 706.1725, 706A.230, 710.159, 711.600, ***sections 26, 36, 37 and 220 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate, including, without limitation, electronically, the confidential information from the information included in the public book or record that is not otherwise confidential.

4. If requested, a governmental entity shall provide a copy of a public record in an electronic format by means of an electronic medium. Nothing in this subsection requires a governmental entity to provide a copy of a public record in an electronic format or by means of an electronic medium if:

(a) The public record:

(1) Was not created or prepared in an electronic format; and

(2) Is not available in an electronic format; or

(b) Providing the public record in an electronic format or by means of an electronic medium would:

(1) Give access to proprietary software; or

(2) Require the production of information that is confidential and that cannot be redacted, deleted, concealed or separated from information that is not otherwise confidential.

5. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in the medium that is requested because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 335. NRS 289.470 is hereby amended to read as follows:

289.470 "Category II peace officer" means:

1. The bailiffs of the district courts, justice courts and municipal courts whose duties require them to carry weapons and make arrests;

2. Subject to the provisions of NRS 258.070, constables and their deputies;

3. Inspectors employed by the Nevada Transportation Authority who exercise those powers of enforcement conferred by chapters 706 and 712 of NRS;

4. Special investigators who are employed full-time by the office of any district attorney or the Attorney General;

5. Investigators of arson for fire departments who are specially designated by the appointing authority;

6. Investigators for the State Forester Firewarden who are specially designated by the State Forester Firewarden and whose primary duties are related to the investigation of arson;

7. Agents of the Nevada Gaming Control Board who exercise the powers of enforcement specified in NRS 289.360, 463.140 or 463.1405, except those agents whose duties relate primarily

to auditing, accounting, the collection of taxes or license fees, or the investigation of applicants for licenses;

8. Investigators and administrators of the Division of Compliance Enforcement of the Department of Motor Vehicles who perform the duties specified in subsection 2 of NRS 481.048;

9. Officers and investigators of the Section for the Control of Emissions From Vehicles and the Enforcement of Matters Related to the Use of Special Fuel of the Department of Motor Vehicles who perform the duties specified in subsection 3 of NRS 481.0481;

10. Legislative police officers of the State of Nevada;

11. Parole counselors of the Division of Child and Family Services of the Department of Health and Human Services;

12. Criminal investigators who are employed by the Division of Child and Family Services of the Department of Health and Human Services;

13. Juvenile probation officers and deputy juvenile probation officers employed by the various judicial districts in the State of Nevada or by a department of juvenile justice services established by ordinance pursuant to NRS 62G.210 whose official duties require them to enforce court orders on juvenile offenders and make arrests;

14. Field investigators of the Taxicab Authority;

15. Security officers employed full-time by a city or county whose official duties require them to carry weapons and make arrests;

16. The chief of a department of alternative sentencing created pursuant to NRS 211A.080 and the assistant alternative sentencing officers employed by that department;

17. Agents of the Cannabis Compliance Board who exercise the powers of enforcement specified in NRS 289.355;

18. Criminal investigators who are employed by the Secretary of State; ~~[and]~~

19. The Inspector General of the Department of Corrections and any person employed by the Department as a criminal investigator ~~[.]~~ ***; and***

20. Investigators and administrators of the Division of Insurance of the Department of Business and Industry who perform the duties specified in NRS 679B.600 to 679B.700, inclusive.

Sec. 336. NRS 315.725 is hereby amended to read as follows:

315.725 1. Except as otherwise provided in subsection 3, any two or more affordable housing entities may establish and participate in a program to jointly self-insure and jointly purchase insurance or reinsurance for coverage under a plan of:

(a) Casualty insurance, as that term is defined in NRS 681A.020, except for workers' compensation and employer's liability coverage;

(b) Marine and transportation insurance, as that term is defined in NRS 681A.050;

(c) Property insurance, as that term is defined in NRS 681A.060;

(d) Surety insurance, as that term is defined in NRS 681A.070; or

(e) Insurance for any combination of the kinds of insurance listed in paragraphs (a) to (d), inclusive.

2. A program established pursuant to subsection 1 must be administered by an entity which is organized as a nonprofit corporation, limited-liability company, partnership or trust, whether

organized under the laws of this State or another state or operating in another state. A majority of the board of directors or other governing body of the entity administering the program must be affiliated with one or more of the affordable housing entities participating in the program.

3. This section does not apply to an affordable housing entity that individually self-insures or participates in a risk pooling arrangement, including a risk retention group or a risk purchasing group, with respect to the kinds of insurance set forth in subsection 1.

4. Except as otherwise provided in this section or by specific statute:

(a) A program established pursuant to subsection 1 and the entity administering the program:

(1) Shall be deemed not to be providing coverage which constitutes insurance; and

(2) Are not subject to the provisions of title 57 of NRS; and

(b) The entity administering a program established pursuant to subsection 1 shall be deemed not to be engaging in the transaction of insurance.

5. The entity administering a program established pursuant to subsection 1 shall provide any affordable housing entity that seeks to participate in the program with a written notice, in 10-point type or larger, before the affordable housing entity begins participating in the program, that the program is not regulated by the Commissioner and that, if the program or the entity administering the program is found insolvent, a claim under the program is not covered by the Nevada Insurance Guaranty Association Act.

6. The entity administering a program established pursuant to subsection 1 shall submit to the Commissioner:

(a) Within 105 days after the end of the program's fiscal year:

(1) An annual financial statement for the program audited by a certified public accountant; and

(2) An annual actuarial analysis for the program prepared by an actuary who meets the qualification standards for issuing statements of actuarial opinion in the United States established by the American Academy of Actuaries or its successor organization; and

(b) Within 30 days after:

(1) Filing with any other regulatory body, a claims audit report relating to the entity or the program, a copy of the claims audit report filed with the other regulatory body;

(2) Issuance by any other regulatory body of a report of examination relating to the entity or the program, a copy of the report of examination issued by the other regulatory body;

(3) The effective date of a plan of financing, management and operation for the entity or the program or any material change in such a plan, a copy of the plan or material change; and

(4) The effective date of any material change in the scope of regulation of the entity or the program by any other state in which the entity operates, a statement of the material change.

7. The Commissioner may order an examination of a program established pursuant to subsection 1 or the entity administering the program based upon any credible evidence that the program or entity is in violation of this section or is operating or being operated while in an unsafe financial condition. Such an examination must be administered in accordance with ~~[NRS 679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** and any regulations adopted pursuant thereto.

8. If the Commissioner determines that a program established pursuant to subsection 1 or the entity administering the program is in violation of this section or is operating or being operated

while in an unsafe financial condition, the Commissioner may issue and serve upon the entity administering the program an order to cease and desist from the violation or from administering or in any way operating the program.

9. The Commissioner may hold a hearing, without a request by any party, to determine whether a program established pursuant to subsection 1 or the entity administering the program is in violation of this section or is operating or being operated while in an unsafe financial condition. A person aggrieved by any act or failure of the Commissioner to act, or by any report, rule, regulation or order of the Commissioner relating to this section, may request a hearing. Any hearing held pursuant to this subsection must be held in accordance with NRS 679B.310 to 679B.370, inclusive, and any regulations adopted pursuant thereto.

10. The provisions of this section must be liberally construed to grant affordable housing entities maximum flexibility to jointly self-insure and jointly purchase insurance or reinsurance to the extent that a program established pursuant to subsection 1 is being administered and otherwise operated in a safe financial condition and in a sound manner.

11. Each entity administering a program established pursuant to subsection 1 shall, on or before January 15 of each odd-numbered year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislature. The report must include, without limitation, a list of the affordable housing entities participating in the program and any other information the Director deems relevant.

12. As used in this section:

(a) "Affordable housing" means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to persons of low income.

(b) "Affordable housing entity" means:

(1) A housing authority created under the laws of this State or another jurisdiction and any agency or instrumentality of a housing authority, including, but not limited to, a legal entity created to enter into an agreement which complies with NRS 277.055;

(2) A nonprofit corporation organized under the laws of this State or another state that is engaged in providing affordable housing; or

(3) A general or limited partnership or limited-liability company which is engaged in providing affordable housing and which is affiliated with a housing authority described in subparagraph (1) or a nonprofit corporation described in subparagraph (2) if the housing authority or nonprofit corporation:

(I) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited-liability company;

(II) Has the power to direct the management or policies of the partnership or limited-liability company; or

(III) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited-liability company.

(c) "Commissioner" means the Commissioner of Insurance.

Sec. 337. NRS 439B.727 is hereby amended to read as follows:

439B.727 "Provider of health care" has the meaning ascribed to it in NRS ~~[695G.070.]~~ ***629.031.***

Sec. 338. NRS 439B.736 is hereby amended to read as follows:

439B.736 1. "Third party" includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS ~~[695G.019,]~~ ***687B.470,*** which provides coverage for medically necessary emergency services;

(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; and

(c) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.

Sec. 339. Chapter 452 of NRS is hereby amended by adding thereto a new section to read as follows:

The Administrator may adopt such regulations as may be necessary to carry out the purposes and provisions of this section and NRS 452.640 to 452.740, inclusive, which relate to endowment care.

Sec. 340. NRS 452.180 is hereby amended to read as follows:

452.180 1. It is unlawful for a cemetery authority, its officers, employees or agents, or a seller or agent certified or licensed pursuant to NRS 689.450 to 689.595, inclusive, to represent that an endowment care fund or any other fund set up for maintaining care is perpetual or permanent, or to sell, offer for sale or advertise any plot under representation that the plot is under endowment care, before an endowment care fund has been established for the cemetery in which the plot is situated. Any person violating any of the provisions of NRS 452.050 to 452.180, inclusive, is personally liable for all damages resulting to any person by reason of such violation, and upon conviction thereof is guilty of a misdemeanor.

2. The Administrator, for the purpose of ascertaining the assets, conditions and affairs of any endowment care cemetery, may examine the books, records, documents and assets of any endowment care cemetery operating, or being organized to operate as such a cemetery, in the State of Nevada, and may make whatever other investigations as may be necessary to determine that the cemetery is complying fully with the provisions of NRS 452.050 to 452.180, inclusive.

3. If, after an examination or investigation, the Administrator has just cause to believe that a cemetery granted a permit under the provisions of NRS 452.050 to 452.180, inclusive, has failed to comply with the provisions and requirements of NRS 452.050 to 452.180, inclusive, and any regulations adopted thereunder, the Administrator may, after due notice and hearing, if the

Administrator finds that the cemetery authority has violated those requirements or regulations, revoke or refuse to renew the permit of that cemetery authority and refer the violation to the Attorney General to determine if further action should be taken under subsection 1.

4. The provisions of ~~[NRS 679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** apply to any examination conducted under this section. 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 "cemetery authority" or the person being examined.

Sec. 341. NRS 452.640 is hereby amended to read as follows:

452.640 As used in NRS 452.640 to 452.740, inclusive, ***and section 339 of this act,*** unless the context otherwise requires:

1. "Administrator" means the Commissioner of Insurance.

2. "Cemetery authority" means a person who owns or controls any real property dedicated for use as a cemetery for pets pursuant to NRS 452.655, and who operates a cemetery for pets on that property.

Sec. 342. NRS 452.735 is hereby amended to read as follows:

452.735 1. It is unlawful for a cemetery authority, its officers, employees or agents, or a seller or agent certified or licensed pursuant to NRS 689.450 to 689.595, inclusive, to:

(a) Represent that a trust fund for the endowment care of the cemetery is perpetual or permanent; or

(b) Sell, offer for sale or advertise any plot under representation that the plot is under endowment care,

➥ before a trust fund for the endowment care of the cemetery has been established for the cemetery in which the plot is situated.

2. The Administrator, for the purpose of ascertaining the assets, conditions and affairs of a cemetery for pets, may examine the books, records, documents and assets of a cemetery for pets operating, or being organized to operate as such a cemetery, in this state and may make any other investigations as may be necessary to determine that the cemetery is complying fully with the provisions of NRS 452.705 to 452.740, inclusive.

3. The provisions of ~~[NRS 679B.230 to 679B.300,]~~ ***sections 2 to 41,*** inclusive, ***of this act*** apply to any examination conducted under this section. 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 "cemetery authority" or the person being examined.

Sec. 343. 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 or its 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 his or her employees required by chapters 616A to 617, inclusive, of NRS; and

(3) 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.

(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. 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 make himself or herself available to communicate 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.

Sec. 344. 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. 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. All records concerning a claim administered pursuant to this subsection must be maintained in those offices.

3. The Commissioner may:

(a) Under exceptional circumstances, waive the requirements of subsections 1 and 2; and

(b) Adopt regulations to carry out the provisions of this section.

Sec. 345. NRS 616B.303 is hereby amended to read as follows:

616B.303 For the purposes of NRS 616B.306, 616B.309 and 616B.318, an employer is insolvent if ~~[the]~~ ***:***

1. The employer's assets are less than the employer's liabilities ~~[.]~~ ***; or***

2. The employer fails to pay its outstanding obligations as they mature in the regular course of its business.

Sec. 346. NRS 616B.395 is hereby amended to read as follows:

616B.395 1. The Commissioner may examine the books, records, accounts and assets of an association of self-insured public or private employers as the Commissioner deems necessary to carry out the provisions of NRS 616B.350 to 616B.446, inclusive. ***The Commissioner shall so examine each association of self-insured public or private employers not less frequently than every 5 years.***

2. The expense of any examination conducted pursuant to this section must be paid by the association.

Sec. 347. NRS 616B.422 is hereby amended to read as follows:

616B.422 1. If the assets of an association of self-insured public or private employers are insufficient to make certain the prompt payment of all compensation under chapters 616A to 617, inclusive, of NRS and to maintain the reserves required by NRS 616B.419, ***as described in subsection 4,*** the association shall immediately notify the Commissioner of the deficiency and:

(a) Transfer any surplus acquired from a previous fund year to the current fund year to make up the deficiency;

(b) Transfer money from its administrative account to its claims account;

(c) Collect an additional assessment from its members in an amount required to make up the deficiency; or

(d) Take any other action to make up the deficiency which is approved by the Commissioner.

➥ Any action taken to address the deficiency must be accompanied by a corrective action plan, filed with the Commissioner and subject to his or her approval, that details how the action will remedy the deficiency and prevent a deficiency from reoccurring.

2. If the association wishes to transfer any surplus from one fund year to another, the association must first notify the Commissioner of the transfer.

3. The Commissioner shall order the association to make up any deficiency pursuant to subsection 1 if the association fails to do so within 30 days after notifying the Commissioner of the deficiency. The association shall be deemed insolvent if it fails to:

(a) Collect an additional assessment from its members within 30 days after being ordered to do so by the Commissioner; or

(b) Make up the deficiency in any other manner within 60 days after being ordered to do so by the Commissioner.

4. For the purposes of this section, the assets of an association are insufficient to maintain the reserves required by NRS 616B.419 if the assets of the association, excluding any securities posted pursuant to NRS 616B.353, are less than the required reserves.

Sec. 348. NRS 616B.428 is hereby amended to read as follows:

616B.428 1. The Commissioner may impose an administrative fine for each violation of any provision of NRS 616B.350 to 616B.446, inclusive, or any regulation adopted pursuant thereto. Except as otherwise provided in those sections, the amount of the fine may not exceed $1,000 for each violation or an aggregate amount of $10,000.

2. The Commissioner may withdraw the certificate of an association of self-insured public or private employers if:

(a) The association's certificate was obtained by fraud;

(b) The application for certification contained a material misrepresentation;

(c) The association is found to be insolvent;

(d) The association fails to have five or more members;

(e) The association fails to pay the costs of any examination or any penalty, fee or assessment required by the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(f) The association fails to comply with any of the provisions of this chapter or chapter 616A, 616C, 616D or 617 of NRS, or any regulation adopted pursuant thereto;

(g) The association fails to comply with any order of the Commissioner within the time prescribed by the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS or in the order of the Commissioner; ~~[or]~~

(h) The association or its third-party administrator misappropriates, converts, illegally withholds or refuses to pay any money to which a person is entitled and that was entrusted to the association in its fiduciary capacity ~~[.]~~ ***; or***

(i) The association fails to notify the Commissioner of a deficiency pursuant to subsection 1 of NRS 616B.422.

3. If the Commissioner withdraws the certification of an association of self-insured public or private employers, each employer who is a member of the association remains liable for his or her obligations incurred before and after the order of withdrawal.

4. Any employer who is a member of an association whose certification is withdrawn shall, on the effective date of the withdrawal, qualify as an employer pursuant to NRS 616B.650.

Sec. 349. NRS 631.3458 is hereby amended to read as follows:

631.3458 1. A person shall not provide dental services through teledentistry to a patient who is located at an originating site in this State unless the person:

(a) Is licensed to practice dentistry, dental hygiene or dental therapy in this State; and

(b) Has complied with subsection 2 of NRS 631.220.

2. The provisions of this chapter and the regulations adopted thereto, including, without limitation, clinical requirements, ethical standards and requirements concerning the confidentiality of information concerning patients, apply to services provided through teledentistry to the same extent as if such services were provided in person or by other means.

3. A licensee who provides dental services through teledentistry, including, without limitation, providing consultation and recommendations for treatment, issuing a prescription, diagnosing, correcting the position of teeth and using orthodontic appliances, shall provide such services in accordance with the same standards of care and professional conduct as when providing those services in person or by other means.

4. A licensee shall not:

(a) Provide treatment for any condition based solely on the results of an online questionnaire; or

(b) Engage in activity that is outside his or her scope of practice while providing services through teledentistry.

5. Nothing in this section or NRS 631.34581 to 631.34586, inclusive, prohibits an organization for dental care or an administrator of a health benefit plan that provides dental

coverage from negotiating rates of reimbursement for services provided through teledentistry with a dentist, dental hygienist or dental therapist.

6. As used in this section:

(a) "Health benefit plan" has the meaning ascribed to it in NRS ~~[695C.019.]~~ ***687B.470.***

(b) "Organization for dental care" has the meaning ascribed to it in NRS 695D.060.

Sec. 350. Any money remaining on July 1, 2025, in the Account for the Regulation and Supervision of Captive Insurers created by NRS 694C.460 remains in the Fund for Insurance Administration and Enforcement created by NRS 680C.100 and may be used for any other purpose for which any money in the Fund may be used.

Sec. 351. 1. Any valid license issued before July 1, 2025, that a person holds as a company adjuster or a staff adjuster shall be deemed to be a license as an independent adjuster and remains valid until its date of expiration.

2. As used in this section:

(a) "Company adjuster" and "staff adjuster" have the meanings ascribed to them in NRS 684A.030, as that section existed on June 30, 2025.

(b) "Independent adjuster" has the meaning ascribed to it in NRS 684A.030, as amended by section 67 of this act.

Sec. 352. 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. 353. The Legislative Counsel shall, in preparing supplements to the Nevada Administrative Code, make such changes as necessary so that references to a "company adjuster" or "staff adjuster" are changed to an "independent adjuster."

Sec. 354. NRS 645.645, 679B.230, 679B.240, 679B.250, 679B.260, 679B.270, 679B.280, 679B.282, 679B.285, 679B.287, 679B.290, 679B.300, 689A.413, 689B.068, 689C.196, 689C.320, 690B.100, 690B.110, 690B.120, 690B.130, 690B.140, 690B.150, 690B.155, 690B.160, 690B.170, 690B.175, 690B.180, 695A.195, 695B.316, 695C.203 and 695D.217 are hereby repealed.

Sec. 355. 1. This section and sections 1 to 327, inclusive, and 329 to 354, inclusive, of this act become effective on July 1, 2025.

2. Section 328 of this act becomes effective on January 1, 2026.

LEADLINES OF REPEALED SECTIONS

645.645 Additional grounds for disciplinary action: Unprofessional and improper conduct relating to sale of insurance for home protection.

679B.230 Examination of insurers.

679B.240 Examination of holding companies, subsidiaries, agents, promoters, independent review organizations and others.

679B.250 Conduct of examination; access to records; corrections; penalty.

679B.260 Appraisal of asset.

679B.270 Report of examination: Filing; contents; evidentiary effect in certain proceedings.

679B.280 Report of examination: Delivery of copy and notice to examinee; right of examinee to review and respond to report; entry of order by Commissioner; Commissioner authorized to order insurer to cure violation.

679B.282 Report of examination: Hearing; filing for public inspection; forwarding filed report to examinee; distribution and presentation of report of examination of domestic insurer.

679B.285 Report of examination: Disclosure; confidentiality.

679B.287 Limitations on actions and liability for communicating or delivering information or data pursuant to examination; Commissioner, representatives and examiners entitled to attorney's fees and costs in certain tort actions.

679B.290 Expense of examination; billing for examination; regulations.

679B.300 Deposit of money; payment of certain expenses.

689A.413 Insurer prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.

689B.068 Insurer prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.

689C.196 Insurer prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.

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.

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.

695A.195 Society prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.

695B.316 Corporation prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.

695C.203 Health maintenance organization prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.

695D.217 Organization for dental care prohibited from denying coverage solely because claim involves act that constitutes domestic violence or applicant or insured was victim of domestic violence.