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

FEBRUARY 19, 2025

Referred to Committee on Health and Human Services

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

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

CONTAINS UNFUNDED MANDATE (§ 12)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

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



Legislative Counsel's Digest:

1 Existing law prescribes certain rights for a patient of a medical facility or a
2 facility for the dependent. (NRS 449A.100-449A.124) **Sections 2-9** of this bill
3 establish certain rights related to assisted reproduction. **Sections 3-6** define certain
4 terms relating to assisted reproduction. **Section 7** applies the provisions of **sections**
5 **2-9** to certain state laws and all local laws and ordinances and the implementation
6 of those laws and ordinances, regardless of when those laws or ordinances were
7 enacted. **Section 8** generally prohibits a governmental entity from enacting or
8 implementing any limitation or requirement that singles out assisted reproduction
9 and substantially burdens: (1) the access of a person to assisted reproduction, any
10 drug or device related to assisted reproduction or information related to assisted
11 reproduction; (2) the ability of a provider of health care to provide assisted
12 reproduction, any drug or device related to assisted reproduction or information
13 related to assisted reproduction within his or her scope of practice, training and
14 experience; (3) the ability of a third party to provide insurance coverage of assisted
15 reproduction or drugs or devices related to assisted reproduction; or (4) the ability
16 of a person to control the use or disposition of his or her reproductive genetic
17 material. **Section 8** creates an exception to such prohibitions if the governmental
18 entity demonstrates by clear and convincing evidence that the burden, as applied to
19 the person, provider of health care or third party who is subject to the burden: (1)
20 furthers a compelling interest; and (2) is the least restrictive means of furthering
21 that interest.

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

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

43 Existing law prescribes certain requirements governing the availability of
44 health insurance plans in this State. (NRS 687B.480, 689A.430-689A.460,
45 689B.300-689B.330, 695A.151-695A.157, 695B.340-695B.370, 695C.163-
46 695C.169, 695F.440-695F.470) **Sections 12, 13, 15, 20, 24, 27-29, 32, 36, 38, 42**
47 **and 45** of this bill require a health insurer, including public and private employers
48 who provide insurance for their employees, to provide a special enrollment period
49 to a person determined by a qualified provider of health care to be pregnant, during
50 which the pregnant person must be allowed to enroll in a health care plan outside of
51 the period of open enrollment. **Section 17** of this bill provides for the enforcement
52 of **section 15**, which governs private employers who provide health benefits to
53 employees through a self-insured plan. **Section 18** of this bill establishes civil and
54 criminal penalties for a violation of **section 15**, which are the same as the penalties



55 for violations of other laws governing benefits provided by private employers.
56 **Sections 21, 26, 34 and 39** of this bill make conforming changes to indicate the
57 applicability of certain definitions to **sections 20, 24, 32 and 36**, respectively.

58 Existing law requires public and private policies of health insurance regulated
59 under Nevada law to include certain coverage. (NRS 287.010, 287.04335,
60 422.2717-422.272428, 689A.04033-689A.0465, 689B.0303-689B.0379,
61 689C.1652-689C.169, 689C.194, 689C.1945, 689C.195, 689C.425, 695A.184-
62 695A.1875, 695A.265, 695B.1901-695B.1948, 695C.050, 695C.1691-695C.176,
63 695G.162-695G.177) Existing law also requires employers to provide certain
64 benefits for health care to employees, including the coverage required of health
65 insurers, if the employer provides health benefits for its employees through a self-
66 insured plan. (NRS 608.1555) **Sections 12-14, 23, 31, 37, 38 and 44** of this bill
67 require Medicaid and public and private health care plans for groups of more than
68 100 insureds to include certain coverage for: (1) the treatment of infertility; and (2)
69 the preservation of fertility where the insured has a medical condition or requires
70 medical treatment that may cause infertility under certain circumstances. **Section**
71 **16** of this bill exempts employers who provide benefits for health care for their
72 employees through a self-insured plan from those requirements. **Sections 12-14, 19,**
73 **23, 31, 37, 38 and 44** of this bill prohibit an insurer from imposing conditions,
74 including cost-sharing, prior authorizations and waiting periods, on infertility
75 treatment or fertility preservation if such conditions are not required for similar
76 benefits that are not related to fertility. **Section 11** of this bill makes a conforming
77 change to require the Director of the Department of Health and Human Services to
78 administer the provisions of **section 14** in the same manner as other provisions
79 relating to Medicaid. **Sections 25, 33 and 40** of this bill make conforming changes
80 to clarify the applicability of provisions indicating that certain insurers are not
81 required to cover fertility drugs.

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

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

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

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

8 **Sec. 3.** *“Assisted reproduction” has the meaning ascribed to*
9 *it in NRS 126.510.*

10 **Sec. 4.** *“Gamete” has the meaning ascribed to it in*
11 *NRS 126.560.*

12 **Sec. 5.** *“Governmental entity” means the State of Nevada or*
13 *any of its agencies or political subdivisions.*



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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

8 2. *A governmental entity may enact a requirement or*
9 *limitation described in subsection 1 if the governmental entity*
10 *demonstrates by clear and convincing evidence that the burden*
11 *imposed by the requirement or limitation described in subsection*
12 *1, as applied to the person, provider of health care or third party*
13 *who is subject to the burden:*

14 (a) *Furtheres a compelling interest; and*

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

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

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

30 5. *A court may find that a person, provider of health care or*
31 *third party is a vexatious litigant if the person, provider of health*
32 *care or third party makes a claim within the scope of sections 2 to*
33 *9, inclusive, of this act which is without merit, fraudulent or*
34 *otherwise intended to harass or annoy a person or entity. If a*
35 *court finds that a person, provider of health care or third party is a*
36 *vexatious litigant pursuant to this subsection, the court may deny*
37 *standing to that person, provider of health care or third party to*
38 *bring further claims which allege a violation of this section.*

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



1 2. *Except as otherwise provided in this section, a person or*
2 *entity that stores or transports embryos for the purpose of assisted*
3 *reproduction or the manufacturer of goods used to facilitate the*
4 *process of assisted reproduction or the transportation of embryos*
5 *stored for the purpose of assisted reproduction is not subject to*
6 *civil or criminal liability, or discipline or other administrative*
7 *sanctions imposed by a professional licensing board or other*
8 *governmental entity, solely because of the death of or damage to*
9 *an embryo.*

10 3. *The provisions of this section do not preclude:*

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

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

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

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

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

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

31 232.320 1. The Director:

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

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

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

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

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

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



1 (b) Shall administer, through the divisions of the Department,
2 the provisions of chapters 63, 424, 425, 427A, 432A to 442,
3 inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS
4 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, *and*
5 *section 14 of this act*, 422.580, 432.010 to 432.133, inclusive,
6 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive,
7 and 445A.010 to 445A.055, inclusive, and all other provisions of
8 law relating to the functions of the divisions of the Department, but
9 is not responsible for the clinical activities of the Division of Public
10 and Behavioral Health or the professional line activities of the other
11 divisions.

12 (c) Shall administer any state program for persons with
13 developmental disabilities established pursuant to the
14 Developmental Disabilities Assistance and Bill of Rights Act of
15 2000, 42 U.S.C. §§ 15001 et seq.

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

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

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

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

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

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

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

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

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



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

4 **Sec. 12.** NRS 287.010 is hereby amended to read as follows:

5 287.010 1. The governing body of any county, school
6 district, municipal corporation, political subdivision, public
7 corporation or other local governmental agency of the State of
8 Nevada may:

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

16 (b) Purchase group policies of life, accident or health insurance,
17 or any combination thereof, for the benefit of such officers and
18 employees, and the dependents of such officers and employees, as
19 have authorized the purchase, from insurance companies authorized
20 to transact the business of such insurance in the State of Nevada,
21 and, where necessary, deduct from the compensation of officers and
22 employees the premiums upon insurance and pay the deductions
23 upon the premiums.

24 (c) Provide group life, accident or health coverage through a
25 self-insurance reserve fund and, where necessary, deduct
26 contributions to the maintenance of the fund from the compensation
27 of officers and employees and pay the deductions into the fund. The
28 money accumulated for this purpose through deductions from the
29 compensation of officers and employees and contributions of the
30 governing body must be maintained as an internal service fund as
31 defined by NRS 354.543. The money must be deposited in a state or
32 national bank or credit union authorized to transact business in the
33 State of Nevada. Any independent administrator of a fund created
34 under this section is subject to the licensing requirements of chapter
35 683A of NRS, and must be a resident of this State. Any contract
36 with an independent administrator must be approved by the
37 Commissioner of Insurance as to the reasonableness of
38 administrative charges in relation to contributions collected and
39 benefits provided. The provisions of NRS 439.581 to 439.597,
40 inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723,
41 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, *and*
42 *section 23 of this act*, paragraphs (b) and (c) of subsection 1 of NRS
43 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033
44 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive,
45 689B.0675, 689B.265, 689B.287 and 689B.500 *and section 24 of*



1 *this act* apply to coverage provided pursuant to this paragraph,
2 except that the provisions of NRS 689B.0378, 689B.03785 and
3 689B.500 only apply to coverage for active officers and employees
4 of the governing body, or the dependents of such officers and
5 employees.

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

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

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

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

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

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

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

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

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



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

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

6 **Sec. 13.** NRS 287.04335 is hereby amended to read as
7 follows:

8 287.04335 If the Board provides health insurance through a
9 plan of self-insurance, it shall comply with the provisions of NRS
10 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409,
11 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255,
12 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162,
13 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,
14 695G.1675, 695G.170 to 695G.1712, inclusive, *and section 44 of*
15 *this act*, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177,
16 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,
17 695G.405 and 695G.415, *and section 45 of this act* in the same
18 manner as an insurer that is licensed pursuant to title 57 of NRS is
19 required to comply with those provisions.

20 **Sec. 14.** Chapter 422 of NRS is hereby amended by adding
21 thereto a new section to read as follows:

22 *1. To the extent that federal financial participation is*
23 *available, the Director shall include under Medicaid coverage for:*

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

31 *(1) At least three completed retrievals of oocytes; and*

32 *(2) Unlimited transfers of embryos, including, without*
33 *limitation, single-embryo transfer where appropriate, in*
34 *accordance with the guidelines of the American Society for*
35 *Reproductive Medicine, or its successor organization.*

36 *(b) Any procedure or service for the preservation of fertility*
37 *consistent with established medical practice or any guidelines*
38 *published by the American Society for Reproductive Medicine or*
39 *the American Society of Clinical Oncology, or their successor*
40 *organizations, that are determined by a qualified provider of*
41 *health care to be medically necessary to preserve fertility because*
42 *the recipient of Medicaid:*

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



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

4 2. *For the purposes of subsection 1:*

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

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

16 3. *Medicaid must not:*

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

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

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

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

31 4. *The Department shall:*

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

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

40 5. *As used in this section:*

41 (a) *“Infertility” means a condition characterized by:*

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



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

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

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

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

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

14 (II) *Physical findings; or*

15 (III) *Diagnostic testing.*

16 (b) *“Provider of health care” has the meaning ascribed to it in*
17 *NRS 629.031.*

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

20 1. *Regardless of whether an employee who is pregnant*
21 *already has health coverage, an employer who provides benefits*
22 *for health care to his or her employees shall ensure that the*
23 *employee is allowed to enroll in any plan to provide such benefits*
24 *without any additional fee or penalty within at least 30 days after*
25 *the employee has been confirmed to be pregnant by a qualified*
26 *provider of health care.*

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

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

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

34 3. *As used in this section, “provider of health care” has the*
35 *meaning ascribed to it in NRS 629.031.*

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

37 608.1555 ~~[Any]~~ 1. *Except as otherwise provided in this*
38 *section, any employer who provides benefits for health care to his*
39 *or her employees shall provide the same benefits and pay providers*
40 *of health care in the same manner as a policy of insurance pursuant*
41 *to chapters 689A and 689B of NRS, including, without limitation,*
42 *as required by NRS 687B.409, 687B.723 and 687B.725.*

43 2. *An employer who employs less than 100 employees and*
44 *provides benefits for health care to his or her employees through a*



1 *plan of self-insurance is exempt from the requirements of section*
2 *23 of this act.*

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

4 608.180 The Labor Commissioner or the representative of the
5 Labor Commissioner shall cause the provisions of NRS 608.005 to
6 608.195, inclusive, *and section 15 of this act* and 608.215 to be
7 enforced, and upon notice from the Labor Commissioner or the
8 representative:

9 1. The district attorney of any county in which a violation of
10 those sections has occurred;

11 2. The Deputy Labor Commissioner, as provided in
12 NRS 607.050;

13 3. The Attorney General, as provided in NRS 607.160 or
14 607.220; or

15 4. The special counsel, as provided in NRS 607.065,

16 ↪ shall prosecute the action for enforcement according to law.

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

18 608.195 1. Except as otherwise provided in NRS 608.0165,
19 any person who violates any provision of NRS 608.005 to 608.195,
20 inclusive, *and section 15 of this act* or 608.215, or any regulation
21 adopted pursuant thereto, is guilty of a misdemeanor.

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

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

26 687B.225 1. Except as otherwise provided in NRS
27 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437,
28 689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312,
29 689B.0313, 689B.0315, 689B.0317, 689B.0319, 689B.0374,
30 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676,
31 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912,
32 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924,
33 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713,
34 695C.1735, 695C.1737, 695C.1743, 695C.1745, 695C.1751,
35 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715,
36 695G.1719 and 695G.177, *and sections 23, 31, 37 and 44 of this*
37 *act*, any contract for group, blanket or individual health insurance or
38 any contract by a nonprofit hospital, medical or dental service
39 corporation or organization for dental care which provides for
40 payment of a certain part of medical or dental care may require the
41 insured or member to obtain prior authorization for that care from
42 the insurer or organization. The insurer or organization shall:

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



1 (b) Unless a shorter time period is prescribed by a specific
2 statute, including, without limitation, NRS 689A.0446, 689B.0361,
3 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703,
4 respond to any request for approval by the insured or member
5 pursuant to this section within 20 days after it receives the request.

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

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

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

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

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

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

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

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

25 689A.420 As used in NRS 689A.420 to 689A.460, inclusive,
26 *and section 20 of this act*, unless the context otherwise requires:

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

31 2. "Order for medical coverage" means an order of a court or
32 administrative tribunal to provide coverage under a policy of health
33 insurance to a child pursuant to the provisions of 42 U.S.C. §
34 1396g-1.

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

37 **Sec. 23.** *1. Except as otherwise provided in subsection 5, an*
38 *insurer that issues a policy of group health insurance with more*
39 *than 100 insureds shall include in the policy coverage for:*

40 *(a) Any procedure or medication determined by a qualified*
41 *provider of health care to be necessary for the diagnosis and*
42 *treatment of infertility in accordance with established medical*
43 *practice or any guidelines published by the American College of*
44 *Obstetricians and Gynecologists or the American Society for*



1 *Reproductive Medicine, or their successor organizations. Such*
2 *coverage must include, without limitation, coverage for:*

3 (1) *At least three completed retrievals of oocytes; and*

4 (2) *Unlimited transfers of embryos, including, without*
5 *limitation, single-embryo transfer where appropriate, in*
6 *accordance with the guidelines of the American Society for*
7 *Reproductive Medicine, or its successor organization.*

8 (b) *Any procedure or service for the preservation of fertility*
9 *consistent with established medical practice or any guidelines*
10 *published by the American Society for Reproductive Medicine or*
11 *the American Society of Clinical Oncology, or their successor*
12 *organizations, that are determined by a qualified provider of*
13 *health care to be medically necessary to preserve fertility because*
14 *the insured:*

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

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

21 2. *For the purposes of subsection 1:*

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

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

33 3. *An insurer shall ensure that the benefits required by*
34 *subsection 1 are made available to an insured through a provider*
35 *of health care who participates in the network plan of the insurer.*

36 4. *An insurer shall not:*

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

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



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

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

8 (e) *Refuse to issue a policy of group health insurance or*
9 *cancel a policy of group health insurance solely because the*
10 *person applying for or covered by the policy uses or may use in the*
11 *future any benefit described in subsection 1;*

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

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

19 (h) *Offer or pay any type of material inducement, bonus or*
20 *other financial incentive to a provider of health care to deny,*
21 *reduce, withhold, limit or delay any benefit described in subsection*
22 *1 to an insured.*

23 5. *An insurer that is affiliated with a religious organization is*
24 *not required to provide the coverage required by subsection 1 if*
25 *the insurer objects on religious grounds. Such an insurer shall,*
26 *before the issuance of a policy of group health insurance that is*
27 *subject to the requirements of subsection 1 and before the renewal*
28 *of such a policy, provide to the group policyholder or prospective*
29 *insured, as applicable, written notice of the coverage that the*
30 *insurer refuses to provide pursuant to this subsection.*

31 6. *A policy of group health insurance with more than 100*
32 *insureds that is subject to the provisions of this chapter and is*
33 *delivered, issued for delivery or renewed on or after January 1,*
34 *2026, has the legal effect of including the coverage required by*
35 *subsection 1, and any provision of the policy or the renewal that*
36 *conflicts with the provisions of this section is void.*

37 7. *As used in this section:*

38 (a) *“Infertility” means a condition characterized by:*

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

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



1 (ii) *At least 6 months of regular, unprotected sexual*
2 *intercourse or therapeutic donor insemination for a person who is*
3 *35 years of age or older;*

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

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

9 (i) *The medical, sexual and reproductive history or age*
10 *of the person;*

11 (ii) *Physical findings; or*

12 (iii) *Diagnostic testing.*

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

19 (c) *“Provider of health care” has the meaning ascribed to it in*
20 *NRS 629.031.*

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

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

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

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

33 **3.** *As used in this section, “provider of health care” has the*
34 *meaning ascribed to it in NRS 629.031.*

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

37 689B.0376 1. An insurer that offers or issues a policy of
38 group health insurance which provides coverage for prescription
39 drugs or devices shall include in the policy coverage for any type of
40 hormone replacement therapy which is lawfully prescribed or
41 ordered and which has been approved by the Food and Drug
42 Administration.

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



1 (a) Require an insured to pay a higher deductible, any
2 copayment or coinsurance or require a longer waiting period or
3 other condition for coverage for a prescription for hormone
4 replacement therapy;

5 (b) Refuse to issue a policy of group health insurance or cancel a
6 policy of group health insurance solely because the person applying
7 for or covered by the policy uses or may use in the future hormone
8 replacement therapy;

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

12 (d) Penalize a provider of health care who provides hormone
13 replacement therapy to an insured, including, without limitation,
14 reducing the reimbursement of the provider of health care; or

15 (e) Offer or pay any type of material inducement, bonus or other
16 financial incentive to a provider of health care to deny, reduce,
17 withhold, limit or delay hormone replacement therapy to an insured.

18 3. A policy subject to the provisions of this chapter that is
19 delivered, issued for delivery or renewed on or after October 1,
20 1999, has the legal effect of including the coverage required by
21 subsection 1, and any provision of the policy or the renewal which is
22 in conflict with this section is void.

23 4. The provisions of this section do not require an insurer to
24 provide coverage for fertility drugs ~~§~~, *except as required by*
25 *section 23 of this act.*

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

28 **Sec. 26.** NRS 689B.290 is hereby amended to read as follows:
29 689B.290 As used in NRS 689B.290 to 689B.330, inclusive,
30 *and section 24 of this act*, unless the context otherwise requires:

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

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

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

40 *1. Regardless of whether a person who is pregnant already*
41 *has health coverage, a carrier shall allow the person to enroll in a*
42 *health benefit plan without any additional fee or penalty within at*
43 *least 30 days after the person has been confirmed to be pregnant*
44 *by a qualified provider of health care.*



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

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

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

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

10 **Sec. 28.** NRS 689C.425 is hereby amended to read as follows:

11 689C.425 A voluntary purchasing group and any contract
12 issued to such a group pursuant to NRS 689C.360 to 689C.600,
13 inclusive, are subject to the provisions of NRS 689C.015 to
14 689C.355, inclusive, *and section 27 of this act* to the extent
15 applicable and not in conflict with the express provisions of NRS
16 687B.408 and 689C.360 to 689C.600, inclusive.

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

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

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

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

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

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

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

35 **Sec. 31.** 1. *Except as otherwise provided in subsection 5, a*
36 *hospital or medical services corporation that issues a policy of*
37 *group health insurance with more than 100 insureds shall include*
38 *in the policy coverage for:*

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



1 (1) *At least three completed retrievals of oocytes; and*
2 (2) *Unlimited transfers of embryos, including, without*
3 *limitation, single-embryo transfer where appropriate, in*
4 *accordance with the guidelines of the American Society for*
5 *Reproductive Medicine, or its successor organization.*

6 (b) *Any procedure or service for the preservation of fertility*
7 *consistent with established medical practice or any guidelines*
8 *published by the American Society for Reproductive Medicine or*
9 *the American Society of Clinical Oncology, or their successor*
10 *organizations, that are determined by a qualified provider of*
11 *health care to be medically necessary to preserve fertility because*
12 *the insured:*

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

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

19 2. *For the purposes of subsection 1:*

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

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

31 3. *A hospital or medical services corporation shall ensure*
32 *that the benefits required by subsection 1 are made available to an*
33 *insured through a provider of health care who participates in the*
34 *network plan of the hospital or medical services corporation.*

35 4. *A hospital or medical services corporation shall not:*

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

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

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



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

5 (e) *Refuse to issue a policy of group health insurance or*
6 *cancel a policy of group health insurance solely because the*
7 *person applying for or covered by the policy uses or may use in the*
8 *future any benefit described in subsection 1;*

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

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

16 (h) *Offer or pay any type of material inducement, bonus or*
17 *other financial incentive to a provider of health care to deny,*
18 *reduce, withhold, limit or delay any benefit described in subsection*
19 *1 to an insured.*

20 5. *A hospital or medical services corporation that is affiliated*
21 *with a religious organization is not required to provide the*
22 *coverage required by subsection 1 if the hospital or medical*
23 *services corporation objects on religious grounds. Such a hospital*
24 *or medical services corporation shall, before the issuance of a*
25 *policy of group health insurance that is subject to the*
26 *requirements of subsection 1 and before the renewal of such a*
27 *policy, provide to the group policyholder or prospective insured, as*
28 *applicable, written notice of the coverage that the hospital or*
29 *medical services corporation refuses to provide pursuant to this*
30 *subsection.*

31 6. *A policy of group health insurance with more than 100*
32 *insureds that is subject to the provisions of this chapter and is*
33 *delivered, issued for delivery or renewed on or after January 1,*
34 *2026, has the legal effect of including the coverage required by*
35 *subsection 1, and any provision of the policy or the renewal that*
36 *conflicts with the provisions of this section is void.*

37 7. *As used in this section:*

38 (a) *“Infertility” means a condition characterized by:*

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

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



1 (II) *At least 6 months of regular, unprotected sexual*
2 *intercourse or therapeutic donor insemination for a person who is*
3 *35 years of age or older;*

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

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

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

11 (II) *Physical findings; or*

12 (III) *Diagnostic testing.*

13 (b) *“Network plan” means a policy of health insurance offered*
14 *by a hospital or medical services corporation under which the*
15 *financing and delivery of medical care, including items and*
16 *services paid for as medical care, are provided, in whole or in part,*
17 *through a defined set of providers under contract with the hospital*
18 *or medical services corporation. The term does not include an*
19 *arrangement for the financing of premiums.*

20 (c) *“Provider of health care” has the meaning ascribed to it in*
21 *NRS 629.031.*

22 **Sec. 32. 1.** *Regardless of whether a person who is pregnant*
23 *already has health coverage, a corporation shall allow the person*
24 *to enroll in a policy of health insurance without any additional fee*
25 *or penalty within at least:*

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

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

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

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

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

39 **3.** *As used in this section, “provider of health care” has the*
40 *meaning ascribed to it in NRS 629.031.*

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

43 **695B.1916 1.** *An insurer that offers or issues a contract for*
44 *hospital or medical service which provides coverage for prescription*
45 *drugs or devices shall include in the contract coverage for any type*



1 of hormone replacement therapy which is lawfully prescribed or
2 ordered and which has been approved by the Food and Drug
3 Administration.

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

7 (a) Require an insured to pay a higher deductible, any
8 copayment or coinsurance or require a longer waiting period or
9 other condition for coverage for a prescription for hormone
10 replacement therapy;


11 (b) Refuse to issue a contract for hospital or medical service or
12 cancel a contract for hospital or medical service solely because the
13 person applying for or covered by the contract uses or may use in
14 the future hormone replacement therapy;

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

18 (d) Penalize a provider of health care who provides hormone
19 replacement therapy to an insured, including, without limitation,
20 reducing the reimbursement of the provider of health care; or

21 (e) Offer or pay any type of material inducement, bonus or other
22 financial incentive to a provider of health care to deny, reduce,
23 withhold, limit or delay hormone replacement therapy to an insured.

24 3. A contract for hospital or medical service subject to the
25 provisions of this chapter that is delivered, issued for delivery or
26 renewed on or after October 1, 1999, has the legal effect of
27 including the coverage required by subsection 1, and any provision
28 of the contract or the renewal which is in conflict with this section is
29 void.

30 4. The provisions of this section do not require an insurer to
31 provide coverage for fertility drugs , *except as required by*
32 *section 31 of this act.*

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

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

36 695B.330 As used in NRS 695B.330 to 695B.370, inclusive,
37 *and section 32 of this act*, unless the context otherwise requires:

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

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

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



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

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

6 **Sec. 36. 1.** *Regardless of whether a person who is pregnant*
7 *already has health coverage, a health maintenance organization*
8 *shall allow the person to enroll in a health care plan without any*
9 *additional fee or penalty within at least:*

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

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

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

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

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

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

25 **Sec. 37. 1.** *Except as otherwise provided in subsection 5, a*
26 *health maintenance organization that issues a group health care*
27 *plan with more than 100 enrollees or a plan that provides health*
28 *care services through managed care to recipients of Medicaid*
29 *under the State Plan for Medicaid shall include in the plan*
30 *coverage for:*

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

38 (1) *At least three completed retrievals of oocytes; and*

39 (2) *Unlimited transfers of embryos, including, without*
40 *limitation, single-embryo transfer where appropriate, in*
41 *accordance with the guidelines of the American Society for*
42 *Reproductive Medicine, or its successor organization.*

43 (b) *Any procedure or service for the preservation of fertility*
44 *consistent with established medical practice or any guidelines*
45 *published by the American Society for Reproductive Medicine or*



1 *the American Society of Clinical Oncology, or their successor*
2 *organizations, that are determined by a qualified provider of*
3 *health care to be medically necessary to preserve fertility because*
4 *the enrollee:*

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

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

11 2. *For the purposes of subsection 1:*

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

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

23 3. *A health maintenance organization shall ensure that the*
24 *benefits required by subsection 1 are made available to an enrollee*
25 *through a provider of health care who participates in the network*
26 *plan of the health maintenance organization.*

27 4. *A health maintenance organization shall not:*

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

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

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

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

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



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

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

8 (h) Offer or pay any type of material inducement, bonus or
9 other financial incentive to a provider of health care to deny,
10 reduce, withhold, limit or delay any benefit described in subsection
11 1 to an enrollee.

12 5. A health maintenance organization which is affiliated with
13 a religious organization is not required to provide the coverage
14 required by subsection 1 if the health maintenance organization
15 objects on religious grounds. Such a health maintenance
16 organization shall, before the issuance of a group health care plan
17 that is subject to the requirements of subsection 1 and before the
18 renewal of such a plan, provide to the group policyholder or
19 prospective enrollee, as applicable, written notice of the coverage
20 that the health maintenance organization refuses to provide
21 pursuant to this subsection.

22 6. A group health care plan with more than 100 enrollees that
23 is subject to the provisions of this chapter and is delivered, issued
24 for delivery or renewed on or after January 1, 2026, has the legal
25 effect of including the coverage required by subsection 1, and any
26 provision of the plan or the renewal that conflicts with the
27 provisions of this section is void.

28 7. As used in this section:

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

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

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

37 (II) At least 6 months of regular, unprotected sexual
38 intercourse or therapeutic donor insemination for a person who is
39 35 years of age or older;

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

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



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

3 (II) *Physical findings; or*

4 (III) *Diagnostic testing.*

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

12 (c) *“Provider of health care” has the meaning ascribed to it in*
13 *NRS 629.031.*

14 **Sec. 38.** NRS 695C.050 is hereby amended to read as follows:

15 695C.050 1. Except as otherwise provided in this chapter or
16 in specific provisions of this title, the provisions of this title are not
17 applicable to any health maintenance organization granted a
18 certificate of authority under this chapter. This provision does not
19 apply to an insurer licensed and regulated pursuant to this title
20 except with respect to its activities as a health maintenance
21 organization authorized and regulated pursuant to this chapter.

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

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

29 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
30 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
31 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
32 695C.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200,
33 inclusive, and 695C.265 do not apply to a health maintenance
34 organization that provides health care services through managed
35 care to recipients of Medicaid under the State Plan for Medicaid or
36 insurance pursuant to the Children’s Health Insurance Program
37 pursuant to a contract with the Division of Health Care Financing
38 and Policy of the Department of Health and Human Services. This
39 subsection does not exempt a health maintenance organization from
40 any provision of this chapter for services provided pursuant to any
41 other contract.

42 5. The provisions of NRS 695C.16932 to 695C.1699,
43 inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731,
44 695C.17333, 695C.17345, 695C.17347, 695C.1736 to 695C.1745,
45 inclusive, 695C.1757 and 695C.204 *and sections 36 and 37 of this*



1 **act** apply to a health maintenance organization that provides health
2 care services through managed care to recipients of Medicaid under
3 the State Plan for Medicaid.

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

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

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

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

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

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

21 695C.161 As used in NRS 695C.161 to 695C.169, inclusive,
22 **and section 36 of this act**, unless the context otherwise requires:

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

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

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

32 695C.1694 1. A health maintenance organization which
33 offers or issues a health care plan that provides coverage for
34 prescription drugs or devices shall include in the plan coverage for
35 any type of hormone replacement therapy which is lawfully
36 prescribed or ordered and which has been approved by the Food and
37 Drug Administration.

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

41 (a) Require an enrollee to pay a higher deductible, any
42 copayment or coinsurance or require a longer waiting period or
43 other condition for coverage for hormone replacement therapy;



1 (b) Refuse to issue a health care plan or cancel a health care plan
2 solely because the person applying for or covered by the plan uses
3 or may use in the future hormone replacement therapy;

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

7 (d) Penalize a provider of health care who provides hormone
8 replacement therapy to an enrollee, including, without limitation,
9 reducing the reimbursement of the provider of health care; or

10 (e) Offer or pay any type of material inducement, bonus or other
11 financial incentive to a provider of health care to deny, reduce,
12 withhold, limit or delay hormone replacement therapy to an
13 enrollee.

14 3. Evidence of coverage subject to the provisions of this
15 chapter that is delivered, issued for delivery or renewed on or after
16 October 1, 1999, has the legal effect of including the coverage
17 required by subsection 1, and any provision of the evidence of
18 coverage or the renewal which is in conflict with this section is void.

19 4. The provisions of this section do not require a health
20 maintenance organization to provide coverage for fertility drugs ~~H~~,
21 *except as required by section 37 of this act.*

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

24 **Sec. 41.** NRS 695C.330 is hereby amended to read as follows:

25 695C.330 1. The Commissioner may suspend or revoke any
26 certificate of authority issued to a health maintenance organization
27 pursuant to the provisions of this chapter if the Commissioner finds
28 that any of the following conditions exist:

29 (a) The health maintenance organization is operating
30 significantly in contravention of its basic organizational document,
31 its health care plan or in a manner contrary to that described in and
32 reasonably inferred from any other information submitted pursuant
33 to NRS 695C.060, 695C.070 and 695C.140, unless any amendments
34 to those submissions have been filed with and approved by the
35 Commissioner;

36 (b) The health maintenance organization issues evidence of
37 coverage or uses a schedule of charges for health care services
38 which do not comply with the requirements of NRS 695C.1691 to
39 695C.200, inclusive, *and section 37 of this act*, 695C.204 or
40 695C.207;

41 (c) The health care plan does not furnish comprehensive health
42 care services as provided for in NRS 695C.060;

43 (d) The Commissioner certifies that the health maintenance
44 organization:



1 (1) Does not meet the requirements of subsection 1 of NRS
2 695C.080; or

3 (2) Is unable to fulfill its obligations to furnish health care
4 services as required under its health care plan;

5 (e) The health maintenance organization is no longer financially
6 responsible and may reasonably be expected to be unable to meet its
7 obligations to enrollees or prospective enrollees;

8 (f) The health maintenance organization has failed to put into
9 effect a mechanism affording the enrollees an opportunity to
10 participate in matters relating to the content of programs pursuant to
11 NRS 695C.110;

12 (g) The health maintenance organization has failed to put into
13 effect the system required by NRS 695C.260 for:

14 (1) Resolving complaints in a manner reasonably to dispose
15 of valid complaints; and

16 (2) Conducting external reviews of adverse determinations
17 that comply with the provisions of NRS 695G.241 to 695G.310,
18 inclusive;

19 (h) The health maintenance organization or any person on its
20 behalf has advertised or merchandised its services in an untrue,
21 misrepresentative, misleading, deceptive or unfair manner;

22 (i) The continued operation of the health maintenance
23 organization would be hazardous to its enrollees or creditors or to
24 the general public;

25 (j) The health maintenance organization fails to provide the
26 coverage required by NRS 695C.1691; or

27 (k) The health maintenance organization has otherwise failed to
28 comply substantially with the provisions of this chapter.

29 2. A certificate of authority must be suspended or revoked only
30 after compliance with the requirements of NRS 695C.340.

31 3. If the certificate of authority of a health maintenance
32 organization is suspended, the health maintenance organization shall
33 not, during the period of that suspension, enroll any additional
34 groups or new individual contracts, unless those groups or persons
35 were contracted for before the date of suspension.

36 4. If the certificate of authority of a health maintenance
37 organization is revoked, the organization shall proceed, immediately
38 following the effective date of the order of revocation, to wind up its
39 affairs and shall conduct no further business except as may be
40 essential to the orderly conclusion of the affairs of the organization.
41 It shall engage in no further advertising or solicitation of any kind.
42 The Commissioner may, by written order, permit such further
43 operation of the organization as the Commissioner may find to be in
44 the best interest of enrollees to the end that enrollees are afforded



1 the greatest practical opportunity to obtain continuing coverage for
2 health care.

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

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

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

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

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

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

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

22 **Sec. 44.** *1. Except as otherwise provided in subsection 5, a*
23 *managed care organization that issues a group health care plan*
24 *with more than 100 insureds or a plan that provides health care*
25 *services through managed care to recipients of Medicaid under*
26 *the State Plan for Medicaid shall include in the plan coverage for:*

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

34 *(1) At least three completed retrievals of oocytes; and*

35 *(2) Unlimited transfers of embryos, including, without*
36 *limitation, single-embryo transfer where appropriate, in*
37 *accordance with the guidelines of the American Society for*
38 *Reproductive Medicine, or its successor organization.*

39 *(b) Any procedure or service for the preservation of fertility*
40 *consistent with established medical practice or any guidelines*
41 *published by the American Society for Reproductive Medicine or*
42 *the American Society of Clinical Oncology, or their successor*
43 *organizations, that are determined by a qualified provider of*
44 *health care to be medically necessary to preserve fertility because*
45 *the insured:*



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

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

7 2. *For the purposes of subsection 1:*

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

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

19 3. *A managed care organization shall ensure that the benefits*
20 *required by subsection 1 are made available to an insured through*
21 *a provider of health care who participates in the network plan of*
22 *the managed care organization.*

23 4. *A managed care organization shall not:*

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

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

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

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

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

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



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

5 (h) *Offer or pay any type of material inducement, bonus or*
6 *other financial incentive to a provider of health care to deny,*
7 *reduce, withhold, limit or delay any benefit described in subsection*
8 *1 to an insured.*

9 5. *A managed care organization that is affiliated with a*
10 *religious organization is not required to provide the coverage*
11 *required by subsection 1 if the managed care organization objects*
12 *on religious grounds. Such a managed care organization shall,*
13 *before the issuance of a group health care plan that is subject to*
14 *the requirements of subsection 1 and before the renewal of such a*
15 *plan, provide to the group policyholder or prospective insured, as*
16 *applicable, written notice of the coverage that the managed care*
17 *organization refuses to provide pursuant to this subsection.*

18 6. *A group health care plan with more than 100 insureds that*
19 *is subject to the provisions of this chapter and is delivered, issued*
20 *for delivery or renewed on or after January 1, 2026, has the legal*
21 *effect of including the coverage required by subsection 1, and any*
22 *provision of the plan or the renewal that conflicts with the*
23 *provisions of this section is void.*

24 7. *As used in this section:*

25 (a) *“Infertility” means a condition characterized by:*

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

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

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

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

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

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

43 (II) *Physical findings; or*

44 (III) *Diagnostic testing.*



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

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

10 **Sec. 45. 1.** Regardless of whether a person who is pregnant
11 already has health coverage, a managed care organization shall
12 allow the person to enroll in a health care plan without any
13 additional fee or penalty within at least:

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

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

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

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

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

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

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

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

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

36 3. Sections 11 to 46, inclusive, of this act become effective:

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

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



