

**[Nev. Rev. Stat. §§ 689B.030 through 689B.0379.]**

§§ 689B.030 through 689B.0379: Group and Blanket Health Insurance Law-- Group Policies—Coverage

**§ 689B.030. Required provisions.**

Each group health insurance policy must contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person are representations and not warranties, and that no statement made for the purpose of effecting insurance voids the insurance or reduces its benefits unless the statement is contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or insured person or a beneficiary of the policyholder or insured person.
2. A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of that employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family.
3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.
4. A provision for benefits for expense arising from care at home or health supportive services if the care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.
5. A provision for benefits for expenses arising from hospice care.

**§ 689B.0303. Required provision concerning coverage for continued medical treatment.**

1. The provisions of this section apply to a policy of group health insurance offered or issued by an insurer if an insured covered by the policy receives health care through a defined set of providers of health care who are under contract with the insurer.
2. Except as otherwise provided in this section, if an insured who is covered by a policy described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during the course of the medical treatment, the policy must provide that:

(a) The insured may continue to obtain medical treatment for the medical condition from the provider of health care pursuant to this section, if:

- (1) The insured is actively undergoing a medically necessary course of treatment; and
- (2) The provider of health care and the insured agree that the continuity of care is desirable.

(b) The provider of health care is entitled to receive reimbursement from the insurer for the medical treatment the provider of health care provides to the insured pursuant to this section, if the provider of health care agrees:

(1) To provide medical treatment under the terms of the contract between the provider of health care and the insurer with regard to the insured, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the provider of health care and the insurer; and

(2) Not to seek payment from the insured for any medical service provided by the provider of health care that the provider of health care could not have received from the insured were the provider of health care still under contract with the insurer.

3. The coverage required by subsection 2 must be provided until the later of:

- (a) The 120th day after the date the contract is terminated; or
- (b) If the medical condition is pregnancy, the 45th day after:

- (1) The date of delivery; or
- (2) If the pregnancy does not end in delivery, the date of the end of the pregnancy.

4. The requirements of this section do not apply to a provider of health care if:

(a) The provider of health care was under contract with the insurer and the insurer terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and

(b) The insurer did not enter into another contract with the provider of health care after the contract was terminated pursuant to paragraph (a).

5. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2003, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal thereof that is in conflict with this section is void.

6. The Commissioner shall adopt regulations to carry out the provisions of this section.

**§ 689B.0306. Required provision concerning coverage for treatment received as part of clinical trial or study.**

1. A policy of group health insurance must provide coverage for medical treatment which a person insured under the group policy receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The insured has signed, before participating in the clinical trial or study, a statement of consent indicating that the insured has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured person.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the policy of group health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of group health insurance for an insured participating in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the insured is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the insured during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the insured during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

Except as otherwise provided in NRS 689B.0303, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay the provider the rate of reimbursement that is paid to other providers with whom the insurer has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to a person insured under the group policy is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the group policy.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the insured's policy of group health insurance, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the insured during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured.

(h) Any costs for the management of research relating to the clinical trial or study.

5. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the insured, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 shall:

(a) Include in any disclosure of the coverage provided by the policy notice to each group policyholder of the availability of the benefits required by this section.

(b) Provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

7. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with this section is void.

8. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 is immune from liability for:

(a) Any injury to the insured caused by:

(1) Any medical treatment provided to the insured in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the insured in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an insured's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the "Policies and Guidelines Relating to the Cancer Center Support Grant" published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

(c) "Provider of health care" means:

- (1) A hospital; or
- (2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.

**§ 689B.031. Required provision concerning coverage of certain gynecological or obstetrical services without authorization or referral from primary care physician.**

1. A policy of group health insurance must include a provision authorizing a woman covered by the policy to obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.
2. The provisions of this section do not authorize a woman covered by a policy of group health insurance to designate an obstetrician or gynecologist as her primary care physician.
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 this section, and any provision of the policy or the renewal which is in conflict with this section is void.
4. As used in this section, “primary care physician” has the meaning ascribed to it in NRS 695G.060.

**§ 689B.0313. Required coverage for certain tests and vaccines relating to human papillomavirus; prohibited acts.**

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 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.



**§ 689B.0317. Required provision concerning coverage for prostate cancer screening.**

1. A policy of group health insurance that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. A policy of group health insurance that provides coverage for the treatment of prostate cancer must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. A policy of group health insurance that provides coverage for the treatment of prostate cancer which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 is void.

**§ 689B.033. Required provision concerning coverage for newly born and adopted children and children placed for adoption.**

1. All group health insurance policies providing coverage on an expense-incurred basis and all employee welfare plans providing medical, surgical or hospital care or benefits established or maintained for employees or their families or dependents, or for both, must as to the family members' coverage provide that the health benefits applicable for children are payable with respect to:

(a) A newly born child of the insured from the moment of birth;

(b) An adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption; and

(c) A child placed with the insured for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement.

The policies must provide the coverage specified in subsection 3 and must not exclude premature births.

2. The policy or contract may require that notification of:

(a) The birth of a newly born child;

(b) The effective date of adoption of a child; or

(c) The date of placement of a child for adoption,

and payments of the required premium or fees, if any, must be furnished to the insurer or welfare plan within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

3. The coverage for newly born and adopted children and children placed for adoption consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

**§ 689B.0335. Required provision concerning coverage for autism spectrum disorders.**

1. A health benefit plan must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the policy of group health insurance under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of the actuarial equivalent of \$72,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a policy of group health insurance to the same extent as other medical services or prescription drugs covered by the policy.

3. A health benefit plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the policy; or

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1.

4. Except as otherwise provided in subsections 1 and 2, an insurer shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

An insurer may request a copy of and review a treatment plan created pursuant to this subsection.

6. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 or 2 is void.

7. Nothing in this section shall be construed as requiring an insurer to provide reimbursement to a school for services delivered through school services.

8. As used in this section:

(a) “Applied behavior analysis” means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) “Autism spectrum disorder” has the meaning ascribed to it in NRS 427A.875.

(c) “Behavioral therapy” means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(d) “Evidence-based research” means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(e) “Habilitative or rehabilitative care” means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(f) “Licensed assistant behavior analyst” means a person who holds current certification as a Board Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability

Services Division of the Department of Health and Human Services and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

(g) “Licensed behavior analyst” means a person who holds current certification as a Board Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services.

(h) “Prescription care” means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(i) “Psychiatric care” means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(j) “Psychological care” means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(k) “Registered behavior technician” has the meaning ascribed to it in NRS 437.050.

(l) “Screening for autism spectrum disorders” means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

(m) “Therapeutic care” means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

(n) “Treatment plan” means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

**§ 689B.034. Required provision concerning effect of benefits under other valid group coverage; subrogation.**

1. Every policy of group health insurance must contain a provision which reduces the insurer’s liability because of benefits under other valid group coverage. To the extent authorized by the Commissioner, such a provision may include subrogation.

2. A provision for subrogation may include a lien upon any recovery by an insured from a third person for the cost of medical benefits paid by the insurer for injuries incurred as a result of the actions of the third person. The lien may not exceed the amount paid by the insurer.

3. An insurer may not deny payment for services because of the inclusion of a provision required by this section.

**§ 689B.0345. Required provision concerning coverage for employee or member on leave without pay as result of total disability.**

1. As used in this section, “total disability” and “totally disabled” mean the continuing inability of the employee or member, because of an injury or illness, to perform substantially the duties related to his or her employment for which the employee or member is otherwise qualified.

2. No group policy of health insurance may be delivered or issued for delivery in this state unless it provides continuing coverage for an employee or member of the insured group, and the dependents of the employee or member who are otherwise covered by the policy, while the employee or member is on leave without pay as a result of a total disability. The coverage must be for any injury or illness suffered by the employee or member which is not related to the total disability or for any injury or illness suffered by the dependent of the employee or member. The coverage for such injury or illness must be equal to or greater than the coverage otherwise provided by the policy.

3. The coverage required pursuant to subsection 2 must continue until:

(a) The date on which the employment of the employee or member is terminated;

(b) The date on which the employee or member obtains another policy of health insurance;

(c) The date on which the group policy of health insurance is terminated; or

(d) After a period of 12 months in which benefits under such coverage are provided to the employee or member,

whichever occurs first.

**§ 689B.035. Required provision concerning termination of coverage on dependent child.**

1. A group health insurance policy delivered or issued for delivery after November 1, 1973, which provides for the termination of coverage on a dependent child of a member of the insured group, when such child attains a contractually specified limiting age, shall also provide that such coverage shall not terminate when the dependent child reaches such age if such child is and continues to be:

(a) Incapable of self-sustaining employment due to a physical handicap or an intellectual disability; and

(b) Dependent on the member of the insured group for support and maintenance.

2. Proof of such child’s incapacity and dependency shall be furnished to the insurer by the member of the insured group within 31 days after such child attains the specified limiting age and as often as the insurer may thereafter require, but no more than once a year beginning 2 years after such child attains the specified limiting age.

**§ 689B.0353. Required provision concerning coverage for treatment of certain inherited metabolic diseases.**

1. A policy of group health insurance must provide coverage for:

(a) Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

(b) At least \$2,500 per year for special food products which are prescribed or ordered by a physician as medically necessary for the treatment of a person described in paragraph (a).

2. The coverage required by subsection 1 must be provided whether or not the condition existed when the policy was purchased.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 1998, 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.

4. As used in this section:

(a) "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

(b) "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

**§ 689B.0357. Required provision concerning coverage for management and treatment of diabetes.**

1. No group policy of health insurance that provides coverage for hospital, medical or surgical expenses may be delivered or issued for delivery in this state unless the policy includes coverage for the management and treatment of diabetes, including, without limitation, coverage for the self-management of diabetes.

2. An insurer who delivers or issues for delivery a policy specified in subsection 1:

(a) Shall include in any disclosure of the coverage provided by the policy notice to each policyholder and subscriber under the policy of the availability of the benefits required by this section.

(b) Shall provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 1998, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with this section is void.

4. As used in this section:

(a) "Coverage for the management and treatment of diabetes" includes coverage for medication, equipment, supplies and appliances that are medically necessary for the treatment of diabetes.

(b) "Coverage for the self-management of diabetes" includes:

(1) The training and education provided to the employee or member of the insured group after the employee or member is initially diagnosed with diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;

(2) Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the employee or member of the insured group and which requires modification of his or her program of self-management of diabetes; and

(3) Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

(c) "Diabetes" includes type I, type II and gestational diabetes.

**§ 689B.0358. Required provision concerning coverage for management and treatment of sickle cell disease.**

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) “Sickle cell disease and its variants” has the meaning ascribed to it in NRS 439.4927.

**§ 689B.0362. Required provision concerning coverage for orally administered chemotherapy.**

1. An insurer that offers or issues a policy of group health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.



**§ 689B.0365. Required provision concerning coverage for use of certain drugs for treatment of cancer.**

Except as otherwise provided in NRS 689B.0306:

1. No group policy of health insurance that provides coverage for a drug approved by the Food and Drug Administration for use in the treatment of an illness, disease or other medical condition may be delivered or issued for delivery in this state unless the policy includes coverage for any other use of the drug for the treatment of cancer, if that use is:

(a) Specified in the most recent edition of or supplement to:

(1) The United States Pharmacopoeia Drug Information; or

(2) The American Hospital Formulary Service Drug Information; or

(b) Supported by at least two articles reporting the results of scientific studies that are published in scientific or medical journals, as defined in 21 C.F.R. § 99.3.

2. The coverage required pursuant to this section:

(a) Includes coverage for any medical services necessary to administer the drug to the employee or member of the insured group.

(b) Does not include coverage for any:

(1) Experimental drug used for the treatment of cancer if that drug has not been approved by the Food and Drug Administration; or

(2) Use of a drug that is contraindicated by the Food and Drug Administration.

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 this section, and any provision of the policy that conflicts with the provisions of this section is void.

**§ 689B.0367. Required provision concerning coverage for screening for colorectal cancer.**

1. A policy of group health insurance that provides coverage for the treatment of colorectal cancer must provide coverage for colorectal cancer screening in accordance with:

(a) The guidelines concerning colorectal cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning colorectal cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. 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, 2003, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with the provisions of this section is void.

**§ 689B.0368. Required provision concerning coverage for prescription drug previously approved for medical condition of insured.**

1. Except as otherwise provided in this section, a policy of group health insurance which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:

(a) Had previously been approved for coverage by the insurer for a medical condition of an insured and the insured's provider of health care determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration;

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the policy that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the policy.

3. Any provision of a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

**§ 689B.0369. Required provision concerning coverage for services provided through telehealth.**

1. A policy of group or blanket health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.
2. An insurer shall not:
  - (a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;
  - (b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;
  - (c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or
  - (d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.
3. A policy of group or blanket health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for that service when provided in person. A policy of group or blanket health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.
4. The provisions of this section do not require an insurer to:
  - (a) Ensure that covered services are available to an insured through telehealth at a particular originating site;
  - (b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
  - (c) Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.
5. A policy of group or blanket health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, 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.
6. As used in this section:

- (a) “Distant site” has the meaning ascribed to it in NRS 629.515.
- (b) “Originating site” has the meaning ascribed to it in NRS 629.515.
- (c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.
- (d) “Telehealth” has the meaning ascribed to it in NRS 629.515.

**§ 689B.0374. Required provision concerning coverage for mammograms for certain women; prohibited acts.**

1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.

2. 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) “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.

**§ 689B.0375. Required provision concerning coverage relating to mastectomy.**

1. A policy of group health insurance which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

- (a) Reconstruction of the breast on which the mastectomy has been performed;
- (b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and
- (c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

- (a) In the next mailing made by the plan or issuer to the participant or beneficiary; or
- (b) As part of any annual information packet sent to the participant or beneficiary,

whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. A plan or issuer may negotiate rates of reimbursement with providers of care.

7. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

8. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, 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.

9. For the purposes of this section, “reconstructive surgery” means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

**§ 689B.0376. Policy covering prescription drugs or devices to provide coverage of hormone replacement therapy in certain circumstances; prohibited actions by insurer; exception.**

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.

**§ 689B.03762. Policy covering prescription drugs to provide coverage for drugs irregularly dispensed for purpose of synchronization of chronic medications.**

1. An insurer who offers or issues a policy of group health insurance which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the insured’s chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and

(2) The insured requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the insurer.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. A policy subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) “Chronic medication” means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) “Synchronization” means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the purpose of improving a patient’s adherence to a prescribed course of medication.

(c) “Unit-of-use packaging” means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

**§ 689B.03764. Policy covering prescription drugs to provide coverage for early refills of topical ophthalmic products.**

1. An insurer who offers or issues a policy of group health insurance which provides coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is otherwise approved for coverage by the insurer when the insured, pursuant to NRS 639.2395, receives a refill of the product:

(a) After 21 days or more but before 30 days after receiving any 30-day supply of the product;

(b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or

(c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.

2. The provisions of this section do not affect any deductibles, copayments or coinsurance authorized or required pursuant to the policy of group health insurance.

3. A policy of group health insurance subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2016, 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 this section is void.

4. As used in this section, “topical ophthalmic product” means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a dropper.



**§ 689B.03766. Policy covering maternity care must not deny coverage for gestational carrier; status of child in relation to intended parent.**

1. An insurer that offers or issues a policy of group health insurance that includes coverage for maternity care shall not deny, limit or seek reimbursement for maternity care because the insured is acting as a gestational carrier.
2. If an insured acts as a gestational carrier, the child shall be deemed to be a child of the intended parent, as defined in NRS 126.590, for purposes related to the policy of group health insurance.
3. As used in this section, “gestational carrier” has the meaning ascribed to it in NRS 126.580.

**§ 689B.0377. Policy covering outpatient care to provide coverage for health care services related to hormone replacement therapy; prohibited actions by insurer.**

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.

**§ 689B.0378. Required provision concerning coverage for drug or device for contraception and related health services; prohibited acts; exceptions.**

1. Except as otherwise provided in subsection 7, 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 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) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same policy of group health insurance;

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

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

(f) Voluntary sterilization for women.

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

3. 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.

4. Except as otherwise provided in subsections 9, 10 and 12, 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.
5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.
6. Except as otherwise provided in subsection 7, 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.
7. 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.
8. If an insurer refuses, pursuant to subsection 7, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.
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 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.

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 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.

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

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

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

(d) “Therapeutic equivalent” means a drug which:

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

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

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

**§ 689B.03785. Required provisions concerning coverage for certain services, screenings and tests relating to wellness; prohibited acts.**

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.

**§ 689B.0379. Required provision concerning coverage for treatment of temporomandibular joint.**

1. Except as otherwise provided in this section, no policy of group health insurance may be delivered or issued for delivery in this state if it contains an exclusion of coverage of the treatment of the temporomandibular joint whether by specific language in the policy or by a claims settlement practice. A policy may exclude coverage of those methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.
2. The insurer may limit its liability on the treatment of the temporomandibular joint to:

(a) No more than 50 percent of the usual and customary charges for such treatment actually received by an insured, but in no case more than 50 percent of the maximum benefits provided by the policy for such treatment; and

(b) Treatment which is medically necessary.

3. Any provision of a policy subject to the provisions of this chapter and issued or delivered on or after January 1, 1990, which is in conflict with this section is void.