

State of Nevada

Silver State Health Insurance Exchange
2310 S. Carson St. #2
Carson City, NV 89701



Nevada Health Link Policy Manual

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Version 2.0

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Nevada Health Link is releasing a Draft Policy Manual for operations as a State Based Exchange. This Manual will serve as the agency's guiding policies as set forth by the Patient Protection and Affordable Care Act (PPACA) and Code of Federal Regulations (CFR) to operate the Nevada Health Link, a State Based Exchange Platform Technology.

Nevada Health Link welcomes comments on this Draft Policy Manual. To the extent that this manual summarizes policies through other rulemaking processes that may have not yet been finalized, stakeholders should comment on those underlying policies through the ongoing rulemaking processes, and not through the comment process for this Manual. Please send comments on aspects of this Manual in writing to Jamie Sawyer jlsawyer@exchange.nv.gov and cc Justin Prazak jprazak@exchange.nv.gov by September 4, 2020. Comments will be most helpful if organized by sections of this Manual outlined in the table of contents.

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1 Overview

1.1 Objective

This document accomplishes the following:

- It provides important information about Nevada Health Link policy requirements.
- It serves as a tool for the proper handling of Nevada Health Link consumer cases.

NOTE: The Nevada Health Link Policy Manual is updated regularly to reflect federal, state, and **local** regulations. It is also updated to improve consumer experience on the Exchange.

1.2 Important Definitions

Advance Premium Tax Credit (APTC)	The Affordable Care Act (ACA) allows individuals to qualify for a tax credit, based on income level and household size, to lower the cost of their monthly premium for insurance plans sold on Nevada Health Link.
Affordable Care Act (ACA)	A federal health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act. It was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
Agent of Record (AOR)	The licensed agent who helps enroll a consumer via the consumer's Exchange account.
American Indian & Alaska Native (AIAN)	A member of a federally recognized tribe, or Alaska Native tribe, band, nation, Pueblo, village, or community that the Department of the Interior acknowledges as an Indian tribe, including Alaska Native Claims Settlement Act (ANCSA) regional village corporations.
Authorized representative	An individual chosen by the consumer to act on their behalf with the Nevada Health Link platform (often a family member or another trusted person). Some authorized representatives might have legal authority to act on the consumer's behalf.
Plan year	A calendar year for which a health plan provides coverage for health benefits.
Centers for Medicare and Medicaid Services (CMS)	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated marketplace.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	A law passed by the U.S. Congress that, among other things, mandates an insurance program which gives some employees the ability to continue health insurance coverage in a group plan after leaving employment.
Code of Federal Regulations (CFR)	The Code of Federal Regulations (CFR) is the codification of the general and permanent rules and regulations (sometimes called administrative law), published in the Federal Register by the executive departments and agencies of the federal government of the United States.
Cost sharing	The share of costs covered by insurance that an individual pays out of their own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

Cost Sharing Reductions (CSR)	A discount that lowers the out-of-pocket expense for health coverage. It's available for individuals/families that earn up to 250 percent of Federal Poverty Level, or for American Indians up to 300 percent. See cost sharing.
Crosswalked plan	A mapping of plan enrollment from one year to the next, used for renewal purposes. For example, a 2019 plan to the 2020 plan that is either the same or most appropriate and similar if the same plan isn't available.
Dependent	Dependents are typically children or spouses/partners of insured individuals. When individuals buy health insurance, they usually have the choice to buy a plan that covers their spouse, partner, or children. Some plans may allow other individuals in their care to be covered under the plan. See also qualified dependent.
Division of Welfare and Supportive Services (DWSS)	Under the State of Nevada Department of Health and Human Services, the Division of Welfare and Supportive Services is the state agency responsible for determining eligibility for Nevada Medicaid benefits.
Employer contributions	Any financial contribution toward an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer, including those made by salary reduction agreement that is excluded from gross income.
Enrollee	A person enrolled in a QHP or off-Exchange plan (see also qualified individual).
Essential Health Benefits (EHBs)	Healthcare service categories that must be covered by Qualified Health Plans and certain plans starting in 2014. Essential Health Benefits must include items and services within each of the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
Failure to Reconcile (FTR)	The failure of a tax-paying individual to submit IRS Form 8962 to report the amount of advance tax credit used versus the tax credit for which the individual qualifies based on the actual income for that year.
Federal Poverty Level (FPL)	A measure of income level issued annually by the Department of Health and Human Services. Federal Poverty Levels are used to determine your eligibility for certain programs and benefits.
Group health plan	An employee benefit plan that provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
Hardship Exemption	A hardship exemption is an exemption from the shared responsibility payment; or access to a catastrophic health plan if an individual is over the age of 30
Health insurance coverage	Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.
Health plan categories (also known as "metal plan levels")	Plans sold on an Exchange/marketplace are primarily separated into three Health Plan Categories (also known as metallic levels)—Bronze, Silver, or Gold—based on the percentage the plan pays of the average overall cost of providing essential health benefits to members.

Household (HH)	Generally considered to be the primary subscriber, their spouse (if married), and any tax dependents.
Individual Coverage Health Reimbursement Arrangement (ICHRA)	<p>A type of Health Reimbursement Arrangement that reimburses medical expenses, like monthly premiums, and requires eligible employees and dependents to have individual health insurance coverage or Medicare Parts A (Hospital Insurance) and B (Medical Insurance) or Part C (Medicare Advantage) for each month they are covered by the individual coverage HRA.</p> <p>An employer can offer an individual coverage HRA instead of other job-based insurance that meets requirements for affordability and minimum value standards.</p> <p>Employees and dependents with an individual coverage HRA offer qualify for premium tax credits only if the employer's offer doesn't meet minimum standards for affordability, and they opt out of individual coverage HRA coverage.</p>
Individual Shared Responsibility Payment	Tax penalty that one must pay if they did not meet the requirements of having insurance or an exemption. Starting 2019 the penalty has been reduced to \$0.
Minimum Essential Coverage (MEC)	The type of coverage an individual must have to meet the individual responsibility requirement under federal law. This includes individual market policies, some employer-sponsored coverage, Medicare, Medicaid, SHIP, TRICARE, and certain other coverage.
Minimum value standard	A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals covered by employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit.
Nevada Health Link SBE Platform	Nevada Health Link is the website created by the state agency, the Silver State Health Insurance Exchange (SSHIX) to help Nevadan's find and purchase health insurance that fits the needs of Nevadan's.
Open Enrollment (OE) Period	The period during which individuals who are eligible can apply for a tax credit and enroll in a Qualified Health Plan through Nevada Health Link.
Plan Year (PY)	A 12-month period of when the individual plan begins and ends coverage. Nevada's plan year begins January 1 and ends December 31 of each calendar year.
Policy Steering Team (PST)	A leadership group that includes representation from carriers, Nevada Department of Insurance (DOI), Nevada Health Link, Enrollment Professionals, and Department of Welfare and Supportive Services (DWSS), which meets monthly to review and update Nevada Health Link policy to comply with the CFR, State of Nevada regulations, and consumer experience needs.
Qualified Dental Plan (QDP)	A dental insurance health plan that is qualified for use on the Exchange.
Qualified dependent	A dependent that may be claimed by the primary subscriber as a member of the household to qualify for an APTC (see also dependent).
Qualified Health Plan (QHP)	An insurance plan that is certified by the Exchange/marketplace. It must provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements.

Qualified individual	A person that qualifies to enroll in health insurance through the Exchange (see also enrollee).
Qualifying Life Event (QLE)	A change in an individual's life can make them eligible for a Special Enrollment Period (SEP) to enroll in health coverage. Examples of Qualifying Life Events (QLE) include moving to a new state, changes in income, or changes in family size (for example, marriage, divorce, and having a baby). This may also be referred to as a Life Change Event (LCE), but that does not guarantee that it is an SEP qualifier.
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	Small employers who don't offer group health coverage to their employees can help employees pay for medical expenses through a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). If your employer offers you a QSEHRA, you can use it to help pay your household's health care costs (like your monthly premium) for qualifying health coverage.
Reasonably compatible	The Exchange must consider consumer information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant's attestation of their eligibility. If the difference or discrepancy of applicant information does not impact the eligibility of the applicant, including the amount of advance premium tax credit or category of cost sharing reductions, then the applicant information is considered reasonably compatible.
Remote Identity Proofing (RIDP)	RIDP is the process of verifying a consumer's identity. This may be done based on answers about your credit history, demographics, or other information. If this cannot be done electronically, a consumer may be required to provide documentation to establish identity. This is a required step in applying for coverage.
Second Lowest Cost Silver Plan (SLCSP)	The second-lowest priced Exchange QHP in the Silver category for which a consumer is eligible. Consumers need to know their SLCSP premium to figure out their final premium tax credit (the SLCSP may not be the plan the consumer selects, but it will affect tax credit amounts). The SLCSP premium is listed on the Form 1095-A.
Silver State Health Insurance Exchange	The state agency that oversees and operates the online health insurance marketplace in Nevada.
Special Enrollment Period (SEP)	A time outside of the annual Open Enrollment Period during which an individual may sign up for, or make a change to, a Qualified Health Plan (QHP) because of a Qualifying Life Event (QLE).
Split household	A household (HH) that is allowed to split APTC onto different policies based on qualified circumstances.
State-Based Exchange (SBE)	A market (aka, the Exchange) where individuals, families, and small businesses can <ul style="list-style-type: none"> • learn about some of their health coverage options, • compare health insurance plans based on cost, benefits, and other important factors, • choose a health insurance plan, and • enroll in coverage.
Student Health Insurance Plan (SHIP)	A health insurance plan qualified to meet federal requirements for students to carry coverage.
System for Electronic Rate and Form Filing (SERFF)	A system designed with the intent to provide a cost-effective method for facilitating the submission, review, and approval of product filings between regulators and insurance companies.

Tax filer	An individual or married couple that expects to <ul style="list-style-type: none">• file an income tax return for the benefit year,• file a joint tax return for the benefit year, if married,• not be claimed by any other taxpayer as a tax dependent for the benefit year, and• claim a personal exemption deduction on their tax return for one or more applicants, which might or might not include self, or self and spouse.
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2 Advance Premium Tax Credit (APTC)/Cost Sharing Reduction (CSR)

2.1 Who Is Eligible

45 CFR 155.305 (f)(g); 45 CFR 155.335

To be eligible to receive the APTC, the consumer must meet certain requirements, including each of the following:

- A United States citizen, national, or “lawfully present”
 - Lawfully present means a non-citizen holds one of the immigration statuses that qualifies as “lawfully present.” See [APTC 2.3: What Is Considered Lawfully Present](#).
 - A consumer holds citizenship or a “lawfully present” status for the entire enrollment period.
- A resident of Nevada
- NOT incarcerated
- A modified, adjusted gross income between 138 percent and 400 percent of the Federal Poverty Level
- A tax filer who is married and filing jointly OR single and filing single

NOTE: Nevada consumers have 90 days from date of Nevada Health Link’s request to provide the documents necessary for a manual verification process, if needed. See [APTC 2.3: What Is Considered Lawfully Present](#).

2.2 Eligibility Verification Standards

45 CFR 155.305 (f)(1-6); 45 CFR 155.315 (a-j); 45 CFR 155.320 (a-e); 45 CFR 155.330 (a-g); 45 CFR 155.335

The Exchange follows the verification standards plan approved by Centers for Medicare and Medicaid Services (CMS).

Forms of documentation commonly used to verify U.S. citizenship or legal status: U.S. passport or passport card, certificate of naturalization, certificate of U.S. citizenship, documented evidence issued by a federally recognized Indian tribe, U.S. birth certificate, copy of the front and back of a resident alien card, or copy of another form of documentation showing legal status

Forms of documentation commonly used to verify income: Wage stubs, tax returns, unemployment benefit statements, Schedule C or E for self-employment earnings, bank statements showing regular deposits, accountant statements, bookkeeping records, or a statement from a knowledgeable source. In addition, the following interfaces are checked to verify income: Department of Labor, Federal Tax Interface, Social Security Administration, and The Work Number.

2.3 What Is Considered Lawfully Present

45 CFR 155.300; 45 CFR 155.305; 26 CFR 1.36-b (2)

- Lawful Permanent Resident (LPR) (without having met the 5-year bar)
- Individual who is seeking, or has been granted, political asylum
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant (granted before 1980)
- Battered spouse, child, or parent

- Victim of trafficking and his/her spouse, children, siblings, or parents
- Granted withholding of deportation or withholding of removal (under immigration laws or under Convention Against Torture (CAT))
- Temporary Protected Status (TPS)
- Lawful Temporary Resident (LPR)
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, Marshal Islands, and Palau)
- Administrative order staying removal issued by the Department of Homeland Security
- Member of federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa
- Deferred Enforced Departure (DED)
- Deferred action status (ineligible for APTC if granted deferred action under DACA program)

OR

An applicant for any of these statuses:

- Adjustment to LPR status
- Temporary Protected Status (TPS) with employment authorization
- Special immigrant juvenile status
- Victim of trafficking visa
- Asylum (those who are granted employment authorization, or are under the age of 14 and have had application pending at least 180 days)
- Withholding of deportation or withholding removal (under immigration laws or under CAT)

OR

With employment authorization:

- Registry applicants
- Order of supervision
- Applicant for cancellation of removal or suspension of deportation
- Applicant for legalization under Immigration Reform and Control Act (IRCA)
 - Legalization under the Legal Immigration Family Equity Act (LIFE)

2.4 Tax Filing Requirements

45 CFR 155.320(c)(B); 45 CFR 155.335

To receive a tax credit, consumer tax returns must be filed as Single, and be unmarried, or divorced. Otherwise, they must file as Married Filing Jointly, if they are living with, or apart from, their spouse AND they are filing taxes together (with spouse).

2.5 Income Eligibility Limits

45 CFR 155.320(c)

Consumers' taxable income must be between 138% and 400% of the Federal Poverty Level to be eligible to receive a tax credit.

Special Income Rule: Lawfully present individuals who are ineligible for Medicaid due to immigration status may be eligible for APTC if household income is less than 138% of the Federal Poverty Level. A family can determine their APTC status by completing the application process.

2.6 Income for APTC Calculation

45 CFR 155.320 (c)(ii); 45 CFR 155.320 (E)(ii)(iii)

Income is used to determine whether an individual or family is eligible to receive APTC, and, if they are eligible, how much APTC they receive.

Tax credits are calculated on taxable income including the following:

- Wages/salaries
- Social Security retirement and Social Security disability
- Unemployment
- Self-employment
- Tips and gratuities
- Compensation for personal services
- Farm income

Non-taxable income is not factored into APTC calculations. This income can include the following:

- Supplemental Security Income (SSI)
- Child support
- Workers' compensation
- Temporary Assistance for Needy Families (TANF)
- Veteran's benefits
- Federal income tax refunds
- Insurance proceeds (accident, health, and life)

2.7 Verification of Income for a Financial Application

45 CFR 155.320 E (iii)

To receive a tax credit, Nevada Health Link must use electronic interfaces to verify the applicant's self-attestation of income. If the data returned is not reasonably compatible, further documentation will be required from the applicant to verify income.

NOTE: Reasonable compatibility is a standard of measure utilized to verify that an applicant's income is between 138 percent and 400 percent of Federal Poverty Level, which would qualify them for tax credit.

NOTE: There are two applications for consumers. A financial application is used for individuals and families who would like to apply for tax credits. A non-financial application is used for individuals or families who do not qualify for a tax credit.

2.8 Determining Tax Credit Amount

26 CFR 1.36 B-1

To determine the tax credit, several factors are taken into consideration. The following are reviewed by the Nevada Health Link:

- Age of consumer(s) as of January 1 of the benefit year
- Household's anticipated, modified adjusted gross income
- Household size
- Number of household members eligible for APTC
- County

APTC tax households include all the individuals that the primary taxpayer will claim an exemption for including

the following:

- Self
- Spouse
- Qualified children (up to age 24)
- Qualified dependents

In cases of divorce, the parent who claims the child as a dependent on their tax returns is the only parent who can claim the child for their APTC calculation.

NOTE: If a child is primarily living with a parent who does not claim them on their taxes, the child may be eligible for Medicaid under MAGI (Modified Adjusted Gross Income) Medicaid rules. In this case, the parent seeking APTC can claim the child in their tax household, but the child cannot be given APTC, since they are eligible for MEC through the other household.

2.9 Calculating Age for Household Members

The Nevada Health Link will calculate APTC using the ages of the family members as of their coverage start date.

2.10 Household Composition

To align with federal tax households, Nevada Health Link allows the following household relationships to be considered as part of the APTC calculation: spouse, child, adopted child, stepson/stepdaughter, ward, and anyone who is in your legal custody (e.g., grandchild). Everyone in a tax household must be included in the APTC calculation.

NOTE: Nevada Health Link's policy is that tax dependent status automatically ends when individuals turn 24. For more details, see [APTC 2.12: 24-Year-Old Dependents and APTC Eligibility](#).

2.11 Household Plan Enrollment

Tax families must all be included in an APTC calculation, and they must enroll in a health insurance plan. Family members may be able to enroll in different plans through a manual process.

2.12 24-Year-Old Dependents and APTC Eligibility

In general, when a child turns 24, that child can no longer be claimed as a "qualified child" on a tax form, so they are no longer eligible for APTC under a parent's application.

In APTC households, when a child turns 24, their dependent status automatically drops at the end of their birthday month. This removes the 24-year-old from the household APTC eligibility, but the child remains covered on the plan and is responsible for the full unsubsidized premium.

If the 24-year-old child prefers to apply for APTC on their own, they may do so by creating a new application. This loss of coverage would qualify them for an SEP. See Special Enrollment Period.

In rare cases, a child who is over 24 may be claimed as a "Qualified Dependent," assuming other IRS-defined qualification criteria are met, if a consumer believes their child is a "Qualified Dependent," they should contact the Nevada Health Link Consumer Assistance Center.

2.13 Employer-Sponsored Coverage

26 CFR 1.36 (b-2)(C)(3); 26 CFR 1.36 (b-1)(e)(2); 26 CFR 1.36(b)(3); 26 CFR 601.105; 45 CFR 155.320(b)

Employer coverage is considered affordable—as it relates to the premium tax credit—if the employee's share of the annual premium for the lowest priced self-only plan is no greater than 9.78% of annual household income. Employees, and their spouse and dependents that are offered employer-sponsored coverage that's affordable

and provides minimum value are not eligible for a premium tax credit. If someone thinks their employer-sponsored coverage does not meet minimum essential coverage, minimum value standard, or affordability requirements, they may file an appeal to have coverage reviewed for APTC eligibility.

2.14 Applying for APTC When Enrolled in Retirement Coverage

26 CFR 1.36 B-2(c)(3)(v); 45 CFR 156.145

If someone is enrolled in retirement health insurance coverage, they can only apply for a tax credit and purchase health insurance if their current coverage does not qualify as minimum essential coverage and it is Open Enrollment.

NOTE: If coverage ends outside of the Open Enrollment period and they choose not to re-enroll, they would be eligible for a Special Enrollment Period.

2.15 Applying for APTC When You Have COBRA

26 CFR 1.36 B(c)

Nevadans who are offered Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) coverage can choose to apply for APTC instead of enrolling in COBRA.

If an individual is enrolled in COBRA coverage, they must wait until that coverage expires, employer contribution to the COBRA enrollment ceases, or until Open Enrollment before applying for APTC or enrolling on the Exchange. They will not be eligible to enroll on the Exchange or receive APTC until their COBRA coverage expires, the employer stops contributing to COBRA, or Open Enrollment allows them to voluntarily leave their COBRA policy and begin a new policy on the Exchange.

NOTE: If an individual is enrolled in COBRA coverage and cease COBRA early due to non-payment they will not qualify for a special enrollment period outside of open enrollment.

2.16 Medicare and APTC

26 CFR 1.36 (B)(c)(2)(v)

- Individuals who receive Medicare are not eligible to receive APTC.
- Individuals who receive **Medicare Part A** at a cost may drop Part A and Part B coverage, or they can choose not to enroll in Medicare at the time they become eligible (these individuals may be subject to tax penalties or Medicare penalties if they defer Medicare enrollment outside of the qualifying time).
- Individuals who receive free **Medicare Part A** cannot drop it without also dropping their retiree benefits (i.e., Social Security) and paying back all received retirement benefits and costs incurred by the Medicare program.
- Individuals over 65 years old who elect not to receive retirement benefits may be eligible for APTC.

NOTE: Medicare Part B alone is not considered minimum essential coverage. However, if someone is eligible for Part B, it is assumed they are also eligible for Part A, and they won’t be eligible for APTC.

2.17 Tax Credit Amount for Automated Renewal

45 CFR 155.340 (f)

When Nevada Health Link re-enrolls consumers, the APTC amount is automatically set so that 100 percent is

applied to the monthly premium. If a consumer prefers a different percentage applied to their monthly premium, they can log into their account to adjust it at any time, which will be effective the first of the month following the change.

Nevada Health Link automatically renews consumer coverage even if they lose eligibility for a tax credit (APTC) or cost-sharing by renewing them into corresponding plans without APTC or cost-sharing benefits.

2.18 Appeals

45 CFR 155.500 – 45 CFR 155.555

The Nevada Health Link will accept appeals for enrollment eligibility, calculations of APTC and/or CSR, eligibility for open enrollment or special enrollment, and failure of timely determination.

Individuals have 90 days from the date of their eligibility notice to file an appeal on any issue listed above. Appeals are submitted by following the instructions on the www.NevadaHealthLink.com site.

The Nevada Health Link will send a letter confirming receipt of the Appeals request and explanation of health coverage while the appeal is pending. The appeal process can take up to 90 days, however the Nevada Health Link will work to resolve appeals promptly.

2.19 Cutoff Date for APTC Redetermination

Information submitted for redetermination of advance premium tax credit and cost sharing reductions must be complete by January 15 to correspond with the end of open enrollment. [See section 6.27 Deadline for Coverage during Open Enrollment](#)

NOTE: If a consumer is eligible for a Special Enrollment Period, the household APTC can be calculated or re-calculated during this time.

2.20 APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Consumers who are currently enrolled on the Exchange with financial assistance and experience a change in APTC will have their updated APTC amount applied to their enrollment starting the first of the month following the date that the updated application is received by Nevada Health Link.

Consumers who are currently enrolled on the Exchange with no financial assistance and gain eligibility for APTC will have their new APTC amount applied to their premiums effective the date of eligibility.

Consumers who are not enrolled and receive a new APTC eligibility determination, or who are currently enrolled and have a change in Cost Share Reduction, will have their new APTC and/or CSR level amount applied to their enrollment following the enrollment rule, or per any guidelines due to Special Enrollment Periods, complex cases, or appeals resolution (see [7.6 APTC and CSR Effective Date](#) and [9.1 Qualifying Life Events for Special Enrollment Period](#)).

2.21 Financial Application

If a financial application is not acted upon within 60 days of approval the application will be closed in Nevada Health Link's system. The consumer(s) receives notification to take action before the application closes. The consumer is required to re-apply for future financial application approval.

2.22 APTC Capping

When a consumer household gains a dependent through birth, adoption, foster placement, or court order coverage for that dependent gain will start on the day of the birth, adoption, foster placement, or court order and premiums may reflect a partial month change. APTC subsidy amount will be adjusted as of the first of that month of the gain but will not be allowed to be granted at a higher rate than the adjusted monthly premium based on a potential partial month change.

3 Application

3.1 Eligibility Verification Documents

Forms of documentation commonly used to verify U.S. citizenship or legal status: U.S. passport or passport card, certificate of naturalization, certificate of U.S. citizenship, documented evidence issued by a federally recognized Indian tribe, U.S. birth certificate, copy of the front and back of a resident alien card, or copy of another form of documentation showing legal status

Forms of documentation commonly used to verify income: Wage stubs, tax returns, unemployment benefit statements, Schedule C or E for self-employment earnings, bank statements showing regular deposits, accountant statements, bookkeeping records, or a statement from a knowledgeable source.

3.2 Address

4 CFR 435.403(f)

Financial and non-financial consumers applying for health insurance coverage through Nevada Health Link must provide a physical address on their application.

Consumers who lack a physical address may contact a broker or the Nevada Health Link Consumer Assistance Center in order to complete their application. Consumers will be directed to work with the Nevada Secretary of State's Confidential Address Program or to complete a Residency Affidavit as appropriate.

3.3 Plan Selection

To complete enrollment a consumer will need to select a plan that best fits their personal needs. If a consumer does not select a plan during the designated Open Enrollment Period they will need to wait to see if they qualify for a SEP.

4 Dental

4.1 Open Enrollment

45 CFR 155.410

Dental insurance has the same Open Enrollment and special enrollment periods as health insurance.

4.2 Rate Codes

To determine the dental premium, count members of the household age 19 or older and the three oldest children who are still 18 years old or younger, and add their individual premium amounts together to get the household premium amount.

4.3 Pediatric Dental Age Limits

Anyone 18 years of age or under can enroll in a pediatric dental plan.

4.4 Pediatric Dental Plans

Households with dependents are not required to purchase Qualified Health Plans with embedded pediatric dental or child-only dental plans.

4.5 Disenrollment

Consumers can end dental coverage without terminating health coverage.

Consumers enrolled in a pediatric dental policy will be automatically disenrolled at the end of the month in which they turn 19.

Consumers enrolled as dependents on a dental policy which includes adult coverage, will be automatically disenrolled at the end of the year in which they turn age 26. However, if applicable, Advanced Premium Tax Credits (APTC) will cease for consumers at the end of the month in which they turn age 19. See Dental 4.7: APTC for loss of APTC for dental coverage at age 19.

See also [Insurance 6.29: Disenrollment](#).

4.6 Renewals

45 CFR 155.335 (j); 77 FR 18309, 18315

Dental health insurance plans will be renewed for consumers during the Open Enrollment period.

4.7 APTC

45 CFR 155.1030; 45 CFR 155.340; 26 CFR 36B-3(e)

Tax credits (APTC) may only be applied to pediatric dental when it is part of healthcare coverage. Tax credits cannot be applied toward dental coverage for consumers age 19 or older.

4.8 Independent Purchase

Consumers will be able to shop and purchase a dental plan without the purchase of a Qualified Health Plan (QHP) associated with their account. The applicant will need to be deemed eligible by the Exchange to purchase a dental plan.

NOTE: APTC is not applicable to Independent Dental Purchases.

NOTE: Eligibility is dependent on citizenship status, Nevada residency, not incarcerated, and not deceased.

5 Hardship Exemption

45 CFR 155.605(d)(1)

5.1 Definition

Hardships exemption is an exemption from the shared responsibility payment; or access to a catastrophic health plan if an individual is over the age of 30.

5.2 Exemption and Catastrophic Plans

If an individual is under 30 years old, they can enroll in a Catastrophic plan whether they have an exemption or not.

If an individual is 30 years old or older, they can enroll in a catastrophic health plan only if they qualify for a hardship exemption.

5.3 Requesting an Exemption

The Centers for Medicare and Medicaid Services (CMS) is responsible for hardship exemption processing for Nevada. To find out more information on how to request an exemption, please visit www.healthcare.gov.

6 Insurance

6.1 Open Enrollment

45 CFR 155.410; 78 FR 13405;

NOTE: Nevada Health Link Open Enrollment dates are determined by the Secretary of the US Department of Health and Human Services, and the Nevada Health Link Board of Directors

[See section 6.27 Deadline for Coverage during Open Enrollment](#)

Plan Year	Open Enrollment Period
2021	November 1, 2020 – January 15, 2021
2020	November 1, 2019 – December 15, 2019
2019	November 1, 2018 – December 15, 2018

6.2 Service Area

Service area is determined from the primary contact’s physical address listed on the application.

NOTE: For exceptions to this policy, see [Application 3.2: Address](#).

6.3 Coverage Start Dates

45 CFR 155.330(f)

Nevada Health Link consumers who enroll in a health insurance plan between the 1st and the 15th of the month will receive coverage starting the 1st of the following month. Consumers who enroll in health insurance plans between the 16th and the end of the month will receive health insurance coverage starting the first of the month after the following month.

EXAMPLE: A consumer enrolls in a health insurance plan on May 15. They will start to receive health insurance coverage on June 1. If a consumer enrolls in a health insurance plan on May 16, their health insurance coverage will start July 1.

See [Special Enrollment Period](#) policies for exceptions.

6.4 Determining Premiums for Households with Dependents

There is no limit to the number of dependents allowed in a household. The three oldest dependents under the age of 21 are factored into the premium calculation from the date of enrollment. Any additional dependents under the age of 21 are covered under the plan at no additional charge.

Dependents age 21 and older have separate health insurance premiums and are billed in addition to the household premium.

NOTE: Minors who are married and have children are considered adults under this calculation formula. For child-only plans, the first three children are used to calculate the premium price and the rest are covered under the plan at no additional charge.

6.5 Calculating Distribution of APTC for Split Household Groups

When a household is split into multiple enrollment groups so a single household can purchase multiple plans or multiple households can purchase a single plan, the APTC will be split between the different family members using the following formula:

APTC offset % applied to each family member = (Total household APTC / Total household premium)

To split an APTC within a household, the household must be enrolled with the same carrier.

EXAMPLE: There are three individuals in a household, broken into two coverage groups:

Mom is on one policy;

Dad and Child are on a second policy;

The family's total APTC amount is \$700.

Actual premiums of second lowest cost silver plans chosen: \$330 Mom, \$525 Dad + Child = \$855 total

APTC offset % applied to each family member = (Total APTC: \$700 ÷ Total medical premium: \$855) = 81.87% of each person's premium that will be covered by APTC

APTC for each group: \$270.17 Mom, \$429.83 Dad + Child = \$700 total Premium after APTC: \$59.83 Mom, \$95.17 Dad + Child = \$155 total

6.6 Splitting APTC between Health Insurance and Dental Insurance

45 CFR 155.340; 26 CFR 1.36B-3(e)

Applicants who enroll in a QHP plan and are given APTC must use the APTC first for the QHP, and if there is any remaining amount of APTC the applicant can then apply the remaining APTC to a QDP pediatric dental plan.

Note: APTC must be applied to the QHP plans first.

6.7 Minimum Essential Coverage

45 CFR 155.420 (e)(6)

As defined earlier, minimum essential coverage (MEC) is any health insurance coverage that satisfies the individual shared responsibility penalty for years 2018 and prior. For years 2019 and beyond, the individual shared responsibility payment has been reduced to \$0. Any of the following plans are considered MEC:

- Any QHP sold on the Exchange (Catastrophic plans sold on the Exchange are considered MEC but are not considered eligible QHPs for application of the APTC.)
- Any employer-based plan that meets the affordability standards
- Any retiree plan
- COBRA
- Any plan with grandfathered status
- Medicaid coverage (excluding pregnancy)
- CHIP (Children's Health Insurance Program)
- Coverage under a parent's plan until the age of 26
- Most student health plans (confirm with your school to see if the plan counts as qualifying health coverage)
- Certain types of veteran coverage
- TRICARE
- Peace Corps
- Part A or Part C Medicare

NOTE: Pregnancy Medicaid is not considered MEC. However, loss of pregnancy-related coverage opens a Special Enrollment Period. (45 CFR 155.420(d)(1)(iii))

Employees who currently have health insurance plans that meet minimum essential coverage requirements are not eligible to receive a tax credit. However, they may buy a health insurance plan through the Exchange without a tax credit. See [Important Definitions](#) for MEC.

6.8 Primary Contact

The primary tax filer for a household is the primary contact for the account.

NOTE: The primary tax filer cannot be changed if the same household composition exists pre- and post- tax filer change, unless it is a very extenuating circumstance.

6.9 Maximum Age of Dependent

The maximum age of a dependent on a health insurance policy is 25 years old. When an individual turns 26, they will need to go onto their own health insurance policy and be removed from the household policy. Nevada Health Link will allow 26-year-olds to stay on the household plan through December 31st of the year they turn 26.

NOTE: It is also important to know that, in general, when a child turns 24, that child may no longer be claimed as a “qualified child” on a tax form but could be claimed as a “qualified dependent,” assuming other qualifications are met based on IRS rules.

For more details, see [2.12 24 Year Old Dependents and APTC Eligibility](#)

6.10 Adding a Dependent during Open Enrollment

If a household has effectuated their health insurance coverage during the Open Enrollment period, they are not allowed to retroactively add another dependent to their plan unless there is an adoption or birth of a child.

NOTE: Consumers can choose to go through the appeals process if they feel they have an exception.

6.11 Children of Undocumented Immigrants

45 CFR 155.300, 305

Nevada Health Link allows children of undocumented immigrants to apply for health insurance coverage. If undocumented immigrants have a tax filer ID and the household files taxes, and the children are citizens, the children may be eligible for APTC even though the parents are not eligible to purchase insurance through the Exchange.

6.12 Unsupported Household Relationship Codes

If a health insurance carrier does not recognize an individual’s relationship to the primary subscriber as a covered relationship, see [SEP 9.1: Qualifying Life Events for Special Enrollment Period, 9.2 SEP Matrix](#). Nevada Health Link will manually split the household to process the case. See [Insurance 6.5: Calculating Distribution of APTC for Split Household Groups](#).

6.13 Enrolling Families with Mixed CSR Status

If a family has mixed cost sharing reduction status, the family will be enrolled using the lowest common denominator CSR status, unless they request split health insurance plans.

6.14 Age in Medicare

45 CFR 155.305; section 1882 (d)(3) of Social Security Act; 26 CFR 1.36B-2;

If a Nevada Health Link consumer becomes eligible for Medicare during a benefit year in which they are enrolled in coverage through the Exchange, they will no longer be eligible for tax credits. If a consumer enrolls in a **Medicare Part A** plan and notifies Nevada Health Link, their health insurance policy through Nevada Health Link will be canceled. In the event a consumer doesn't terminate their plan upon converting to Medicare, Nevada Health Link may backdate terminations on Medicare-eligible consumers at the request of the carrier or consumer.

Conversely, if Nevada Health Link learns that a consumer is eligible for **Medicare Part A**, the consumer will be notified that they are no longer eligible to receive a tax credit, but they can still maintain their enrollment.

Consumers will also be informed if they can cancel their coverage and enroll in **Medicare Part A**. Nevada Health Link allows individuals to purchase a full price Qualified Dental Plan from the Exchange without APTC, see [Dental 4.8: Direct Purchase](#).

6.15 Dual Enrollment in Medicaid and Full Price QHP

If Nevada Health Link becomes aware of a consumer accepted into Medicaid, Nevada Health Link will automatically drop APTC eligibility and disenroll the consumer.

6.16 Plan Eligibility

Eligibility is determined based on eligibility results, not a household's application.

EXAMPLE: If a household of four applies for health insurance coverage but one person is deemed ineligible, then the other three members of the household can still enroll in health insurance.

6.17 Displaying Health Insurance Plans in the System

Nevada Health Link shows consumers all Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs) within their county address that are reviewed by the Nevada Department of Insurance and certified by the Silver State Health Insurance Exchange. For plans effective 1/1/2020 and after, Nevada Health Link uses the county associated with the primary contact address.

6.18 Catastrophic Health Insurance Plans

Individuals who are under the age of 30 (even if they will turn 30 during the plan year) or who have an eligible [hardship exemption](#) number may enroll in catastrophic health insurance plans. See [Tax 10.1: 1095 A Tax Statement](#).

6.19 American Indians and Alaska Natives

Section 206 25 USC 1621e; and Section 408 25 USC 1647a

A carrier shall comply with all applicable federal laws, regulations, and all applicable requirements related to the provision of Health Plan coverage to American Indians and Alaska Natives (AIAN).

6.20 Tobacco Status

45 CFR 147.102 (a)(iv)

If a Nevada Health Link consumer has used tobacco products four times or more per week within the last six months, then they are considered a tobacco user.

Nevada Health Link will only allow smoking status to be determined during enrollment for the entire plan year until a subsequent enrollment is made during a valid Special Enrollment Period (SEP) or Open Enrollment Period (OEP)

For appeals for application misstatements, such as smoking, carriers will work with Nevada Health Link to update the consumer's information.

6.21 Electronic and Telephonic Signatures

Nevada Health Link will allow consumers to give their signatures either electronically or verbally over the phone for their health insurance applications.

6.22 Self-Attestation for Employer-Sponsored Coverage

Nevada Health Link will allow consumers to provide self-attestation on their access to employer-sponsored health insurance coverage.

NOTE: If an applicant has access to employer-sponsored coverage that meets the minimum essential coverage requirements, but claims they do not have access, they will be financially responsible for any accrued APTC that they were not entitled to.

6.23 Consumer Assistance & Complaint Resolution

45 § 155.205

The Exchange will provide assistance to all consumers seeking health insurance coverage through Nevada Health Link via phone, and email on issues such as enrollment, application changes, eligibility, life event changes and all questions related to the Exchange and the plans offered. Some of these processes may include, processing life event changes, special enrollment periods, eligibility verification, relationship management and issue resolution with carriers and APTC recalculations.

If a consumer has a complaint and/or dissatisfaction regarding any aspect of the consumer's experience with their online application, eligibility determination, or working with an Exchange call center representative, or an insurance carrier, the Exchange will ensure that the consumer is aware that they can call Nevada Health Link's toll-free number, **1-800-547-2927** to speak to a member of our call center staff who can assist them with their complaint.

6.24 QHP Certification Outside of Standard Timeframe

Nevada Health Link will only add Qualified Health Plans to the Exchange one time each year—the Exchange will not add any additional plans outside of the designated certification period, which is set by the Nevada Division of Insurance.

6.25 Active Application Timeframe

Once Nevada Health Link consumers have completed an application in the system, it will remain active throughout the Open Enrollment period.

6.26 Disenrollment by Carrier

Health insurance carriers will be allowed to disenroll consumers for non-payment, fraud, or intentional misrepresentation.

6.27 Deadline for Coverage during Open Enrollment

During Open Enrollment, if a household wants health insurance coverage to start by January 1, they must

complete their enrollment no later than December 15 of the prior year.

Consumers who enroll in coverage between 11/1/2020-12/31/2020 will receive a coverage effective date of January 1, 2021. Consumers who enroll in coverage between 01/01/2021-01/15/2021 will receive a coverage effective date of February 1, 2021.

6.28 Changing Plans during Open Enrollment

During the Open Enrollment period, a household may prospectively enroll, disenroll, or change their health insurance plan.

Updates to financial eligibility outside of Open Enrollment dates follow the enrollment rules in [APTC 20: APTC and CSR Effective Date](#). Special enrollment cases are reviewed individually during Open Enrollment to honor consumer coverage dates.

NOTE: See [Insurance 6.3: Coverage Start Dates](#) for coverage start dates.

6.29 Disenrollment

A Nevada Health Link consumer can voluntarily disenroll and set the date for the end of the current month, next month, or the following month. That date is always the last day of the month, unless it is death-related. Disenrollment for non-payment happens at the carrier's discretion and in accordance with state and federal law.

When a child is on a parent's health insurance policy, they are automatically disenrolled from the plan at the end of the year in which they turn 26. Dependents who turn 24 and lose their tax credit can remain on their parents' plan without APTC.

When a consumer or agent reports dual coverage and requests a termination of their Exchange policy, Nevada Health Link will:

- require documentation of group coverage,
- terminate to the last day of the month that the consumer reported; and
- retroactively terminate, if requested and validated within 14 days of the requested termination date.

When a consumer or agent reports a move from the state and requests a retro termination, Nevada Health Link will:

- terminate to the last day of the month in which the consumer reported the move to the Exchange.

Additionally, if a consumer fails to provide required verifications within the specified timeframe, the enrollment may be terminated to the last day of the month following the deadline.

Updated termination dates on enrollments are only applied through carrier or consumer appeals.

An enrollee may end their health coverage without terminating their dental coverage. However, if an enrollee was receiving APTC that was also applied to their dental coverage that APTC will end when their medical coverage ends.

See also [Dental 4.5: Disenrollment](#).

6.30 Agent Certification

Agents and brokers who wish to sell health insurance through Nevada Health Link must be actively licensed through the Nevada Division of Insurance and complete annual training, including Nevada

Health Link specific training sessions, and certification testing with passing scores. Agents are allowed three attempts to pass the test.

Nevada Health Link certified agents and brokers are required to adhere to the Nevada Health Link Broker Code of Conduct.

NOTE: If an agent fails the test three times, they can appeal only if a technical reason prevented them from passing on the final attempt.

6.31 Appeals

45 § 155.520

Appeals for enrollment and plan eligibility will need to be submitted to Nevada Health Link following the instructions available on the [Nevada Health Link](#) website.

Individuals have 90 days from the date of the notice of enrollment determination to file an appeal. Nevada Health Link will work to resolve appeals prior to hearing. Should an appeal require adjudication, the appeal will be heard by the Division of Welfare and Supportive Services for final determination. The Nevada Division of Welfare and Supportive Services will issue written notice of the appeal decision within 90 days of the date an appeal request is received.

Individuals seeking assistance to file an appeal may visit the Appeals section of the [Nevada Health Link](#) website; Call the Nevada Health Link Customer Service Phone Line at 1-800-547-2927 TTY 771; or work with their Agent of Record.

See [Advance Premium Tax Credit \(APTC\)](#) for information about appealing tax credits.

6.32 Appeals Decisions Definitions

Definitions	Description
Dismissed	Consumer or agent has requested to withdraw the request. Or , the requested actions are already reflected on account. Or , the consumer failed to appear at scheduled appeal hearing without cause.
Invalid	Appeal request is not accepted due to the following possible reasons: <ul style="list-style-type: none"> • Failure to submit your appeal request within 90 days from the date of your notice of eligibility determination. • Request does not constitute a valid subject of appeal under applicable regulations. • Request is not within the jurisdiction of Nevada Health Link. • Nevada Health Link does not have responsibility for hearing your appeal. Your appeal request relates to an eligibility determination for programs such as Medicaid, CHIP, or any other program outside of the authority of Nevada Health Link. • Information is missing from your appeal request form. • Additional clarification is required.
Overtured	Original decision has been changed based on statute, the Code of Federal Regulations and/or the Nevada Health Link Policy Manual.
Upheld	Original decision has not been changed based on statute, the Code of Federal Regulations and/or Nevada Health Link Policy Manual. If a decision is upheld, the

	consumer has 30 days from the date of receiving the informal resolution to request a formal appeal hearing conducted by the U.S. Department of Health and Human Services.
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6.33 Agent Disciplinary Action

If Nevada Health Link observes or becomes aware of fraudulent or unethical actions or behaviors from agents, brokers, or enrollment counselors, Nevada Health Link will formally send a compliance notice to the agents, brokers, or enrollment counselors. Failure to comply with compliance will allow Nevada Health Link, in its discretion, the ability to decertify the individual, precluding them from selling plans on the Exchange. Nevada Health Link will report concerns to the Nevada Department of Insurance (DOI) for further investigation and possible discipline by DOI.

NVHL will respond to consumer complaints and suspected agent, broker, or enrollment counselor ethical misconduct, breach of agreements, and regulatory violations by enrollment professionals. Compliance actions related to reported or suspected misconduct include, notices of complaints, formal compliance inquiries, suspensions from platform activity, and decertification. Compliance action will be based on suspected violation details, severity, history of conduct, and cooperation with compliance inquiries and corrective actions.

Decertification from Nevada Health Link may last for a designated period or be indefinite. Re-certification, subsequent compliance-based decertification, may include corrective training requirements. Corrective training requirements may also be attached to any level of compliance action prior to decertification. Nevada Health Link will report concerns to the Nevada Department of Insurance (DOI) for further investigation and possible discipline by DOI.

6.34 Reinstatement

Consumers requesting reinstatement for any reason must contact their insurance carrier and request to be reinstated.

6.35 Eligibility to Enroll on the Exchange

45 CFR 155.305

Nevada Health Link will allow a consumer whom shows proof of a Nevada address to enroll in an On Exchange plan. A Nevada Health Link consumer must also be one of the following:

- a citizen of the United States
- a non-citizen who is lawfully present and is reasonably expected to become a citizen or national
- a non-citizen who is lawfully present for the entire time in which enrollment is sought. A Nevada Health Link consumer is neither of the following:
 - incarcerated
 - receiving or eligible for Medicare coverage

6.36 Re-Enrollment Following Termination for Non-Payment

45 CFR 155.400e(1)(iv); 45 CFR 147.104-5

A consumer with a policy (or policies) previously terminated by the carrier for non-payment of premium, who re-enrolls on the Exchange, may be required by the carrier to arrange repayment of unpaid delinquent premiums due up to 12 months prior to effectuation of the new policy. The carrier may extend the binder payment deadline while the consumer makes payments on the delinquency.

Carriers may terminate coverage for a consumer's failure to complete the repayment option with the carrier.

6.37 Rate Calculation

Nevada Health Link calculates premium rates per the effective date of the covered member; Nevada Health Link does not recalculate rates per member on applications if there is only a change in CSR or if the primary subscriber leaves the plan and there are no other plan changes. Carriers may terminate coverage for a consumer's failure to complete the repayment option with the carrier.

6.38 Rate Review Process

NRS Chapter 687B

Nevada law requires prior approval by the Nevada Division of Insurance for any individual or small group rate change. Insurers are required to submit all proposed rate changes to the Division of Insurance for Evaluation.

For more information please visit the DOI's website on the [Rate Review Process](#)

7 Renewals

7.1 Automatically Renewing Coverage

45 CFR 155.335; 45 CFR 156.290 (5); 45 CFR 155.430

Nevada Health Link automatically renews consumer health insurance coverage for the next plan year if consumers are deemed eligible, and have elected into auto-renewal

If a consumer is deemed conditionally eligible for the next plan year, they are renewed. The consumer may need to supply additional information, if requested, to prove eligibility. Conditionally eligible consumers may have their APTC, or Exchange coverage automatically end if they do not provide the requested additional documentation within 30 days.

Nevada Health Link automatically renews consumer coverage even if they lose eligibility for a tax credit (APTC) or cost-sharing by renewing them into a corresponding plan without APTC or cost-sharing benefits.

Consumers who are no longer eligible to purchase health insurance on the Exchange are not renewed.

When an insurance carrier does not renew, or they are decertified by the Exchange at the end of the plan year, the Exchange terminates the consumer's enrollment at the end of the plan year. Consumers are automatically enrolled in a crosswalked plan, as directed by the Division of Insurance.

Consumers may change coverage during the Open Enrollment Period.

7.2 Changing Plans through Open Enrollment Period

Even if a consumer has already renewed their health insurance plan and paid for the coverage, they can still choose to change plans through the end of the Open Enrollment Period.

7.3 Changes to Cost Sharing Reduction or APTC

Even if there are changes to a consumer's cost sharing reduction level or tax credit, Nevada Health Link will automatically renew their coverage unless they have turned 26 and aged out of their family's qualified health plan, or they have specifically requested their health insurance coverage end with the plan year.

7.4 Changing Subscriber for Child-Only Policy

If a family has a child-only health insurance policy, the subscriber role will be assigned to the youngest child.

7.5 Carrier Use of Payment

45 CFR 155.400; 156.270

New enrollments completed during an eligible enrollment period require the first full payment to be made by the initial payment due date for coverage to become effective.

Renewed plans are considered a continuation of coverage and do not need an initial binder payment for coverage to be effective. The 90-day grace period for payment carries over for renewed enrollments if APTC is used to lower monthly premiums. If a delinquency exists on the account, carriers may apply any payments received to the delinquency.

7.6 APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Consumers who are currently enrolled on the Exchange with financial assistance and experience a change in APTC will have their updated APTC amount applied to their enrollment starting the first of the month following the date that the updated application is received by Nevada Health Link.

Consumers who are currently enrolled on the Exchange with no financial assistance and experience a change in APTC will have their updated APTC amount applied to their enrollment to match the approved effective date.

Consumers who are not enrolled and receive a new APTC eligibility determination, or who are currently enrolled and have a change in Cost Share Reduction, will have their new eligibility applied to their enrollment following the enrollment rule, or per any guidelines due to Special Enrollment Periods, complex cases, or appeals resolution (see [APTC 2.20: APTC and CSR Effective Date](#); [SEP 9.1: Qualifying Life Events for Special Enrollment Period](#); and [Special Enrollment Matrix](#)).

7.7 Carrier Terminations during Renewal Period

45 CFR 155.310; 45 CFR 155.340; 45 CFR 156.270

In cases in which a carrier does not communicate terminations for non-payment to Nevada Health Link in a timely manner (30 days prior to the renewal date), and renewals are processed, carriers will accept the renewal as a new enrollment, subject to enrollment rules and expectations.

Carriers will be able to dispute renewals that are processed within 30 days of the renewal date.

8 Small Business Health Options Program (SHOP)

8.1 Definition

Nevada Health Link's Small Business Health Options Program (SHOP) is open to small businesses in Nevada with up to 50 employees. Employees are defined as working 30 hours or more per week on average.

8.2 Enrolling in SHOP Insurance

Once you're ready to enroll in SHOP coverage, you will want to contact your selected insurance company and enroll directly through them.

To find out more information about SHOP coverage please visit the [Nevada Health Link Small business Health Options Program Page](#).

9 Special Enrollment Period

9.1 Qualifying Life Events for Special Enrollment Period

45 CFR 155.420

9.2 Special Enrollment Matrix

The **SEP Type** column reflects federal and Nevada Health Link designations:

1. Loss of MEC
2. Change in Household Size
3. Change in Residency (with Limitations)
4. Change in Financial Eligibility
5. Exceptions/Other
6. Change in Eligibility Status

The **Exchange Enrollment Required Prior to QLE** column indicates Nevada Health Link or MEC coverage, which must be ≥ 1 day of the previous 60 days

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	1.1	<p>Expiration of Off-Exchange Plan: Consumer loses coverage in any non-calendar year group health plan or individual health insurance coverage due to off-Exchange plan or coverage expiring. * Individual is eligible even if they have the option to renew their previous policy, including those enrolled on COBRA plans during group plan renewal time.</p>	Yes	MEC	Up to 60 days before event, through 60 days after event	<p>1st day of month following loss of coverage, if plan enrollment is completed before 1st day of month. If loss of coverage is reported after the event, effective date is the 1st of month following plan enrollment.</p>	45 CFR 155.420(d)(1)(ii)
Loss of MEC	1.2	<p>Loss of MEC: 1) Loss of subscriber (divorce, incarceration, or moves out of state) 2) Loss of employer coverage (must be MEC) 3) Moving into the state (requires proof of coverage if moving between US states; if moving from outside the country or from US territory, no prior proof of coverage required; see SEP 9.14) 4) Cancelled exemption 5) Aged out a. Child turns 26 b. Child applies as separate tax household. Example: Child turns 24 and ages out of family tax household (financial plan). c. Person turns 31 and becomes ineligible for catastrophic plan. 6) Loss of other coverage (TriCare, Peace Corps, or Medicaid, etc.) 7) Released from incarceration 8) Exhaustion or loss of employer contribution to COBRA enrollment</p>	Yes	MEC	Up to 60 days before event through 60 days after event	<p>If plan enrollment is completed prior to last day of the month, the 1st day of following month If plan enrollment is completed after last day of the month, the 1st of month after month following plan enrollment date.</p>	45 CFR 155.420(b)(2)(ii); 45 CFR 155.420(d)(1)(i); 45 CFR 155.420(c)(2)(ii); COBRA Overview and QSERHRA Assistance and Special Enrollment Period (SEP) Overview on https://www.cms.gov

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	1.3	Loss of MEC Due to Death of Subscriber: Consumer has loss of MEC due to death of subscriber in other application.	Yes	MEC	60 days from QLE (Loss of MEC)	Enrollment is terminated retroactive to 1 day after the date of death.	45 CFR 155.420 (b) (3)
Loss of MEC	1.4	Loss of MEC Due to Voluntary Termination: Subscriber chooses to terminate existing plan. Policy ends.* * Subscriber is not eligible to reapply.	No	N/A	Consumer reports to Carrier / Exchange	Consumer determines desired end date: 1. End of current month 2. End of next month End of third month	45 CFR 155.420(e)
Loss of MEC	1.5	Loss of MEC Due to Fraud: Subscriber performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.	No	N/A	NA	The discontinuance of coverage will have a retroactive effect to the beginning of coverage.	45 CFR 147.128(a)(2); 45 CFR 155.420(e)
Loss of MEC	1.6	Loss of MEC Due to Non-Payment: Subscriber decides not to pay.* * Dependents can appeal Exchange eligibility as "Loss of MEC" due to subscriber non-payment.	No	N/A	Carriers will report through cancellation 834s or will system-generate by Exchange	Financial Consumers: Termed retroactively to last day of month after last month in which premium was paid in full Non-Financial Consumers: Termed retroactively to end of last month premium was paid in full	45 CFR 156.270(d)(1); 45 CFR 155.420(e)
Loss of MEC	1.7	Subscriber Has Gain of MEC: Subscriber gains coverage through other means (includes incarceration of subscriber) or moves out of state (assumed will gain MEC in other state). Policy ends.* * Dependents can reapply for coverage following SEP Matrix 1.2 ("Loss of MEC" LCE") if they do not also gain MEC.	No	N/A	Up to 60 days before the event through 60 days after the event	On-Exchange coverage is terminated to the 1 st day of the month following gain of MEC when consumer disenrolls (and, if necessary, cancels financial eligibility).	45 CFR 155.420(c)(2)(ii)
Loss of MEC	1.8	Loss of SHIP (Student Health Insurance Program): Consumer needs coverage due to enrollment in a Nevada university.* SHIP must meet MEC criteria	Yes	SHIP	Up to 60 days before the loss of SHIP through 60 days after loss of SHIP	1 st day of month following plan enrollment	45 CFR 155.420(d)(i)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Loss of MEC	1.9	Loss of employer contribution to COBRA enrollment	Yes	COBRA	Up to 60 days before the event through 60 days after the event	1 st day of month following plan enrollment	45 CFR 155.420(d)(1)(i)
Change in Household Size	2.1	Gain Dependent to QHP Due to QLE: Dependent has QLE and doesn't have coverage on subscriber's policy. Dependent may or may not be an existing tax dependent on subscriber's application.* * If the HH has a change in APTC/CSR due to the gain of the dependent, follow "Change in APTC/CSR LCE."	Yes	Nevada Health Link	60 days from dependent's QLE	1 st day of month following plan enrollment	45 CFR 155.330 (f)(1)(iii); 45 CFR 155.420 (d)
Change in Household Size	2.2	Birth, Adoption, or Court-Appointed Ward	Yes	No	60 days from date of QLE	Retroactively to date of event OR The 1 st day of the month following plan enrollment * * For financial consumers, APTC and CSR are granted retroactively to the date of event, which is applied when the consumer reconciles their taxes. Additionally, an SEP is granted for parent(s) regardless of if child goes on CHIP or Medicaid. * Consumers who report an added dependent after Open Enrollment closes, but before the new plan year effectuates, may add the dependent on the date of the event or the first of the month following plan enrollment; additionally, they may enroll in a crosswalked plan for the upcoming plan year or select a new plan for the new year in a special enrollment period.	45 CFR 155.420(b) (2)(i)(1,2); 45 CFR 155.420 (d) (2)(i); 45 CFR 155.330(g);

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Household Size	2.3	Divorce* *If the consumer is not enrolled on the Exchange but experiences a loss of MEC due to divorce, refer to SEP Matrix #1.2.	Yes* *Eligible enrollees must lose coverage due to the divorce.	No	60 days from the effective date on the court order	1 st day of month following plan enrollment	45 CFR 155.420(d)(2)(ii)
Change in Household Size	2.4	Death of Dependent	No	N/A	N/A	Dependent is removed retroactively to date of death.	45 CFR 155.420 (b) (3); 45 CFR 155.420 (d)(2)(ii)
Change in Household Size	2.5	Loss of Dependent (Not Death or Loss of Subscriber): 1) Age out; 2) Incarceration of Dependent; 3) Give child up for Adoption; 4) Loss for another reason* * In some situations, dependents may qualify for loss of MEC.	No	N/A	N/A	1 st day of month following QLE (date of loss)	45 CFR 155.330 (f)(1)(iii); 45 CFR 155.420 (d)(2)(ii)
Change in Household Size	2.6	Marriage* If neither party is enrolled on the Exchange and the couple has a QLE, both can enroll; if one party is on Exchange, the subscriber can add a dependent or the couple may elect to enroll in a new plan; or, if both parties are on Exchange, parties can choose to remain on separate plans (if separate tax HH), or one party must disenroll and the other party adds the spouse to the policy. The Exchange recognizes any marriage legally enacted in a jurisdiction outside of Nevada and applies the federal definition of marriage, which includes same-sex couples.	Yes	No	60 days from QLE	1 st day of month following plan enrollment	45 CFR 155.420 (d)(2); 45 CFR 155.420(b)(2)(ii)
			At least one partner in a marriage-related QLE must demonstrate at least one day of coverage in 60 days prior to marriage, unless moving from out of country, per CMS guidelines (effective June 19, 2017).				

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Household Size	2.7	Subscriber Dies: Subscriber dies and policy ends on date of death.* * Dependents can reapply for coverage following SEP Matrix 1.3 ("Loss of MEC").	No	MEC	60 days from QLE	Termination is dated retroactively to the date of death.	45 CFR 155.420 (b) (3)
Change in Residency (with Limitations)	3.1	Permanent Move: Consumer has a change of physical address (within the state of Nevada) or moves into Nevada from other state or outside of country.	Yes*	MEC	60 days from QLE	1 st day of the month following plan enrollment	45 CFR 155.420 (d)(7); 45 CFR 155.420 (b)(2)(iv)
			* Only if qualified individual or consumer and dependents become eligible for different QHPs as a result of the move between zip codes and change service areas OR the move is from outside the state. Must demonstrate at least one day of coverage in 60 days prior to move, unless moving from out of country, per CMS Guidelines (effective July 11, 2016).				
Change in Residency (with Limitations)	3.2	Demographic Change: Consumer reports change in mailing address, name, or other demographic info.	No	N/A	N/A	Immediately	
Change in Financial Eligibility	4.1	APTC Amount Change: Exchange-enrolled household with existing APTC has a change in APTC amount, or it adjusts the APTC amount applied on the APTC slider.	No	Nevada Health Link	N/A	APTC will be applied the 1 st day of the month following the approval of the application. *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 2.20.)	45 CFR 155.330(f)(1)(i); 45 CFR 155.420 (d) (6); 45 CFR 156.425(b)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Financial Eligibility	4.2	APTC Amount Change: Exchange-enrolled household with no previous APTC becomes eligible for APTC (no CSR).	Yes	Nevada Health Link	60 days from date of QLE	Change effective date will follow the 1 st of the month enrollment rules, or if a plan change is completed the effective date of the new plan selected will follow in line with the 15/16 rule. Updated APTC will be applied the 1st day of the month following the date of the approved application. *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 2.20.)	45 CFR 155.330(f)(1)(i); 45 CFR 155.420 (d) (6); 45 CFR 156.425(b)
Change in Financial Eligibility	4.3	CSR Tier Change or Change in CSR Eligibility: Exchange-enrolled household is newly eligible or ineligible for CSR or has a change in CSR tier eligibility.	Yes	Nevada Health Link	60 days from date of QLE	Coverage effective date will follow the 1 st of the month enrollment rules if a plan change is completed. Updated CSR will be applied the 1 st day of the month following the receipt of the DWSS approved application.* *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 2.20.)	45 CFR 155.420(d)(4); 45 CFR 155.420 (d)(6); 45 CFR 155.330(f)(3); 45 CFR 156.425(b);
Although 155.420(b(1) indicates that plan enrollment follows the "15-day rule," the Exchange has determined that it is best for both the Exchange and the consumer to follow the effective date that aligns with the CSR tier change as identified in 155.330(f)(3)."							
Change in Financial Eligibility	4.4	Income Change: Non-Exchange household reports a decrease change in income.	Yes	N/A	60 days from date of QLE	Coverage effective date will follow the 15/16 rule. Required to show a decrease in income, and proof of MEC within the last 60 days prior to the decrease in income.	45 CFR 155.420(d)(6)(v)(A)(B)(C)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Financial Eligibility	4.5	Newly Eligible or Ineligible for APTC: Consumer with existing MEC (can be on/off Exchange) becomes newly eligible or ineligible for APTC.	Yes	Varies	60 days from QLE	Coverage effective date will follow the 1 st of the month enrollment rules if an enrollment or plan change is completed. Updated APTC will be applied the 1 st day of the month following the receipt of the DWSS approved application or applied retroactively up to 60 days.* *Carriers must retain accumulations if consumers change APTC amount but retain the same policy. (See APTC 2.20.)	45 CFR 155.330(f)(3); 45 CFR 155.420 (d) (6)
			*Approved QLE for tier change or eligibility is limited to silver level or lower, approved 5/16/2017 but not applicable until technology can be updated.				
Gain QSEHRA/ICHRA	4.6	Gains access to individual coverage HRA or newly provided QSEHRA	Yes	No	60 days from QLE	Coverage begins the first of the following month following the date of the event. If plan selection is made after the day of the triggering event coverage will begin the first day of the month following plan selection.	45 CFR 155.420 (b)(2)(vi)
Exceptions/Other	5.1	Erroneous / Unintentional / Other Enrollment Error Made by Marketplace: Consumer or Exchange/marketplace identifies error in consumer account.	Case by case basis – handled via appeal process	N/A	Case by case, but no more than 60 days from time error is identified	Case by case basis	45 CFR 155.420(c)(3); 45 CFR 155.420(d)(4)
Exceptions/Other	5.2	QHP Materially Violated Contract: Consumer or Exchange identifies error in consumer contract.	Case by case basis*	N/A	Case by case basis, but no more than 60 days from time error identified	Case by case basis	45 CFR 155.420(c)(3); 45 CFR 155.420(d)(5)
			* Handled through appeals process				

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Eligibility Status	6.1	Exceptional Circumstances: Due to extenuating circumstances, consumer needs to choose a new plan (unable to pay previous premiums due to extreme circumstances, natural disaster, or domestic violence, etc.).	Case by case basis*	Varies	Case by case basis	Case by case basis	45 CFR 155.420(c)(3); 45 CFR 155.420(d)(9)
Change in Eligibility Status	6.2	American Indian or Alaska Native: Consumer is American Indian or Alaska Native and recently gains status as American Indian or Alaska Native.	Yes	No	All can have SEP once a month.*	If plan enrollment prior to 15 th , then 1st of following month If plan enrollment after 15 th , then 1 st of month after month following report date	45 CFR 155.350(c)
Change in Eligibility Status	6.3	Date of Birth Change: Consumer sees incorrect birth date and updates it.	No*	N/A	Anytime	1 st day of month following plan enrollment date	45 CFR 155.420(d)(4)
			*If DOB change results in eligibility change for current plan, then follow loss of MEC; i.e., if consumer becomes eligible for different priced premiums or change in APTC/CSR, then they should follow those QLEs.				
Change in Eligibility Status	6.4	Gains Citizenship: Consumer gains U.S. citizenship.	Yes	No	60 days from QLE	If plan enrollment is completed prior to 15 th of the month, the 1 st of following month; or, if plan enrollment is completed after 15 th of the month, the 1 st of month after month following plan enrollment date	45 CFR 155.420(d)(3)
Change in Eligibility Status	6.5	Gain of Legal Presence: Consumer gains legal presence.	Yes	No	60 days from QLE	If plan enrollment is completed prior to 15 th of the month, the 1 st of following month; or, if plan enrollment is completed after 15 th of the month, the 1 st of month after month following plan enrollment date	45 CFR 155.420(d)(3)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Eligibility Status	6.6	Loss of Legal Presence: Consumer loses legal presence.	No*	N/A	N/A	1 st day of month following report date	
			*Consumer is disenrolled as of date of loss of legal presence. Consumer may request earlier termination, if desired, based on voluntary termination rules. If a dependent is disenrolled, household follows the SEP Matrix #15 (LCE "Loss of Dependent"). If a subscriber is disenrolled, the household follows the SEP Matrix #1.7 (LCE "Loss of Subscriber").				
Change in Eligibility Status	6.7	SSN: Consumer reports change in SSN.	No	N/A	N/A	N/A	
Change in Eligibility Status	6.8	Failure to Reconcile Taxes (FTR): Enrollee on Exchange completes tax reconciliation.	No*	N/A	60 days from notice of reconciliation approval	1 st day of month following plan enrollment date (if guidelines are met) Nevada Health Link requires previous Exchange enrollment in last month of previous plan year and proof of loss of financial eligibility due to FTR process with Internal Revenue Service (IRS). Proof includes dated letter from IRS indicating clearance and updated financial application approval. Resolution of FTR within last 60 days qualifies for SEP. Exceptions are made for consumers who are new residents to Nevada, managed case by case. Enrollments following loss of eligibility due to FTR have updated financial eligibility automatically applied when confirmed with DWSS, following IRS clearance.	26 CFR 1.36B-4
			*Enrollees who have lost tax credit due to FTR will be automatically updated at the time of application. Consumers who have cancelled coverage due to FTR may be eligible for SEP.				

9.3 Life Events That **Do Not Trigger** a Special Enrollment Period

- Voluntarily dropping coverage
- Loss of eligibility for coverage when the person was not enrolled in it (i.e., loses job, but was not in the employer's health plan)
- Income change
See [SEP 9.1: Qualifying Life Events for Special Enrollment Period](#) for exceptions.
- Termination from other coverage for not paying premiums or for fraud
- Death of a family member without a resulting loss of coverage
- Becoming pregnant
- Loss of a dependent

9.4 Timeline for Reporting a Qualifying Life Event (QLE) and Obtaining Coverage

45 CFR 155.305-320; 45 CFR 155.420

Consumers have 60 days to report a QLE, validate the event, and enroll in a plan on the Exchange. If an individual knows they are losing minimum essential coverage, they can report the loss of that coverage up to 60 days in advance. Consumers seeking a first of the month effective date, who are in a pending verification status, may request an earlier effective date to be considered upon approval of the QLE. Those who do not complete validation in a timely manner may appeal to request an earlier effective date.

If an existing Nevada Health Link consumer's address is updated after 60 days of the event (either through reconciliation or consumer/agent request) or a death is reported outside of the required 60-day timeframe, and the consumer made all payments with the carrier, Nevada Health Link either maintains the consumer's enrollment if they are eligible for the plan, offers a crosswalk plan with the same carrier, or offers a crosswalk plan within the same plan level.

NOTE: If an individual reports multiple Qualifying Life Events at one time, the effective date of their health insurance policy is dated to the earliest effective date for the Qualifying Life Events.

Once an individual enrolls in a health insurance plan, their Special Enrollment Period closes, and they cannot change their plan until the next Open Enrollment or Qualifying Life Event occurs.

9.5 Mid-Month Coverage Start Date

Health insurance coverage obtained through a Special Enrollment Period will not start mid-month, except in cases of death of subscriber or birth of a dependent. In the event of death of subscriber, the coverage for the remaining dependents may begin on the day after the death. In the event of the birth of a child or court appointment of a ward, the coverage starts on the event date. Coverage always starts at the first of the month, regardless of when an individual enrolls in a plan.

9.6 Parents Add a New Dependent

If a family has a baby, adopts a child, or is appointed by a court as the ward for a child, they are entitled to a Special Enrollment Period, even if the child gains alternative health insurance coverage such as CHIP. The new APTC eligibility calculation will be effective the first of the month of the reported event.

NOTE: Pregnancy does not qualify for a Special Enrollment Period. Additionally, if an individual is granted a Special Enrollment Period for a reason other than having a baby, adoption, or becoming a child ward, another dependent cannot be added to their health insurance plan.

Dependents can only be added to a health insurance plan if they have their own Qualifying Life Event.

9.7 Loss of Off-Exchange Health Insurance Coverage Outside of Open Enrollment

Nevadans who are enrolled in health insurance plans sold off Exchange will be granted a Special Enrollment Period if the plan they are enrolled in expires outside of Nevada Health Link's Open Enrollment—even if they are given the option to renew their coverage.

NOTE: If an individual ages out of their pediatric dental plan, they do not qualify for a Special Enrollment Period. All coverage lost must meet MEC standards.

9.8 Loss of a Dependent

Nevada Health Link will not grant households a Special Enrollment Period if they lose a dependent. A loss of a dependent (i.e. change in household size) will auto update a consumers existing enrollment. The Special Enrollment Period will be open for the dependent if they apply on their own through Nevada Health Link.

9.9 Student Losing SHIP

College and university students in Nevada who are losing their student health insurance coverage (SHIP) will be granted a Special Enrollment Period. To receive the Special Enrollment Period, students will need to have a certificate of credible coverage, the previous year's school transcripts and a letter from the university informing them of the loss of coverage. This is a one-time Special Enrollment Period for the academic year.

NOTE: SHIP coverage must meet MEC standards to be eligible for SEP. Contact your school to confirm if your SHIP plan meets MEC.

9.10 Domestic Violence

If an individual is granted a Special Enrollment Period due to a domestic violence situation, Nevada Health Link does not require proof that domestic violence took place rather takes the victim's self-attestation.

9.11 Consumer Takes No Action and Current Plan Unavailable

If a consumer reports a life event, their current plan might not be available to them as a result. If the consumer does not select a new plan, Nevada Health Link will disenroll the consumer from their current plan when their Special Enrollment Period ends. Alternately, the consumer whose plan is no longer available due to the reported change can choose to enroll in a different plan during their Special Enrollment Period.

9.12 Validate Consumer Action Prior to Loss of MEC

If a consumer, or their designated agent, broker, or enrollment counselor, tries to take action prior to losing minimum essential coverage, the effective date will be backdated to the first of the month

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following the event that caused them to lose coverage. Nevada Health Link will validate action was taken from a recording of a consumer’s phone call, an affidavit provided by the agent/broker, or a ticket or support email that was received. The consumer, or their designee, must act within 60 days of the event. If action cannot be validated within 60 days of the event, coverage will start the first of the month following the notification of the loss of minimum essential coverage.

Consumers seeking a first of the month effective date, who are in a pending verification status on the last business day of the month, must notify Nevada Health Link of the urgency for the effective date to be considered potentially eligible. Consumers may also appeal to adjust dates.

9.13 Validation of Application and Enrollment

Health insurance carriers may validate life change events and enrollment eligibility with evidence of fraud or intentional misrepresentation.

9.14 Validation documents

When an individual is granted a Special Enrollment Period due to a Qualifying Life Event (QLE), they must provide appropriate documentation as outlined in the following table. This ensures consistent validation methods for carriers, consumers, and Nevada Health Link. Each QLE has its own requirements.

Qualifying Life Event	Acceptable Validation Documentation
Change in marital status (Marriage/Divorce)	<p>BOTH</p> <ul style="list-style-type: none"> • Marriage certificate OR Copy of court order, decree, or petition for name change OR Domestic legal document <p>AND (if reporting marriage)</p> <ul style="list-style-type: none"> • Proof of coverage is required for at least one partner for at least one of the previous 60 days prior to the marriage (after June 19, 2017, per Market Stabilization Rule, 4/13/2017). The plan cannot be termed for non-payment or voluntarily termed. Any COBRA benefits must demonstrate that eligibility has been exhausted.
Death of primary tax filer/subscriber	<p>Death certificate OR Signed affidavit OR Obituary</p>
Change in dependents	<p>Birth certificate OR Court order (indicating the addition or removal of dependent(s) and the effective date)</p>

<p>Change in address</p>	<p>Combination of documentation:</p> <ul style="list-style-type: none"> • Proof of coverage is required for at least one of the previous 60 days prior to the move. • Demonstrated exhaustion of eligibility for any COBRA benefits <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • Valid Nevada Driver’s license, state-issued identification, or U.S. passport <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Nevada Voter Registration Card <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • Proof of previous address and current address, including two of the following documents dated within 60 days of the change in address: <ul style="list-style-type: none"> ○ Student college enrollment letter ○ Nevada automobile registration ○ Rental agreement ○ Home purchase agreement ○ Utility bills (dated bills showing previous and new addresses) ○ Property tax notice (homeowner’s exemption for Nevada must be demonstrated) ○ Home payment notice <p>Offer of employment</p>
<p>Change in American Indian status</p>	<p>Certificate of Degree of Indian Blood or Alaska Native Blood from the Bureau of Indian Affairs</p> <p style="text-align: center;">OR</p> <p>Tribal Membership</p>
<p>Loss of Minimal Essential Coverage (MEC) <i>*Coverage may not have been terminated for non-payment. COBRA benefits must demonstrate that eligibility has been exhausted or employer contribution has expired</i></p>	<p>Termination letter from prior carrier; email termination notices from prior carrier that can be validated may also be accepted (including and limited to carriers participating with the Exchange).</p> <p style="text-align: center;">OR</p> <p>Termination letter from a government provider (i.e., Medicaid)</p> <p style="text-align: center;">OR</p> <p>Screenshot of current enrollment from carrier’s website or portal AND a non-editable letter (PDF) from the previous employer confirming loss of coverage</p>
<p>Loss of Minimum Essential Coverage (MEC) due to exhaustion of employer contribution to COBRA enrollment (prior to end of COBRA eligibility)</p>	<p>COBRA notice of termination of employer contribution to enrollment</p> <p style="text-align: center;">OR</p> <p>Employer letter of exhaustion of contribution to COBRA enrollment</p>
<p>Change in citizenship or immigration status</p>	<p>Use the government interfaces (SSI) to validate</p>
<p>Exceptional circumstances</p>	<p>Examples:</p> <ul style="list-style-type: none"> • Called to active military duty in another country: Official military evidence is required. • Medicaid conditions such as coma: Letter from the physician is required. <p>Technical difficulty: Nevada Health Link approved documentation is required.</p>

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9.15 Guaranteed Availability of Coverage

45 CFR 157.104 and 105

If a consumer's plan availability ends prior to the end of the plan year, the Exchange terminates enrollment when the plan availability ends. The consumer is granted a Special Enrollment Period due to loss of MEC, unless otherwise directed by the Division of Insurance (DOI).

10 Tax Reporting

10.1 Tax 1: 1095 A Tax Statement

[IRS Forms and Publications](#)

Nevada Health Link provides annual tax statements to all enrolled consumers, except for those enrolled in catastrophic or dental-only plans.

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11 Revision History

Version	Issue Date	Changes	Drafted	Approved
1.0	September 9, 2019	Initial Release	J. Sawyer	H. Korbolic
2.0	October 28, 2020	Revised Versio Final Release	J. Sawyer	H. Korbolic