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 6

Nevada Health Link complies with all applicable federal civil rights laws pertaining to eligibility and determination and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Nevada Health link does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

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1 Overview

1.1 Objective

This document was created with the intent to provide Nevada Health Link consumers, partner organizations, staff, enrollment facilitators, and the public, with an overview of the policies and processes of Nevada Health Link (NVHL), aka the Silver State Health Insurance Exchange (SSHIX) or the Exchange. It provides important information regarding general operations, timelines, eligibility, consumer requests, compliance, and Exchange structure.

This document is updated annually, to reflect regulatory changes, consumer best interests, clarity, and evolving knowledge of best practices for exchanges.

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 broker/agent/navigator/family member/friend who helps enroll a consumer via the consumer's Exchange account and may also be referred to as an authorized representative. AOR's are designated by consumers directly and have the authority to make decisions regarding consumer enrollments.
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.
American Rescue Plan Act (ARPA)	The American Rescue Plan Act was enacted in 2021 and extended in 2022 and provided increased subsidies for enrollees of State-Based Exchanges and the Federal Marketplace, as well as updates and improvements of the scope and durability of the Affordable Care Act (ACA).
Authorized representative	An individual chosen by the consumer to act on their behalf with the Nevada Health Link platformNoted (often a family member or another trusted person). Some authorized representatives might have legal authority to act on the consumer's behalf.
Broker/Agent	Used interchangeably with "Agent" or Broker/Agent. A licensed professional approved by the NV Division of Insurance to assist and enroll consumers into health insurance plans, and if operating on NVHL, certified by the Exchange to do so. Also see Authorized representative, above.
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)	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. An employer can offer an individual coverage HRA instead of other job-based insurance that meets requirements for affordability and minimum value standards. 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.
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.
Periodic Data Matching (PDM)	Periodic examination of data sources to identify consumers enrolled in Exchange plans with financial subsidies while eligible or enrolled in Medicare Part A or Part C. PDM is conducted in order to avoid duplication of benefits.
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.
Quality Rating System (QRS)	A national rating system for comparing health insurance coverage plans, based on survey feedback collected by the Centers for Medicaid and Medicare Services, and published via Exchanges.
Reasonable Opportunity Period (ROP)	The period for a consumer to provide proof of attested information for verification by Nevada Health Link. If a consumer fails to provide adequate proof of attestation within the ROP, any Qualified Health Plan (QHP) enrollment or associated federal subsidies such as Advanced Premium Tax Credits (APTC) and/or Cost Share Reductions (CSR) may be automatically revoked by the Exchange. The length of an ROP for a Data Matching (DMI) Issue generated due to a consumer submitted application is 90 days and 30 days if the DMI was generated due to automated program integrity functions such as Periodic Data Matching.
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.
Renewals	The process of a consumer transitioning from one plan year to another, without a gap in coverage. A renewal can be active, when a consumer takes steps to update application information and select a plan for an upcoming plan year during the regular Open Enrollment Period (OEP) or passive, when a consumer is automatically renewed into the upcoming plan year, without acting.
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 • 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 • 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.

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 enroll in a Qualified Health Plan (QHP), the consumer must meet certain requirements, including each of the following:

- Be a United States citizen or national, or be considered a "lawfully present" immigrant
    - 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.
- Be a resident of Nevada
- NOT be incarcerated

To be eligible for advanced premium tax credits (APTC) to reduce monthly premiums a consumer must be a tax filer who is married and filing jointly, or single and filing single, and meet the following income standards:

- Income between 138 percent and 400 percent of the federal poverty level without a Medicaid denial required
- Or income above 400 percent of the Federal Poverty Level for plan years 2021 and 2025 based on American Rescue Plan and Inflation Reduction Act provisions
- Or income between 100 and 138 percent of the Federal Poverty Level with a Medicaid denial due to income or assets
- Or an income below 100 percent of the Federal Poverty Level with a Medicaid Denial DUE TO immigration status

To be eligible for cost share reductions (CSR) to reduce the out-of-pocket costs of care a consumer must meet APTC eligibility standards and one of the following additional standards:

- A modified, adjusted gross income between 100 and 250 percent of the federal poverty level and be enrolled in a silver level plan
- Or be an American Indian or Alaskan Native (AIAN) from a federally recognized tribe and enrolled in a bronze, silver, gold, or platinum level plan with an income between 100% of FPL and 300% of FPL for zero-dollar cost share
- Or be an AIAN in any metal level plan tier with an income below 100% of FPL or above 300% of FPL for a "limited cost share" which applies specifically to specific providers such as Indian Health Services (IHS) provider.

NOTE: Consumers who attest to information that conflicts with federal Hub services verification may be granted conditional eligibility for 90 days. If attested information is not verified by either a new Hub services check or manual verification prior to the 90-day period, those consumers will lose either financial or QHP enrollment eligibility.

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 another official form of documentation showing legal status

Note: Unofficial, alternative forms of documentation such as a Letter of Explanation may not be used to manually verify citizenship or eligible immigrant 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, to include Deferred Action for Childhood Arrivals (DACA) status, effective November 1, 2024.

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 pended 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 CRF 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).

Consumers requesting tax credits must attest to intention to file tax returns for the year of plan coverage, even if they wouldn't otherwise be required to file, reconcile tax credits for any prior years in which they received tax credits except for the 2020 plan year, and consent to allow Nevada Health Link to verify reported income with Internal Revenue Filings. Failure to reconcile tax credits for two or more years will result in the loss of subsidy eligibility.

Note: Consumers may be liable for part or all of the tax credits they received in excess of the total amount of tax credits they were determined to be eligible for by the Internal Revenue Service at the time of tax filing. This process is called reconciliation of tax credits.

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, unless they have an appropriate Medicaid denial and are below 138% of the Federal Poverty Level or are above 400% but meet additional criteria set forth in either the American Rescue Plan Act or Inflation Reduction Act.

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 100% of the Federal Poverty Level. A family can determine their APTC status by completing the application process.

Medicaid Denied Consumers: Consumers who are citizens and have an income between 100% and 138% of the FPL may qualify for financial assistance if they are denied Medicaid for excess income or over assets. Consumers seeking subsidy eligibility after an assessment for Medicaid based on reported income, must obtain a full determination of Medicaid to qualify for APTC between the 100% and 138% FPL levels. Procedural denials of Medicaid eligibility, due to non-cooperation with the Division of Welfare and Supportive Services (DWSS) are not considered denial of eligibility determinations for APTC eligibility purposes.

American Rescue Plan Act/Inflation Reduction Act: Some consumers who have household income above 400% of the Federal Poverty Level may be eligible for tax credits for plan year 2021 through plan year 2025.

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
- Gambling winnings
- 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 disability income benefits
- Federal income tax refunds
- Insurance proceeds (accident, health, and life)

- **Note**: Consumers are only required to report income information if they are requesting a determination for financial eligibility.

2.7 Verification of Income for a Financial Application

45 CFR 155.320 E (iii) 45 CFR 155.315(f)(7)

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. The reasonable opportunity period that consumers are allowed to maintain conditional eligibility for financial benefits while providing documents for manual verification is 150 days from the date of the mismatch with federal information. After 150 days, without manual verification of income, NVHL is required to terminate conditional financial eligibility.

Consumers who do not provide consent to verify financial data with the Internal Revenue Service may lose financial assistance in the process of Automatic Renewals or verification of income data during the plan year.

NOTE: Reasonable compatibility is a standard of measure utilized to verify an applicant's income for the purpose of making a determination of eligibility for tax credits.

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 are not seeking Advanced Premium Tax Credits.

2.8 Determining Tax Credit Amount

26 CFR 1.36 B-1

Advanced Premium Tax Credits (APTC) is determined by tax household and only one tax household will be evaluated per application. To determine the tax credit, several factors are taken into consideration. The following are reviewed by Nevada Health Link:

- Age of consumer(s) at the time of the policy's effective date
- Household's anticipated, modified adjusted gross income
- Household size and composition
- Number of household members eligible for APTC
- Service area of residence

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 for the purposes of APTC)
- Qualified tax-dependents based on IRS standards

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 enrolled in an Exchange plan receiving APTC, since they are eligible for MEC through the other household.

2.9 Calculating Age for Household Members

Nevada Health Link will calculate APTC using the ages of the family members as of their policy coverage start date at the time of plan enrollment. If application changes are reported that cause a re-determination of APTC mid-year, APTC will be recalculated using the age of household members at the time of reporting said change. Recalculations of age affecting APTC will take effect on the first day of the month following any submission of a consumer application after any member of the household has had a birthday transpire.

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). Income must be reported for everyone in a tax household on a financial application. APTC will be determined based on tax filing requirement levels for dependent income.

> **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 Enrollment Grouping Rules

Only members of a single tax household will be considered for eligibility on an application and may enroll into Exchange plans. Plan selection is up to consumer choice and consumers may shop for plans for multiple members or separately, based on the following enrollment grouping rules below:

- A primary applicant and his/her spouse may generally enroll in the same plan so long as one or the other does not elect to enroll in a plan requiring unique eligibility factors, such as a catastrophic plan or one only open to American Indian or Alaskan Native (AIAN) consumers

- A primary applicant and his/her child-dependents (tax dependents) may generally enroll in the same plan baring unique plan eligibility factors such as AIAN status or catastrophic plan eligibility OR the overage dependent requirements listed below

- No overage-dependents (dependents to the primary applicant who are 26 years old or older) other than a spouse of the primary applicant may enroll in the same coverage plan.

- In cases where enrollment eligible members within a single household have differing Cost Share Reduction (CSR) Eligibility levels, such as one member being eligible for CSRs and another member not being eligible for CSRs the lowest level of eligible plans will be shown, non-CSR plans, if both members shop for enrollment together.

- **NOTE:** If consumer enrollment groupings are discovered by the Exchange or brought to the Exchange's attention which do not conform to the above enrollment grouping rules, those consumers will have their enrollment groupings corrected to match the above requirements.

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 on a separate Nevada Health Link Account. 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 a tax professional regarding qualified dependent status or refer to IRS resources.

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 CRF 155.320(b)

Employer coverage is considered affordable for the employee—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 below the annually determined threshold published by the Internal Revenue Service (IRS).

Employer coverage for an employee's family may be considered affordable or unaffordable separately from the determination of the employee's self only coverage. Based on the separate determinations employer sponsored coverage may be affordable for either the employee or the whole family.

An up-to-date affordability threshold can be found at www.IRS.gov. 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.

Additionally, consumers who are found eligible for APTC after attesting that Employer sponsored coverage is not

offered, does not provide minimum value, or is not affordable, are subject to an appeal of that eligibility if said employer does offer affordable, minimum value coverage. Consumers may also be liable for paying back some or all of tax credits used if they received them while having an offer of affordable, minimum value employer coverage.

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.

Most retirement coverage plans count as minimum essential coverage. Medicare Part A with no cost coverage counts as minimum essential coverage.

> **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, unless other Qualifying Life Event criteria are met.

2.16 Medicare and APTC

26 CFR 1.36 (B)(c)(2)(v); 45 CFR 155.330(d)(1)(ii)

- Individuals who receive Medicare are not eligible to receive APTC.
- Individuals who are offered **Medicare Part A** at a cost can choose not to enroll in Medicare at the time they become eligible in order to be potentially eligible for APTC (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.
- Nevada Health Link will conduct Periodic Data Matching (PDM) in accordance with federal regulations, to identify consumers who may not be eligible for APTC due to Medicare eligibility and/or enrollment.
- 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. Once any Medicare coverage is started, consumers lose eligibility for APTC permanently.

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 with a capped value set at the total 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 for all consumers actively enrolled in coverage through the end of the year, who are still eligible for enrollment, at the time of auto-renewals, even if they lose eligibility for a tax credit (APTC) or cost-sharing. Consumers who lose APTC/CSR eligibility will be renewed into corresponding plans without APTC or cost-sharing benefits.

2.18 Appeals

45 CFR 155.500 – 45 CFR 155.555

Nevada Health Link has the authority to process appeals regarding enrollment eligibility, calculations of APTC and/or CSR, eligibility for open enrollment or special enrollment, and failure of timely determination. Appeals received outside the scope of authority for Nevada Health Link will be dismissed as not valid.

Individuals have 90 days from the date of their eligibility notice to file an appeal of a determination within the eligibility notice and meeting the criteria for validation noted above. Appeals may be submitted by postal mail, phone, or online. Instructions to file an appeal can be found on www.NevadaHealthLink.com under the "Services" tab.

Nevada Health Link will send a confirmation 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 Nevada Health Link will work to resolve appeals promptly. Consumers should submit an appeal for Expedited processing only if the life or health of the appellant is in jeopardy.

2.19 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.

For more details regarding effective dates of eligibility due to Special Enrollment Periods or complex cases see 7.6 APTC and CSR Effective Date and 9.1 Qualifying Life Events for Special Enrollment Period.

2.20 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 act before the application closes. The consumer is

required to re-apply for future financial application approval.

2.21 APTC Capping

Consumers may be eligible for more APTC than is needed to fully cover the premium cost of a plan depending on plan enrollment choices. In the case of APTC exceeding premium cost, APTC will be capped so as not to consume more APTC than 100% of the plan premium.

Additionally, 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.

2.22 Program Integrity

45 CFR 155.330(d)(1)(ii); 45 CFR 155.1200

Nevada Health Link will conduct semi-random data matching inquiries with federal service databases a minimum of twice annually, as required per federal regulations to compare consumer attested data with federal information. Nevada Health Link will notify consumers of any discrepancies and provide reasonable opportunity of 30 days for consumers to verify the accuracy of any discrepancies identified. Any discrepancies not addressed adequately may result in denial of Exchange enrollment and/or eligibility of federal subsidies such as premium tax credits and cost share reductions.

3 Application

3.1 Application Attestations

45 CFR 155.315

Consumers must complete an application for eligibility for each tax household containing members seeking coverage. Consumers may choose whether to seek eligibility only for enrollment purposes (non-financial application) or for enrollment and financial subsidies (financial application) such as advanced premium tax credits and or cost share reductions. Consumers must include complete and accurate information as needed to make a determination for the eligibility sought. Consumer attested information will be verified by electronic data sources as necessary per Code of Federal Regulations and regulatory guidance.

Consumers must agree to application attestations under penalty of perjury, agree to report changes affecting eligibility determinations and enrollments within 30 days of change occurring, agree to not being incarcerated, and agree to accept tax reconciliation liability upon enrollment in an Exchange plan in cases where advanced premium tax credits are paid to a carrier on the consumer's behalf. Consumers may choose to provide consent for Nevada Health Link to verify their federal tax information with the IRS for one to five years if they would like to be considered for continuing financial subsidies as part of the automatic renewal process or may opt to withhold consent and be auto renewed without subsidies.

3.2 Eligibility Verification Documents

45 CFR 155.315

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 another official form of documentation showing legal status.

> **NOTE:** Alternative form submissions, such as a Letter of Explanation may not be used to resolve data matching issues for verification of citizenship or legal status, due to federal regulations.

Forms of documentation commonly used to verify income: Pay 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.

3.3 Residency

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 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.

For eligibility purposes the physical address of consumers must be in Nevada for those seeking coverage, with the exception of out of state addresses that may be used for dependent children attending school outside of Nevada, with a primary tax filer parent residing in Nevada.

3.4 Plan Selection and Effectuation

To complete enrollment a consumer will need to select a plan or plans that best fits their household needs and pay at least the first month's enrollment premium to the insurance carrier within the payment deadline. If a consumer does not select a plan during the designated Open Enrollment Period, they must meet criteria for a Qualifying Life Event to be granted a Special Enrollment Period, during which they may select plans.

Consumer enrollment groupings are chosen by the consumer on a prospective basis according to consumer selected enrollment groupings and within the enrollment grouping rules outlined in section "2.11 Enrollment Grouping Rules" at the time of plan selection. Automatic renewal processes will maintain consumer grouping selections if applicable, in accordance with relevant federal, state, and Exchange policies.

NOTE: Mid-year plan changes from a cost share reduction (CSR) supported plan to a non-CSR plan or vice versa require a new policy start and may require a restart of deductibles and out of pocket max contributions.

4 Dental

4.1 Open Enrollment

45 CFR 155.410

Dental insurance has the same Open Enrollment and special enrollment periods as health insurance. **NOTE**: Qualified Dental Plans are subject to waiting periods prior to use for services. Consumers should thoroughly review plan benefits to learn more.

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 automatically renewed for consumers prior to the Open Enrollment period each year, as long as coverage at the time of renewal extends to December 31, of the current plan year..

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, and the consumer household is eligible for tax credits that surpass the cost premiums for an enrolled Qualified Health Plan. 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 or lawful immigration status, Nevada residency, non-incarceration status, and non-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.

NOTE: Since 2017 the cost of the shared responsibility payment for consumers not enrolled in any health coverage has been reduced to $0 in value. No consumers face a financial penalty for not enrolling in health insurance annually.

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.

Open Enrollment is held annually during a designated Open Enrollment Period for coverage in the upcoming plan year. During open enrollment consumers may make plan selections for the upcoming year without the need to have a qualifying life event. Outside of open enrollment periods consumers must report qualifying life events to qualify for a special enrollment period.

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

Plan Year	Open Enrollment Period
2025	November 1, 2024 – January 15, 2025
2024	November 1, 2023 – January 15, 2024
2023	November 1, 2022 - January 15, 2023
2022	November 1, 2021 – January 15, 2022
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 applicant's physical address listed on the application. Nevada has the following four service areas throughout the state. In certain cases consumers may be required to confirm their county when they live within a zip code located in multiple counties.

Service Area 1: Clark County and Nye County
Service Area 2: Washoe County

Service Area 3: Carson City, Douglas County, Lyon County, and Storey County

Service Area 4: Churchill County, Elko County, Esmeralda County, Eureka County, Humboldt County, Lander County, Lincoln County, Mineral County, Pershing County, and White Pine County.

NOTE: Consumers must provide their physical address on applications to receive accurate plan and rate information. Failure to provide accurate physical address information may lead to billing errors or revocation of coverage.

6.3 Coverage Start Dates

45 CFR 155.420(b)(3); 45 CFR 155.410

Nevada Health Link consumers who enroll in a health insurance plan during an open enrollment period (OEP), between November 1st and December 31st will receive coverage starting January 1st of the upcoming plan year. OEP consumers who enroll in health insurance plans between January 1st and January 15th, will receive a coverage effective date of February 1st.

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 within a singular enrollment group from the date of enrollment. Any additional dependents under the age of 21 are covered under the plan at no additional charge. This is often referred to as the 4th is free rule. Dependents within the same household who enroll in separate plans will not be eligible for the 4th is free premium reduction.

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 and be in excess of the amount utilized for the QHP to then have any remaining amount applied to the QDP.

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 plans
- COBRA
- Any plan with grandfathered status under the Affordable Care Act
- Medicaid coverage (excluding pregnancy only coverage and Emergency Medicaid)
- 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)
- Veterans' Health Administration coverage
- CHAMP VA Coverage for Veteran dependents
- TRICARE coverage for retired veterans and dependents
- 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 Applicant

When creating a consumer account at www.NevadaHealthLink.com the owner of the account is the default primary applicant for the household.

NOTE: The primary applicant cannot be changed after account creation.

6.9 Maximum Age of Dependent

The maximum age of a child dependent on a health insurance policy is 25 years old. When a child dependent turns 26, they will need to go onto their own health insurance policy and be removed from a shared 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, birth, foster placement, or other court appointment.

Note: If consumers believe they have an exception, they may complete an Effective Date Change Request form, found on www.nevadahealthlink.com

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 U.S. citizens, the children may be eligible for APTC even though the parents are not eligible to purchase insurance through the Exchange due to immigration status.

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 tax household has mixed Cost Share Reduction (CSR) eligibility status, they may enroll members into separate plans to maximize CSR eligibility. If consumers with mixed CSR eligibility choose to enroll in a shared health insurance policy, the lowest common eligibility for CSRs will be attached to the shared plan. A consumer who is eligible for CSRs enrolls in a shared health insurance policy with a consumer who is not eligible for CSRs, the shared plan will not have CSRs attached.

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 zero cost Medicare Part A 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, cost or cost free 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 for up to 6 months prior to the received notification of coverage.

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.

> **NOTE**: It is the responsibility of consumers to notify Nevada Health Link when Medicare coverage or eligibility is gained for any enrolled members.

6.15 Dual Enrollment in Medicaid/CHIP and Full Price QHP

If Nevada Health Link becomes aware of a consumer enrolled in Medicaid/CHIP coverage, Nevada Health Link will automatically drop APTC eligibility. Enrollment in Exchange coverage may continue at full price without subsidy eligibility while enrolled in Medicaid/CHIP or while awaiting a Medicaid/CHIP assessment.

NOTE: It is the responsibility of consumers to notify Nevada Health Link when Medicaid or CHIP coverage or eligibility is gained for any enrolled members.

6.16 Qualified Health Plan Enrollment Eligibility

Eligibility is determined based on member-level eligibility results.

> **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 service area and applicable to their Cost Share level, 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 service area associated with the primary applicant' physical address unless the primary applicant is out of state and the dependent seeking coverage is in Nevada, in which case the physical address of the dependent seeking coverage will determine the service area.

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 (AIAN)

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

Issuers 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).

AIAN consumers belonging to federally recognized tribes, with an income between 100% and 300% of the federal poverty level may qualify for Zero-Cost Share plans. AIAN consumers below the 100% federal poverty level or above the 300% federal poverty level qualify for Limited Cost Share plans with zero out of pocket cost when using Exchange coverage at Indian Health Services providers, Tribal Health Clinics, or when referred to a provider by either of those providers. AIAN consumers may also utilize CSRs for any metal level qualified health plan on the Exchange, but not for catastrophic plans.

6.20 Aggregated Billing for Tribal Health Clinics

45 CFR § 156.1250 requires QHP Issuers to accept premium and cost-sharing payments for tribal members directly from Indian tribes, tribal organizations, or urban Indian organizations. By default, the monthly premiums for these enrollments are managed on an individual-policy basis. Carriers offering plans on the Exchange may choose to participate in aggregate payment of premiums for tribal enrollee's and will be identified as a participant of the aggregate billing program if they elect to do so.

The intent of this policy is to simplify the administration of tribal enrollments by allowing clinics to remit a single, aggregated monthly payment representing their entire enrolled population. To facilitate aggregated billing SSHIX will provide a list of applicable enrollments, referred to as the Tribal Enrolled Consumers report, to participating Tribal Clinics by the fifth (5th) of each month.

Tribal Health Clinics who participate in the Aggregated Billing Process are subject to the terms and

conditions of the Operator Agreement. Tribal Clinics are also responsible for keeping their enrollments up to date, and clinics will be financially responsible for all active enrollments as of the first (1st) of each month.

Issuers who participate in the Aggregated Billing Process are subject to the terms and conditions of SSHIX's annual Issuer Agreement. Issuers are responsible for generating a monthly Aggregated Invoice for participating clinics, and also for ensuring that aggregated premium payments are appropriately applied to each of the individual policies listed on the Aggregated Invoice.

6.21 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. Consumers may initially make a tobacco status selection during plan selection and may alter tobacco status at any point during the year. When a consumer reports a change in tobacco status, changes will be applied on the first of the following month.

Consumers are responsible for maintaining accurate reporting of their tobacco status. Evidence of fraudulent reporting of tobacco status may invalidate coverage or result in financial impact on past premiums.

Smoking status will only be considered for consumers who are at least 21 years of age, as the criterion for purchasing cigarettes is barred for individuals under 21 years.

6.22 Electronic and Telephonic Signatures

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

6.23 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. Consumers must report any offers of employer sponsored coverage, attest to whether offered coverage meets minimum essential criteria, and provide coverage cost.

> **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.

6.24 Consumer Assistance & Complaint Resolution

45 § 155.205

The Exchange will make assistance available 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 (TTY line 711; for those who are deaf, hard of hearing, or speech disabled)** to speak to a member of our call center staff who can assist them with their complaint.

A list of call center hours, workdays, and holidays can be found at www.NevadaHealthLink.com

6.25 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.

6.26 Active Application Timeframe

Once Nevada Health Link consumers have completed an application in the system, it will remain active throughout the Open Enrollment period. If an application is completed outside the open enrollment period, it will remain active until the expiration of an ROP (90 days) period or there are data matching issues or 60 days from the application submission date.

6.27 Disenrollment by Carrier

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

6.28 Reasonable Opportunity Periods

When a consumer completes an application submission, consumer attested information will be compared electronically based to determine accuracy and consumer eligibility. Any mismatch with electronically compared information will result in a notice to consumers requiring additional document verification. Consumers will be provided a minimum of 90 days from the date of application submission to provide any requested verification documentation. Consumers who do not provide documentation within the established timeframe may have their Qualified Health Plan (QHP) enrollment and/or financial assistance eligibility revoked.

When a Reasonable Opportunity Period is required due to a data-matching issue that was generated from required periodic data matching conducted by the exchange, it will be for 30 days in length. These ROPs may be created from the Exchange completing mandated program integrity checks on enrolled consumers who may be dually enrolled in multiple forms of government benefit programs for coverage.

During the ROP period consumers will have conditional eligibility based on attested information. Consumers may be liable for any use of advanced premium tax credits during conditional eligibility which they do not turn out to be eligible for. Conditional eligibility will expire at the end of the ROP if consumers have not manually verified their eligibility by that time. Manual verification of attested information will resolve the mismatch and confer final eligibility to consumers.

> **NOTE: In addition to the required 90-150 days allowed for consumers to verify information from consumer initiated submissions and the 30 days required for periodic data matching generated inconsistencies Nevada Health Link may provide an 15 additional days in both cases prior to adverse action, in order to account for delays in receiving and processing consumer submitted documents.**

6.29 Changing Plans during Open Enrollment

During the Open Enrollment period, a household may prospectively enroll, disenroll, or change their health insurance plan. Changes made to upcoming year eligibility and coverage before January 1 of the upcoming

year, will take effect on January 1. Changes made between January 1 and January 15 will take effect on February 1. Open enrollment is open for the upcoming plan year, but consumers may still report changes or apply for coverage via a Special Enrollment Period for the current year via a separate dashboard tab in the consumers portal.

Updates to financial eligibility outside of Open Enrollment dates follow the enrollment rules in section 3.19.

NOTE: See section 9. Special Enrollment Period for coverage start dates.

6.30 General Disenrollment

45 CFR 162.1501; 45 CFR 155.430

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.

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 requests and processed by Nevada Health Link staff. Consumers are required to submit an Effective Date Change Request form found on the Nevada Health Link website. All requests for change in coverage effective dates will be processed based on limitations set forth in 45 CFR 155.430, regarding reasonable notice.

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.

NOTE: Voluntary consumer withdrawals from coverage always take place at the end of a calendar month.

6.31 Retroactive Disenrollment

45 CFR 155.430

Consumers, or third parties paying premiums on behalf of consumers (e.g., Tribal Health Clinics), are responsible for premium payment as of the first day of each respective coverage month. Consumers may apply for a retroactive termination dates only in cases of reasonably unintentional and/or recently discovered dual enrollment in minimum essential coverage outside of Nevada Health Link. Retroactive terminations are at the discretion of the Exchange and in accordance with federal regulations.

Retroactive terminations of Exchange coverage follow the below timeframes:

- Retroactive terminations for Medicare-based enrollment may be terminated up to six months back
- Retroactive dual coverage terminations for enrollment in Medicaid/CHIP may be terminated up to 60 days back from the reporting date.
- Retroactive terminations for other MEC coverage or general consumer error may be allowed if they are

requested within 14 days of the requested termination date

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

- require documentation of group coverage as needed and terminate within the above timeframes; OR
- terminate to the last day of the month that the consumer reported

Note: Retroactive termination requests will not be processed with mid-month end-dates, and consumers may be liable for any service provider claims submitted during the period of retroactively termed coverage.

6.32 Disenrollment Due to a Move out of State

Consumers are required to terminate their coverage through Nevada Health Link if they move out of state. Termination of coverage for a move can be pre-set by the consumer based on general disenrollment procedures.

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; and
- request verification of move in cases where backdating is required, if notification to the Exchange was made in past months, but processed late, due to technical or Nevada Health Link error, or due to severe workload.

6.33 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, maintain good-standing with Nevada Health Link Compliance Department, be able to show certification with at least one Nevada Health Link carrier, and complete annual NVHL certification training, including Nevada Health Link specific training sessions, and certification testing with passing scores. Agents are allowed three attempts to pass the test and may appeal the results of a final attempt only if a technical reason prevented a successful score.

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

Nevada Health Link may decline to certify agents or brokers in cases of non-compliance with required conduct, a lack of communication or cooperation with Nevada Health Link requests, or evidence of negligence to consumer best interests.

NOTE: New brokers/agents (without prior year consumers) seeking Exchange certification in an upcoming year and who are not resident producers of Nevada based on Nevada Division of Insurance licensing, will not be invited to certification training.

6.34 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 their eligibility notice to file an appeal of the determination made in the notice. An eligibility determination notice is required for an appeal to be found valid for

consideration.

Nevada Health Link will work to informally resolve consumer appeals prior to a formal hearing. Should an appellant request 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. If consumers are dissatisfied with a hearing decision, they may appeal the decision to the Centers for Medicaid and Medicare Services. Instructions to file an appeal with CMS are provided on the hearing decision letter.

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.

Outcomes for appeals decisions can be found on the Nevada Health Link website.

6.35 Appeals Decisions Definitions

Definitions	Description
Dismissed	Appeal request may be dismissed due to not meeting criteria for a valid appeal found in 45 CFR 155.520: • 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 if 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. Appeals may additionally be dismissed due to a consumer or agent requesting to withdraw the appeal. **Or** the requested actions are already reflected on account. **Or** the consumer failed to appear at scheduled appeal hearing without cause.
Overturned	Original decision has been changed based on statute, the Code of Federal Regulations, additionally provided information effecting eligibility determination, 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.

6.36 Broker/Agent Disciplinary Action

If Nevada Health Link observes, becomes aware, or has reason to believe fraudulent or unethical

actions or behaviors from agents, brokers, or enrollment counselors, has taken place, Nevada Health Link will formally send a compliance notice to the agents, brokers, or enrollment counselors. Failure to comply with compliance actions, repeated violations, or severity of a single violation, may result in decertification from Nevada Health Link, at its discretion, 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 action 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.

NOTE: Brokers/Agents are certified by the Exchange at the discretion of Nevada Health Link and may be decertified or have their certification renewal declined by NVHL due to compliance history or non-responsiveness to NVHL communications.

6.37 Reinstatement

Consumers requesting reinstatement of coverage are obligated to pay all past due premiums that would be due from the period that is being reinstated. Any consumers seeking a reinstatement for an enrollment terminated due to non-payment to the carrier, must contact the carrier for approval to reinstate, in those cases. Carriers have the authority to deny approval for reinstatement requests for non-payment terminations.

All consumers requesting a reinstatement of a policy should contact the Nevada Health Link Call center regarding the request at 1-800-547-2927 (TTY 711).

6.38 Eligibility to Enroll on the Exchange

45 CFR 155.305

Nevada Health Link will allow a consumer who attests to Nevada residence 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 or
- 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

6.39 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. Termination of a coverage receiving APTC may happen after a 90-day grace period for non-payment and after a 30 day grace period for coverage not receiving APTC.

6.40 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.

Premium rates are not recalculated due to changes only in advanced premium tax credit calculations caused by an application update, such as a change in income.

6.41 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

6.42 Quality Rating System

45 CFR 156.1120

Nevada Health Link will display Quality Rating System (QRS) data based on Health and Human Services (HHS) established guidance and data provided by Qualified Health Plan (QHP) issuers operating on Nevada Health Link. Additional details regarding QRS reporting can be found on the Nevada Health Link website.

While shopping for plans in either window shopping or consumer accounts, QRS ratings will be displayed for all plans for which a current rating value exists. New plans may not have rating data to display.

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 active coverage which extends to December 31, of the current plan year at the time of automatic renewal processing, prior to open enrollment. Those consumers who enroll in current year coverage via a special enrollment period during open enrollment are advised to actively shop for future year coverage as they may have missed the opportunity for automatic 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 may update their applications with changes to receive a new eligibility determination during open enrollment.

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 cross walked plan, as directed by the Division of Insurance.

> **NOTE:** Consumers should review all auto-renewal plans for changes affecting coverage and use prior to January 1, to ensure that auto-renewed plans meet consumer needs.

7.2 Changing Plans through Open Enrollment Period

Consumers may change coverage during the Open Enrollment Period by selecting a plan other than the one they were automatically enrolled in, changing enrollment groupings, or canceling coverage altogether.
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.

NOTE: Addition of cost share reductions (CSR) to an existing plan enrollment without current CSRs attached requires enrollment into a new policy ID even if the selected plan has the same name. This new policy ID will cause a reset of accrued out of pocket limits and deductible values. Changing from a CSR active plan to a non-CSR plan will do the same.

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, known as the binder 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 gain of 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

Small Business Health Options Program (SHOP) is a group insurance program defined in the Affordable Care Act for small businesses with up to 50 employees. Nevada Health Link does not currently Provide a SHOP program. Consumers interested in group coverage should contact insurance carriers directly.

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 effective for at least 1 day of the previous 60 days

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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**	**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.	Yes * Rule does not apply to non-MEC policies, such as hospital indemnity policies, short-term policies, or other non-MEC policies.	MEC	Up to 60 days before event, through 60 days after event	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.	45 CFR 155.420(d)(1)(ii)
Loss of MEC	**1.2**	**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	Yes	MEC	Up to 60 days before event through 60 days after event For loss of Medicaid/CHIP coverage the SEP window will be extended to 90 days.	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.	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

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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 request 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 1st 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	1st day of month following plan enrollment	45 CFR 155.420(d)(i)

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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	1st 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	1st 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 1st 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);

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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	1st 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 from coverage 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	1st 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 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).	No	60 days from QLE	1st day of month following plan enrollment	45 CFR 155.420 (d)(2); 45 CFR 155.420(b)(2)(ii)

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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	1st 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 in the platform but it may take several business days for carriers to process the information.	
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 1st 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)

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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 1st of the month enrollment rules. 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 1st of the month enrollment rules if a plan change is completed. Updated CSR will be applied the 1st day of the month following the receipt of the submission of an 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	Required to show a decrease in income, and proof of MEC within the last 60 days prior to the decrease in income. *1st day of month following plan enrollment.	45 CFR 155.420(d)(6)(v)(A)(B)(C)

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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 *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.	Varies	60 days from QLE	Coverage effective date will follow the 1st of the month enrollment rules if an enrollment or plan change is completed. Updated APTC will be applied the 1st day of the month following the submission of 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)
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	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* * Handled through Quality Assurance process	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)

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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. *	1st day of month following plan enrollment.	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	1st 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	*st day of month following plan enrollment.	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	1st day of month following plan enrollment.	45 CFR 155.420(d)(3)

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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	1st 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	1st 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.				

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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 whom was not the plan subscriber

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. Consumers must complete and submit an Effective Dates Change Request form if they seek to alter their coverage effective date. Forms can be found on www.NevadaHealthLink.com.

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, adoption, or court appointment of a ward, the coverage starts on the event date unless consumers request a coverage start on the first of the month after the birth, adoption, or court appointment. Coverage always starts on the first of a month, regardless of when an individual enrolls in a plan.

NOTE: Mid-month coverage start dates are only available for gain of dependent situations noted above and the death of a subscriber with dependents. All other start dates must be 1st of the month start dates.

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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 only 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

Consumers who are victims of domestic violence which prevents them from reasonably enrolling in coverage with their spouse may contact Nevada Health Link's Customer Assistance Center at 1-800-547-2927 Monday-Friday 9:00 am to 5:00 pm PST.

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.

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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. In this case 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 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 should go to www.NevadaHealthLink.com to complete an Effective Date Change Request form or contact the Nevada Health Link Call Center for assistance.

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)	**BOTH** • Marriage certificate OR Copy of court order, decree, or petition for name change OR Domestic legal document **AND** (if reporting marriage) • 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.

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Death of primary tax filer/subscriber	Death certificate **OR** Signed affidavit **OR** Obituary
Change in dependents	Birth certificate **OR** Court order (indicating the addition or removal of dependent(s) and the effective date)
Change in address	**Combination of documentation:** • 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 **AND** • Valid Nevada Driver's license, state-issued identification, or U.S. passport **OR** • Nevada Voter Registration Card **AND** • Proof of previous address and current address, including **two** of the following documents dated within 60 days of the change in address: ○ ○ 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 Offer of employment
Change in American Indian status	Certificate of Degree of Indian Blood or Alaska Native Blood from the Bureau of Indian Affairs **OR** Tribal Membership
Loss of Minimal Essential Coverage (MEC) **Coverage may not have been terminated for non-payment. COBRA benefits must demonstrate that eligibility has been exhausted or employer contribution has expired*	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). **OR** Termination letter from a government provider (i.e., Medicaid) **OR** Screenshot of current enrollment from carrier's website or portal AND a non-editable letter (PDF) from the previous employer confirming loss of coverage
Loss of Minimum Essential Coverage (MEC) due to exhaustion of employer contribution to COBRA enrollment (prior to end of COBRA eligibility)	COBRA notice of termination of employer contribution to enrollment **OR** Employer letter of exhaustion of contribution to COBRA enrollment

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Change in citizenship or immigration status	Use the government interfaces (SSI) to validate
Exceptional circumstances	Examples: • Called to active military duty in another country: Official military evidence is required. • Medicaid conditions such as coma: Letter from the physician is required. Technical difficulty: Nevada Health Link approved documentation is required.

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) and in accordance with state and federal statutes and guidance.

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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. Korbulic
2.0	October 28, 2020	Revised Version Final Release	J. Sawyer	H. Korbulic
3.0	October 1, 2021	Revised language, added definitions, sections, and clarity.	J. Prazak	H. Korbulic
4.0	October 27, 2022	Revised language, definitions added, and updates for clarity.	J. Prazak	G. Castaneda
4.1	6/14/23	Revised language, added language on Tribal Aggregated billing	R. Cook	R. Cook
5.0	8/25/2023	Enrolment Grouping Rules, revised language for clarity, updated timelines, and ROP information	J. Prazak	B. Lyons
5.1	9/1/2023	Contextual Changes	M. Werth Ranson	B. Lyons
6.0	8/19/24	Annual Update	B. Lyons	