State of Nevada
Nevada Health Authority
Division of Consumer Health Services
Silver State Health Insurance Exchange

NEVADA HEALTH AUTHORITY
DIVISION OF CONSUMER HEALTH SERVICES
SILVER STATE HEALTH INSURANCE EXCHANGE
POLICY MANUAL

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Version 8

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1. Overview

1.1 Objective

This document outlines the policies related to consumer eligibility, enrollment, and support for Nevada's State-based Exchange (SBE), Nevada Health Link. This document is updated at least annually.

1.2 Background

The Silver State Health Insurance Exchange (SSHIX) is a state agency established by Nevada Revised Statues (NRS) Chapter 695I and operates under the Division of Consumer Health Services within the Nevada Health Authority. SSHIX is responsible for operating and managing Nevada Health Link, Nevada's health insurance marketplace where consumers can shop and enroll in coverage. Eligible consumers may also receive financial assistance, including federal subsidies, to help reduce monthly premiums and out-of-pocket healthcare costs. Nevada Health Link plays a critical role in expanding access to affordable health and dental coverage to Nevadans statewide.

1.3 Important Definitions

Advance Premium Tax Credit (APTC)	An advance of the Premium Tax Credit (PTC) paid to an insurance company to reduce the cost of monthly premiums for eligible individuals buying Qualified Health Plans (QHPs). The APTC amount is based on the consumer's household size and estimated income.
Affordable Care Act (ACA)	The comprehensive federal health care reform law enacted to provide access to affordable coverage through access to financial subsidies and Health Insurance Marketplaces in each state.
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.
Authorized Representative	An individual chosen by the consumer to act on their behalf with the Nevada Health Link platform (often a family member or another trusted person). Some authorized representatives might have legal authority to act on the consumer's behalf.
Agent/Broker	Individuals licensed to sell health insurance products in Nevada who are certified by Nevada Health Link and licensed by the Nevada Division of Insurance. Certified agents/brokers assist consumers with the consumer application and enrollment processes. Certified agents/brokers are appointed by Nevada Health Link companies to sell health insurance plans and are compensated via commission.
Centers for Medicare and Medicaid Services (CMS)	CMS is the federal agency that provides health coverage through Medicare, Medicaid, the Children's Health Insurance Program, and the federally facilitated Health Insurance Marketplace.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	A federal law that allows employees and their families to continue health insurance coverage after losing their jobs or experiencing other qualifying events.

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.
Crosswalk 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.
Data matching issue (DMI)	Inconsistency of consumer generated data submitted to Nevada Health Link by consumer versus the data returned from trusted data source, such as the IRS, a data matching issue will be issued to the consumer. The data matching issue (DMI) must be resolved within 90 days of initial notice.
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 Social Services (DSS)	Under the State of Nevada Department of Human Services, the Division of Social 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)	Services that health insurance plans must cover under the ACA. All insurance plans certified by Nevada Health Link are required by federal law to include EHBs. These include ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services including chronic disease management; pediatric services, including dental 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 (FPLs) 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	The Exchange may grant a hardship exemption when a person cannot afford to enroll in a qualified health plan because of unexpected expenses or other circumstances. All Nevada hardship exemption requests are processed by the Centers for Medicare & Medicaid Services (CMS) through HealthCare.gov.
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 the minimum value standard if it provides payment for at least 60% of the total cost of medical services for a standard population. Individuals covered by employer-sponsored coverage that provides minimum value are ineligible for a premium tax credits.
Nevada Health Link State Based Exchange (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 and dental insurance that fits their individual health needs.
Open Enrollment (OE) Period	The annual period when consumers may enroll in an individual health insurance plan for the upcoming plan year.
Periodic Data Matching (PDM)	Periodic examination of data sources to identify consumers enrolled in Exchange plans with financial subsidies while eligible or enrolled in duplicative coverage. PDMs are conducted to avoid duplication of benefits. If a data matching issue (DMI) is identified through the PDM process, consumers will have a 30-day reasonable opportunity period to resolve the issue and provide necessary documentation or verification.

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.
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 Reasonable Opportunity Period (ROP) is the period during which conditionally eligible consumers can submit verification documents to Nevada Health Link and clear data inconsistencies in their application. 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.
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 (SSHIX)	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.

1.4 Nondiscrimination and Accessibility Statement

Nevada Health Link complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation.

2. Consumer Eligibility Policies

2.1 Eligibility Overview

Nevada Health Link must determine a consumer's eligibility for Marketplace coverage before a consumer can enroll in a health plan offered on the Marketplace. Eligibility policies included in this section outline how Nevada Health Link assesses and determines eligibility for consumers.

2.1.1 Minimum Essential Coverage

26 CFR 1.5000A-2

Minimum Essential Coverage (MEC)[1] is any type of insurance plan that meets the ACA requirement for having health coverage under the Affordable Care Act. 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 health plans are considered MEC:

- Any Qualified Health Plan (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.
- Including Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and retiree coverage)
- 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) or Nevada Check Up
- 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
- Medicare Part A or Medicare Part C (Medicare Advantage)

[1] See Minimum Essential Coverage | CMS

- Refugee Medical Assistance supported by the Administration of Children and Families
- State high risk pools for plan or policy years that begin on or before December 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as MEC)
- Other coverage recognized by the Secretary of HHS as MEC

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 are generally not eligible for advanced premium tax credits (APTC) if their employer-sponsored health plan is considered affordable, meaning the plan offers minimum essential coverage (MEC) and provides minimum value. To meet the "minimum value standard", employer-sponsored health plans must cover at least 60% of the total cost of benefits provided by the plan. However, they may purchase a qualified health insurance plan through Nevada Health Link without federal subsidies.

2.1.2 Verification of Income for a Financial Application

45 CFR 155.320 E: 45 CFR 155.315(f)

To receive a tax credit, Nevada Health Link uses trusted electronic data sources 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 (ROP) that consumers are allowed to maintain conditional eligibility for financial benefits while providing documents for manual verification is 90 days from the date of the mismatch with federal information. After 90 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.

2.1.3 Qualified Health Plan (QHP) Eligibility

Eligibility is determined based on member-level eligibility results. For 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.

2.1.3.1 Who Is Eligible for QHP

45 CFR 155.3; 45 CFR 155.335; 45 CFR 155.20; 45 CFR 155.300; 45 CFR 155.305; 26 CFR 1.36-b (2); H.R. 1 (PL No.119-21) Sec. 71301, 71302, 71119

To be eligible for enrollment in a Qualified Health Plan (QHP), the consumer must meet the following requirements:

- Be a United States citizen, a U.S. national, or a noncitizen that is "lawfully present" as defined by 45 CFR 155.20 (See section Lawfully Present Criteria) for the entire period for which enrollment is sought;

1. Be a resident of Nevada; and
2. Not be incarcerated, other than incarceration pending disposition of charges.

2.1.3.2 Who Is Eligible for APTC

To be eligible for federal advanced premium tax credits (APTC) to reduce monthly premiums, a consumer must meet the following requirements:

1. Be eligible to enroll in a QHP;
2. Intend to file taxes (and if married, must be married filing jointly); and
3. Is not eligible for other Minimum Essential Coverage (MEC);
4. Has annual project income between 100% and 400% of the federal poverty level (FPL); and
5. For coverage beginning on or after January 1, 2027, is a U.S. citizen, a U.S. national, or a lawfully present noncitizen that is an "eligible noncitizen" as defined by 45 CFR 155.20.

Consumers who are ineligible for Medicaid/CHIP solely due to failure to satisfy community engagement or work requirements are ineligible for APTC or CSR.

Effective for coverage on or after January 1, 2027, only lawfully present noncitizens who are considered "eligible noncitizens" may qualify for APTC or CSR. "Eligible noncitizens" includes:

- Lawful permanent resident (LPRs or green card holders),
- Cuban-Haitian Entrants, and
- Compacts of Free Association (COFA) migrants

Other lawfully present noncitizens may enroll into an unsubsidized QHP. Lawfully present immigrants who are not considered "eligible aliens" are not eligible for APTC or CSR for coverage on or after January 1, 2027, including, but not limited to:

- Refugees,
- Asylees,
- certain parolees,
- trafficking survivors,
- and others.

Note: Prior to January 1, 2026, lawfully present noncitizens with projected annual income under 100% of the Federal Poverty Level that were ineligible for Medicaid due to immigration status were eligible for APTC and CSR. Effective for coverage on or after January 1, 2026, consumers with projected annual income under 100% FPL are only eligible for full cost QHPs with no APTC or CSR.

2.1.3.3 Who Is Eligible for CSR

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

1. Have projected annual income between 100 and 250 percent of the federal poverty level (FPL) and be enrolled in a silver level plan, or,

2. Be an American Indian or Alaskan Native (AI/AN) from a federally recognized tribe and be enrolled in any metal level plan.

3. Consumers who are AI/AN from a federally recognized tribe with projected annual income between 100% and 300% of FPL are eligible for zero-dollar cost share.

4. Consumers who are AI/AN from a federally recognized tribe with projected annual income below 100% FPL or above 300% FPL are eligible for a limited cost share which applies specifically to specific providers such as Indian Health Services (IHS) provider.

2.1.3.4 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

Nevada Health Link 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 lawful presence 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. 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.

Consumers who attest to information that conflicts with Nevada Health Link's Federal Hub services verification may be granted conditional eligibility for 90 days. If attested information is not verified by either the Hub services check or manual verification prior to the 90-day period, consumers with unresolved data matching issues (DMIs) will lose eligibility for APTC/CSR, QHP enrollment, or both.

2.1.3.5 QHP Certification Outside of Standard Timeframe

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

2.1.4 Lawfully Present Criteria

45 CFR 155.20; 26 CFR 1.36-b (2)

To be considered "lawfully present" and eligible to enroll into Marketplace coverage, a consumer must meet one of the following requirements:

- Lawful Permanent Resident (LPR/Green Card holder),
- 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 and parent
- Victim of trafficking and his/her Spouse, child, siblings or parent
- Granted withholding of deportation or withholding of removal under the immigration laws or under the Convention Against Torture (CAT)
- Individual with non-immigrant status (includes worker visas, student visas)
- Compact of Free Association (COFA) Migrants (Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau who are lawfully residing in the U.S.)
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Lawful Temporary Resident
- Administrative order staying removal issued by the Department of Homeland Security
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa
- Family Unity beneficiary, including those who are under section 1504 of the Legal Immigration and Family Equity (LIFE) Act Amendments
- A consumer is also considered lawfully present if they are an applicant with any of these statuses:
    - Temporary Protected Status with Employment Authorization
    - Special Immigrant Juvenile Status
    - Victim of Trafficking Visa
    - Adjustment to LPR Status
    - Asylum (see note below)
    - Withholding of deportation, or withholding of removal under the immigration laws or under CAT)
    - Violence Against Women Act (VAWA) Self-Petitioner

NOTE: *Applicants for asylum are eligible for Marketplace coverage only if they've been granted employment authorization or are under the age of 14 and have had an application pending.*

A consumer is also considered lawfully present if they have employment authorization along with one of the following:

- 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 (LIFE) Act

NOTE: *Information about immigration status will be used only to determine eligibility for coverage and not for immigration enforcement.*

2.1.5 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 can still apply for coverage without a home address, however, the consumer will need to provide a mailing address where they can receive notices and other information regarding coverage.

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, except for 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.

Evidence of immigration status cannot be used to determine that an applicant is not a resident of Nevada, per 45 CFR 155.315(d)(4)).

2.2 Financial Assistance

2.2.1 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.

2.2.2 MAGI and Annual Income Calculations

Modified Adjusted Gross Income (MAGI) is the household income measure utilized in Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR) eligibility calculations. MAGI is a combination of[2]:

- Adjusted gross income (AGI),
- Excluded (untaxed) foreign income,
- Non-taxable Social Security benefits, and

[2] https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/

- Tax-exempt interest

Nevada Health Link can assist consumers in generating projected annual MAGI for the coverage year. For consumers whose income is consistent and predictable, the prior year's federal tax return (at the time of application) is a helpful starting point. However, Marketplace financial assistance is based on expected household income for the coverage year. If a consumer's current income differs from the prior year's income due to changes in employment, wages, retirement, self-employment earnings or other factors the consumers should build an estimate based on more current information as accurately as possible.

Below are common types of income that count as part of MAGI[3]:

- Taxable wages / salaries
- Tips (cash and non-cash)
- Self-employment income
- Unemployment compensation
- Social Security (both taxable and non-taxable income)
- Social Security Disability Income (SSDI)
- Retirement or pension income
- Capital gains
- Investment income
- Rental and royalty income
- Excluded (untaxed) foreign income
- Other taxable income
- Alimony (for divorces or separations finalized before January 1, 2019)

Note that the following do not count as types of income: Supplemental Security Income (SSI) is not included in Marketplace MAGI. Veterans' disability payments, worker's compensation, veterans' disability payments, proceeds from loans (like student loans, home equity loans, or bank loans), gifts, child tax credit checks or deposits (from the IRS), child support, alimony for divorces and separations finalized on or after January 1, 2019.

2.2.3 Tax Filing Requirements

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

To receive premium tax credits (PTC), eligible individuals must file annual tax returns according to their marital status. Single tax filers must be unmarried or divorced. Married individuals must file as married filing jointly and living with, or apart from, their spouse.

If an individual is married and files taxes as married filing separately, the individual will not be eligible for the premium tax credit unless the individual is a victim of domestic abuse or spousal abandonment and can meet certain criteria. Details regarding this relief are in the instructions for IRS Form 8962 and IRS Publication 974.

[3] https://www.healthcare.gov/income-and-household-information/income/

Generally, a taxpayer who lives apart from his or her spouse for the last six months of the tax year is considered unmarried if the taxpayer files a separate return, maintains a household that is also the main home of the taxpayer's dependent child for more than half the year, and furnishes more than half the cost of the household during the tax year.

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, and consent to allow Nevada Health Link to verify reported income with Internal Revenue Filings. Failure to reconcile tax credits for one or more years may result in the loss of subsidy eligibility.

For tax years beginning after December 31, 2025, Marketplace enrollees are liable for the entirety of tax credits they receive, no matter their income level. If the premium tax credit received was in excess of the amount of tax credits, they were determined to be eligible for by the IRS, the individual is responsible for repayment of all excess credits that will be recaptured by the IRS.

Please note, Nevada Health Link cannot give consumers tax advice.

2.2.4 Financial Application Closures

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.

2.2.5 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 child is free rule. Dependents within the same household who enroll in separate plans will not be eligible for the 4th child is free premium reduction.

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

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.

2.2.6 Aggregated Billing for Tribal Health Clinics

45 CFR § 156.1250; 45 CFR 155.240(b)

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, monthly premiums for these enrollments are managed on an individual-policy basis. Carriers offering plans on Nevada Health Link may choose to participate in aggregate payment of premiums for tribal enrollees and will be identified as a participant of the

Tribal 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. Tribal Health Clinics who participate in the aggregated billing process are subject to the terms and conditions of the agreement with the Exchange. 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. Tribal enrollments will be subject to the same grace period rules as non-tribal enrollments with respect to termination for nonpayment, i.e. 90 days for policies with APTC and 30 days for policies with no APTC.

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

2.2.7 Advance Premium Tax Credit (APTC)/Cost Sharing Reduction (CSR)

2.2.7.1 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.

For 2026 coverage, "lawfully present" immigrants with a 5-year bar with an income of 100% - 400% of the FPL may receive PTC. Effective for coverage beginning on or after 1/1/2027, for lawfully present noncitizens, they must be considered "eligible noncitizens" (See section Lawfully Present Criteria) to receive APTC.

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, and higher income levels for certain people including children or pregnant individuals for reasons other than community engagement or work requirements.

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 Supportive Services (DSS), are not considered denial of eligibility determinations for APTC eligibility purposes.

2.2.7.2 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. Consumers are only required to report income information if they are requesting a determination for financial eligibility.

Tax credits are calculated on taxable income including the following:	**The following non-taxable income is *not* factored into APTC calculations:**

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

2.2.7.3 Determining Tax Credit Amount

FR 1.36 B-1

Advanced Premium Tax Credits (APTC) are 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.

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.

2.2.7.4 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.

2.2.7.5 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 a Special Enrollment Period (SEP).

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.

2.2.7.6 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 reductions (CSR). Consumers who lose APTC/CSR eligibility will be renewed into corresponding plans without these subsidized benefits.

2.2.7.7 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 to the first of the following month following the date that the application is received by Nevada Health Link.

For more details regarding effective dates of eligibility due to Special Enrollment Periods or complex cases see section Qualifying Life Events for Special Enrollment Period.

2.2.7.8 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.

2.2.7.9 APTC Rebalancing

When an enrollee reports income changes mid-plan year, they receive a revised monthly APTC amount based off their new projected annual income, without factoring in the available APTC already consumed. Starting in Plan Year 2027, Nevada Health Link's system will enable APTC rebalancing to ensure the consumer can maximize the use of available APTC while reducing the risk of over consumption that must be paid back when reconciling taxes. When APTC Rebalancing is enabled, the monthly APTC is rebalanced, factoring in the APTC already consumed in previous months, each time the consumer submits an application with revised eligibility.

2.2.7.10 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:

- Parent 1 is on one policy.
- Parent 2 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

2.2.7.11 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.

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.

2.2.7.12 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.

2.2.7.13 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.

2.2.7.14 Quality Rating System

45 CFR 156.1120

Nevada Health Link will display Quality Rating System (QRS) data based on CMS 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.

2.3 Employer-Sponsored Coverage

26 CFR 1.36B-2(c)(3); 26 CFR 1.36B-1(e)(2); 26 CFR 1.36B-3; 26 CFR 601.105; 45 CRF 155.320(b); 45 CFR 156.145

Under the ACA, employees are generally not eligible for advanced premium tax credits (APTC) if their employer-sponsored health plan is considered affordable, meaning the plan offers minimum essential coverage (MEC) and provides minimum value. To meet the "minimum value standard", employer-sponsored health plans must cover at least 60% of the total cost of benefits provided by the plan. Employer-sponsored 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 affordability threshold published by the Internal Revenue Service (IRS).

Employer-sponsored coverage for an employee's family (spouse and/or any dependents) 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 deemed affordable for either the employee or the whole family.

Consumers who qualify for APTC after attesting that employer-sponsored coverage is unavailable, does not meet

minimum value, or is unaffordable may have their eligibility appealed if the employer actually offers affordable coverage that meets minimum value. Consumers may be required to repay some or all the tax credits they received if those credits were granted while they had an offer of affordable employer-sponsored coverage that met minimum value and affordability standards.

2.3.1 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. 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.

2.4 Small Business Health Options Program (SHOP)

2.4.1 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 have any SHOP QHP issuers; and therefore, does operate a SHOP. Consumers interested in group coverage should contact insurance carriers directly.

2.5 Medicare, Medicaid, CHIP, COBRA, and Other MEC

2.5.1 Applying for APTC When Enrolled in Retirement Coverage

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

If an individual is enrolled in retirement health insurance coverage, they can apply for APTC and purchase health insurance if their current coverage does not qualify as minimum essential coverage and it is Open Enrollment. If an individual's coverage ends outside of the Open Enrollment period and they choose not to re-enroll, they would be eligible for a Special Enrollment Period.

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

2.5.2 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 or a Special Enrollment Period allows them to voluntarily leave their COBRA policy and begin a new policy on Nevada Health Link.

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.

2.5.3 Medicare and APTC

45 CFR 156.440, 26 CFR 1.36B-2; 26 CFR 1.5000A-2

The following applies to consumers eligible for Medicare:

- Consumers who receive Medicare are not eligible to receive financial assistance.
- Consumers who receive Medicare Part A at a cost may drop Part A and Part B coverage, or they can choose not to enroll in Medicare at the time they become eligible (these consumers may be subject to tax penalties or Medicare penalties if they defer Medicare enrollment outside of the qualifying time). Consumers who drop Medicare or Medicare Part A at a cost can enroll in health insurance coverage through Nevada Health Link with financial assistance.
- Consumers 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.
- Consumers over 65 years old who elect not to receive retirement benefits may be eligible for health insurance coverage and financial assistance through Nevada Health Link.
    - Medicare Part B alone is not considered MEC. However, if a consumer is eligible for Medicare Part B, it is assumed they are also eligible for Medicare Part A and not eligible for financial assistance.

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

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 section Independent Purchase.

2.5.5 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 may automatically drop APTC eligibility. It is the responsibility of consumers to notify Nevada Health Link when Medicaid or CHIP coverage or eligibility is gained for any enrolled members. Enrollment in Exchange coverage may continue at full price without subsidy eligibility while enrolled in Medicaid/CHIP or while awaiting a Medicaid/CHIP assessment.

2.6 Data Verification & Program Integrity

2.6.1 Eligibility Verification Documents

45 CFR 155.315

Consumers when filing both financial and non-financial applications must provide eligibility verification documentation for determining U.S. citizenship or legal status and income.

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.

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.
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.

2.6.2 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.

2.6.3 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.

2.6.4 Electronic and Telephonic Signatures

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

2.6.5 Reasonable Opportunity Periods

The Reasonable Opportunity Period (ROP) is the period during which conditionally eligible consumers can submit verification documents to Nevada Health Link and clear data inconsistencies in their application. If a consumer fails to provide adequate proof of documentation 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 Nevada Health Link. When a consumer completes an application submission, consumer attested information will be confirmed by Nevada Health Link 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 90 days from the date of application submission to provide any requested verification documentation.

Nevada Health Link conducts periodic data matching (PDM) examinations of data sources to identify consumers enrolled in Nevada Health Link plans with financial subsidies while eligible or enrolled in duplicative coverage. PDMs are conducted to avoid duplication of benefits. If a data matching issue (DMI) is identified through the PDM process, consumers will have a 30-day reasonable opportunity period to resolve the issue and provide necessary documentation or verification.

2.6.6 Data Matching Issues (DMI) and Periodic Data Matching (PDM)

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

As noted in section Eligibility Verification Standards, consumers who attest to information that conflicts with the Nevada Health Link's Federal Hub services verification may be granted conditional eligibility for 90 days. If attested information is not verified by either the Hub services check or manual verification prior to the 90-day

period, consumers with unresolved data matching issues (DMIs) will lose either financial or QHP enrollment eligibility.

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

3. Enrollment Policies

3.1 Open Enrollment Dates

45 CFR 155.410

Open Enrollment is held annually during a designated Open Enrollment Period (OEP) to apply for coverage in the upcoming plan year. During OEP, new and returning consumers may make plan selections for the upcoming year without the need to have a qualifying life event. Outside of OEP consumers must report qualifying life events to qualify for a special enrollment period (SEP).

Plan Year	Open Enrollment Period
2027	November 1, 2026 – January 15, 2027
2026	November 1, 2025 – January 15, 2026
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

3.2 Coverage Start Dates

3.2.1 Open Enrollment Effective 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. Consumers who enroll during OEP in January will receive coverage starting February 1st.

3.2.2 SEP Effective Dates

Please see section Special Enrollment Period Matrix for coverage dates by qualifying life event (QLE).

3.3 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 Household and 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.

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.

3.3.1 Active Application Timeframe

Once Nevada Health Link consumers have completed an application in the system, it will remain active throughout the Open Enrollment period or until a new application has been submitted.

3.3.2 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 plan year eligibility and coverage during the annual open enrollment period, will take effect on January 1 of the upcoming year. Outside of the annual OEP, 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 Nevada Health Link portal.

3.3.3 Health Savings Account

Consumers can contribute to a Health Savings Account when enrolled in an eligible High-Deductible Health Plan, such as a Bronze or Catastrophic plan. Plans in other categories may also be eligible, depending on their deductibles and out-of-pocket maximums.

Once enrolled in a Health Savings Account-eligible plan, consumers can open a Health Savings Account through a financial institution, like a bank or credit union.

To find a financial institution that will set up a Health Savings Account:

- Search for "Health Savings Account providers" online.

- Check with your health insurance company to see if they partner with Health Savings Account financial institutions.
- Ask your bank if they offer a Health Savings Account option that meets your needs.

For more information on how to set-up a Health Savings Account visit: https://www.healthcare.gov/high-deductible-health-plan/hdhp-hsa-information/

3.4 Service Areas

A Nevada service area is determined from the primary applicant's physical address listed on the application. 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. 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.

3.5 Household and 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:

- The 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 a member only open to American Indian or Alaskan Native (AIAN) consumers.
- The primary applicant and his/her child-dependents (tax dependents) may generally enroll in the same plan bearing unique plan eligibility factors such as AIAN status or catastrophic plan eligibility OR the overage dependent requirements listed below.
- No over age-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.

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.

3.5.1 Primary Applicant

When creating a consumer account at www.NevadaHealthLink.com the owner of the account is the default primary applicant for the household. The primary applicant cannot be changed after account creation.

3.5.2 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 must then obtain their own health insurance policy and will be removed from the Nevada Health Link shared policy. Nevada Health Link will maintain plan coverage for 26-year-olds through December 31st of the plan year they turn 26. 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. Please see section 24 Year Old Dependents and APTC Eligibility.

3.5.3 Children of Undocumented Immigrants

45 CFR 155.300, 45 CFR 155.305

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.

3.5.4 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 section Qualifying Life Events for Special Enrollment Period, 3.14.2 SEP Matrix. Nevada Health Link will manually split the household to process the case. See section Calculating Distribution of APTC for Split Household Groups.

3.5.5 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.

3.6 Premium Payments and Binder Payments

45 CFR 155.400; 45 CFR 155.410; 45 CFR 155.420

Consumers must make their binder payment (the first month's premium payment) to complete enrollment and effectuate coverage. Insurance companies may set the deadline for consumers to pay their binder payment no earlier than, and no later than 30 calendar days after the coverage effective date.

Ongoing premium payments after the initial binder payment are due by the last day of the month prior to the month of

coverage.

Nevada Health Link allows insurers to have a net premium payment threshold policy under which they can consider consumers to have effectuated their coverage if their payment meets or exceeds a reasonable and pre-established threshold. This premium payment threshold can be applied to binder payments and if met or exceeded, will not trigger a grace period or a termination. An insurer's payment threshold policy must be reasonable and applied in a uniform manner to all consumers.

3.7 Grace Periods

3.7.1 Grace Period Window

45 CFR 156.270 (d) and (g)

Consumers with effectuated coverage are granted a grace period before their coverage can be terminated for non-payment. If the premium payment has not been received by the insurance company on or before the 30th day of the coverage month, a grace period is triggered. The grace period is different for consumers who receive APTCs:

- For consumers with APTCs, the grace period is three consecutive months (90-days), beginning with the month of non-payment.
- For consumers without APTCs, the grace period is 31 days.

Partial payments do not adjust a grace period. If a consumer is eligible for APTCs but elects not to receive the credit in advance, they do not qualify for the three-month grace period. The three-month grace period only applies to consumers who are receiving APTCs.

3.8 Claims During Grace Periods

3.8.1 Payment of Medical Claims Incurred During the Grace Period

For consumers with APTCs, insurance companies must pay all appropriate claims for services rendered to the consumer during the first month of the grace period and may pend claims for services rendered to the consumer in the second and third months of the grace period. Insurance companies must notify providers of the possibility for denied claims when a consumer is in the second and third months of the grace period.

If the consumer's coverage is terminated for non-payment of premiums retroactively to the last day of the first month of the grace period, the insurance company may deny any claims that were pended for services received during the second and third months of the grace period. However, the insurance company cannot retroactively deny claims from the first month of the grace period.

If the consumer is not receiving APTC at the time they enter the grace period, the insurer can hold off paying any health care claims for care during the 30-day grace period.

If the amount owed for all outstanding premium payments is not paid in full by the end of the grace period, the insurer can terminate coverage. However, the grace period only applies if the consumer has paid at least one month's premium within the current plan year.

In general, insurers are supposed to inform health care providers when someone's claims are being held due to

nonpayment. If this happens, providers may request consumers pay the full cost of care out of pocket, or they may not provide care until the premiums are fully paid.

3.9 Disenrollment

3.9.1 Disenrollment by Carrier

45 CFR 147.104(i)

Health insurance carriers are permitted to disenroll consumers for non-payment, fraud, or intentional misrepresentation.

3.9.2 General Disenrollment

45 CFR 162.1501; 45 CFR 155.430

A Nevada Health Link consumer can voluntarily disenroll and set the date prospectively 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 is at the carrier's discretion, in accordance with applicable state and federal laws.

When a child is on a parent's health insurance policy, they are automatically disenrolled from the plan on December 31st 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 section Disenrollment.

3.9.3 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 date 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 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.

Retroactive terminations of Exchange coverage follow the below timeframes:

- Retroactive terminations for Medicare-based enrollment may be terminated up to six months back from the reporting date.
- Retroactive dual coverage terminations for enrollment in Medicaid/CHIP may be terminated up to 60 days back from the reporting date.
- Consumers who are deemed eligible for Medicaid can request retroactive terminations of their QHP coverage up to 60-days prior to the date the eligibility change is reported to the Exchange. If requests are received to back date termination of enrollment more than 60-days, 45 CFR 155.430(d)(2)(v) allows the Exchange to back date the termination to the day before Medicaid eligibility was granted if the consumer demonstrates he or she attempted to terminate coverage but experienced a technical error; or demonstrates the enrollment in a QHP was unintentional, inadvertent, or erroneous and was the result of the error or misconduct. Such requests must be provided to the Exchange within 60-days of discovering the error and will be approved on a case by case basis.
- Retroactive terminations for other minimum essential coverage (MEC) 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:
- Terminate to the last day of the month that the consumer reported.

3.9.4 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 authorized representative 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.

3.10 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).

Additionally, a reinstatement request may be submitted for actions outside of past due premiums or non-payment events. These requests are subject to review by the Exchange for approval.

3.11 Re-Enrollment Following Termination for Non-Payment

45 CFR 155.400(e)(1); 45 CFR 147.104

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 all unpaid delinquent premiums before effectuating new coverage. 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.

3.12 Renewals

3.12.1 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. Consumers should review all auto-renewal notices and health plans for changes affecting coverage and use prior to January 1, to ensure that auto-renewed plans meet consumer needs. The consumer may need to supply additional information, if requested, to prove eligibility. Conditionally eligible consumers may have their APTC, or Nevada Health Link coverage automatically end if they fail to provide the requested additional documentation within 90 days.

Nevada Health Link automatically renews consumer coverage even if they lose eligibility for federal financial assistance 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 Nevada Health Link are not renewed.

When an insurance carrier does not renew their Nevada Health Link certification, or they are decertified by Nevada Health Link at the end of the plan year, the consumer's enrollment will terminate at the end of the plan year. Consumers are then automatically enrolled in a cross-walked plan, as directed by the Division of Insurance.

3.12.2 Changes to Cost Sharing Reduction or APTC

If changes are made 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.

Additional 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.

3.12.3 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.

3.12.4 Carrier Use of Payment

45 CFR 155.400; 45 CFR 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.

3.12.5 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.

3.13 Dental

3.13.1 Open Enrollment

45 CFR 155.410

The Open Enrollment Period dates and Special Enrollment Period rules are the same for Qualified Dental Plan enrollments as they are for Qualified Health Plan insurance.

Qualified Dental Plans are subject to waiting periods prior to use for services. Consumers should thoroughly review plan benefits to learn more.

3.13.2 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.

3.13.3 Pediatric Dental Age Limits

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

3.13.4 Pediatric Dental Plans

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

3.13.5 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 age 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 also section Disenrollment.

3.13.6 Renewals

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

Dental 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.

3.13.7 APTC

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

Advanced Premium 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 aged 19 or older.

3.13.8 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 in order to purchase a dental plan.

APTC is not applicable to Independent Dental Purchases. Eligibility is dependent on citizenship or lawful immigration status, Nevada residency, non-incarceration status, and non-deceased.

3.14 Special Enrollment Period

3.14.1 Qualifying Life Events for Special Enrollment Period

45 CFR 155.420

A change in an individual's life can make them eligible for a Special Enrollment Period (SEP) to enroll in health coverage outside of the annual Open Enrollment Period or during open enrollment. Examples of common Qualifying Life Events (QLE) can include loss of health coverage, changes in household (marriage, divorce, or birth of a child), and changes in residency. Other events, such as gaining citizenship, leaving incarceration, or becoming eligible/ineligible for certain subsidies, can also trigger a Special Enrollment Period.

See section SEP Validation Documents

3.14.2 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.

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	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)
			* Rule does not apply to non-MEC policies, such as hospital indemnity policies, short-term policies, or other non-MEC policies.				
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 9.13) 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

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)

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"	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);

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)

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.	45 CFR 155.330(f)(1)(i); 45 CFR 155.420 (d) (6); 45 CFR 156.425(b)

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Financial Eligibility	**4.2**	**APTC Amount Change:** Exchange-enrolled household with no previous APTC becomes eligible for APTC (no CSR).	Yes	Nevada Health Link	60 days from date of QLE	Change effective date will follow the 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.	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.	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)

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

Type	#	Type of Qualifying Life Event (QLE) & Scenario	QLE Merits SEP	Exchange Enrollment Required Prior to QLE	Timeframe to Report and Enroll in a Plan (SEP)	Coverage or Change Effectuates	Regulation Reference
Change in Eligibility Status	**6.1**	**Exceptional Circumstances:** Due to extenuating circumstances, consumer needs to choose a new plan (unable to pay previous premiums due to extreme circumstances, natural disaster, or domestic violence, etc.).	Case by case basis*	Varies	Case by case basis	Case by case basis	45 CFR 155.420(c)(3); 45 CFR 155.420(d)(9)
Change in Eligibility Status	**6.2**	**American Indian or Alaska Native:** Consumer is American Indian or Alaska Native and recently gains status as American Indian or Alaska Native.	Yes	No	All can have SEP once a month. *	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	1st 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)

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 DSS, 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.				

3.14.3 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 section 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 who was not the plan subscriber.

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

45 CFR 155.305-320; 45 CFR 155.420

For most QLEs, 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 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. If an existing Nevada Health Link consumer's address is updated more than 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.

3.14.5 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.

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.

3.14.6 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.

Pregnancy does not qualify for a Special Enrollment Period. However, if a life change such as a pregnancy is reported it may change the individual's eligibility for Medicaid.

3.14.7 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.

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.

3.14.8 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.

Separately, the Special Enrollment Period will be open for the dependent if they report that there was a change in household size and they are no longer a dependent. They can apply on their own through Nevada Health Link and report that they lost coverage.

3.14.9 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.

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

3.14.10 Domestic Violence

Consumers who are survivors or 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 takes the victim's self-attestation as proof of being a survivor or victim of domestic violence.

Note that individuals may qualify or a hardship exemption if they experienced domestic violence and more details are noted in section Hardship Exemptions. They may also qualify for an exception to the requirement to file a joint federal tax return as a condition of receiving Marketplace premium tax credits (PTCs).

3.14.11 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.

3.14.12 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.

3.14.13 SEP Validation Documents

3.14.13.1 Validation of Application and Enrollment

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

3.14.13.2 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.

Adoption

To qualify for a SEP, you must provide proof of the adoption event. Here's a list of documents that you can upload:

Proof of adoption within the last 60 days

ADOPTION_LETTER	Adoption letter or record showing date of adoption dated and signed by a court official
LEGAL_GUARDIANSHIP_LETTER	Government issued or legal document showing the date legal guardianship was established
FOREIGN_ADOPTION_LETTER	U.S. Department of Homeland Security immigration

	document for foreign adoptions
FOSTER_CARE_LETTER	Foster care papers dated and signed by a court official
GOV_ADOPTION_LETTER	Government issued or legal document showing the date that the child was placed in the home
COURT_ORDER	Court order showing the effective date of the order
MEDICAL_SUPPORT_ORDER	Medical support order

Birth

To qualify for a SEP, you must provide proof of the birth event. Here's a list of documents that you can upload: Proof of birth within the last 60 days.

BIRTH_CERT	Birth Certificate
BIRTH_CONF	Birth Confirmations
MEDICAL_RECORD	Copy of the medical record from a clinic, hospital, physician, midwife, institution, or other medical provider showing the child's date of birth
HOSPITAL_RECORD	Letter from a hospital, clinic, physician, or other medical provider attesting the child's date of birth.
MILITARY_BIRTH_RECORD	Copy of the military record showing the child's date and place of birth
FOREIGN_BIRTH_RECORD	Copy of a foreign birth record showing the child's date and place of birth
RELIGIOUS_BIRTH_RECORD	Copy of a religious record showing the child's date and place of birth

Change in Incarceration/ Incarceration

To qualify for a SEP, you must provide proof of the change in your incarceration status. Here's a list of documents that you can upload: Proof of termination of incarceration within the last 60 days.

TIME_SERVED_LETTER	Verification of time served
CONV_DISPOSITION_LETTER	Conviction Disposition Charges

Change in Legal Presence

To qualify for a SEP, you must provide some documentation as a proof of your legal status. Here's a list of documents that you can upload: Proof of change in legal presence within the last 60 days.

I551	I-551 resident alien card (green card)
T_I551	Temporary I-551 resident alien card (temporary green card)
I766	I-766 employment authorization card
CUR_VISA_STATUS	Proof of current visa status (for example, a stamp in your passport or, an approval letter from the United States Citizenship and Immigration Services (USCIS))
COURT_ORDER_IMMIGRATION	Proof of resolution in Immigration court (all pages)
NOTICE_OF_HEARING	Notice of hearing from the Executive Office for Immigration Review
IMMIGRATION_CONF	Confirmation that your application for an immigration status was received
USCIS_LETTER	Letters to or from USCIS
I797_APPROVAL	I-797 USCIS Notice of Action *APPROVAL Notice ONLY, or I-797c with green card*
ICE_LETTER	Order of Supervision from ICE
ICE_STATUS_LETTER	Other documents from USCIS or ICE that show your current status
I94	I-94 arrival/departure record
I130	An approved immediate relative 1-130 petition
I571	Refugee Travel Document (I-571)
I327	Re-entry Permit (I-327)
DS2019	SEVIS ID (I-20 or DS 2019) (all pages)
ORR_LETTER	Office of Refugee Resettlement (ORR) or Office on Trafficking In Persons (OTIP) Certification or eligibility letter (all pages)
WITHHOLDING_LETTER	Withholding of Removal
ASYLUM_LETTER	Asylum
REMOVAL_CANCELLATION	Cancellation of Removal

ADMIN_CLOSURE	Administrative Closure
ADMIN_STAY_ORDER	Administrative Order Staying Removal
ORDER_OF_SUPERVISION	Order of Supervision
PROOF_OF_STAY	Proof that you lived continuously in the U.S. before 1972 (for example, your lease agreement or proof of employment)

Change In American Indian/Alaskan Native Status and Gain of American Indian Status

To qualify for a SEP, you must provide documentation as proof of your AI/AN status. Here's a list of documents that you can upload: Proof for American Indian / Alaskan Native Status

BIA_CERTIFICATION	Certificate of Indian Alaskan from BIA
TRIBAL_MEMBERSHIP	Tribal membership

Change In Citizenship

To qualify for a SEP, you must provide documentation as proof of the change in your citizenship status. Here's a list of documents that you can upload: Proof of change in citizenship status within 60 days.

N550	Certificate of U.S. citizenship (N-560, N-561) or Certificate of Naturalization (N-550, N-570)
US_PASSPORT	U.S. Passport book or card (acceptable even if expired)
REAL_ID	Real ID Driver's License (enhanced) or State Real ID (enhanced State ID)
US_BIRTH_CERT	United States birth certificate or a birth certificate from a US territory, military record showing U.S. place of birth, other official or religious records showing U.S. place of birth, or adoption decree

Exemption Cancelled

To qualify for a SEP, you must provide documentation as proof of your Qualifying life event. Here's a list of documents that you can upload: Proof of exemption cancelled within the last 60 days.

EXEMPTION_LETTER	Exemption approval letter

ICHRA SEP

To qualify for a SEP, you must provide documentation as proof of your Qualifying life event. Here's a list of documents that you can upload: Proof of ICHRA change within the last 60 days.

ICHRA Letter	Notice from the employer showing when individual coverage or ICHRA will begin

QSEHRA SEP

To qualify for a SEP, you must provide documentation as proof of your Qualifying life event. Here's a list of documents that you can upload: Proof of QSEHRA change within the last 60 days.

QSEHRA Letter	Notice from the employer showing when individual coverage or QSEHRA will begin

Income Change APTC or CSR

To qualify for a SEP, you must provide documentation as proof of your Qualifying life event. Here's a list of documents that you can upload: Proof of income change within the last 60 days.

PAYCHECK	Paycheck stubs showing employee information, pay date or pay period, and gross amount of pay.
FORM_1040	1040 federal or state tax return from the previous year if representative of attested income.
WAGES	Wages and tax statement (W-2 and/or 1099, including 1099 MISC, 1099G, 1099R, 1099 SSA, 1099 DIV, 1099 SS, 1099 INT) showing first/last name, income amount, year, and employer name (if applicable).
EARNINGS_STATEMENT	A signed earning statement from your employer showing first/last name, company contact information and gross pay information, signed by the employer, and dated
TERM_LETTER	Termination letter from employer
SELF_EMPL_LETTER	Self-employment ledger documentation showing first/last name, company name, income amount. If you're submitting a self-employment ledger, include the dates covered by the ledger, and the net income from profit/loss (can be a Schedule C, the most recent quarterly or year-to-date profit and loss statement, or self-employment ledger).
FORM_1040_SE	1040 SE with Schedule C, F, or SE (for self-employment

	income)
FORM_1065	1065 Schedule K1 with Schedule E
UNEMPLOYMENT_LETTER	Unemployment benefits letter
TAX_RETURN	Tax return
PROFIT_LOSS_STMT	Most recent quarterly or year-to-date profit and loss statement

Divorce/ Legal Separation

To qualify for a SEP, you must provide documentation as proof of your Qualifying life event. Here's a list of documents that you can upload: Proof of existing or prior coverage within the last 60 days and proof of divorce within the last 60 days.

CARRIER_TERM_LETTER	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)
GOV_TERM_LETTER	Termination letter from a government provider (i.e., Medicaid)
COBRA_TERM	COBRA notice of termination of employer contribution to enrollment
COVERAGE_EXHAUSTION_LETTER	Employer letter of exhaustion of contribution to COBRA enrollment
PEBPS_LETTER	Dated letter from PEBPS
PREV_EMPL_LETTER	Letter from the previous employer confirming loss of coverage
MARKETPLACE_LETTER	Document from another state's Marketplace
STUDENT_HEALTH_COV	A document proving you had student health coverage
DEDUCTION_PAYSTUB	A paystub showing health coverage deductions
DIVORCE_DECREE	Divorce decree/Certificate

Loss of Coverage Through Employer

To qualify for a SEP, you must provide proof of the loss of your existing Employer coverage. Here's a list of documents that you can upload: Proof of existing or prior coverage within the last 60 days.

CARRIER_TERM_LETTER	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)
GOV_TERM_LETTER	Termination letter from a government provider (i.e., Medicaid)
COBRA_TERM	COBRA notice of termination of employer contribution to enrollment
COVERAGE_EXHAUSTION_LETTER	Employer letter of exhaustion of contribution to COBRA enrollment
PEBPS_LETTER	Dated letter from PEBPS
PREV_EMPL_LETTER	Letter from the previous employer confirming loss of coverage
MARKETPLACE_LETTER	Document from another state's Marketplace
STUDENT_HEALTH_COV	A document proving you had student health coverage
DEDUCTION_PAYSTUB	A paystub showing health coverage deductions

Loss of Medicaid

To qualify for a SEP, you must provide proof of the loss of your existing Medicaid coverage. Here's a list of documents that you can upload: Proof of existing or prior coverage.

MEDICAID_LETTER	Notice of Decision from DSS (NOD)

Loss of MEC

To qualify for a SEP, you must provide proof of the loss of your existing coverage. Here's a list of documents that you can upload: Proof of existing or prior coverage within the last 60 days.

CARRIER_TERM_LETTER	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)
GOV_TERM_LETTER	Termination letter from a government provider (i.e., Medicaid)
COBRA_TERM	COBRA notice of termination of employer contribution to enrollment

COVERAGE_EXHAUSTION_LETTER	Employer letter of exhaustion of contribution to COBRA enrollment
PEBPS_LETTER	Dated letter from PEBPS
PREV_EMPL_LETTER	Letter from the previous employer confirming loss of coverage
MARKETPLACE_LETTER	Document from another state's Marketplace
STUDENT_HEALTH_COV	A document proving you had student health coverage
DEDUCTION_PAYSTUB	A paystub showing health coverage deductions

Marriage

To qualify for a SEP, you must provide proof that at least one partner had coverage within the last 60 days prior to the event. Here's a list of documents that you can upload: Proof of existing or prior coverage within the last 60 days and proof of marriage within the last 60 days.

CARRIER_TERM_LETTER	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)
GOV_TERM_LETTER	Termination letter from a government provider (i.e., Medicaid)
COBRA_TERM	COBRA notice of termination of employer contribution to enrollment
COVERAGE_EXHAUSTION_LETTER	Employer letter of exhaustion of contribution to COBRA enrollment
PEBPS_LETTER	Dated letter from PEBPS
PREV_EMPL_LETTER	Letter from the previous employer confirming loss of coverage
MARKETPLACE_LETTER	Document from another state's Marketplace
STUDENT_HEALTH_COV	A document proving you had student health coverage
DEDUCTION_PAYSTUB	A paystub showing health coverage deductions
MARRIAGE_LETTER	Marriage certificate
DOMESTIC_PARTNER_CERT	Domestic legal document

MARRIAGE_AFFIDAVIT	Marriage affidavit or affidavit of support that's signed and dated by the person who officiated the marriage or the official witness of the marriage.
RELIGIOUS_MARRIAGE_LETTER	A religious document showing who got married and the date of the marriage.

Moved Into State

To qualify for a SEP, you must provide proof that you had qualifying coverage prior to moving, provide documentation of your prior residence and your new residence. Here's a list of documents that you can upload: Proof of existing or prior coverage within the last 60 days, proof of current address and proof of prior address.

Proof of existing or prior coverage within the last 60 days	CARRIER_TERM_LETTER	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)
	GOV_TERM_LETTER	Termination letter from a government provider (i.e., Medicaid)
	COBRA_TERM	COBRA notice of termination of employer contribution to enrollment
	COVERAGE_EXHAUSTION_LETTER	Employer letter of exhaustion of contribution to COBRA enrollment
	PEBPS_LETTER	Dated letter from PEBPS
	PREV_EMPL_LETTER	Letter from the previous employer confirming loss of coverage
	MARKETPLACE_LETTER	Document from another state's Marketplace
	STUDENT_HEALTH_COV	A document proving you had student health coverage
	DEDUCTION_PAYSTUB	A paystub showing health coverage deductions

Proof of prior address and current address	STATE_ID	State Issued ID
	DRIVERS_LIC	Driver's License
	RENGAT_AGREEMET	Rental agreement

Proof of prior address and current address	UTIL_BILLS	Utility Bills
	VOTER_CARD	Voter Card
	AUTO_REGISTRATION	Automobile Registration
	HOME_PAYMENT	Home payment notice
	COLLEGE_ENROLLMENT_LETTER	College Enrollment letter
	PROPERTY_TAX	Property Tax notice
	OFFER_OF_EMPLOYMENT	Offer of Employment
	HOME_PURCHASE_AGREEMENT	Home purchase agreement
	POSTAL_ADDRESS_LETTER	Postal Service change of address confirmation letter, including your mail forwarding date and the address mail will be forwarded to.
	GOV_LETTERHEAD	Letter from a government organization on official letterhead or stationery
	BANK_STMT	Bank Statement
Proof of prior address	STATE_ID	State Issued ID
	DRIVERS_LIC	Driver's License
	RENGAT_AGREEMET	Rental agreement
	UTIL_BILLS	Utility Bills
	VOTER_CARD	Voter Card
	AUTO_REGISTRATION	Automobile Registration
	HOME_PAYMENT	Home payment notice
	COLLEGE_ENROLLMENT_LETTER	College Enrollment letter
	PROPERTY_TAX	Property Tax notice
	OFFER_OF_EMPLOYMENT	Offer of Employment
	HOME_PURCHASE_AGREEMENT	Home purchase agreement
	POSTAL_ADDRESS_LETTER	Postal Service change of address confirmation letter,

		including your mail forwarding date and the address mail will be forwarded to.
	GOV_LETTERHEAD	Letter from a government organization on official letterhead or stationery
	BANK_STMT	Bank Statement

3.15 Eligibility 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. Individuals have 90 days from the date of their eligibility notice to file an appeal and meet the criteria for validation noted above. Appeals received outside the scope of authority for Nevada Health Link will be dismissed as not valid. Consumers should submit an appeal for expedited processing only if the life or health of the appellant is in jeopardy.

Nevada Health Link will send a Notice of Acceptance of a valid appeal request while the appeal is pending. Nevada Health Link will work to informally resolve consumer appeals prior scheduling a formal hearing. Should an appellant request adjudication, the appeal will be heard by the Nevada Division of Social Services (DSS) for final determination. The Nevada DSS 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 (CMS). 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. Appeals may be submitted by postal mail, phone, or online. Instructions to file an appeal can be found on www.NevadaHealthLink.com under the “Manage Your Plan” and “How to File an Appeal” tab.

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.
Reversed	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.

3.16 Catastrophic Eligibility

Catastrophic health plans have low monthly premiums and very high deductibles. They may be an affordable way to protect yourself from worst-case scenarios, like getting seriously sick or injured.

Catastrophic plans cover the same 10 essential health benefits as other Marketplace plans, including preventive services at no cost. They also cover at least 3 primary care visits per year before you've met your deductible.

Consumers who qualify for the premium tax credit or cost-sharing reductions may find a better value in a Bronze or Silver plans and should compare their plan options.

Catastrophic health plans are available to the following consumers if such plan is offered in their service area:

- People who are under the age of 30 (even if they will turn 30 during the plan year)
- People over the age of 30 can enroll in a catastrophic health plan only if they qualify for a hardship exemption and individuals must include their exemption certificate number to enroll in a catastrophic plan. To read more about hardship exemptions refer to section Hardship Exemption.

Effective January 1, 2026, Catastrophic and Bronze plans are treated as Health Savings Account (HSA) compatible high-deductible health plans (HDHPs).

3.17 Exemptions

3.17.1 Hardship Exemption

45 CFR 155.605

A hardship exemption is an exemption from the shared responsibility payment; and provides access to enroll into a catastrophic health plan. Exemptions can be granted to individuals who meet certain hardship requirements (e.g., homelessness, bankruptcy, domestic violence, eviction or foreclosure) or qualify for an exemption because their coverage is unaffordable.

3.17.2 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 https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/.

4. Consumer Support Policies

4.1 Consumer Support Overview

This section describes consumer support policies and procedures available through Nevada Health Link. Direct consumer support is provided by Nevada Health Link call center representatives, insurance carriers, certified brokers, agents, Navigators, and certified enrollment counselors (CECs). Consumers can find additional information on the Nevada Health Link website.

4.2 Nevada Health Link Website

Consumers can visit the Nevada Health Link website to access a wide range of Consumer Resources and Help options, including the following information:

- The Customer Assistance Center hours and contact information
- Local Enrollment Assistance
- A list of certified preferred Agents/Brokers and their contact information
- A list of certified Navigator organizations and In Person Assisters and their contact information
- A calendar of open enrollment events or activities in a specific area
- Frequently Asked Questions

4.3 Consumer Assistance & Complaint Resolution

45 CFR 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.

4.4 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 Division of Insurance and certified by the Silver State Health Insurance Exchange (SSHIX). 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.

4.5 American Indians and Alaska Natives (AIAN)

Section 206 25 USC 1621e; and Section 408 25 USC 1647a; 45 C.F.R. § 155.350(a), 45 C.F.R. § 155.350(b), 45 C.F.R. § 155.350(c), 45 C.F.R. § 155.420(d)(14)

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.

Households with AIAN members of federally recognized tribes and non-AIAN family members can enroll in the same Marketplace plan. However, a member of a federally recognized Tribe won't be able to use extra savings (known as cost-sharing reductions) if they enroll in the same Marketplace plan with a non-Tribal member. As such, Tribal members and non-Tribal members should enroll in separate plans to take advantage of all potential savings.

Members of federally recognized Tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders qualify for a Special Enrollment Period which allows them to change plans any month for coverage this year.

4.6 Certified Brokers, Agents, and Certified Enrollment Counselors

4.6.1 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, be able to show certification with at least one Nevada Health Link carrier, adhere to all items set forth in Nevada Health Link's Broker/Agent Rules of Behavior and Code of Conduct, complete annual NVHL certification training with passing scores, and attend Nevada Health Link specific training sessions. 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 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.

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.

4.6.2 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 Division of Insurance (DOI) for further investigation and possible discipline by DOI.

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

4.6.3 Navigators/Exchange Enrollment Facilitators

45 CFR 155.205; 45 CFR 155.210; 45 CFR 155.215; NRS Chapter 695J

Navigators are individuals who are designated and licensed by the Nevada Division of Insurance as Exchange Enrollment Facilitators and certified by Nevada Health Link to provide education and consumer support regarding Nevada Health Link health and dental plans. Certified Navigators are typically employed by Navigator Grantee Organizations but can also be volunteers. Navigator Grantee Organizations receive state funds through a grant process. Certified Navigators are licensed to help consumers understand Nevada Health Link and fill out applications. However, certified Navigators are legally prohibited from conducting certain actions, such as providing plan selection advice or directly enrolling a consumer into a plan. Certified Navigators are intended to primarily provide in-person support for consumers.

4.7 Authorized Representatives

45 CFR 155.227

Consumers may represent themselves or appoint an authorized representative to assist enrollment facilitation. The authorized representative may be a friend, relative, attorney, certified Broker/Agent, certified Navigator, call center representative, or another trusted individual. Consumers may designate an authorized representative through the Nevada Health Link website, by calling the call center, or by signing and submitting written documentation which can be accessed here: SSHIX-CONSENT-TO-SERVE-AS-AN-AUTHORIZED-REPRESENTATIVE-2024.pdf.

4.8 Issuer / Carrier Responsibilities

Insurance companies provide back-end, post-enrollment support for consumers. Insurance companies integrate with the Nevada Health Link eligibility system to receive and transfer consumer enrollment files and maintain integrity with CMS to receive APTC payments for eligible consumers. Insurance company member services usually provide consumer support post-enrollment, including:

- Insurance company account questions
- Enrollment questions
- Billing questions

4.9 Notices

4.9.1 Consumer Notices

Consumer notices or letters as specified in 45 CFR 155.230 are correspondences between Nevada Health Link and consumers relating to eligibility and enrollment. Consumers may also receive notices from issuers directly.

4.9.2 Notice Delivery

All consumer notices are generated by the Nevada Health Link eligibility system, either automatically or manually or Nevada Health Link staff.

Consumers can access notices via multiple methods, including by mail, Nevada Health Link, or by reaching out to the call center. Consumers select their notice preference for either electronic or paper notices within the consumer application. The default notice preference within the application is electronic and can be updated through the Nevada Health Link portal at any time by the consumer.

4.9.3 Notice Accessibility Options

Consumers may request a different format of their Marketplace notice by contacting the Nevada Health link call center. Possible formats upon request include, but are not limited to, the following:

- Large print notices
- Braille notices
- Spanish translation

4.10 Accessibility Assistance

45 CFR 155.205(C)

Nevada Health Link partners and the call center provide accessibility services to consumers with accessibility needs. Information must be provided to consumers in plain language and in an accessible and timely manner to individuals living with disabilities.

Required accessibility support for consumers includes:

- Providing a teletypewriter (TTY) line or informing consumers to dial 711 when contacting the call center
- Providing support to read notices
- Providing large print notices
- Providing additional accessibility support services

If a Nevada Health Link partner or certified agent is unable to provide the requested support, they must escalate the request to the call center for further assistance and resolution. If a certified enrollment assister/Navigator or call center representative cannot fulfill a consumer's accessibility request, they must submit a ticket to the call center for further assistance and resolution.

If a ticket requires support beyond what a call center representative can provide, Nevada Health Link will coordinate with the representative and external vendors to ensure the requested accessibility assistance is provided. This escalation may include the following assistance:

- Providing a braille translation
- Providing a video relay
- Providing cued speech and tactile interpreters

4.11 Language Assistance

*45 CFR 155.205(C), 45 CFR 92.101*Language assistance is available to consumers participating in Nevada Health Link. Information must be provided to applicants with limited English proficiency through the provision of language services at no cost to the individual. Limited English Proficiency (LEP) is a term used to describe individuals who are not proficient in the English language.

Consistent with the Exchange limited English proficiency language access plan, during in person encounters, the Exchange uses the following tools to determine whether an individual is LEP, and what their primary language is:

- Broker and Navigator grantees will provide in-person enrollment assistance and services providing information about free interpreting services in multiple languages.
- Bilingual staff members, brokers/agents and Navigators assist in identifying a LEP individual's language.
- On telephone calls, via the Call Center, the Exchange and Call Center representatives use the following tools to find out if an individual is LEP, and what their primary language is:
- Call Center Representatives (CSR's) will make those determinations based on experience and consumer needs/requests.

- Bilingual staff will assist in identifying an LEP individual's language.
- TTY Line designed for those who are deaf, hard of hearing, or speech disabled.
- Multi-language options are available through the Call Center and at NevadaHealthLink.com.

4.12 Complaints and Escalations

Consumers can file complaints about Nevada Health Link, Nevada Health Link partners, certified agents, or insurance companies with the call center. Reasons for complaint may include:

- Ineligible for APTCs or CSRs
- Eligible for APTC, but the amount is incorrect
- Ineligible for a Special Enrollment Period
- Ineligible for a QHP or Standalone Dental Plan
- Cancelation or termination of a plan by Nevada Health Link
- Denial to change enrollment coverage end date or effective date
- Denial of coverage reinstatement request
- Eligibility determination due to a life change that affects health insurance coverage or savings
- Eligibility determination and notice provision was untimely
- General complaint about Nevada Health Link

To file a complaint, consumers should visit the Nevada Health Link website or contact the call center during hours of operation.

4.12.1 Division of Insurance Consumer Services Complaint

Consumers may file a complaint with the Nevada Division of Insurance (DOI) Section of Consumer Services for the following reasons:

- Improper denial or delay in settlement of a claim
- Alleged improper cancelation or nonrenewal of insurance policy
- Problems concerning insurance premiums and rates
- Alleged misconduct by an agent, broker or exchange enrollment facilitator.

To submit a complaint to DOI, consumers can visit https://doi.nv.gov/Consumers/File-A-Complaint/ or call the DOI Consumer Services contact center during hours of operation.

5. Tax Reporting Policies

5.1 Form 1095-A

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. This 1095-A form comes from the Nevada Health Link, not the Internal Revenue Service (IRS), in the mail by mid February. The form should also be available in the Nevada Health Link account as soon as mid January. Form 1095-A is sent by Nevada Health Link to the individual identified on the application as the tax filer and will not be sent to anyone other than the tax filer. Households enrolled in more than one plan will receive a 1095-A Form for each plan. The 1095-A includes information about Nevada Health Link plans any member of the household had during the coverage year, including:

- Part I provides information about the start and end dates for Nevada Health Link coverage.
- Part II provides information about each member of the Nevada Health Link "coverage household," inclusive of everyone covered through the same plan as well as their respective coverage start and end dates.
- Part III provides information for every month of the year on:
    - The selected plan's monthly premium,
    - The Second Lowest Cost Silver Plan's monthly premium; and
    - The monthly APTC amount received
    - If a consumer had coverage but did not use the premium tax credit.

If the 1095-A is not received or if it is incorrect, contact Nevada Health Link at 1-800-547-2927 (TTY: 711).

5.2 Form 8962 and APTC Reconciliation

Form 1095-A provides information consumers need to complete the IRS tax Form 8962, Premium Tax Credit. This Form 8962 is used to "reconcile" whether there are any differences between the premium tax credit the consumer used and the amount they qualify for. This filing requirement applies regardless of whether the individual is otherwise required to file a return.

More information about Form 1095-A from the IRS can be found here.

5.3 Corrected Forms 1095-A

If a consumer receives a corrected 1095-A but already filed a tax return using an earlier version the consumers may need to file an amended return using information on the corrected 1095-A.

6. Revision History / Change Log

6.1 Version 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	
7.0	July 31, 2025	Annual Update, updated policies impacted by H.R.1 and CMS MIA rule, formatting	K. Powers	J. Krupp
8.0	August 31, 2026	Revised language to reflect federal rule updates, including H.R.1 and CMS regulations; provided revised language and reorganized policy sections for clarity, and additional information that is useful to consumers (e.g. notices, assister roles, tax forms etc).	J. Filippi	J. Krupp

6.2 Summary of Annual Policy Changes

This policy manual incorporates updates from the Working Families Tax Cut, signed into law in July 2025, and recent Marketplace regulations, including the Marketplace Integrity and Affordability Rule and the Notice of Benefit and Payment Parameters for 2026 and 2027. Certain provisions of these regulations are currently subject to court orders that stay or otherwise limit their implementation pending ongoing litigation. As a result, those provisions are not

currently in effect and are not reflected in this manual. Nevada Health Link will update this manual, operational procedures, and consumer communications as necessary to reflect future court decisions, regulatory changes, or additional federal guidance. Current litigation affecting implementation of certain Marketplace regulations includes *City of Columbus et al. v. Kennedy (Columbus I)*, *City of Columbus et al. v. Kennedy (Columbus II)*, and *California v. Kennedy*.