



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

## NOTICE OF DISMISSAL - WITHDRAWAL

Notice Date: November 3, 2014

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP00000000941

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED],

On September 8, 2014, you requested an appeal regarding the September 5, 2014 eligibility determination made by the Marketplace. That determination stated that you remained eligible to enroll in a qualified health plan and receive \$0.00 in advance premium tax credit because your household income of \$70,369.30 was over the allowable income limit of \$68,925.00 to be eligible for tax credits.

However, on September 23, 2014, the Marketplace issued an eligibility redetermination in your case. That determination stated that you were eligible for Medicaid and your coverage under Medicaid will begin September 1, 2014.

On October 1, 2014, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. At that hearing, you testified that you were satisfied with your current eligibility determination and had spoken with the Customer Service Unit to withdraw your appeal. You also testified that you no longer wished to continue your appeal. Under sworn testimony, you verbally withdrew your hearing request on the record.

Accordingly, we are dismissing your appeal.

## **How does this Dismissal Affect My Eligibility?**

Your appeal request of the August 15, 2014 eligibility determination is dismissed in accordance with your verbal request.

The current eligibility determination issued on September 23, 2014 finding you eligible for Medicaid remains in effect.

## **If You Think Your Appeal Should Not Be Dismissed**

If you think your appeal should not be dismissed, you can ask us to vacate (cancel) this dismissal. You must ask us in writing within 30 days after the date on this notice.

The Marketplace's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, the Marketplace will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and the Marketplace will take no further action on your appeal.

## **Appeal Identification Number**

When communicating with the Marketplace about this appeal, please reference Appeal Identification Number [REDACTED].

## **How to Contact the Marketplace**

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).

## **Legal Authority**

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.530.

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**This Notice Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]

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