



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: February 17, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001157

[REDACTED]
[REDACTED]
[REDACTED] [REDACTED] [REDACTED]
[REDACTED]

Dear Mr. and Mrs. [REDACTED],

On November 17, 2014, the Marketplace issued a disenrollment notice informing you that your health coverage with EssentialCare Platinum Plan would end effective November 30, 2014, because you both were no longer eligible to enroll in health coverage through New York State of Health. The reason for the disenrollment was because neither of you had provided proof of citizenship status.

On December 8, 2014, you appealed the Marketplace's disenrollment from your health plan.

On December 16, 2014, you both provided proof of your citizenship status and your resident alien cards and alien registration receipt cards were uploaded to your Marketplace account.

On December 19, 2014, the Marketplace sent you a letter confirming that you were both enrolled in HealthPlus, an Amerigroup Company beginning January 1, 2015. In addition, the letter confirmed that Mr. [REDACTED] had Medicaid Fee for Service coverage beginning December 1, 2014, and Mrs. [REDACTED] had Medicaid Fee for Service coverage beginning September 1, 2014.

On December 31, 2014, the Marketplace sent you a notice that it had scheduled a telephone hearing based on your appeal request for January 15, 2015 at about 9:00 a.m.

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: 1-877-662-4886).

On January 15, 2015, you had a telephone hearing with a Hearing Officer from New York State of Health's Appeals Unit. Mrs. [REDACTED] spoke as the authorized representative for Mr. [REDACTED] and on her own behalf. During the hearing, through sworn testimony, Mrs. [REDACTED] stated that neither of you wanted to continue with your appeal. Mrs. [REDACTED] further testified that she understood by withdrawing the appeal that your current enrollments were final. Accordingly, we are dismissing your appeal.

How does this Dismissal Affect Your Eligibility?

This dismissal does not affect your eligibility. It simply confirms that you have withdrawn your appeal.

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. In that writing, explain why you did not appear for your hearing as scheduled.

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. No further action will be taken on it by the Marketplace.

Appeal Identification Number

When communicating with the Marketplace about this appeal, please refer to the Appeal Identification Number at the top of this notice.

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: 1-877-662-4886).

Legal Authority

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

A Copy of this Notice of Dismissal Has Been Provided To

[REDACTED]
[REDACTED]
[REDACTED] [REDACTED] [REDACTED]
[REDACTED]