



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

## NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: February 19, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001352

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED],

On January 6, 2015, you requested an appeal regarding [REDACTED] enrollment start date with New York State Catholic Health Plan, Inc.

On January 7, 2015, an enrollment confirmation notice was issued which stated that [REDACTED] enrollment with New York State Catholic Health Plan, Inc. would begin February 1, 2015.

On February 10, 2015, you were scheduled to appear for a telephone hearing. A Hearing Officer from the Marketplace's Appeals Unit called you to conduct the hearing. While under oath, you identified yourself and withdrew your appeal on the record. You testified that since it was February, [REDACTED] coverage had started so there was no need to appeal regarding coverage in January.

You further testified that you understood that when you withdrew your appeal, [REDACTED] February 1, 2015 enrollment start date with New York State Catholic Health Plan, Inc. would become final.

Accordingly, we are dismissing your appeal, pursuant to 45 CFR § 155.530(a)(1).

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

The January 7, 2015 enrollment confirmation notice remains in effect.

██████████ remains enrolled in New York State Catholic Health Plan, Inc. as of February 1, 2015.

## **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 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)(1)(i)(B).

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**This Notice Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]

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