



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

## NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: February 27, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001353

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED],

On January 6, 2015, you reapplied for health insurance through New York State of Health. The Marketplace prepared a preliminary eligibility determination notice stating: [REDACTED] and [REDACTED] are eligible to receive advance premium tax credits of \$292.00 per month and cost-sharing reductions, and [REDACTED] and [REDACTED] are eligible to enroll in Child Health Plus with a \$9.00 premium per month, effective February 1, 2015.

On that same day you spoke to the Marketplace Account Review Unit and appealed the preliminary eligibility determination regarding the effective date of Child Health Plus.

On January 7, 2015, the Marketplace issued an eligibility determination consistent with the January 6, 2015, preliminary determination.

On January 23, 2015, the Marketplace issued a Notice of Telephone Hearing scheduling your hearing for February 11, 2015, at 10:00 am.

On February 11, 2015, you failed to appear by telephone for your scheduled hearing. An impartial hearing officer attempted to contact you at the phone number you provided. However, an automated message indicated that telephone numbers with blocked numbers are unable to contact you. Therefore, we were unable to reach you.

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).

Accordingly, we are dismissing your case.

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

The Marketplace's January 7, 2015, eligibility determination continues in effect.

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

Under some circumstances, 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 you also must state a good reason for us to do this.

If you ask us in writing to vacate this dismissal, the Marketplace's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that 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 reference 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.

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**A Copy of this Notice of Dismissal Has Been Provided To**

[REDACTED]  
[REDACTED]  
[REDACTED]

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