



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: February 18, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001421

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On December 31, 2014, the Marketplace received your written appeal request regarding the December 22, 2014 notice of eligibility determination, for yourself and your spouse, issued by the Marketplace. That determination stated that you and your spouse were eligible to purchase a qualified health plan at full cost through New York State of Health because your renewal period and income data were not available.

On January 3, 2015, the Marketplace issued an eligibility redetermination in your case. It stated that you and your spouse are eligible to receive up to \$530.00 in advance premium tax credit to help pay for the cost of health coverage. It also stated that you and your spouse are eligible to receive cost sharing reductions.

On January 22, 2015, you called the NY State of Health Appeals Unit to withdraw your appeal. A Hearing Officer from the Marketplace's Appeals Unit received your call and placed you under oath.

While under oath, you identified yourself and withdrew your appeal on the record.

You testified that you are satisfied with your advance premium tax credit determination.

You further testified that you understand that when you withdraw your appeal, the December 22, 2014 eligibility determination will remain unaffected and your subsequent January 3, 2015 eligibility determination will continue in affect.

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

How does this Dismissal Affect My Eligibility?

The December 22, 2014 eligibility determination remains unchanged.

The subsequent January 3, 2015 eligibility determination continues 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 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

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.530(a)(q)(i)(B).

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

[REDACTED]
[REDACTED]
[REDACTED]

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).