



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

## NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: February 6, 2015

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000001362, AP000000001446

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED],

On November 6, 2014, the Marketplace issued a notice of renewal in your case. It noted that you were eligible for an advance premium tax credit (APTC) of up to \$12.19 per month, not eligible for cost-sharing reductions (CSR), and not eligible for Medicaid. It further found you eligible for coverage beginning January 1, 2015. This determination was “based on information about you from state and federal data sources obtained as of November 5, 2014.”

On January 7, 2015, you spoke with the Marketplace’s Account Review Unit to appeal the November 6, 2014 eligibility determination. The Marketplace assigned this appeal request under AP000000001362.

On January 9, 2015, the Marketplace received a revised application in which you attested to an expected annual household income of \$31,700.00.

On January 10, 2015, the Marketplace issued a notice of eligibility redetermination based on your January 9, 2015 application. It found that you were eligible to receive an APTC of up to \$203.00 per month and, if you selected a silver-level plan, eligible for CSR. However, you were found not eligible for Medicaid. It further found you eligible for this coverage beginning February 1, 2015.

On January 13, 2015, you spoke with the Marketplace Account Review Unit to appeal the January 10, 2014 eligibility determination. The Marketplace assigned this appeal request a new appeal number, AP000000001446.

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 26, 2015, the Marketplace received a further revised application in which you removed your spouse from your household and attested to an expected annual household income of \$1,700.00.

On January 27, 2015, the Marketplace issued a notice of eligibility redetermination based on your January 26, 2015 application. It found you were eligible for Medicaid coverage beginning January 1, 2015.

On January 29, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit.

During the hearing, through sworn testimony, you stated that you wished to withdraw the appeal of both the November 6, 2014 and January 10, 2015 eligibility determinations because you were satisfied with the Marketplace's subsequent determination issued on January 27, 2014 that found you eligible for Medicaid coverage beginning January 1, 2015.

Accordingly, we are dismissing your appeal.

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

The Marketplace's November 6, 2014 and January 10, 2015 eligibility determinations continue in effect; however, they have effectively been replaced by the January 27, 2014 eligibility determination.

You remain eligible for Medicaid coverage beginning January 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.

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## **Appeal Identification Number**

When communicating with the Marketplace about this appeal, please reference Appeal Identification Number(s) 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.

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

[REDACTED]  
[REDACTED]  
[REDACTED]

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