



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

## NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: March 10, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001450

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED] [REDACTED],

On January 13, 2015, you requested an appeal regarding the January 13, 2015 preliminary eligibility determination that stated you were eligible to receive up to \$109.00 per month in advance premium tax credit and cost-sharing reductions.

On January 14, 2015, an eligibility determination notice was issued that stated you were eligible to receive up to \$109.00 per month in advance premium tax credit and, if you enrolled in a silver-level plan, cost-sharing reductions. You were not eligible for Medicaid.

On March 6, 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 your issue had been resolved and you wished to cancel you hearing.

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

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

An eligibility redetermination notice was issued on January 28, 2015 that superseded the notice that was under appeal, and it is not affected by this decision.

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).

You remain eligible for up to \$286.00 in advance premium tax credit and, if you enroll in a silver level health plan, cost-sharing reductions.

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

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**This Notice Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]

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