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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: February 24, 2015

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000001470

[redacted]

Dear [redacted],

On December 17, 2014, you submitted an application to the Marketplace seeking financial assistance in which you attested to an expected yearly income of $64,200.00.

On December 18, 2014, the Marketplace issued a notice of eligibility determination based on your December 17, 2014 application. It said that you and your spouse, [redacted] were eligible to enroll in a qualified health plan (QHP) and eligible to receive an advance premium tax credit (APTC) of up to $297.00 per month. You and your spouse, however, were found ineligible for cost-sharing reductions and ineligible for Medicaid. The notice further said that your children, [redacted] and [redacted] were eligible to enroll in Child Health Plus (CHP) with financial assistance but ineligible for Medicaid.

On January 15, 2015, you spoke with the Marketplace's Account Review Unit and appealed the December 18, 2014 determination to the extent that it found you and your family ineligible for Medicaid coverage.

On January 16, 2015, a Marketplace representative updated you and your family's eligibility to reflect their coverage under Medicaid effective January 1, 2015.

On January 17, 2015, the Marketplace issued a notice of eligibility determination formalizing the Marketplace's finding that you and your family are Medicaid eligible with coverage beginning January 1, 2015.

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 February 18, 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 your December 18, 2014 eligibility determination since your family had been subsequently found eligible for Medicaid coverage beginning January 1, 2015.

Accordingly, we are dismissing your appeal.

How does this Dismissal Affect Your Eligibility?

The Marketplace's December 18, 2014 eligibility determination continues in effect, but has effectively been replaced by the January 17, 2015 eligibility redetermination.

You and your family 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.

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

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]

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