



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

## NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: March 31, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001498

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED],

On January 16, 2015, you requested an appeal regarding the January 16, 2015 preliminary eligibility determination, which stated that you are eligible to receive an advance premium tax credit of up to \$288.00 per month and cost-sharing reductions effective March 1, 2015, and not January 1, 2015.

On February 23, 2015, a Hearing Officer from the Marketplace's Appeals Unit called you at the scheduled date and time to hold the hearing regarding your appeal request. At that time, you requested to adjourn the hearing. Your hearing was adjourned to March 5, 2015 at 2:00 p.m.

On March 5, 2015 at 2:00 p.m., the Hearing Officer from the Marketplace's Appeals Unit called you to hold the rescheduled hearing. At that time, you requested to adjourn the hearing. Your hearing was adjourned to March 6, 2015 at 3:00 p.m.

On March 6, 2015, you had a telephone hearing with the Hearing Officer from the Marketplace's Appeals Unit. At that hearing, you testified that you were satisfied with your current enrollment and no longer wished to continue your appeal.

Under sworn testimony, you verbally withdrew your hearing request on the record.

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).

Accordingly, we are dismissing your appeal.

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

The January 17, 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

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).

## **Legal Authority**

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.530.

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**This Notice Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

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