



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

## NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: March 5, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001640

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED]

On January 30, 2015, the Marketplace issued a notice of eligibility redetermination based on your January 30, 2015 updated application. The notice said that you are eligible to purchase a qualified health plan at full cost through New York State of Health, with an eligibility effective date of March 1, 2015.

On January 30, 2015, you appealed that eligibility redetermination.

On February 6, 2015, the Marketplace issued a second notice of eligibility redetermination that said you are newly eligible to receive an advance premium tax credit of up to \$299.00 per month and, if you enrolled in a silver-level qualified health plan, for cost-sharing reductions, with an eligibility effective date of March 1, 2015.

On February 13, 2015, you called the New York 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 no longer wished to pursue your appeal.

You further testified you understand that, by withdrawing your appeal, the February 6, 2015 Marketplace eligibility notice will continue in effect.

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).

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

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

The February 6, 2015 Marketplace eligibility notice 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. No further action will be taken on it by the Marketplace.

## **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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**A Copy of this Notice Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]