



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 Number: [REDACTED]
Appeal Identification Number: AP000000001669

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On February 2, 2015, you requested an appeal regarding the February 2, 2015 eligibility determination issued by the Marketplace. The determination stated that you and [REDACTED] were eligible to purchase a qualified health plan at full cost. You and [REDACTED] were not eligible to receive advance premium tax credits because you were already enrolled in or eligible for minimum value employer sponsored insurance.

On February 18, 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 had made an error when you filled out the original application. That error has since been resolved and you have been found eligible for an advance premium tax credit. On February 4, 2015, an eligibility determination notice was issued by the Marketplace that states you and [REDACTED] are now eligible for \$492.00 per month in advance premium tax credit.

You further testified that you understood that by withdrawing your appeal, the February 4, 2015 determination would continue in effect.

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

How does this Dismissal Affect Your Eligibility?

The February 4, 2015 eligibility determination continues in effect.

You and [REDACTED] remain eligible to receive \$492.00 per month in advance premium tax credit.

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: 1-877-662-4886).

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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