



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

## **NOTICE OF DISMISSAL – FAILURE TO APPEAR**

Notice Date: May 4, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000002112

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

Dear Ms. [REDACTED],

On March 18, 2015, the Marketplace issued an eligibility determination notice that stated you were eligible to purchase a qualified health plan at full cost. You were not eligible for advance premium tax credits (APTC), cost-sharing reductions, or Medicaid because your income was over the allowable limits for those programs.

On March 19, 2015, you requested an appeal insofar as you were not eligible for APTC.

On March 25, 2015, the Marketplace issued a Notice of Telephone Hearing to advise you that the hearing you requested was scheduled for April 21, 2015 at 11:00 a.m.

Between 11:00 a.m. and 11:30 a.m. on April 21, 2015, a Hearing Officer called the telephone number that you gave the Marketplace. The Hearing Officer placed three calls to that telephone number but was unable to reach you. Since you did not appear for your hearing as scheduled, we are dismissing your appeal.

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

The March 18, 2015 eligibility determination notice remains 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).

You are eligible to purchase a qualified health plan at full cost.

## **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. In that writing, explain why you did not appear for your hearing as scheduled.

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.

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

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

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