



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

NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: May 20, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000002376

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On April 10, 2015, the Marketplace prepared a preliminary eligibility determination that stated you were eligible to receive up to \$255.00 per month in advance premium tax credit (APTC) and you were eligible for cost-sharing reductions if you enrolled in a silver level health plan.

Also on April 10, 2015, you requested an appeal of that determination insofar as you were not eligible for Medicaid.

On April 11, 2015 the Marketplace issued an eligibility determination notice that stated you were conditionally eligible to receive up to \$255.00 per month in APTC and you were conditionally eligible for cost sharing reductions if you enrolled in a silver level health plan. You were not eligible for Medicaid because your income was over the allowable limit for that program. The notice further requested that you submit documentation of your income before July 9, 2015.

On April 20, 2015 the Marketplace issued a Notice of Telephone Hearing to advise you that the hearing you requested was scheduled for May 11, 2015 at 3:00 p.m.

Between 3:00 p.m. and 3:30 p.m. on May 11, 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.

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).

How does this Dismissal Affect Your Eligibility?

The April 11, 2015 eligibility determination notice remains in effect.

You remain conditionally eligible to receive up to \$255.00 per month in APTC and you are conditionally eligible for cost sharing reductions if you enroll in a silver level health plan.

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

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.

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A Copy of this Notice Has Been Provided To:

[REDACTED]
[REDACTED]
[REDACTED]

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