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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: December 16, 2015

NY State of Health Number:
Appeal Identification Number: AP000000004839

Dear ,

On September 13, 2015, a renewal notice was issued stating that it was time to renew your NY State of Health coverage. The notice explained that if you want to keep your present health plan for the next year and the information on your application was still accurate, you were re-enrolled in your current health plan for another year. Your child was set to be enrolled in MetroPlus Health Plan with a start date of November 1, 2015. Your child's eligibility was determined to be qualified for Child Health Plus for a cost of $60.00 per month effective November 1, 2015.

On September 30, 2015, the Marketplace received your updated application for financial assistance.

That same day an eligibility determination was made finding your child eligible to enroll in Child Health Plus for a cost of $45.00 per month effective November 1, 2015. This eligibility was based on your household income of $49,462.67.

Additionally on that same day you contacted the Marketplace's Account Review Unit and appealed the September 30, 2015 eligibility determination in regards to the level of Child Health Plus premiums you were found eligible for.

On November 4, 2015, a notice of telephone hearing was issued for a telephone hearing on December 8, 2015 at 1:00 pm.

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).).

On December 8, 2015, at 1:00 pm, a Hearing Officer from the NY State of Health Appeals Unit called you. You identified yourself for the record and stated that you no longer wished to pursue your appeal of your child's level of premium assistance you were deemed eligible for.

You therefore withdrew your appeal on the record. Accordingly, we are dismissing your appeal, pursuant to Code of Federal Regulation (CFR) 45 CFR § 155.530(a)(1).

How does this Dismissal Affect Your Eligibility?

The Appeals Unit of NY State of Health will not be reviewing this matter at this time.

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 reference 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 45 CFR § 155.530.

A Copy of this Notice of Dismissal Has Been Provided To