



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

## NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: January 19, 2016

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000004982

[REDACTED]

Dear [REDACTED],

On October 21, 2015, you contacted the Marketplace to request your coverage under your qualified health plan be terminated.

That same day, you contacted the Marketplace's Account Review Unit and appealed the termination date of your qualified health plan. You stated that you believed you had requested that your health plan be terminated effective November 30, 2015.

On October 22, 2015, a disenrollment notice was issued ending your coverage under Health Republic effective October 31, 2015.

On January 7, 2016, at 9:00 am a Hearing Officer from the NY State of Health Appeals Unit called you and you identified yourself for the record. While under oath you testified that you no longer were looking to appeal the termination date of your qualified health plan as you did not use it for the month of November. In addition you did not want to be responsible for a premium payment for the month of November.

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).

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 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.

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



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