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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: April, 15 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005976

[redacted]

Dear [redacted],

On December 31, 2015, the NY State of Health issued a notice of eligibility determination, stating that you and your household were found conditionally eligible to receive up to $790.00 per month in advance payments of the premium tax credit, as well as cost-sharing reductions, effective February 1, 2016. You appealed that determination.

On April 7, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath.

While under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal because you had enrolled in the Essential Plan and were satisfied with the coverage you were receiving. You testified that you had contacted the Marketplace to withdraw your appeal in writing, and did not require an appeal at this time.

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

Please take special note: an enrollment confirmation notice was issued on March 8, 2016 after you had requested a telephone hearing. That notice confirmed your enrollment in the Essential Plan 1, with a premium responsibility

of $20.00 per month with a start date of April 1, 2016. The notice further explained your spouse needed to pick a health plan now or her coverage under the Essential Plan would not begin. Please be sure to select a health plan for your spouse as soon as possible to ensure the proper coverage start date.

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, or 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

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 45 CFR § 155.530.

A Copy of this Notice of Dismissal Has Been Provided To

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