



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

## NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: June 10, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000006623

[REDACTED]

Dear [REDACTED],

On December 24, 2015, the New York State of Health (NYSOH) issued an enrollment notice confirming that on December 23, 2015, you and your spouse enrolled in an Essential Plan 2 Plus Vision and Dental plan with a plan enrollment start date of February 1, 2016.

On January 30, 2016, NYSOH issued a notice confirming that on January 29, 2016 you requested an appeal insofar as the plan enrollment start date of your Essential Plan.

On June 7, 2016, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. At the hearing you stated that you no longer wanted to pursue your appeal because you were notified by NYSOH that you were enrolled in Medicaid, effective January 1, 2016. Therefore, you withdrew your appeal on the record through sworn testimony.

Accordingly, we are dismissing your appeal.

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

The Appeals Unit of NY State of Health will not review your appeal at this time.

This dismissal will not affect any determinations made after the appeal request.

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).

## **If You Think Your Appeal Should Not Be Dismissed**

Under some circumstances, 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 you also must state a good reason for us to do this.

If you ask us in writing to vacate this dismissal, the Marketplace's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that 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 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 Federal regulation 45 CFR § 155.530.

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



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