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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: September 26, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000007689

[redacted]

Dear [redacted]

On March 5, 2016, NY State of Health (NYSOH) issued an enrollment notice confirming in part that, on March 3, 2016, you had selected and were enrolled in a bronze-level qualified couple's health plan (bronze plan), effective March 1, 2016. That notice stated that your monthly premium responsibility was $905.12 and your annual deductible was $3,500.00 per person and $7,000 per group. You appealed that determination.

According to your NYSOH account and your testimony, you are appealing the deductible amounts regarding prescription medication.

On August 31, 2016, you testified at the hearing that you chose the bronze plan based on the prescription drug formularies and the information on NYSOH's website that limited the co-payment and deductible amounts for prescription medication. You further testified that the packet you received from your health insurance plan stated that you had a $7,000.00 deductible, which was not stated in the information you reviewed online and you feel was a gross misrepresentation. You also testified that your health plan told you that these deductibles were one of the terms of your contract. You are seeking reimbursement for the prescription medications you had to pay for out-of-pocket since March 2016.

You were directed to submit a screenshot of the information you reviewed online by September 12, 2016. As of September 13, 2016, no documentation was provided so the record was closed.

On September 2, 2016, NYSOH processed your request to cancel your appeal [redacted] as a duplicate appeal in your case. A notice to this effect was uploaded to your NYSOH on September 9, 2016.

Why Your Appeal Request Is Not Valid

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Your appeal was requested to dispute the health plan deductibles relative to your prescription medication. This issue relates to contractual terms and health plan coverage, which is not an issue that the NY State of Health Appeals Unit is authorized to address. Therefore, we must dismiss your appeal.

How does this Dismissal Affect Your Eligibility?

This decision does not change your current eligibility for or enrollment in a qualified health plan, or the monthly premium amount that you pay for your health plan.

You may have additional options outside of the Appeals Unit of New York State of Health, such as through your health plan or through the Department of Financial Services.

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. In that writing, you must explain why you think this

dismissal should be vacated and if your issue differs from the one discussed above.

If you ask us in writing to vacate this dismissal, NYSOH'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 NYSOH.

Appeal Identification Number

When communicating with NYSOH about this appeal, please reference Appeal Identification Number and the Account ID at the top of this notice.

How to Contact NYSOH

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

[redacted]

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).