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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: March 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014177

Dear [redacted]

On December 19, 2016, an application for financial assistance was submitted through New York State of Health (NYSOH).

On December 20, 2016, NYSOH issued an eligibility determination stating that: (1) Your youngest child was eligible to enroll in Child Health Plus with a monthly premium of $30.00; and (2) you, your spouse, and eldest child were determined eligible to enroll in a qualified health plan with up to $654.00 per month of advance premium tax credit, effective as of February 1, 2017.

Also on December 20, 2016, NYSOH issued an enrollment notice confirming, in relevant part, that your youngest child was enrolled in a Child Health Plus on December 19, 2016, with a plan enrollment start date of January 1, 2017.

On December 21, 2016, NYSOH issued an enrollment notice confirming, in relevant part, that you, your, and eldest child were enrolled in a qualified health plan on December 19, 2016, with an enrollment start date of February 1, 2017.

On February 28, 2017, NYSOH issued a Notice of Telephone Hearing stating that your hearing was scheduled for March 27, 2017 at 9:00 a.m.

On March 3, 2017, NYSOH uploaded the Evidence Packet, in anticipation for your telephone hearing, to your account [redacted]. According to the

Appeal Summary, you submitted a complaint and requested an appeal on December 20, 2016 ([redacted]). The complaint states:

> On 12/19/2016, the appellant, [redacted] contacted the Marketplace to update the account. The appellant and family were determined eligible for CHP and APTC effective 2/2/2017. The appellant, [redacted] is disputing the 2/1/2017 effective date of coverage; requesting coverage be made effective 1/1/2017.

On March 27, 2017, you and your spouse appeared for your scheduled telephone hearing. During your telephone hearing with a Hearing Officer from NYSOH's Appeals Unit, you testified that the issue under appeal was the denial of the service authorization of [redacted] for your youngest child. Furthermore, you testified that the issue of health insurance coverage for January 2017 was not under appeal.

During the hearing, you referenced multiple documents that directed you to request an external appeal from NYSOH regarding the denial of that service authorization. The Hearing Officer directed you to submit those documents to NYSOH's Appeals Unit.

On March 27, 2017, you faxed eleven-pages of documents to NYSOH's Appeals Unit. That fax has been entered in the record and will be referred to as "Appellant Exhibit A." You submitted: (1) A January 9, 2017, notice from Fidelis Care informing you that the service requested by your provider was not approved by Fidelis Care New York because it did not meet Fidelis' meaning of "necessary medical care." The notice states that if you are not satisfied with the decision, you may be eligible for an external appeal by contacting Fidelis Care's Member Services at (1-888-FIDELIS) or file a complaint with New York State Department of Health at (1-800-206-8125) [redacted]. (2) A March 3, 2017, final adverse determination from Fidelis Care stating you filed an action appeal on March 2, 2017, and the service requested does not meet Fidelis' meaning of "necessary medical care." The notice states that you may ask for an external appeal through New York State Department of Financial Services at (1-800-400-8882) or file a complaint with the New York State Department of Health at (1-800-206-8125)[redacted]

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)).

You testified that the issue under appeal was the denial of the service authorization of [redacted] for your youngest child. Furthermore, and the issue of health insurance coverage for January 2017 was not under appeal.

The issue of whether your child's service authorization for [redacted] was properly denied, is not an issue that NYSOH's Appeal Unit has jurisdiction to address. Since NYSOH Appeals Unit does not have jurisdiction over this issue, we cannot reach the merits as to whether the service authorization was properly denied. Therefore, we must dismiss your appeal.

How does this Dismissal Affect Your Eligibility?

This decision does not change your youngest child's current eligibility for or enrollment in Child Health Plus.

You may have additional options outside of the Appeals Unit of NYSOH, such as an external appeal through NYS Department of Financial Services (1-800-400-8882) or by submitting a complaint through NYS Department of Health, Managed Care Complaint Unit (1-800-206-8125).

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

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).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية(Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

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বাংলা **(Bengali)**

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी **(Hindi)**

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 **(Japanese)**

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली **(Nepali)**

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu)اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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