



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

## NOTICE OF DISMISSAL – UNTIMELY APPEAL REQUEST

Notice Date: May 16, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015102

[REDACTED]

Dear [REDACTED],

On June 28, 2016, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible to receive up to \$237.00 in advance payments of the premium tax credit (APTC) and conditionally eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2016. The notice further directed you to provide documentation confirming your income before September 25, 2016.

On June 28, 2016, NYSOH issued a notice confirming your enrollment in qualified health plan with APTC, effective August 1, 2016.

No documentation was received by NYSOH before September 25, 2016.

On October 5, 2016, NYSOH redetermined your eligibility for financial assistance.

On October 6, 2016, NYSOH issued an enrollment notice confirming your enrollment in a Bronze level qualified health plan without the application of APTC or cost-sharing reductions effective August 1, 2016.

On October 10, 2016, NYSOH issued an eligibility determination notice based on your October 5, 2016 eligibility redetermination stating that you were newly eligible to purchase a qualified health plan at full cost. The notice stated that you

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were not eligible to receive APTC or cost-sharing reductions because NYSOH did not receive the income documentation needed to verify the income listed in your application. This eligibility was effective November 1, 2016.

On January 12, 2017, you updated your application for financial assistance.

On January 13, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$326.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective February 1, 2017.

On January 24, 2017, you enrolled, and then disenrolled in a qualified health plan effective March 1, 2017.

On January 24, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your APTC for the months of November, and December, 2016.

On April 20, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the proceeding.

The record indicates the following (1) you are appealing the termination of your eligibility for APTC towards your premium responsibility for the months of November, and December, 2016, (2) on January 24, 2017 a formal appeal was filed regarding the termination of your APTC, (3) you testified you did not pay your premium responsibility to your health plan for the months of November, and December, 2016, (4) you testified you did not use your health insurance during the months of November, and December, 2016, (5) you testified you are currently enrolled in health insurance through your school as of January 1, 2017.

## **Why Your Appeal Request Is Not Valid**

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

For an appeal to have been valid on the issue of termination of APTC, as addressed in the October 10, 2016, notice, an appeal should have been filed by December 14, 2016. According to the credible evidence in the record, you did not contact NYSOH until January 24, 2017, to file a formal complaint and a formal appeal was not filed until that date. This date is well beyond 60 days from the October 10, 2016 eligibility determination notice.

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Therefore, there has been no valid timely appeal of the October 10, 2016 eligibility determination notice and your appeal on the issue of your ineligibility for APTC as stated in that notice is DISMISSED.

### **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.

### **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.

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 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.

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).

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



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## **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)**

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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.

### **বাংলা (Bengali)**

এই একটি গুরুত্বপূর্ণ নথি। আপনি যদি এটি বুঝতে সাহায্যের প্রয়োজন হয়, তবে দয়া করে 1-855-355-5777 নম্বরে ফোন করে একটি মুক্ত ভাষা পরিভাষিকার সাহায্য চান।

### **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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ 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 کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

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### **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.