



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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: September 20, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019340

[REDACTED]

[REDACTED],

On March 3, 2017, NY State of Health (NYSOH) received your and your husband’s application for financial assistance with your health insurance.

On March 4, 2017, NYSOH issued a notice stating you were exempt from certain cost-sharing responsibilities, like co-pays and co-insurance, if you use services at certain providers. These include the [REDACTED], an [REDACTED], [REDACTED], or [REDACTED], or referrals under contract health services. If you access health care outside of these organizations, you will have to pay your share. Your husband was found eligible for advance payments of the premium tax credit up to \$316.00 per month for a limited time, effective April 1, 2017. The notice requested you provide proof of your membership in an [REDACTED] by May 3, 2017, and proof of your husband’s Citizenship Status by May 3, 2017.

On March 4, 2017, an enrollment notice was issued confirming your and your husband’s enrollment in a bronze level qualified health plan effective April 1, 2017.

On March 27, 2017, you faxed documentation to NYSOH.

On April 7, 2017, NYSOH representatives invalidated your proof of tribal affiliation and your husband’s citizenship documentation due to them being illegible.

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).

On April 8, 2017, NYSOH issued a notice stating the documentation reviewed does not confirm the information in your application. The notice requested you provide proof of your membership in an [REDACTED], and your husband's proof of Citizenship Status by May 3, 2017.

No further documentation was received by May 3, 2017.

On May 23, 2017, NYSOH redetermined your husband's eligibility for financial assistance.

On May 24, 2017, NYSOH issued a notice stating your husband was no longer eligible for health insurance through NYSOH as you did not provide the information to confirm his citizenship status, effective June 1, 2017.

On May 24, 2017, a disenrollment notice was issued confirming your husband's disenrollment from his bronze level qualified health plan, effective May 31, 2017.

On May 30, 2017, you contacted NYSOH's Account Review Unit and requested an appeal, to dispute your husband's ineligibility to enroll in health insurance through NYSOH.

On September 6, 2017, you appeared at your scheduled telephone hearing based on your May 30, 2017 appeal request. You testified that your husband has since been reenrolled in a qualified health plan, and that you are no longer appealing his disenrollment from his qualified health plan as of June 1, 2017. You further testified that you were not seeking a backdate in coverage.

However, you testified that you were now appealing NYSOH requesting proof of your membership in an [REDACTED], and your husband's proof of citizenship status still being pending. You also submitted documentation that showed you and your husband are members of the [REDACTED] in the form of your unexpired [REDACTED] Cards from the [REDACTED].

You testified that you wanted to continue with your appeal hearing because you do not want yourself or you husband disenrolled from your health plan in the future because of the pending documentation requested from NYSOH.

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. 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).

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) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) 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 you are no longer appealing your husband's ineligibility for enrollment in a qualified health plan as of June 1, 2017 because at the time of your hearing, he was enrolled in a qualified health plan. You testified that you are now disputing the fact that NYSOH has a pending documentation request for you to submit proof of your membership in an [REDACTED] and [REDACTED], and your husband's proof of citizenship status still being pending. You testified that you do not want you or your husband to be disenrolled for this pending request. This issue relates to a future disenrollment that had not occurred prior to your hearing and was not part of the record at the time of the hearing. Since your appeal request is based on an issue that had not occurred at the time of your hearing, the Appeals Unit of NYSOH is not authorized to address it and we must DISMISS your appeal.

How does this Dismissal Affect Your Eligibility?

This decision does not change your or your husband's 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 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.

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).

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.

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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)

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).

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)

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 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 srε wo, frε 1-855-355-5777. ye&εtumi ama wo obi a okyerε 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.

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