



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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: October 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020962

[REDACTED]

Dear [REDACTED]

On February 23, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On February 24, 2017, NYSOH issued an eligibility determination notice stating that, for a limited time, you were eligible to receive up to \$289.00 per month in advanced premium tax credits (APTC) and cost-sharing reductions if you enrolled into a silver-level qualified health plan, effective April 1, 2017. This notice also directed you to submit income documentation by May 24, 2017.

Also on February 24, 2017, NYSOH issued a plan disenrollment notice stating that your coverage with your Essential Plan would end on March 31, 2017.

On March 2, 2017, NYSOH received your updated application for financial assistance with health insurance.

On March 3, 2017, NYSOH issued an eligibility determination notice stating that, for a limited time, you were eligible to receive up to \$289.00 per month in APTC and eligible for cost-sharing reductions if you enrolled into a silver-level qualified health plan, effective April 1, 2017. This notice also directed you to submit income documentation by May 24, 2017.

On April 3, 2017, NYSOH received your updated application for financial assistance with health insurance.

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 4, 2017, NYSOH issued an eligibility determination notice stating that, for a limited time, you were eligible to receive up to \$289.00 per month in APTC, and cost-sharing reductions if you enrolled into a silver-level qualified health plan, effective April 1, 2017. This notice also directed you to submit income documentation by May 24, 2017.

On April 5, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan with the application of your APTC, effective May 1, 2017.

On May 6, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a full pay qualified health plan, effective June 1, 2017.

Also on May 6, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan with no APTC applied to the monthly premium, effective May 1, 2017.

On June 17, 2017, NYSOH received your updated application for financial assistance with health insurance.

On June 18, 2017, NYSOH issued an eligibility determination notice stating that, for a limited time, you were eligible to receive up to \$289.00 per month in APTC and eligible cost-sharing reductions if you enrolled into a silver-level qualified health plan, effective August 1, 2017. This notice also directed you to submit income documentation by September 15, 2017.

Also on June 18, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in your qualified health plan with the application of your APTC, effective July 1, 2017.

On July 6, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost through NYSOH, effective August 1, 2017.

Also on July 6, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in your qualified health plan with no application of APTC, effective May 1, 2017.

On July 19, 2017, NYSOH received your updated application for financial assistance with health insurance.

On July 20, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$161.00 per month in APTC, effective September 1, 2017.

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).

Also on July 20, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in your qualified health plan with the application of your APTC, effective August 1, 2017.

On July 29, 2017, NYSOH received your updated application for financial assistance with health insurance. That day a preliminary determination was prepared stating that you were eligible to receive up to \$161.00 in APTC, effective September 1, 2017.

Also on July 29, 2017, you filed an appeal. The appeal notes dated July 29, 2017 stated that the reason for your appeal was that you were disputing the August 1, 2017 effective date of your APTC, and requesting that your APTC be made effective May 1, 2017.

On October 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You testified that your APTC were terminated as of April 31, 2017 without your knowledge. You testified that you were unable to afford the premium payments without your APTC; therefore, you were disenrolled from your qualified health plan. You testified that you initially filed the appeal to have your financial assistance reinstated and to be reenrolled into your qualified health plan as of May 1, 2017.

However, during the hearing, you testified that you were no longer interested in being reenrolled in your qualified health plan with the application of your APTC reinstated as of May 1, 2017. Therefore, the Hearing Officer agreed to no longer hear the issue that was on appeal and to proceed with the hearing to receive testimony and develop the record as to the remedy you were seeking through the appeal.

During the hearing, you testified that the remedy you were seeking was to be redetermined eligible for financial assistance with health insurance. However, after review of the record, there is no record of an application being filed with NYSOH since August 23, 2017, nor any recent eligibility determination on file for NYSOH's Appeals Unit to review.

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) 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

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).

special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

During the hearing, you testified that you no longer wish to be enrolled into coverage retroactively and requested that no testimony be heard on that matter. You further requested that the remedy you were seeking through the appeal was to be redetermined eligible for financial assistance with health insurance. However, there is no record of an application being filed with NYSOH since August 23, 2017, nor is there any recent eligibility determination notices on file. An applicant has the right to appeal an eligibility determination; however, in this present case there is no recent eligibility determination for NYSOH's Appeals Unit to review and as such your case is not ripe for review. Therefore, we must dismiss your appeal.

You may submit a new application through NYSOH at any time online or by telephone at 1-855-355-5777 to determine your current eligibility.

How does this Dismissal Affect Your Eligibility?

You may submit a new application for financial assistance at any time online or by telephone at 1-855-355-5777 to determine your current eligibility.

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.

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.

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).

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 مجاناً.

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.

Twí (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. y&b&tumi ama wo obi a okyer& kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

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۔

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).

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.