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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022049

[redacted]

Dear [redacted],

On April 22, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating, in part, that your children were eligible to enroll in Child Health Plus plans with no monthly premiums for a limited time, effective June 1, 2017. The notice further directed you to provide documentation confirming your household income before June 20, 2017.

On April 26, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in Child Health Plus plans with no monthly premiums, effective June 1, 2017.

On May 9, 2017, you faxed a five-page document to NYSOH; which was uploaded to your NYSOH account on May 10, 2017.

On June 26, 2017, NYSOH issued an eligibility determination stating, in part, that your children were eligible to enroll in Child Health Plus plans with $45.00 monthly premiums, effective August 1, 2017. This notice further stated that this was because you did not send in documentation to confirm the household income listed in your application and that your children's Child Health Plus plan premiums were based on information from federal and state data sources.

Also on June 26, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in their Child Health Plus plans with $45.00 monthly premiums.

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 July 18, 2017, you faxed an eight-page document to NYSOH; which was uploaded that same day.

Also on July 18, 2017, NYSOH validated the documentation and an updated application was submitted on your family's behalf.

On July 19, 2017, NYSOH issued an eligibility determination stating, in part, that your children were eligible to enroll in Child Health Plus plans with $9.00 monthly premiums, effective September 1, 2017.

Also on July 19, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in their Child Health Plus plans with $9.00 monthly premiums, effective September 1, 2017.

On August 31, 2017, you spoke to NYSOH's Account Review Unit and appealed your children's financial assistance eligibility for the month of August 2017.

On September 8, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment their Child Health Plus plans with $9.00 monthly premiums, effective August 1, 2017.

On November 1, 2017, you had a telephone hearing with a Heating Officer from NYSOH's Appeals Unit. You testified that you initially filed the appeal in order to have your children's Child Health Plus plans with $9.00 monthly premiums, effective August 1, 2017 and not September 1, 2017. The record reflects that NYSOH had corrected the issue that was on appeal prior to the hearing, and enrolled your children into their Child Health Plus plans with $9.00 monthly premiums, effective August 1, 2017.

You further testified that you are now seeking partial reimbursement of the premium payments you paid to your children's Child Health Plus plan for August 2017 coverage. Therefore, the Hearing Officer agreed to amend the appeal to reflect this change.

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

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

The record reflects that NYSOH has corrected the issue on appeal prior to the hearing, and your children have been reenrolled into their Child Health Plus plans with $9.00 monthly premiums as of August 1, 2017. During the hearing, you testified that you are now seeking partial reimbursement of the premium payments you paid to your children's Child Health Plus plan for August 2017 coverage. This issue relates to reimbursement of premium payments which is not an issue that the NYSOH's Appeals Unit is authorized to address. Therefore, we must dismiss your appeal.

Your children's Child Health Plus plan may be able to help you with your request for partial reimbursement.

In addition, since your issue concerns a health insurer and/or payment, reimbursement, coverage, benefits, rates and premiums, you can contact NY Department of Financial Services at their Consumer Hotline at (800) 342-3736 (Monday through Friday, 8:30 AM to 4:30 PM); or locally to (212) 480-6400; or you can file a complaint at http://www.dfs.ny.gov/consumer/fileacomplaint.htm .

How does this Dismissal Affect Your Eligibility?

This Decision does not affect your children's current eligibility.

You may have additional options outside of the Appeals Unit of New York State of Health, such as through your children's 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).

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.

(Bengali)

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1-855-355-5777

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.

اردو(Urdu)

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۔

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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.

(Yiddish) אידיש

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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