



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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: January 08, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023513

[REDACTED]

[REDACTED]

On September 23, 2017, NY State of Health (NYSOH) issued a plan enrollment notice stating that your children were enrolled into Child Health Plus plans, effective August 1, 2016.

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

Also on October 19, 2017, you filed an appeal. The appeal notes, dated October 19, 2017, stated that the reason for your appeal was that your children’s Child Health Plus plan with Empire BlueCross BlueShield was effective December 1, 2017 and not November 1, 2017 ([REDACTED])

On October 20, 2017, NYSOH issued an eligibility determination, based on your October 19, 2017 application, stating that your children were eligible to enroll into Child Health Plus plans with \$9.00 monthly premiums, effective December 1, 2017.

Also on October 20, 2017, NYSOH issued a plan enrollment notice confirming your children’s enrollment in a Child Health Plus plan with Empire BlueCross BlueShield HealthPlus, effective December 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).

On October 21, 2017, NYSOH issued a plan disenrollment notice confirming your children's disenrollment from their Child Health Plus plans with UnitedHealthcare Community Plan (United Healthcare), effective November 30, 2017.

On December 13, 2017, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. During that telephone hearing, you testified that you were no longer interested in having your children's Child Health Plus plan backdated. You testified that you were informed by your children's Child Health Plus plan provider, UnitedHealthcare, that you were late with premium payments, and as a result, your children were disenrolled from coverage for non-payment of premiums, effective September 30, 2017. You further testified that your children's Child Health Plus plan stated that if you paid the premium amounts that were due that the Child Health Plus plan would reinstate your children into coverage, effective October 1, 2017.

You testified that, after paying the premium that was due, your children's Child Health Plus plan stated that they were not going to reinstate your children into their health plans. You testified that you have not received the premium payments back from UnitedHealthcare, nor did your children have access to the health insurance coverage for October 2017 and November 2017. Therefore, you testified that, through this appeal, you are seeking to be reimbursed for the premium payments that you made to your children's Child Health Plus plans with UnitedHealthcare for the months that your children were not able to access their health insurance coverage.

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)).

During the hearing, you testified that you are no longer interested in backdating your children's Child Health Plus coverage. You further testified that you are now seeking reimbursement of the premium payments you made to your children's Child Health Plus plan for October 2017 and November 2017 coverage. After hearing your testimony and reviewing the record, the issues on appeal relate to non-payment of premiums and the reimbursement of premium payments, which

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are not issues that NYSOH is authorized to address. Therefore, we must dismiss your appeal.

However, we are RETURNING your case to NYSOH's Plan Management Unit to further investigate your case.

How does this Dismissal Affect Your Eligibility?

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

It does return your case to NYSOH's Plan Management Unit to further investigate the issue.

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>.

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.

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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.

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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.

(Bengali)

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 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. 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۔

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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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