



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

## Notice of Decision

Decision Date: March 08, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000023970

[REDACTED]

Dear [REDACTED]

On January 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 26, 2017 eligibility determination and disenrollment notices, October 31, 2017 eligibility determination notice, and November 3, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

### Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: March 08, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000023970

[REDACTED]

## Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health (NYSOH) properly redetermine that your Essential Plan and your child's Child Health Plus (CHP) plan ended as of October 31, 2017?

Did NYSOH properly determine you were eligible to receive up to \$188.00 per month in advance payments of the premium tax credit (APTC), effective December 1, 2017?

Did NYSOH properly determine that you were eligible for cost-sharing reductions?

Did NYSOH properly determine that you were not eligible for the Essential Plan, effective December 1, 2017?

## Procedural History

According to your NYSOH account, you were enrolled in the Essential Plan with a \$20.00 monthly premium and your child was enrolled in a CHP plan with a \$9.00 monthly premium, effective August 1, 2017.

On October 26, 2017 and October 31, 2017, NYSOH issued eligibility determination notices stating that you and your child did not qualify for Medicaid, CHP, the Essential Plan, or to receive premium tax credits or cost sharing reductions. You and your child were also not eligible to purchase a qualified

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health plan through NYSOH. This was because notices about your eligibility and coverage were returned to NYSOH as undeliverable by mail. Your and your child's eligibility ended November 1, 2017.

Also on October 26, 2017, a disenrollment notice was issued stating that your Essential Plan and your child's CHP plan would end on October 31, 2017, because you and your child were no longer eligible for health insurance through NYSOH.

On November 2, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to \$188.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, and that your child was eligible for CHP with a \$9.00 monthly premium, effective December 1, 2017.

Also on November 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of your financial assistance and your and your child's disenrollment from your respective health plans as of October 31, 2017.

On November 3, 2017, NYSOH issued an eligibility determination notice, consistent with its preliminary eligibility determination, stating that you were eligible to receive up to \$188.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective December 1, 2017. The notice stated that you were not eligible for the Essential Plan because your income was over the allowable income limit for that program. The notice also stated that your child was eligible for CHP with a \$9.00 monthly premium, also effective December 1, 2017.

On November 10, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a \$20.00 monthly premium for a limited time, effective November 1, 2017, because you were granted Aid to Continue until a decision is made on your appeal.

Also on November 10, 2017, a plan enrollment notice was issued confirming your and your child's enrollment in your respective Essential Plan and CHP plan, effective November 1, 2017.

On January 29, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to February 16, 2018, to allow you to submit supporting documents.

As of close of business on February 16, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

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## Findings of Fact

A review of the record supports the following findings of fact:

- 1) According to your NYSOH account, you initially applied for health insurance for yourself and your child through NYSOH on June 26, 2017.
- 2) On September 5, 2017, NYSOH issued a notice, which was returned as undeliverable by the US postal Service on October 23, 2017, and which resulted in you and your child being terminated from your respective health plans, effective October 31, 2017.
- 3) According to your NYSOH account and testimony, the September 5, 2017 notice was sent to an incorrect address. Instead of "[REDACTED]," which is your correct address, the correspondence dated September 5, [REDACTED] was addressed to "[REDACTED]." This notice was returned to NYSOH as "Return to Sender: Not Deliverable as Addressed" (see Document [REDACTED]).
- 4) You testified you realized that you and your child were disenrolled from your health plans when you received the October 26, 2017 disenrollment notice from NYSOH. You further testified that you did not understand why your and your child's coverage was discontinued as you have never had any issues with your mail.
- 5) You testified that you want your and your child's health plan reinstated for November 2017, because you have medical bills for that month.
- 6) According to your NYSOH account, your child's coverage in her CHP plan was reinstated as of November 1, 2017.
- 7) You testified that you are also seeking enrollment in the Essential Plan going forward because you believe that you would still be enrolled in that plan had NYSOH not sent your notice to an incorrect address.
- 8) According to your NYSOH account and testimony, you expect to file your 2017 taxes with a tax filing status of single. You will claim one dependent on that tax return.
- 9) The application that was submitted on June 26, 2017, listed an annual household income of \$31,200.00 in earnings from your employment.
- 10) The updated application that was submitted on November 2, 2017, listed an annual household income of \$34,650.00 in earnings from your employment. You testified that this amount was correct but that this

amount did not include a retirement savings deduction and student loan interest deduction.

11) You failed to submit any proof of your income deductions for the 2017 tax year.

12) According to your NYSOH account, no deductions are listed.

13) According to your NYSOH account and testimony, you and your child live in Monroe County, NY.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## **Applicable Law and Regulations**

### Child Health Plus

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY Public Health Law § 2511(2)(a)(iii)).

To be eligible for CHP, the child:

- Must be under 19 years of age;
- Must be a New York State Resident;
- Must not have other health insurance coverage; and
- Must not be eligible for, or enrolled in, Medicaid

(NY Public Health Law § 2511(2)(a)-(e)).

The “period of eligibility” for CHP is “that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date,” unless the CHP premiums are not timely paid, or the child no longer resides in New York State, gains access to or obtains other health insurance coverage, or becomes eligible for Medicaid (NY Public Health Law § 2510(6)).

“A State must specify a method for determining the effective date of eligibility for CHP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between CHP and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage,” (42 CFR § 457.340(f); 42 CFR §457.343).

### Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals *who are eligible for enrollment*, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

### State Residency Requirement

To be eligible for enrollment in an Essential Plan or a CHP plan through the New York State of Health, an applicant must be a resident of New York State (NY Public Health Law § 2510(6)).

### Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

- 1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

*minus*

- 2) the taxpayer's expected contribution amount

(*see* 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

### Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

### Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

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In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036.).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (see 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

New York State has elected to redetermine Essential Plan enrollees every 12 months from the effective date of eligibility as long as enrollees are under age 65, not enrolled in minimum essential coverage, and remain state residents. An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12-month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, or failure to make the applicable premium payment. (42 CFR § 600.340(f); NY Social Services Law § 369-gg (3) and (4)(d)). Enrollees are required to report changes in circumstances within 30 days, which NYSOH will assess and act upon accordingly (New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

### Requirement for Individuals to Report Changes

In addition, NYSOH must require an applicant to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change (45 CFR §155.330(b), 45 CFR §155.305, 42 CFR §435.403, 42 CFR §435.406, 42 CFR §425.603).

### Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term “modified adjusted gross income” means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

“Adjusted gross income” means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, deductions

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attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that your enrollment in your Essential Plan and your child's enrollment in her CHP plan ended effective October 31, 2017.

You and your child were originally found eligible for an Essential Plan and CHP and were enrolled in health plans, effective August 1, 2017.

According to your NYSOH account, on September 5, 2017, NYSOH issued correspondence that was returned as undeliverable on October 23, 2017. A review of the record reflects that no other notices were returned as undeliverable that were sent to your mailing address.

As a result, you were disenrolled under the returned mail rule on the basis that you did not meet the state residency requirement. As such, on October 26, 2017, NYSOH issued eligibility determination and disenrollment notices, stating respectively that you and your child were no longer eligible to enroll in the health plans and that your coverages would end effective October 31, 2017.

However, the credible evidence of the record reflects that the NYSOH September 5, 2017 notice issued, was sent to an incorrect address. Instead of "[REDACTED]", which is your correct address, the correspondence dated September 5, 2017 was addressed to "[REDACTED]". This notice was returned to NYSOH as "Return to Sender: Not Deliverable as Addressed" (see Document [REDACTED]).

Based on the incorrect spelling of your street address, it is reasonable to conclude that address information was entered incorrectly on the September 5, 2017 correspondence, which resulted in this notice being returned as undeliverable. Since this error was through no fault of your own, it is reasonable to conclude that your and your child's disenrollment from your health plans was also in error.

Therefore, the October 26, 2017 eligibility determination and disenrollment notices must be RESCINDED.

It follows that the October 31, 2017 eligibility determination notice is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of November 2017, and to notify you accordingly.

Since your child was already reinstated in her CHP plan as of November 1, 2017, no further action is required by NYSOH regarding your child's enrollment.

The second issue under review is whether NYSOH properly determined that you were eligible for APTC of up to \$188.00 per month, effective December 1, 2017.

It is noted you testified that you are seeking enrollment in the Essential Plan going forward because you believe that you would still be enrolled in that plan had NYSOH not sent the September 5, 2017 notice to an incorrect address.

Although, NYSOH has elected to redetermine Essential Plan enrollees every 12 months from the effective date of eligibility, an individual is required to notify NYSOH of any changes or updates that could affect that individual's eligibility for the Essential Plan within 30 days of that change. In your case, you testified that your income of \$34,650.00 was correct, but that you would be taking deductions for retirement savings and student loan interest. You were directed to provide proof of such deductions, but did not comply within the timeframe allotted. Therefore, it is reasonable to conclude that the application dated June 26, 2017 and your Essential Plan eligibility was based on an incorrect income of \$31,200.00, or that your income had increased during the 2017 tax year.

According to applicable law and New York's Basic Health Plan Blueprint, enrollees are required to report changes in circumstances within 30 days, which NYSOH will assess and act upon accordingly.

Based on your duty to notify NYSOH of your increased income within 30 days of the discovery of an error in your reported income or a change in your reported income, it is determined that your November 2, 2017 updated application, in which NYSOH was required to change your income and eligibility going forward, was not in error.

The application that was submitted on November 2, 2017, listed an annual household income of \$34,650.00 and the eligibility determination relied upon that information. You testified that this amount was correct but that this amount did not include a retirement savings deduction and student loan interest deduction. The record was kept open to February 13, 2018, to allow you time to submit proof of these deductions. As stated earlier, you did not submit this proof and, therefore, this decision must be based on the evidence in the record, which reflects an annual expected income of \$34,650.00.

According to your NYSOH account and testimony, you expect to file your 2017 taxes with a tax filing status of single. You will claim one dependent on that tax

return. Therefore, for purposes of these analyses, you are in a two-person household.

You reside in Monroe County, where the second lowest cost silver plan available for an individual through NYSOH costs \$390.79 per month.

An annual income of \$34,650.00 is 216.29% of the 2016 FPL for a two-person household. At 216.29% of the FPL, the expected contribution to the cost of the health insurance premium is 7.01% of income, or \$202.41 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county (\$390.79 per month) minus your expected contribution (\$202.41 per month), which equals \$188.38 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$188.00 per month in APTC, based on the information you provided.

The third issue under review is whether you were properly found eligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of \$34,650.00 is 216.29% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The fourth issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective December 1, 2017.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$16,020.00 for a two-person household. Since an annual household income of \$34,650.00 is 216.29% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the November 3, 2017 eligibility determination notice properly stated that, based on the updated information in your November 2, 2017 application, you were eligible for up to \$188.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

## **Decision**

The October 26, 2017 eligibility determination and disenrollment notices must be RESCINDED.

The October 31, 2017 eligibility determination notice is also RESCINDED.

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Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of November 2017, and to notify you accordingly.

Since your child was already reinstated in her CHP plan as of November 1, 2017, no further action is required by NYSOH regarding your child's enrollment.

The November 3, 2017 eligibility determination notice is AFFIRMED.

Your case is further RETURNED to NYSOH to redetermine your eligibility going forward in 2018 using a two-person household and an annual income of \$34,650.00, for an individual residing in Monroe County, NY.

**Effective Date of this Decision:** March 08, 2018

### **How this Decision Affects Your Eligibility**

Your case is being sent back to NYSOH to reinstate you in your Essential Plan for the month of November 2017. NYSOH will notify you once this is completed

Since your child was already reinstated in her CHP plan as of November 1, 2017, no further action is required by NYSOH regarding your child's enrollment.

You were properly determined eligible for up to \$188.00 in APTC as of December 1, 2017.

You are properly determined eligible for cost-sharing reductions as of December 1, 2017.

You are properly determined ineligible for the Essential Plan as of December 1, 2017.

NYSOH will redetermine your eligibility in 2018, based on the information stated above. If you have a change in circumstances, such as a change in income, you are required to report any such change to NYSOH within 30 days.

### **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This

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must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:  
Health Insurance Marketplace  
Attn: Appeals  
465 Industrial Blvd.  
London, KY 40750-0061
- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

### **If You Have Questions about this Decision (Customer Service Resources):**

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

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## Summary

The October 26, 2017 eligibility determination and disenrollment notices must be RESCINDED.

The October 31, 2017 eligibility determination notice is also RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of November 2017, and to notify you accordingly.

Since your child was already reinstated in her CHP plan as of November 1, 2017, no further action is required by NYSOH regarding your child's enrollment.

The November 3, 2017 eligibility determination notice is AFFIRMED.

Your case is further RETURNED to NYSOH to redetermine your eligibility going forward in 2018 using a two-person household and an annual income of \$34,650.00, for an individual residing in Monroe County, NY.

Since your child was already reinstated in her CHP plan as of November 1, 2017, no further action is required by NYSOH regarding your child's enrollment.

The November 3, 2017 eligibility redetermination notice is AFFIRMED.

Your case is being sent back to NYSOH to reinstate you in your Essential Plan for the month of November 2017. NYSOH will notify you once this is completed

Since your child was already reinstated in her CHP plan as of November 1, 2017, no further action is required by NYSOH regarding your child's enrollment.

You were properly determined eligible for up to \$188.00 in APTC as of December 1, 2017.

You are properly determined eligible for cost-sharing reductions as of December 1, 2017.

You are properly determined ineligible for the Essential Plan as of December 1, 2017.

NYSOH will redetermine your eligibility in 2018, based on the information stated above. If you have a change in circumstances, such as a change in income, you are required to report any such change to NYSOH within 30 days.

## **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.545.

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**A Copy of this Decision Has Been Provided To:**



## 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 1-855-355-5777 번으로 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 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।

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).

## **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&btumi 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۔

## **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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