



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

Notice of Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024699

[REDACTED]

[REDACTED]

On January 11, 2018 you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2017 eligibility determination notice, and December 16, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024699

[REDACTED]

Issues

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

Did NY State of Health (NYSOH) properly determine that your eligibility for \$207.00 in advance payments of the premium tax credit was effective December 1, 2017?

Did NYSOH properly determine that you were eligible to receive up to \$348.00 per month in advance payments of the premium tax credit, effective January 1, 2018?

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?

Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On July 14, 2017, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible to receive up to \$326.00 in advance payments of the premium tax credit (APTC) and conditionally eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017. The notice further directed you to provide documentation confirming your income before October 11, 2017.

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Also on July 14, 2017 NYSOH issued a notice confirming your enrollment in qualified health plan with APTC and cost-sharing reductions, effective August 1, 2017.

NYSOH did not receive documentation confirming your income by October 11, 2017. As a result, on October 16, 2017, NYSOH used information from state and federal data sources to determine your household income. NYSOH updated the income in your household application based on this information, and submitted an application your behalf.

On October 17, 2017, NYSOH issued a notice of eligibility redetermination stating that you were eligible to receive up to \$207.00 in APTC if you enrolled in a silver level qualified health plan, effective December 1, 2017. The notice stated that NYSOH did not receive proof of your household income within the required time frame, and that it based this determination of your household income on information contained in state and federal data sources. The notice further stated that based on that information your APTC had been adjusted, you were no longer eligible for cost-sharing reductions, or eligible for Medicaid.

On October 24, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by December 15, 2017 or you might lose the financial assistance you were currently receiving.

On November 21, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your APTC for the month of December 2017.

On December 15, 2017, you contacted NYSOH and updated your account.

On December 16, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$348.00 in APTC and eligible to receive cost-sharing reductions, effective January 1, 2018.

Also on December 16, 2017 NYSOH issued a notice confirming your enrollment in qualified health plan with APTC and cost-sharing reductions, effective January 1, 2018.

On January 11, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During that hearing, your appeal was amended to include an appeal of your December 16, 2017 eligibility determination, insofar as you were not eligible for more financial assistance with health insurance. The record was developed during the hearing and held open until February 2, 2018,

to allow you time to submit your final paystub for 2017 from each of your two employers.

On January 17, 2018, the Appeals Unit received via fax copies of your final 2017 paystub from each of your employers. The documents submitted did not contain all of the information required by the Hearing Officer. Accordingly, on January 19, 2017, NYSOH Appeal's Unit contacted you and requested that you submit all of your paystubs from December 2017 from both employers, and that the record would continue to remain open until February 2, 2018 to allow you time to submit these documents.

On January 31, 2017, the Appeals Unit received via fax copies of your paystubs from each of your employers for the month of December 2017. The documents received on January 17, 2018 and January 31, 2018 were collectively marked as Appellant's Exhibit #1, and incorporated into the record. The record is now closed.

Findings of Fact

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

- 1) You are seeking insurance for yourself.
- 2) You testified that you are seeking reinstatement of your \$326.00 in APTC and cost-sharing reductions as of December 1, 2017.
- 3) You testified, and your account indicates, that you receive all of your notices from NYSOH by regular mail.
- 4) You testified that you received the July 14, 2017 notice stating that your eligibility was only conditional and that you needed to provide documentation of your household's income.
- 5) You testified that you asked your employer to submit a letter stating your gross income to NYSOH on your behalf, but that your employer did not submit the letter.
- 6) Your NYSOH account indicates that on October 16, 2017, NYSOH submitted an application on your behalf based on income information contained in state and federal data sources, and based on that information, you were found no longer eligible for \$326.00 in APTC and cost-sharing reductions as of December 1, 2017.
- 7) You testified that you are seeking additional financial support for 2018.

- 8) The application that was submitted on December 15, 2017 listed annual household income of \$27,000.00 for the year 2018, consisting entirely of income you earn from your employment. You testified that this amount was correct.
- 9) You testified that you have two employers, [REDACTED]. You testified that your income at both employers varies based on the number of shifts are able to work per week. You testified that your anticipated gross income at [REDACTED] is approximately \$24,000.00 for 2018. You testified that your anticipated gross income at [REDACTED] is \$3,000.00 for 2018.
- 10) You submitted paystubs from each of your employers for the month of December 2017, which show your total gross income for that month was \$3,313.00.
- 11) You testified that you believe your expenses, such as your rent, groceries and other living expenses, should be taken into consideration and deducted when determining your eligibility for financial assistance because you believe it more accurately reflects your household income.
- 12) You testified that you expect to file your 2018 tax return with a tax filing status of single. You will not claim any dependents on that tax return.
- 13) Your application states that you will not be taking any deductions on your 2018 tax return.
- 14) Your application states that you live in New York County.

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

Applicable Law and Regulations

Verification of Eligibility for Advance Payments of the Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, 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)).

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An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant in order to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

Redetermination During a Benefit Year

When a redetermination is issued as a result of a change in an applicant's information, NYSOH must generally make that redetermination effective on the first day of the month following the date NYSOH is notified of the change (45 CFR § 155.330 (f)(1)(ii)). However, NYSOH may determine that its policy will be that any change made after the 15th of any month will not be effective until the first of the second following month (45 CFR § 155.330(f)(2)).

When an eligibility redetermination results in a change in the amount of advance payments of the premium tax credit (APTC) for the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for that benefit year (45 CFR § 155.330(g)).

Advance Payments of Premium Tax Credit

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APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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

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Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan 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 qualified health plan (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 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).

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

A person who has a household income that is at or below 150% of the FPL has a \$0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a \$20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

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)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State

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plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 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 (*id.*).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your eligibility for \$207.00 in APTC was effective December 1, 2017.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to their household's projected annual income. For individuals seeking APTC, NYSOH must request income data from federal data sources in order to verify an individual's income attestation.

If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on July 14, 2017, you were advised that your eligibility for APTC was only conditional, and that you needed to confirm your household's income before October 11, 2017.

You testified that you received the July 14, 2017 notice stating that your eligibility was only conditional and that you needed to provide documentation of your household's income.

Therefore, NYSOH properly notified you of an inconsistency in your account and that documentation was needed to confirm the income you listed in the account.

You testified that you asked your employer to submit a letter stating your gross income to NYSOH on your behalf, but that your employer did not submit the letter. If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine an individual's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation. Since you did not provide the required documentation, NYSOH relied on state and federal data sources to determine your household income. On October 16, 2017, NYSOH recalculated your household income based on information contained in state and federal data sources.

When changes in an application for financial assistance for health insurance are made on or before the fifteenth of any month, NYSOH must make the redetermination that results from the change effective the first day of the following month. Changes made in an application on or after the sixteenth day of the month will go into effect on the first day of the second following month.

Since an application for financial assistance based on NYSOH data sources was submitted on October 16, 2017, the eligibility properly took effect on the first day of the second month following October, that is December 1, 2017.

Therefore, the October 17, 2017 eligibility redetermination notice applying your updated APTC amount to your qualified health plan premium, effective December 1, 2017 is AFFIRMED.

The second issue is whether NYSOH properly determined that you were eligible to receive up to \$348.00 per month in advance payments of the premium tax credit, effective January 1, 2018.

On December 15, 2017 an updated application for financial assistance for the 2018 coverage year was submitted. That application listed an annual household

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income of \$27,000.00 and the eligibility determination relied upon that information.

During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, including rent, groceries and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent and groceries to be deducted from the calculation of your adjusted gross income, they cannot be deducted when NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be \$27,000.00.

You are in a one-person household. You expect to file your 2018 income tax return as single and will not claim any dependents on that tax return.

You reside in New York County, where the second lowest cost silver plan available for an individual through NYSOH costs \$509.30 per month.

An annual income of \$27,000.00 is 223.88% of the 2017 FPL for a one-person household. At 223.38% of the FPL, the expected contribution to the cost of the health insurance premium is 7.18% of income, or \$161.55 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 (\$509.30 per month) minus your expected contribution (\$161.55 per month), which equals \$347.75 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$348.00 per month in APTC.

The third issue is whether you were properly determined 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 \$27,000.00 is 223.88% 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 you were not eligible for the Essential Plan.

The Essential Plan is generally 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 \$12,060.00 for a one-person household. Since an annual household income of \$27,000.00 is 223.88%

of the 2017 FPL, NYSOH correctly determined you were not eligible for the Essential Plan.

The fifth issue is whether NYSOH properly determined that you were not eligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$12,060.00 for a one-person household. Since \$27,000.00 is 223.88% of the 2017 FPL, NYSOH properly found you were not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted paystubs from each of your employers for the month of December 2017, which show your total gross income for that month was \$3,313.00.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,387.00 per month. Since the documentation you provided shows that you earned \$3,313.00 in December 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the December 16, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$348.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The October 17, 2017 notice of eligibility determination is AFFIRMED.

The December 16, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 07, 2018

How this Decision Affects Your Eligibility

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Your eligibility for \$207.00 in advance premium tax credits properly began as of December 1, 2017.

You are eligible for up to \$348.00 in APTC as of January 1, 2018.

You are eligible for cost-sharing reductions as of January 1, 2018.

You are not eligible for the Essential Plan.

You are not eligible for Medicaid.

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 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.

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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

Summary

The October 17, 2017 notice of eligibility determination is AFFIRMED.

Your eligibility for \$207.00 in advance premium tax credits properly began as of December 1, 2017.

The December 16, 2017 eligibility determination notice is AFFIRMED.

You are eligible for up to \$348.00 in APTC as of January 1, 2018.

You are eligible for cost-sharing reductions as of January 1, 2018.

You are not eligible for the Essential Plan.

You are not eligible for Medicaid.

Legal Authority

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

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&etumi 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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