



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

Notice of Decision

Decision Date: March 02, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025416

[REDACTED]

Dear [REDACTED],

On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 12, 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: March 02, 2018

NY State of Health Account ID [REDACTED]
Appeal Identification Number: AP000000025416

[REDACTED]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) properly determine that you were not eligible to enroll in coverage through NYSOH as of January 1, 2018?

Procedural History

On December 6, 2017, you updated your application for health insurance and financial assistance through NYSOH.

That day, a preliminary eligibility determination was prepared stating that you were not eligible to purchase health coverage through NYSOH.

Also on December 6, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not eligible for financial assistance with health insurance or to enroll in a qualified health plan at full cost.

On December 11, 2017, you updated your application for health insurance and financial assistance through NYSOH. Specifically, you indicated that you were pregnant.

On December 12, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for health insurance through NYSOH, effective January 1, 2018. That notice also stated that you were not eligible for the Essential Plan, advance payments of the premium tax credit (APTC) and cost-

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sharing reductions, or to enroll in a qualified health plan at full cost. This was because NYSOH was unable to verify your citizenship or immigration status. This notice also stated that you were not eligible for Medicaid because your annual household income was over the allowable income limit for that program.

On February 13, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Spanish Interpreter # [REDACTED] assisted. The record was developed during the hearing and held open until February 27, 2018, to allow you time to submit supporting documents.

On February 26, 2018, NYSOH received your supporting documents via upload to your NYSOH account. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

- 1) You testified that you expect to file a tax return for 2018 with a tax filing status of married filing jointly. You will claim your children as dependents on that tax return.
- 2) You testified that you reside with your spouse and your two children.
- 3) You are seeking insurance for yourself.
- 4) You testified that you are pregnant with one child and your due date is [REDACTED]. You testified that you learned that you were pregnant in October 2017 or November 2017. The record reflects that you reported your pregnancy to NYSOH on [REDACTED].
- 5) The application that was submitted on December 11, 2017 listed annual household income of \$85,965.88.
- 6) On January 8, 2018, you updated the income information in your application. This application listed annual household income of \$79,999.99, consisting of wages your spouse earns from employment.
- 7) You testified that you do not have any income.
- 8) You testified that your spouse's annual expected income is currently \$79,999.99.
- 9) Your application states, and you confirmed, that you will not be taking any deductions on your 2018 tax return.

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- 10) Your application states, and you confirmed, that you live in Richmond County.
- 11) You testified that you have no immigration status nor have you ever had an immigration status.
- 12) You testified that you have not submitted any applications to change your immigration status.
- 13) You testified that you entered the United States [REDACTED] or [REDACTED], and have lived in New York State since that time.
- 14) You testified that you rent an apartment with your spouse.
- 15) You testified that you do not have a social security number, and are not eligible to apply for a social security number.
- 16) On February 26, 2018, you uploaded eleven of your spouse's paystubs to your NYSOH account; the first is for pay date December 1, 2017 for a gross pay amount of \$1,244.00; the second is for pay date December 8, 2017 for a gross pay amount of \$1,256.00; the third is for pay date December 15, 2017 for a gross pay amount of \$2,496.00; the fourth is for pay date December 11, 2017 for a gross pay amount of \$960.00; the fifth is for pay date December 29, 2017 for a gross pay amount of \$1,218.84 and a gross year to date pay amount of \$77,616.90; the sixth is for pay date January 5, 2018 for a gross pay amount of \$1,038.00; the seventh is for pay date January 12, 2018 for a gross pay amount of \$1,328.76; the eighth is for pay date January 19, 2018 for a gross pay amount of \$1,873.32; the ninth is for pay date January 26, 2018 for a gross pay amount of \$1,930.00; the tenth is for pay date February 2, 2018 for a gross pay amount of \$1,256.50; the eleventh is for pay date February 9, 2018 for a gross pay amount of \$1,487.50.

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

Applicable Law and Regulations

Qualified Health Plan

To enroll in a qualified health plan (QHP) through the Marketplace, an applicant must be a citizen or national of the United States or a non-citizen who is lawfully present in the United States and reasonably expects to become a citizen or

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remain a lawfully present noncitizen for the entire period for which enrollment is being sought (45 CFR § 155.305(a)(1)).

NYSOH must verify or obtain information in order to determine that an applicant is eligible for enrollment in a qualified health plan, including the certification of citizenship, status as a national, or lawful presence (45 CFR § 155.315(a), (c)).

Advance Payments of 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), 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 \$28,780.00 for a five-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.10% and 9.56% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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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 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 \$28,780.00 for a five-person household (82 Fed. Reg. 8831).

Lawfully present non-citizens who are eligible for Essential Plan include qualified aliens in the five-year ban, certain persons Permanently Residing Under Color of Law (PRUCOL) and temporary non-immigrants meeting residency requirements (45 CFR § 152.2(2) and (4)(i); 16 OHIP/ADM-01 (01/20/2016)). Immigrants who are pregnant or are under 21 years of age, and are in the first five years of their qualified status or are PRUCOL, are eligible for federal financial participation and, therefore, are not eligible for Essential Plan and will remain in Medicaid (*id.*).

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,

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which is \$16,020.00 for a two-person household (80 Federal Register 3236, 3237).

Lawfully Present Non-Citizens Transitioned to the Essential Plan

In New York State, lawfully present non-citizens who were formerly eligible for state-funded Medicaid, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of April 1, 2015 (New York's Basic Health Plan Blueprint, p. 19, as approved March 2015; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>). This category of non-citizens includes lawful permanent residents who are still in their first five years of permanent residency (18 NYCRR § 349.3, 8 USC § 1613).

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 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 New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

Generally, no person except a United States citizen, naturalized citizen, qualified alien, or person permanently residing in the United States under color of law (PRUCOL) is eligible for full Medicaid benefits (NY Soc. Serv. Law § 122(1); 18 NYCRR § 360-3.2(j)).

An applicant of, or recipient of, medical assistance must provide "evidence of his or her citizenship status as a qualified immigrant or PRUCOL alien". (18 NYCRR §360-3.2(j)(3)).

However, Pregnant women are not required to document citizenship/immigration status for ongoing Medicaid eligibility. Citizenship/immigration status is not an eligibility requirement for a pregnant woman throughout her pregnancy and for 2 months after the month in which the pregnancy ends (N.Y. Soc. Serv. Law § 366 (4)(b)).

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return,

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and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

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 December 2017 applications, that was the 2017 FPL, which is \$28,780.00 for a five-person household (82 Fed. Reg. 8831). On the date of your application January 8, 2018 application, that was the 2018 FPL, which is \$29,420.00 for a five-person household (83 Fed. Reg. 2642).

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).

Clarification on PRUCOL Status for Medicaid Eligibility

An alien is considered PRUCOL if they are “residing in the United States with the knowledge and permission or acquiescence of the Federal Immigration Agency and whose departure from the U.S. such agency does not contemplate enforcing. An alien will be considered as one whose departure the Federal Immigration Agency does not contemplate enforcing if, based on all the facts and circumstances in a particular case, it appears that the Federal Immigration Agency is otherwise permitting the alien to reside in the United States indefinitely or it is the policy or practice of such agency not to enforce the departure of aliens in a particular category” (18 NYCRR § 360-3.2(j)(1)(ii)).

The following categories of aliens are considered PRUCOL:

- (a) aliens paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act for less than one year;
- (b) aliens residing in the United States pursuant to an order of supervision;
- (c) deportable aliens residing in the United States pursuant to an indefinite stay of deportation;
- (d) aliens residing in the United States pursuant to an indefinite voluntary departure;

- (e) aliens on whose behalf an immediate relative petition has been approved, and members of their families covered by the petition, who are entitled to voluntary departure and whose departure the Federal Immigration Agency does not contemplate enforcing;
- (f) aliens who have filed an application for adjustment to lawful permanent resident status pursuant to section 245 of the Immigration and Nationality Act, whose application the Federal Immigration Agency has accepted as properly filed or has granted, and whose departure the Federal Immigration Agency does not contemplate enforcing;
- (g) aliens granted stays of deportation by court order, statute or regulation or by individual determination of the Federal Immigration Agency pursuant to section 243 of the Immigration and Nationality Act, whose departure the Federal Immigration Agency does not contemplate enforcing;
- (h) aliens granted voluntary departure status pursuant to section 242(b) of the Immigration and Nationality Act whose departure the Federal Immigration Agency does not contemplate enforcing;
- (i) aliens granted deferred action status;
- (j) aliens who entered and have continuously resided in the United States since before January 1, 1972;
- (k) aliens granted suspension of deportation pursuant to section 244 of the Immigration and Nationality Act whose departure the Federal Immigration Agency does not contemplate enforcing; and
- (l) any other alien living in the United States with the knowledge and permission or acquiescence of the Federal Immigration Agency and whose departure such agency does not contemplate enforcing. (18 NYCRR § 360-3.2(j)(1)(ii)).

Some aliens are PRUCOL because the federal immigration agency has granted them a status. Other aliens are PRUCOL because they have applied for a particular immigration status which has not yet been granted or denied. If an alien seeking Temporary Protected Status has an application before USCIS which remains pending the Medicaid worker must find the individual PRUCOL. However, if USCIS has denied the alien's application or otherwise indicates that it is not permitting the alien to reside in the U.S. indefinitely, the Medicaid worker must find that individual is not PRUCOL. In such cases, the alien if otherwise eligible may receive Medicaid only for care and services necessary to treat an emergency medical condition (NYS Department of Health Informational Letter

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“Clarification of PRUCOL Status for Purposes of Medicaid Eligibility” 07 OHIP/INF-2, pg. 2-3, March 15, 2007).

Immigration Status

Generally, no person except a United States citizen, a naturalized citizen, a qualified alien, and persons permanently residing in the United States under color of law (PRUCOL), is eligible for medical assistance from the state (NY Soc. Serv. Law § 122(1); 18 NYCRR § 360-3.2(j)).

Lawfully present is defined to mean (1) A qualified alien as defined in section 431 of the Personal Responsibility and Work Opportunity Act (PRWORA) (8 United States Code (USC) §1641): or (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission (45 CFR § 152.2).

A PRUCOL alien is a person who is residing in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the United States such agency does not contemplate enforcing (18 NYCRR §360-3.2(j)).

Legal Analysis

The issue is whether NYSOH properly determined that you were not eligible to enroll in coverage through NYSOH as of January 1, 2018.

On December 6, 2017, you updated your application for financial assistance. As a result, NYSOH determined that you were ineligible for health insurance through NYSOH.

Thereafter, on December 11, 2017, you updated your application for financial assistance to reflect that you are pregnant with one child with a due date of [REDACTED]. As a result of this application, NYSOH issued a notice of eligibility determination stating that you were ineligible for the Essential Plan, APTC or cost-sharing reductions, or to enroll in a qualified health plan this was because NYSOH could not confirm your citizenship or immigration status. You also were not eligible for Medicaid because your household income was over the allowable income limit for that program.

In order to be eligible for advance payments of the premium tax credit, a tax filer must meet the requirements to enroll in a qualified health plan. In order to be eligible for cost-sharing reductions, a tax filer must be eligible for advance payments of the premium tax credit.

In order to enroll in a qualified health plan through NYSOH, an applicant must be a citizen or a non-citizen who is lawfully present in the United States and reasonably expects to become a citizen or remain a lawfully present noncitizen for the entire period for which enrollment is being sought.

Lawfully present is federally defined to mean a qualified alien or an alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission

Generally, to qualify for the Essential Plan through NYSOH, an applicant must have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size and must be lawfully present and have a valid immigration or citizenship status. Lawfully present immigrants who are eligible for the Essential Plan include qualified aliens in the five-year ban, certain persons Permanently Residing Under Color of Law (PRUCOL) and temporary non-immigrants meeting residency requirements.

You testified that you entered the United States approximately [REDACTED]. You testified that you do not have an immigration status nor have you ever had an immigration status. You testified that you have not applied for an immigration status. You also testified that you have not applied for nor are your eligible for a social security number.

Therefore, you are not considered “lawfully present” for purposes of the federal definition.

While individuals who have been determined to be qualified aliens and were formerly eligible for state-funded Medicaid, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of April 1, 2015, this is not the case for persons who are not lawfully present immigrants under the federal definition.

Since you do not meet the federal definition of a lawfully present immigrant NYSOH was correct in finding you ineligible for coverage under the Essential Plan, for APTC and cost-sharing reductions, or to enroll in a qualified health plan at full cost.

Medicaid can be provided through NYSOH to pregnant women who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% of the FPL for the applicable family size.

Due to your immigration status, you do not meet the nonfinancial criteria to be eligible for Medicaid. However, you credibly testified that at the time of your application, you were pregnant, and immigration status is not an eligibility requirement for Medicaid for a pregnant woman throughout her pregnancy.

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Therefore, due to your pregnancy, you meet the non-financial requirements for Medicaid.

You reside with your spouse and two children. You are pregnant with one child. Therefore, you are in a five-person household.

On the date of your application December 11, 2017 application, the relevant FPL was \$28,780.00 for a five-person household. Furthermore, the relevant FPL at the time of your January 8, 2018 application was \$29,420.00. Since \$79,999.99 is 277.97% of the 2017 FPL, and 271.92% of the 2018 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your applications.

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 that show in December 2017 your household income was \$7,164.84. You also submitted paystubs that show in January 2018 your household income was \$6,170.08.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 223% of the 2017 FPL, which is \$5,349.00 per month. Since the documentation you provided shows that your spouse earned \$7,164.84 in December 2017, you do not qualify for Medicaid based on monthly income as of the date of your December 11, 2017 application. Furthermore, you would need to have an income no greater than 223% of the 2018 FPL, which is \$5,467.00 per month. Since the documentation you provided shows that your spouse earned \$6,170.08 in January 2018, you do not qualify for Medicaid based on monthly income as of the date of your January 8, 2018 application.

Since the December 12, 2017 eligibility determination notice properly stated that, based on the information you provided, you were ineligible for Medicaid, the Essential Plan, APTC or cost-sharing reductions, or to purchase a qualified health plan at full cost, it is correct and is AFFIRMED.

Decision

The December 12, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 02, 2018

How this Decision Affects Your Eligibility

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).

You are ineligible for APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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

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- 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

Summary

The December 12, 2017 eligibility determination notice is AFFIRMED.

You are ineligible for APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible 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&btumi ama wo obi a okyerE 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.