



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

Notice of Decision

Decision Date: March 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025691

[REDACTED]

Dear [REDACTED]

On February 16, 2018, your mother, [REDACTED], appeared as your Authorized Representative by telephone at a hearing on your appeal of NY State of Health's December 13, 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 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025691



Issue

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

Did NY State of Health (NYSOH) properly determine your household's eligibility for financial assistance, effective January 1, 2018?

Procedural History

On August 30, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your two children remained eligible for Medicaid, effective August 1, 2017.

Also on August 30, 2017, NYSOH issued a notice of enrollment confirming that you, your spouse, and your two children were enrolled in a CDPHP Medicaid Managed Care (MMC) plan.

On October 28, 2017, NYSOH issued a notice of renewal, stating that you, your spouse, and your two children were eligible for Medicaid, effective January 1, 2018, and that no further action was required for anyone in your household. The notice also stated that you were all enrolled in the same CDPHP MMC plan, effective January 1, 2018. If you needed to make changes, you needed to update your account between November 16, 2017 and December 15, 2017.

On November 17, 2017, you updated your NYSOH application.

On November 18, 2017, NYSOH issued a notice of eligibility determination stating that your spouse was newly eligible to purchase a qualified health plan

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(QHP) at full cost, and your youngest child was eligible to enroll in Child Health Plus (CHP) with a monthly premium of \$9.00, effective January 1, 2018. The notice did not state what you or your oldest child were eligible for, but did state that both of your eligibilities were effective January 1, 2018.

Also on November 18, 2017, NYSOH issued a disenrollment notice, stating that your spouse and youngest child's MMC plan enrollment was ending, effective December 31, 2017, because they were no longer eligible to remain enrolled in that plan.

That same day, NYSOH issued a notice of enrollment confirmation, confirming that you and your oldest child were enrolled in a CDPHP MMC plan.

On December 12, 2017, you updated your NYSOH account. That day, a preliminary eligibility determination was prepared stating that you and your oldest child were no longer eligible for Medicaid, but that your Medicaid coverage would continue because certain individuals deemed eligible for Medicaid remain eligible for benefits for twelve continuous months. The preliminary eligibility determination also stated that your spouse was eligible to purchase a QHP at full cost through NYSOH, and your youngest child was eligible to enroll in CHP with a \$9.00 monthly premium, effective January 1, 2018.

Also on December 12, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice, insofar as your spouse and oldest child were not found eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On December 13, 2017, NYSOH issued an eligibility determination notice stating that you and your oldest child were no longer eligible for Medicaid, but that your Medicaid coverage would continue until January 31, 2019 because certain individuals who qualified for Medicaid get coverage for twelve continuous months. The notice also stated that your spouse was eligible to purchase a QHP at full cost, effective January 1, 2018, and not eligible to receive financial assistance with the cost of that plan because the waiting period for your employer-sponsored insurance was over. Finally, the notice stated that your youngest child was eligible for CHP with a monthly premium of \$9.00, effective January 1, 2018.

On December 14, 2017, you uploaded documentation to your NYSOH account.

On December 28, 2017, NYSOH issued a notice stating that your spouse and oldest child were eligible for Medicaid for a limited time, effective January 1, 2018. This was because your request for Aid to Continue, pending the outcome of your appeal, was granted.

Also on December 28, 2017, NYSOH issued an enrollment confirmation notice stating that you, your spouse, and your two children were enrolled in a CDPHP MMC plan.

On February 16, 2018, your mother, [REDACTED], appeared as your Authorized Representative (AR) at a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through March 5, 2018, to allow you time to submit supporting documents.

On February 17, 2018, NYSOH received your supporting documents by upload. The documents were incorporated into the record, and the record was closed.

Findings of Fact

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

- 1) Your AR testified that this appeal was filed because it did not make sense that half of your household was eligible for Medicaid, and the other half was not.
- 2) Your AR testified that you still expect to file your 2018 income tax return with a status of married, filing jointly, and that you will claim two dependents on that return.
- 3) The application that was filed on December 12, 2017 listed an expected annual income of \$44,990.00 consisting of income that you earn. Your AR testified that this amount is correct.
- 4) Your AR testified that you earn \$21.63 an hour, and work forty hours per week. She further testified that you began working at your current job in March 2017.
- 5) Your application reflects, and your AR testified, that your spouse does not have any income.
- 6) Your AR testified that your spouse previously had health insurance coverage through her parents, but that this coverage ended when [REDACTED].
- 7) Your NYSOH account reflects that a United Healthcare printout of benefits and coverage was uploaded to your NYSOH account on December 14, 2017 showing that your spouse had dependent coverage on a United Healthcare plan, which ended on November 30, 2016 (Document [REDACTED]).

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- 8) Your AR testified that you have access to employer-sponsored health insurance coverage through your own employment.
- 9) Your NYSOH account reflects that the application submitted on December 12, 2017 reflected that you had access to employer-sponsored insurance through your employer and were qualified to enroll as of January 1, 2018. The same application indicated that your spouse had access to your employer-sponsored health insurance coverage, effective January 1, 2018.
- 10) Your AR testified that you have never been enrolled in your employer-sponsored coverage, and that the cost to enroll a family through your employer would be over \$500.00 a pay period.
- 11) Your AR testified that you enrolled your spouse in coverage through your employer as of January 1, 2018, because she was not eligible for any financial assistance through NYSOH.
- 12) Your AR testified that you enrolled your youngest child in a CHP plan, and you and your oldest child still have Medicaid coverage.
- 13) Your NYSOH account reflects that you updated your application again on January 15, 2018, while your appeal was pending. That application update indicated that you and your spouse had access to coverage through your employer for a \$160.64 biweekly premium.
- 14) The January 15, 2018 application update also indicated “yes” next to the question, “Is [REDACTED] [sic] parent or stepparent a public employee, and can get family coverage through a state health benefits plan,” and indicated that this coverage would cost \$219.91 biweekly.
- 15) The January 15, 2018 application also reflected a “yes” answer to the question above for [REDACTED]
- 16) There is no indication in the record that you or your spouse are public employees with access to a state health benefits plan.
- 17) Your AR testified that you expect to have a student loan interest deduction of \$128.00 when you file your tax return for 2017, but that it will be less next year.
- 18) Your application states that you live in Saratoga County.
- 19) After the hearing, you uploaded documentation to your NYSOH account consisting of the following:

- a. A one-page cover sheet;
- b. Two biweekly paystubs from your current employer for the following dates and gross earnings:
 - i. February 2, 2018: \$1,602.21, after a medical pre-tax deduction of \$160.64;
 - ii. February 16, 2018: \$1,610.32, after a medical pre-tax deduction of \$160.64;
- c. A printout entitled [REDACTED] 2018 Benefit Plans” showing two insurance options:
 - i. An “EPO” plan with an individual premium of \$50.72 biweekly, a 2-person premium of \$245.76 biweekly, and a family premium of \$337.96 biweekly;
 - ii. An [REDACTED]” plan with an individual premium of \$11.19, a 2-person premium of \$160.64, and a family premium of \$219.91

(Document [REDACTED]).

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

Applicable Law and Regulations

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).

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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 \$24,600.00 for a four-person household (82 Federal Register 8831).

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 \$24,600.00 for a four-person household (82 Fed. Reg. 8831).

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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 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 \$24,600.00 for a four-person household (82 Fed. Reg. 8831).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY SSL § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (see New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

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 PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be “eligible for medical assistance”; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL §

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2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from \$9.00 per month to \$60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is \$9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than \$27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

The CHP premium is \$15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than \$54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is \$30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than \$90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

The CHP premium is \$45.00 per month for a child whose family household income is between 301% and 350% of the FPL, but no more than \$135.00 per month per family (NY PHL § 2510(9)(d)(v)).

The CHP premium is \$60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than \$180.00 per child (NY PHL § 2510(9)(d)(vi)).

In an analysis of Child Health Plus 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 was \$24,600.00 for a x-person household (82 Fed. Reg. 8831).

Employer-Sponsored Insurance

An employee who may enroll in an employer-sponsored health insurance plan, and an individual who may enroll in the plan because of a relationship to the employee are considered eligible for minimum essential coverage as long as the plan “is affordable and provides minimum value” (26 CFR § 1.36B-2(c)(3)(i)).

An eligible employer-sponsored plan is “affordable” if the portion of the annual premium that the employee or related individual must pay for self-only coverage does not exceed the required contribution. The required contribution percentage is 9.56% of the employee’s household income for 2018 (26 CFR §1.36B-2(c)(3)(v), IRS Rev. Proc. 2017-36).

Legal Analysis

The issue under review is whether NYSOH properly determined your household’s eligibility for financial assistance, effective January 1, 2018.

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You, your spouse, and your children were enrolled in Medicaid and an MMC plan, as confirmed in an eligibility determination dated August 30, 2017.

On October 30, 2017, NYSOH issued a renewal notice stating that it was time to renew your coverage for next year (2018). However, the notice further stated that no action was necessary, as you, your spouse, and your children were eligible for Medicaid, effective January 1, 2018, and were being re-enrolled into your CDPHP MMC plan as of January 1, 2018 as well.

On November 17, 2017, you chose to update your NYSOH application for financial assistance. That application indicated that you and your spouse could enroll in coverage through your employer, effective January 1, 2018.

On November 18, 2017, NYSOH issued a notice of eligibility determination. The notice stated that your spouse could not receive tax credits toward the cost of coverage because you had not provided information on the lowest cost premium amount, and she was not eligible for the Essential Plan because, to qualify for the Essential Plan, you must not be eligible to enroll in other coverage. It also stated that your youngest child was eligible for CHP with \$9.00 monthly premium.

For reasons that are unclear, NYSOH omitted any mention of you and your oldest child's eligibility in the November 18, 2017 eligibility determination. However, your NYSOH account reflects, and the eligibility determination issued on December 13, 2017 confirms, that NYSOH determined that you and your oldest child were no longer eligible for Medicaid, but would continue to receive Medicaid until January 31, 2019.

On December 12, 2017, you updated your application and again indicated that you and your spouse had access to employer-sponsored coverage. This application listed no cost under your name, but listed a premium amount of \$11.19 under your spouse's name. Once again, NYSOH determined that your spouse was not eligible for any financial assistance and that your youngest child was eligible for CHP with a \$9.00 premium, but that you and your oldest child would remain in your Medicaid coverage through January 31, 2019.

During the hearing, your AR testified that she did not understand how half of your household could be eligible for Medicaid, while the other half was not. After reviewing the determinations of November 18, 2017 and December 13, 2017, it is unclear how NYSOH arrived at its determination to keep you and your oldest child in Medicaid, while simultaneously finding your youngest child eligible for CHP, and your spouse eligible for a full-cost QHP.

Since the decisions issued on November 18, 2017 and December 13, 2017 are seemingly unsupported by the facts or the law, and are unclear as to the basis of the eligibility determinations contained within, both of these decisions are

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RESCINDED, as are all subsequent eligibility determinations not related to your Aid to Continue coverage.

Your AR testified that your spouse has since been enrolled into coverage through your employer because she was not found eligible for any financial assistance through NYSOH. The income documents you submitted indicate that a medical premium of \$160.64 is being deducted from your biweekly paycheck, which is the exact amount of the two-person premium for an "[REDACTED]" listed in the 2018 benefit plan printout you uploaded to your NYSOH account. Therefore, it is concluded that you and your spouse have access to coverage in a high-deductible plan through your employer for a cost of \$160.64 biweekly.

After the hearing, you uploaded documentation showing that your average biweekly gross income is \$1,606.27 (after the deduction of your \$160.64 medical premium). Therefore, your expected gross annual income is \$41,763.02, after medical premiums are deduction (\$1,606.27 times 26 biweekly pay periods).

Your NYSOH account reflects that, in an application update of January 15, 2018, your application was changed to reflect that your children allegedly had access to state health plan benefits because one of their parents or stepparents was a public employee. However, it is concluded that this entry was a mistake, as there is nothing in the record to indicate that you or your spouse are public employees, and the premium amount listed for the coverage indicated is a precise match for the family coverage premium for the "[REDACTED]" offered through your non-state employer (\$219.91 biweekly).

In light of the Hearing Officer's findings, your case is RETURNED to NYSOH, and NYSOH is directed to:

1. RESCIND the November 18, 2017 and December 13, 2017 eligibility determinations, as well as all subsequent determinations issued that do not relate to your Aid to Continue coverage;
2. Determine whether the health insurance you and your spouse have access to is affordable and provides minimum value, under the law;
3. Redetermine you and your spouse's eligibility for financial assistance for 2018 based on a household of four with an expected annual income of \$41,763.02, residing in Saratoga County, and taking into account you and your spouse's access to employer-sponsored insurance, as outlined in Document [REDACTED];
4. Update your NYSOH account to reflect that your children do NOT have access to NYSHIP, or any other state health benefits plan;
5. Redetermine your children's eligibility for financial assistance for 2018 based on a four-person household with an expected annual income of \$41,763.02;
6. Issue a new eligibility determination in writing for your entire household.

Decision

The November 18, 2017, December 13, 2017, and all subsequent eligibility determinations NOT related to your Aid to Continue coverage are RESCINDED.

Your case is RETURNED to NYSOH to update your NYSOH account to reflect that your children do NOT have access to NYSHIP or any other state health benefits plan;

Your case is RETURNED to NYSOH to redetermine your children's eligibility for financial assistance with health insurance for 2018, based on a four-person household with an expected annual income of \$41,763.02;

Your case is RETURNED to NYSOH to determine whether you and your spouse have access to employer-sponsored coverage that meets affordability and minimum value standards;

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance for 2018, based on a household of four with an expected annual income of \$41,763.02, residing in Saratoga County, with access to employer-sponsored health insurance as detailed in Document [REDACTED];

NYSOH will issue an eligibility determination notice informing you of your household's new eligibility.

Effective Date of this Decision: March 15, 2018

How this Decision Affects Your Eligibility

You and your family's eligibility for financial assistance in 2018 has not been properly determined.

Your case is being sent back to NYSOH to determine whether the health insurance you and your spouse have access to through your employer is considered minimum essential coverage, and to determine what, if any, financial assistance you and your spouse are eligible for.

Your case is being sent back to NYSOH to correct your account so that it does not state that your children have access to a state health benefit plan through a parent or stepparent, and to redetermine your children's eligibility for financial assistance with health insurance for 2018.

NYSOH will send you a new eligibility determination notice.

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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
- 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):

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- By fax: 1-855-900-5557

Summary

The November 18, 2017, December 13, 2017, and all subsequent eligibility determinations NOT related to your Aid to Continue coverage are RESCINDED.

Your case is RETURNED to NYSOH to update your NYSOH account to reflect that your children do NOT have access to NYSHIP or any other state health benefits plan;

Your case is RETURNED to NYSOH to redetermine your children's eligibility for financial assistance with health insurance for 2018, based on a four-person household with an expected annual income of \$41,763.02;

Your case is RETURNED to NYSOH to determine whether you and your spouse have access to employer-sponsored coverage that meets affordability and minimum value standards;

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance for 2018, based on a household of four with an expected annual income of \$41,763.02, residing in Saratoga County, with access to employer-sponsored health insurance as detailed in Document

NYSOH will issue an eligibility determination notice informing you of your household's new eligibility.

You and your family's eligibility for financial assistance in 2018 has not been properly determined.

Your case is being sent back to NYSOH to determine whether the health insurance you and your spouse have access to through your employer is

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considered minimum essential coverage, and to determine what, if any, financial assistance you and your spouse are eligible for.

Your case is being sent back to NYSOH to correct your account so that it does not state that your children have access to a state health benefit plan through a parent or stepparent, and to redetermine your children's eligibility for financial assistance with health insurance for 2018.

NYSOH will send you a new eligibility determination notice.

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。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 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 مجانًا.

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 איך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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