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

Notice of Decision

Decision Date: March 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025949

[redacted]

Dear [redacted]

On February 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 19, 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.

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).

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

Decision

Decision Date: March 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025949

[redacted]

Issues

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

> Did NY State of Health properly determine that you were eligible to receive up to $111.00 per month in advance payments of the premium tax credit, effective February 1, 2018?
>
> Did NY State of Health properly determine that you were ineligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for the Essential Plan?
>
> Did NY State of Health properly determine that your child was eligible to enroll in Child Health Plus with a $45.00 monthly premium, effective February 1, 2018?
>
> Did NY State of Health properly determine that you and your child were ineligible for Medicaid?

Procedural History

On December 18, 2017, you applied for health insurance and financial assistance through NY State of Health (NYSOH) for your household.

That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to $111.00 per month in advance payments of the

premium tax credit (APTC), effective February 1, 2018, and that your child was eligible for Child Health Plus with a $45.00 monthly premium, effective February 1, 2018.

Also on December 18, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you and your child were not eligible for Medicaid.

On December 19, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $111.00 per month in APTC, effective February 1, 2018, and that your child was eligible for Child Health Plus with a $45.00 monthly premium, effective February 1, 2018. That notice also stated that you were not eligible for the Essential Plan, and that you and your child were not eligible for Medicaid, because your annual household income was over the allowable income limits for those programs.

On January 8, 2018, you updated your household's application for financial assistance; specifically, you added deductions for student loan interest.

On January 9, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $138.00 per month in APTC, effective February 1, 2018, and that your child was eligible for Child Health Plus with a $30.00 monthly premium, effective February 1, 2018.

Also on January 9, 2018, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a qualified health plan with a plan enrollment start date of February 1, 2018 and that your APTC would be applied to your monthly premium as of February 1, 2018, and that your child was enrolled in a Child Health Plus plan with a $30.00 premium with a plan enrollment start date of February 1, 2018.

On February 3, 2018, NYSOH issued a notice of eligibility determination stating that you and your child were newly eligible to purchase a qualified health plan at full cost through NYSOH, effective March 1, 2018, and that you and your child no longer qualified for APTC and Child Health Plus as of February 28, 2018. This was because federal and state data sources showed that you and your child were already enrolled in Medicaid, Child Health Plus, or another program.

Also on February 3, 2018, NYSOH issued a notice of changes to your insurance coverage stating that your coverage with your qualified health plan had been cancelled as of February 28, 2018, as well as a notice of changes to your insurance coverage stating that your child's coverage with her Child Health Plus plan had been cancelled as of February 28, 2018.

On February 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until March 7, 2018, to allow you time to submit supporting documents.

Also on February 21, 2018, you uploaded your December 2017 and January 2018 paystubs 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 your tax return for 2018 with a tax filing status of head of household. You will claim one dependent on that tax return.

2) You testified that you are seeking for yourself and your child to be found eligible for Medicaid.

3) The application that was submitted on December 18, 2017 listed annual household income of $50,000.00 consisting of wages you receive from employment. This application did not list any deductions.

4) At the time of your December 18, 2017 application, your child [redacted].

5) You testified that you expect to have earned income of $50,000.00 for 2018.

6) You testified that you will be taking deductions for student loan interest of $2,400.00. You testified that you will also be taking deductions for tuition, but you do not yet know the amount of this deduction. You testified that you will claim no other deductions on your 2018 tax return.

7) On January 8, 2018, you updated your application for financial assistance. This application listed earned income of $50,000.00 less deductions of $2,400.00 for a modified adjusted gross income of $47,600.00.

8) You testified that you have one employer and that you are paid on a biweekly basis.

9) You submitted four paystubs; the first is for pay date December 7, 2017 for a gross pay amount of $2,086.95; the second is for pay date December 22, 2017 for a gross pay amount of $2,086.96; the third is for pay date

January 5, 2018 for a gross pay amount of $2,086.95; the fourth is for pay date January 22, 2018 for a gross pay amount of $2,086.95.

10) Your application states, and you confirmed, that you live in Bronx County.

11) You testified that you have bills including $1,014.14 per month for rent, $75.00 per week for child care, $59.95 per month for utilities, $72.00 per month for cable, $120.00 per month for transportation, as well as credit card payments that you would like considered when determining your eligibility for financial assistance.

12) You testified that you [redacted] through the NYC Human Resources Administration (HRA).

13) You testified that you do not receive any child support.

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).

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 $16,240.00 for a two-person household (82 Federal Register 8831).

For annual household income in the range of at least 300% but less than 400% of the 2017 FPL, the expected contribution is between 9.56% 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

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 $16,240.00 for a two-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)).

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 § 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 $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)).

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 December 18, 2017 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

Medicaid for Adults

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 December 18, 2017 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

On the date of your application January 8, 2018 application, that was the 2018 FPL, which is $16,460.00 for a two-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).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all

persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

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 18, 2017 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

On the date of your application January 8, 2018 application, that was the 2018 FPL, which is $16,460.00 for a two-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).

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 tax 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 is whether NYSOH properly determined that you were eligible for up to $111.00 per month in APTC, effective February 1, 2018.

The application that was submitted on December 18, 2017 listed an annual household income of $50,000.00 and the eligibility determination relied upon that information.

During the hearing, you testified that you expect to receive a gross amount of $50,000.00 in wages in 2018. However, you asked that your current expenses, which include $1,014.14 per month for rent, $75.00 per week for child care, $59.95 per month for utilities, $72.00 per month for cable, $120.00 per month for transportation, as well as credit card payments, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable, and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for the purpose of determining your eligibility for financial assistance. Therefore, NYSOH correctly determined your household income to be $50,000.00.

You expect to file your 2018 income tax return as head of household and will claim one dependent on that tax return. Therefore, you are in a two-person household.

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

An annual income of $50,000.00 is 307.88% of the 2017 FPL for a two-person household. At 307.88% of the FPL, the expected contribution to the cost of the health insurance premium is 9.56% of income, or $398.33 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 ($398.33 per month), which equals $110.97 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $111.00 per month in APTC.

The second issue is whether you were properly determined ineligible 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 $50,000.00 is 307.88% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you were ineligible 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 $16,240.00 for a two-person household. Since an annual household income of $50,000.00 is 307.88%

of the 2017 FPL, NYSOH correctly found you to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that your child was eligible to enroll in Child Health Plus with a $45.00 monthly premium, effective February 1, 2018.

You expect to file your 2018 tax return as head of household and will claim your one child as a dependent. Therefore, your child is in a two-person household.

In your December 18, 2017 application, you attested to an expected household income of $50,000.00. The application also stated that your child [redacted] NYSOH relied upon this information.

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 301% and 350% of the FPL are responsible for a $45.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $50,000.00 is 307.88% of the 2017 FPL, NYSOH properly found your child to be eligible for Child Health Plus with a $45.00 per month premium payment.

The fifth issue is whether NYSOH properly determined that you and your child were ineligible 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.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 154% of the FPL for the applicable family size.

On the date of your application December 18, 2017 application, the relevant FPL was $16,240.00 for a two-person household. On the date of your January 8, 2018 application, the relevant FPL was 16,460.00. Since $50,000.00 is 307.88% of the 2017 FPL and 303.77% of the 2018 FPL, NYSOH properly found you and your child ineligible 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 that show in December 2017 you received $4,173.91 and in January 2018 you received $4,173.90.

To be eligible for Medicaid as of the December 18, 2017 application, you would need to meet the non-financial criteria and have an income no greater than 138% of the 2017 FPL, which is $1,868.00 per month, and your child would need to meet the non-financial criteria and have an income no greater than 154% of the 2017 FPL, which is $2,085.00 per month. Since the documentation you provided shows that you earned $4,173.91 in December 2017, you and your child do not qualify for Medicaid based on monthly income as of the date of your December 18, 2017 application.

To be eligible for Medicaid as of the January 8, 2018 application, you would need to meet the non-financial criteria and have an income no greater than 138% of the 2018 FPL, which is $1,893.00 per month, and your child would need to meet the non-financial criteria and have an income no greater than 154% of the 2018 FPL, which is $2,113.00 per month. Since the documentation you provided shows that you earned $4,173.90 in January 2018, you and your child do not qualify for Medicaid based on monthly income as of the date of your January 8, 2018 application.

Since the December 19, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $111.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, and that your child was eligible for Child Health Plus with a $45.00 monthly premium and ineligible for Medicaid, it is correct and is AFFIRMED.

During the hearing, you testified that you expect to claim deductions on your 2018 tax return. On January 8, 2018, you updated your application to reflect these deductions, therefore, the NYSOH Appeals Unit declines to return your case for a redetermination.

On February 3, 2018, NYSOH issued a notice of eligibility determination stating that you and your child were newly eligible to purchase a qualified health plan at full cost through NYSOH, effective March 1, 2018, and that you and your child no longer qualified for APTC and Child Health Plus as of February 28, 2018.

Also on February 3, 2018, NYSOH issued a notice of changes to your insurance coverage stating that your coverage with your qualified health plan had been cancelled as of February 1, 2018, as well as a notice of changes to your insurance coverage stating that your child's coverage with her Child Health Plus plan had been cancelled as of February 1, 2018.

This determination is not under appeal and cannot be addressed in this decision.

If you wish to be found eligible for financial assistance with health insurance, you must contact NYSOH and update your application.

Decision

The December 19, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 12, 2018

How this Decision Affects Your Eligibility

NYSOH properly found you eligible for up to $111.00 in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, based on your December 18, 2017 application.

NYSOH properly found your child eligible for Child Health Plus with a $45.00 monthly premium and ineligible for Medicaid, based on your December 18, 2017 application.

This decision does not affect any subsequent eligibility determinations.

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.

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 19, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly found you eligible for up to $111.00 in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, based on your December 18, 2017 application.

NYSOH properly found your child eligible for Child Health Plus with a $45.00 monthly premium and ineligible for Medicaid, based on your December 18, 2017 application.

This decision does not affect any subsequent eligibility determinations.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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).

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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 yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 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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