



SEAN WAYLAND  
652 5th Ave  
Brooklyn, NY 11215-6305

April 4, 2020  
Account ID: AC0009057016

Dear SEAN WAYLAND,

This notice concerns your health insurance through NY State of Health.

We got your request for help with paying bills for medical care received in the three month period prior to your application for health insurance for **SEAN WAYLAND**.

**We have made a decision on eligibility for the time period(s) listed below for the following individual(s).**

**Household Member**

**Eligibility Results**

SEAN WAYLAND  
**Marketplace ID:**  
HX0001710633  
**CIN:** MM75423Y

You are **eligible** for Medicaid for **October 1, 2019 through December 31, 2019**.

Because your household monthly income of \$0.00 is at or below the allowable monthly income limit of \$1,945.00, you are eligible for Medicaid.

**How to Get Unpaid Medical Bills Paid by Medicaid**

If you have any unpaid medical bills for a month that you were determined eligible for Medicaid, please give the provider (if a Medicaid provider) your Client Identification Number (CIN) and ask them to bill Medicaid for services that are covered by Medicaid.

**How to Request Reimbursement of Paid Medical Bills**

You may be eligible for reimbursement if you have paid bills for medical care you received in the three month period prior to your application for health insurance.

**Please follow these directions carefully.**

1. Please send a copy of the medical bills and proof that they were paid.

2. The bills must include:

- Dates of service
- Description of service and procedure code (CPT code)
- Prescription drug name, quantity, strength and National Drug Code (NDC)

3. Be sure to include your name, contact information and account number with the bills.

4. Send to:

Reimbursement Unit  
P.O. Box 11780  
Albany, NY 12211

**Please note:** If you owe documents to prove you were eligible for Medicaid in the three month period prior to your application, please return those documents to NY State of Health **before** you submit paid bills for reimbursement. After you receive notification from NY State of Health that you are eligible for Medicaid during this time period, then you can go ahead and send your paid bills to the address above.

Reimbursement is generally limited to no more than the Medicaid rate in effect at the time of service, even if you or your representative paid more. Processing time is approximately 90 days. **Please submit the bills right away.**

## If You Think We Made A Mistake

If you think we made a mistake about your eligibility, you can call us to discuss your concerns. Call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220).

### Decisions you can appeal

- Decision that you do not qualify to buy a health plan for yourself or your family through NY State of Health.
- Decision that you do not qualify for federal help paying for a health plan purchased through NY State of Health.
- Decision on how much you must pay for your monthly premium if you applied for financial help.
- Decision that you do not qualify for Medicaid or Child Health Plus.
- Decision on how much money you must pay for Child Health Plus coverage if your children are eligible for this program.

- Decision that you do not meet the rules for signing up for insurance through NY State of Health during a "special enrollment period."

You will find more information on how to ask for an appeal in the "How to Request an Appeal and Additional Information" section at the end of this notice.

## **How to Contact NY State of Health**

Contact us if you have any questions about this Notice. Let us know if you need help applying for or accessing your health insurance coverage.

- **Call:** 1-855-355-5777 (TTY: 1-800-662-1220)
- **Mail:** NY State of Health  
PO Box 11727  
Albany, New York 12211

Sincerely,

**NY State of Health, The Official Health Plan Marketplace**

### **Legal Reference:**

This decision is based on Section 366(1)(b) of the Social Services Law.

Eligibility standards for enrollment through NY State of Health may be found at 45 CFR §155.305.

Applicant has the right to appeal an eligibility determination pursuant to 45 CFR §155.355 and 155.505(b).

We are sending you this notice based on federal regulation 45 CFR §155.310(g).

## **How to Request an Appeal and Additional Information**

An appeal is your request to NY State of Health to review and change a decision we have made about your eligibility.

### **How and When to Ask for an Appeal**

You can request an appeal by doing one of these things:

- Call us at 1-855-355-5777 (TTY: 1-800-662-1220).
- Mail your request to: NY State of Health, PO Box 11729, Albany, NY 12211.
- Fax your request to 1-855-900-5557.

You have 60 calendar days from the date on this notice to ask for an appeal. You will receive a letter from NY State of Health saying that we received your request. We will send you a letter telling you the date and time of your appeal hearing.

### **Asking for Aid to Continue**

You can ask for Aid to Continue to keep your current coverage while you go through the appeals process. You must ask for this when you ask for an appeal. This means that your current insurance program will continue until a decision is made about your appeal.

If you have Medicaid coverage, we will continue your coverage if you request Aid to Continue within 10 days from the date of this notice OR before the eligibility effective date listed in this notice, whichever is later.

### **The Appeal Hearing**

The hearing is your chance to explain why you disagree with the NY State of Health's decision. A hearing officer will make a decision about your appeal. The hearing officer will not take sides and will not favor you or NY State of Health. The officer will conduct the hearing by phone. Here is what you need to do before, during, and after the hearing.

#### *Before the hearing*

- Look at the documents NY State of Health used to make a decision about your eligibility.
- You can send us information that might help us understand your appeal.
- You can request specific policy materials necessary to help you decide whether to ask for an appeal or to help you prepare for your appeal hearing.
- We may try to resolve your issues through an informal dispute resolution process.

### *During the hearing*

- You can have someone with you during your telephone hearing if you want to. That person can be a friend, relative, lawyer, or other individual. Or you can participate in your hearing on your own.

### *After the hearing*

- The outcome of an appeal could change the eligibility of other people on your account even if they do not ask for an appeal.
- If the appeal is not resolved in your favor, you may be responsible for the cost of the health coverage that you used while your appeal was being processed. Here are some examples of what you may have to do when the appeal is not resolved in your favor:
  - If you received coverage through Medicaid while your appeal is being determined, you may have to pay back the cost of Medicaid benefits you received.
  - If you were enrolled in the Essential Plan or Child Health Plus while your appeal was being determined, you may have to pay back your premium, if you have a premium.
  - If your appeal found that you are not qualified for tax credits, the IRS will reconcile your tax credits when you file your federal tax return, which may result in a tax penalty.

## **HIPAA Privacy Notice**

New York State is committed to protecting your privacy. To learn more about NY State of Health's privacy practices go to [www.nystateofhealth.ny.gov](http://www.nystateofhealth.ny.gov) or call customer service at 1-855-355-5777 (TTY: 1-800-662-1220).

## **Notice of Nondiscrimination Policy**

NY State of Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability in its health program and activities.

NY State of Health also complies with applicable state laws and does not discriminate on the basis of race, color, national origin, creed/religion, sex, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

NY State of Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- TTY through NY Relay Service
- Written information in other formats such as large print, audio, accessible electronic formats and other formats

Provides free language assistance services to people whose primary language is not English, such as:

- Qualified interpreters
- Written information in other languages

If you need these services or for more information, contact 1-855-355-5777 (TTY 1-800-662-1220).

If you believe that NY State of Health has discriminated against you, you may file a complaint by going to: [http://www.health.ny.gov/regulations/discrimination\\_complaints/](http://www.health.ny.gov/regulations/discrimination_complaints/) or by emailing the Diversity Management Office at [DMO@health.ny.gov](mailto:DMO@health.ny.gov).

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 800-368-1019 (TTY 800-537-7697). Complaint forms are available at <https://hhs.gov/ocr/office/file/index.html>.

## 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. Podemos proporcionarle gratuitamente un intérprete en el idioma que habla.

### **繁體中文 (Traditional Chinese)**

這是一份重要文件。如果您在理解這份文件上需要幫助，請撥打電話：1-855-355-5777。我們可為您免費提供一名會講您的語言的口譯人員。

### **简体中文 (Simplified Chinese)**

這是一份重要文件。如果您在理解這份文件上需要幫助，請撥打電話：1-855-355-5777。我們可為您免費提供一名會講您的語言的口譯人員。

### **Русский (Russian)**

Это важный документ. Если вам нужна помощь, чтобы понять его, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить вам переводчика на ваш родной язык.

### **Kreyòl Ayisyen (Haitian Creole)**

Sa a se yon dokiman enpòtan. Si ou bezwen èd pou w konprann li, tanpri rele 1-855-355-5777. Nou ka ba ou yon entèprèt gratis nan lang ou pale a.

### **বাংলা (Bengali)**

এটি একটি গুরুত্বপূর্ণ নথি। যদি এটি বুঝতে আপনার সাহায্যের প্রয়োজন হয় তবে অনুগ্রহ করে 1-855-355-5777 এ কল করুন। আপনি যে ভাষায় কথা বলেন আমরা আপনাকে বিনামূল্যে সে ভাষায় দোভাষী প্রদান করতে পারি।

### **اللغة العربية (Arabic)**

هذه الوثيقة مهمة. وإذا كنت بحاجة إلى مساعدة لفهم الوثيقة، يُرجى الاتصال على الرقم 1-855-355-5777. ويمكننا أن نوفر لك مترجمًا فورًا باللغة التي تتحدثها مجانًا.

### **한국어 (Korean)**

중요 문서입니다. 이해하는 데 도움이 필요하시면, 1-855-355-5777번으로 전화하십시오. 귀하가 사용하는 언어의 무료 통역사를 제공해드릴 수 있습니다.

### **Français (French)**

Ceci est un document important. Si vous avez besoin d'aide pour le comprendre, appelez le 1-855-355-5777. Nous pouvons vous offrir gratuitement les services d'un interprète qui parle votre langue.

### **Polski (Polish)**

Ten dokument jest ważny. Jeśli potrzebuje Pan(i) pomocy w jego zrozumieniu, proszę zadzwonić pod numer 1-855-355-5777. Możemy zapewnić bezpłatne usługi tłumacza w Pana(i) języku.

### **हिन्दी (Hindi)**

यह एक महत्वपूर्ण दस्तावेज है। यदि आपको इसे समझने के लिए सहायता की आवश्यकता हो, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपको आप जो भाषा (हिंदी) बोलते हैं उसमें निःशुल्क दुभाषिया सेवा प्रदान कर सकते हैं।

## **اردو (Urdu)**

یہ اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے میں مدد درکار ہے، تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی زبان میں مفت ترجمان فراہم کر سکتے ہیں۔

## **shqip (Albanian)**

Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, lutemi merrni në telefoni në 1-855-355-5777. Mund t'ju caktojmë një përkthyes pa pagesë, në gjuhën në të cilën ju flisni.

## **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।

## **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.

## **Italiano (Italian)**

Questo è un documento importante. Se ha bisogno di assistenza per capirlo, chiami il numero 1-855-355-5777. Possiamo fornirle gratuitamente un interprete per la lingua da lei parlata.

## **日本語 (Japanese)**

これは重要な書類です。理解するのにアシスタンスが必要な場合は1-855-355-5777までお電話下さい。お客様の話しになる言語の通訳を無料でお付け致します。

## **Ελληνικά (Greek)**

Αυτό είναι ένα σημαντικό έγγραφο. Αν χρειάζεστε βοήθεια με την κατανόησή του, καλέστε στο 1-855-355-5777. Μπορούμε να σας παρέχουμε δωρεάν διερμηνέα στη γλώσσα που μιλάτε.

## **Tagalog (Tagalog)**

Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong upang maunawaan ito, mangyaring tawagan ang 1-855-355-5777. Maaari ka naming bigyan ng isang interpreter ng libre sa (Tagalog) wika na sinasalita mo.

## **Soomaali (Somali)**

Kani waa dokumenti muhiim ah. Haddi aad caawimaad ugu baahantahay fahamkiisa, fadlan wac 1-855-355-5777. Waxaan si bilaash ah kuugu siin karnaa adeeg turjumaan luuqadda aad ku hadasha ah.

## **אידיש (Yiddish)**

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף דאס צו פארשטיין, ביטע רופט 1-855-355-5777. דמיר קענען אייך געבן א דאלמעטשער אומזיסט אינעם שפראך וואס איר רמיר.

## **Kiswahili (Swahili)**

Hii ni hati muhimu. Ikiwa unahitaji msaada wa kuielewa, tafadhali piga simu kwa 1-855-355-5777. Tunaweza kukupa mkalimani bila malipo kwa lugha unayozungumza.

## **Akan kasa (Twi)**

Wei ye nhomaa eho sombo. Se wobe hia mboa de ateasie a, ye sre fre 1-855-355-5777. Ye be tumi ama wo nkyerekyeremuni a yen gye ho hwee wo kasa wo ka mu.