Health Insurance Marketplace

OMB Exempt

Employer Eligibility Appeal Request

Complete this form **within 90 days** of the Marketplace notice stating an employee enrolled in a qualified health plan with advance payments of the premium tax credit and cost-sharing reductions (if applicable) in part because your business didn't offer the employee affordable health coverage that met minimum value requirements. **Please complete and submit a separate form for each employee listed on the notice you're appealing.**

Important: The appeal can only determine if your employee was eligible for help with the costs of coverage through the Marketplace. **The appeal will NOT determine if your organization has to pay the Employer Shared Responsibility Payment.** Only the Internal Revenue Service (IRS), not the Health Insurance Marketplace® or the Marketplace Appeals Center, can determine which employers are subject to the Employer Shared Responsibility Payment as stated under section 4980H of the Internal Revenue Code.

STEP 1 Contact information

Primary Contact

The person listed in this section will serve as the main contact during your appeal.

First name:

Last name:

Title:

Organization (if applicable):

Daytime phone number:

Email:

Mailing address:

Apartment or suite number:

City:

State:

ZIP code:

Secondary Contact (Optional)

This is an additional person who may act on your behalf during the appeal.

First name:

Last name:

Title:

Organization (if applicable):

Daytime phone number:

Email:

Mailing address:

Apartment or suite number:

City:

State:

ZIP code:

STEP 2 Information about the employer that's appealing

Business name:

Employer identification number (EIN):

Daytime phone number:

Email:

Mailing address:

Apartment or suite number:

City:

State:

ZIP code:

STEP 3 Information about the notice you're appealing

Please submit a copy of the Marketplace notice that identifies the employee when you file your appeal.

Notice date (mm/dd/yyyy):

Employee's Application ID# (if available on the notice):

Employee's first name:

Employee's last name:

Employee's mailing address:

Apartment or suite number:

City:

State:

ZIP code:

What Marketplace issued the notice?

- ☐ Access Health CT
- ☐ BeWellNM
- ☐ Connect for Health Colorado
- ☐ CoverME
- ☐ Covered California
- ☐ DC Health Link
- ☐ Get Covered NJ
- ☐ Health Source Rhode Island
- ☐ Kynect
- ☐ MNSure
- ☐ Maryland Health Connection
- ☐ Massachusetts Health Connector
- ☐ New York State of Health
- ☐ Pennie
- ☐ Vermont Health Connect Your
- ☐ Virginia's Insurance Marketplace
- ☐ Your Health Idaho
- ☐ The federally-facilitated Health Insurance Marketplace

STEP 4 Reason for appeal

Why are you appealing the Marketplace determination?

- ☐ This employee was enrolled in employer-sponsored coverage.
- ☐ This employee was enrolled in an individual coverage Health Reimbursement Arrangement (HRA).
- ☐ This employee was offered affordable employer-sponsored coverage which met the minimum value standard.
- ☐ This employee was offered an affordable individual coverage HRA.
- ☐ This employee was eligible for affordable employer-sponsored coverage which met the minimum value standard after the end of a waiting period.
- ☐ This employee was eligible for an affordable individual coverage HRA after the end of a waiting period.

Note: The Marketplace Appeals Center doesn't have the authority to review the following issues:

- The employee listed on the Marketplace notice hasn't worked for your company this year.
- The employee listed on the notice isn't a full-time employee.
- The employee listed on the notice is not your company's employee.
- Your company doesn't have at least 50 employees.

Explain why you think the Marketplace determination is wrong.

Your explanation should include the reason you think this employee shouldn't be eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable).

STEP 5 Submit documents to help your appeal (optional)

You may want to submit documents with your request to help show why you think the Marketplace decision to award advance payments of the premium tax credit and cost-sharing reductions (if applicable) was incorrect. Submit copies, not originals, since your documents won't be returned.

In addition to submitting a copy of the notice you received from the Marketplace, include documents that verify:

- The employee was offered coverage or an individual coverage HRA (for example, a form or letter confirming the employee's election of benefits, an employer-sponsored coverage declaration form or notice, the employee's benefits summary chart, or a letter from the health insurance company stating the employee is enrolled in employer-sponsored coverage)
- The coverage was affordable (for example, a rate sheet of the coverage offered to the employee or a Benefits Summary with effective dates of coverage)
- The lowest cost self-only plan meets the minimum value standard (for example, a Summary of Benefits and Coverage (SBC) Sheet with beginning and end dates of coverage or a report of minimum value certification from an actuary accredited by the American Academy of Actuaries)

For more information about the type of documents you can submit, see the Employer Appeal Document Verification Guide at cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Employer-Initiatives.

STEP 6 Signature

By completing, signing, and dating below, I authorize the Marketplace Appeals Center to perform a review of whether the employer named on this form offered minimum essential coverage through an employer-sponsored plan that's considered affordable with respect to the relevant employee, and meets the minimum value standard.

I understand I may request a copy of my Marketplace appeal record and that certain information about the relevant employee's eligibility determination may or may not be made available to me as described in 45 CFR §155.555(g)(2) and 45 CFR §155.555(h).

By signing this form under penalty of perjury, I declare that I've provided true answers to all the questions that I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

Printed name (First name, Last name)

Signature

Date (mm/dd/yyyy)

STEP 7 How to submit your appeal

Sign the completed form and send your documents either:

- **By Mail:** Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061
- **By Secure Fax:** 1-877-369-0131

For More Help
If you have questions, call the Marketplace Appeals Center at 1-855-231-1751. TTY users can call 711. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET).

Language Assistance
If you need help in a language other than English, call 1-855-231-1751 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users can call 711.

Accessibility
You have the right to get Marketplace information in an accessible format, like large print, braille, or audio. Call the Marketplace Appeals Center at 1-855-231-1751 for more information. TTY users can call 711.

Privacy & Use of Your Information
The Marketplace protects the privacy and security of information about you that you've provided. To view the Privacy Act Statement, go to HealthCare.gov/individual-privacy-act-statement. We're authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152), implementing regulations in 45 CFR part 155, subpart F, and the Social Security Act. For more information about the privacy and security of your information, visit HealthCare.gov/privacy.

Nondiscrimination
The Health Insurance Marketplace doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex (including sexual orientation and gender identity), or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800- 537-7697), visiting hhs.gov/civil-rights/filing-a-complaint/complaint-process, or writing to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.

This product was produced at U.S. taxpayer expense.

This Notice has Important Information. This notice has important information about your Marketplace eligibility appeal. Look for key dates in this notice. You may need to take action by certain deadlines. You have the right to get this information and help in your language at no cost. Call 1-855-231-1751 and tell the agent the language you need and you'll be connected with an interpreter.

العربية (Arabic) هذا الإشعار به معلومات هامة. هذا المعلومات به معلومات هامة عن جاذبيتك للأهلية في السوق. ابحث عن التواريخ الأساسية في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء بحلول مواعيد نهائية معينة. لديك الحق في الحصول على هذا المعلومات والمساعدة بلغتك دون تكلفة. اتصل برقم 1-855-231-1751 وأخبر المندوب باللغة التي تحتاجها وسيتم الاتصال بك بحضور مترجم.

中文 (Chinese) 本通知包含重要資訊。本通知包含與您的 Marketplace 資格申訴相關的重要信息。 **請在此通知中**查找關鍵日期。您可能需要在一定的截止日期前採取行動。您有權免費獲取此資訊及以您的語言提供的幫助。請致電 1-855-231-1751 并將您所需要的語言告訴代理，**會有譯員與您**聯絡。

Français (French) Cet avis contient des informations importantes. Cet avis contient des informations importantes sur l'appel que vous avez fait au sujet de votre admissibilité au Marché de l'assurance santé. Vérifiez les dates clés dans cet avis. Il se peut que vous ayez des démarches à entreprendre avant certaines dates. Vous pouvez obtenir ces informations ainsi que de l'aide dans votre langue gratuitement. Appelez le 1-855-231-1751 et dites à l'agent la langue souhaitée, on vous mettra alors en contact avec un(e) interprète.

Kreyòl (French Creole) Avi sa a gen Enfòmasyon Enpòtan ladan. Avi sa a gen enfòmasyon enpòtan ladan konsènan kontestasyon kalifikasyon pou Mache ou a. Chèche dat kle yo ki nan avi sa a. Ou ka bezwen aji avan sèten dat limit. Ou gen dwa pou jwenn enfòmasyon sa a ak èd nan lang ou gratis. Rele 1-855-231-1751 epi di ajan an ki lang ou bezwen epi y ap mete ou an kontak ak yon entèprèt.

Deutsch (German) Dieser Hinweis enthält wichtige Information. Dieser Hinweis enthält wichtige Informationen bezüglich Ihres Berufung von Anspruchsberechtigung bei Marketplace. Suchen Sie in diesem Hinweis nach den relevanten Daten. Behalten Sie Fristen im Auge. Ein kostenloser Service bei dem Sie Informationen und Hilfe in Ihrer Muttersprache erhalten steht Ihnen unter der Nummer 1-855-231-1751 zur Verfügung. Rufen Sie an und geben Sie Ihre Muttersprache an. Sie werden daraufhin mit einem Dolmetscher verbunden.

ગુજરાતી (Gujarati) આ નોટિસ માં અગત્યની માહિતી છે. આ નોટિસમાં તમારી માર્કેટપ્લેસ અપીલ વિશે અગત્યની માહિતી છે. આ નોટિસમાં રહેલી મહત્વની તારીખો જુઓ. તમારે અમુક ડેડલાઈન્સ સુધીમાં ચોક્કસ પગલાં લેવાની જરૂર પડી શકે છે. તમને કોઈ પણ પ્રકારના ખર્ચા વિના આ માહિતી મેળવવાનો અને તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. 1-855-231-1751 પર કોલ કરો અને એજન્ટને તમને જોઈતી ભાષા વિશે કહો. તમારો સંપર્ક તરત જ એક દુભાષિયા સાથે કરાવવામાં આવશે.

Italiano (Italian) Questo avviso contiene informazioni importanti. Questo avviso contiene informazioni importanti relative all'appello da lei presentato a Marketplace circa la sua idoneità. Cerchi nell'avviso le date chiave: potrebbe esserle richiesto di agire entro certe scadenze. Lei ha diritto a ricevere gratuitamente aiuto e spiegazioni nella sua lingua. Chiami il numero 1-855-231-1751 e dica all'operatore la lingua di cui ha bisogno; l'operatore la metterà in contatto con un interprete.

日本語 (Japanese) 本通知には**重要な情報**が**含まれています。本通知**には、 Marketplace **資格申立**に**関**する重要な**情報**が**含**まれています。**本通知内**の主な日付を確認してください。指定された日付に申立を行う必要があります。あなたは、本情報を取得する**権**利があり、無料の言語**翻訳**サービスを受けることができます。**1-855-231-1751** にお**電話**いただければ、あなたの**国**の言語で話すことができる**通訳者**につながります。

한국어 (Korean) 이 통지에는 중요한 정보가 있습니다. 이 통지에는 마켓플레이스 적격성 항소에 대한 중요한 정보가 있습니다. 이 통지서에서 중요한 날짜를 찾으십시오. 일정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하는 이 정보를 얻고 무료로 언어 도움을 받을 수있는 권리가 있습니다. 1-855-231-1751 로 전화하여 상담원에게 필요한 언어를 알려 주시면 통역사와 연결됩니다.

Polski (Polish) To zawiadomienie zawiera ważne informacje. To zawiadomienie zawiera ważne informacje na temat Państwa odwołania w kwestii kwalifikowalności na Marketplace. Prosimy zwrócić uwagę na kluczowe daty w tym zawiadomieniu. Być może będą Państwo musieli podjąć jakieś działania w określonych terminach. Mają Państwo prawo do uzyskania tej informacji w swoim języku bez ponoszenia dodatkowych kosztów. Prosimy o telefon pod numer 1-855-231-1751, aby porozmawiać z naszym przedstawicielem i powiedzieć, o jaki język chodzi, a zostaniecie Państwo połączeni z tłumaczem.

Português (Portuguese) Este comunicado contém informações importantes. Este comunicado contém informações importantes sobre o seu pedido de notificação de elegibilidade do Marketplace. Procure datas importantes neste aviso. Talvez você precise tomar medidas de acordo com determinados prazos. Você tem o direito de obter essas informações e conseguir ajuda, sem custo algum, no seu próprio idioma. Ligue para 1-855-231-1751 e informe o representante da central de atendimento sobre o idioma do qual necessita para que você seja conectado com um intérprete.

Русский (Russian) В этом уведомлении содержится важная информация. В этом уведомлении содержится важная информация о Вашей апелляции относительно соответствия требованиям системы Marketplace. Найдите важные даты в этом уведомлении. Возможно, Вам нужно предпринять действия к определенному сроку. У Вас есть право получить эту информацию и помощь на Вашем родном языке бесплатно. Позвоните по номеру 1-855-231-1751 и сообщите агенту, какой язык Вам нужен, и Вас соединят с переводчиком.

Español (Spanish) Este Aviso contiene Información Importante. Este aviso tiene información importante acerca de su apelación de elegibilidad del Mercado. Preste atención a las fechas importantes que aparecen en este aviso. Es posible que deba tomar acción dentro de ciertos plazos. Usted tiene derecho a recibir esta información y asistencia en su idioma sin costo alguno. Llame al 1-855-231-1751 e indique al agente el idioma que necesita y lo pondrán en comunicación con un intérprete.

Tagalog (Tagalog) Ang Abisong Ito ay May Mahalagang Impormasyon. Ang abisong ito ay may mahalagang impormasyon tungkol sa apela mo sa pagiging nararapat sa Marketplace. Maghanap ng mga pangunahing petsa sa abisong ito. Maaaring kailanganin mong kumilos bago sumapit ang mga partikular na deadline. May karapatan kang makuha ang impormasyong ito sa wika mo ng wala kang gagastusin. Tumawag sa 1-855-231-1751 at sabihin sa agent ang kailangan mong wika at ikokonekta ka sa tagapagsalin ng wika.

Tiếng Việt (Vietnamese) Thông Báo Này có chứa Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về kháng cáo tính đủ điều kiện của Thị Trường. Tìm những ngày quan trọng trong thông báo này. Quý vị có thể cần phải thực hiện theo thời hạn nhất định. Quý vị có quyền nhận thông tin này và nhận được trợ giúp miễn phí bằng ngôn ngữ của quý vị. Vui lòng gọi số 1-855-231-1751 và báo cho đại l biết ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.