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

Notice of Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014751

[redacted]

Dear [redacted]

On March 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 17, 2016 disenrollment notice, and January 11, 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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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).

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

Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014751

[redacted]

Issues

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

> Did NY State of Health properly determine your enrollment in your Medicaid Managed Care plan ended effective January 31, 2017?
>
> Did NY State of Health properly determine that you were eligible to receive up to $179.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for cost-sharing reductions, effective February 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for the Essential Plan, effective February 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid, effective February 1, 2017?

Procedural History

On April 5, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid effective April 1, 2016.

On April 7, 2016 NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan effective May 1, 2016.

On December 3, 2016, a renewal notice was issued stating it was time to renew your NYSOH coverage. The notice stated you could not enroll in your current health plan for the next coverage year, you must select a different health plan between December 16, 2016 and January 15, 2017 to continue your coverage. The notice stated you no longer qualify for health coverage under Medicaid, Child Health Plus, the Essential Plan, or for tax credits or cost sharing reductions to help pay for coverage. But you do now qualify to buy a health plan at full cost effective February 1, 2017.

On December 17, 2016, a disenrollment notice was issued terminating your Medicaid Managed Care plan effective January 31, 2017.

On January 10, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to $179.00 per month in APTC, effective February 1, 2017.

Also on January 10, 2017, you spoke to NYSOH's Account Review Unit and appealed the determination of APTC effective February 1, 2017.

On January 11, 2017, NYSOH issued a notice of eligibility determination, based on the January 10, 2017 application, stating that you were eligible to receive up to $179.00 in APTC, effective February 1, 2017. That notice also stated that you were not eligible for cost sharing reductions, Medicaid, or the Essential Plan because your income was over the allowable income limits for those programs.

On March 28, 2017, 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 April 12, 2017, to allow you to submit supporting documents.

On April 10, 2017, NYSOH received income documentation in the form of a six-page upload to your NYSOH account and has been marked as Appellant's Exhibit 1. The record is now closed.

Findings of Fact

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

1) You were found eligible for Medicaid effective April 1, 2016 and were enrolled in a Medicaid Managed Care plan effective May 1, 2016.

2) You were disenrolled from your Medicaid Managed Care plan effective January 31, 2017.

3) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

4) You are seeking insurance for yourself.

5) The application that was submitted on January 10, 2017 listed annual household income of $35,000.00, consisting of income you earn from your employment. You testified that this amount was correct.

6) You testified you currently work 27 hours a week at a rate of $25.00 per hour.

7) You testified you are paid weekly.

8) You provided documentation that your monthly income for January 2017 was $3,200.00 (See Appellant's Exhibit 1).

9) Your application states that you will not be taking any deductions on your 2016 tax return.

10) Your application states that you live in [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

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) 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 QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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 (CSR) are available to a person who (1) is eligible to enroll in a QHP 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 QHP (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 federal poverty level (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 2016 FPL, which is $ 11,880.00 for a one-person household (81 Fed. Reg. 4036.).

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/basic-health-program.html).

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)).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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).

Continuous Coverage

Most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage offered through Medicaid Managed Care, even if the adult loses Medicaid eligibility because of any changes or updates they make to their account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage,” and is set based on the start date of the original Medicaid eligibility determination or the date of any subsequent Medicaid eligibility determination based on modified adjusted gross income (*see* 42 CFR § 435.916; NY Social Services Law (NY SSL) § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Legal Analysis

The first issue is whether NYSOH properly disenrolled you from your Medicaid Managed Care plan effective January 31, 2017.

You were originally found eligible for Medicaid effective April 1, 2016. You then enrolled into a Medicaid Managed Care plan with a start date of May 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's December 3, 2016 renewal notice stated could not enroll in your current health plan for the next coverage year, you must select a different health plan between December 16, 2016 and January 15, 2017 to continue your coverage. The notice also stated you no longer qualified for health coverage under Medicaid, Child Health Plus, the Essential Plan, or for tax credits or cost sharing reductions to help pay for coverage. The notice stated you did now qualify to buy a health plan at full cost effective February 1, 2017.

Because there was no timely response to this notice, you were terminated from your Medicaid Managed Care plan effective January 31, 2017.

However, most applicants determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because

of any changes or updates they make to their account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage,” and is set based on the start date of the original Medicaid eligibility determination or the date of any subsequent Medicaid eligibility determination based on modified adjusted gross income.

Since you were determined eligible for Medicaid effective April 1, 2016, your eligibility would continue for 12 months until March 31, 2017 regardless of whether your income increased above the Medicaid limit.

Therefore, NYSOH’s December 17, 2016 disenrollment notice terminating your enrollment in your Medicaid Managed Care plan effective January 31, 2017 is RESCINDED.

Your case is RETURNED to NYSOH to ensure your Medicaid Managed Care plan is reinstated for the months of February, and March 2017.

The second issue is whether NYSOH properly determined that you were eligible for an APTC of up to $179.00 per month, effective February 1, 2017.

The application that was submitted on January 10, 2017 listed an annual household income of $35,000.00 and the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in [redacted] where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $35,000.00 is 294.61% of the 2016 FPL for a one-person household. At 294.61% of the FPL, the expected contribution to the cost of the health insurance premium is 9.50% of income, or $277.08 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 ($456.46 per month) minus your expected contribution ($277.08 per month), which equals $179.38 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $179.00 per month in APTC.

The third issue is whether you were properly found 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 $35,000.00 is 294.61% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The fourth issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan, effective February 1, 2017.

The Essential Plan is 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 $11,880.00 for a one-person household. Since an annual household income of $35,000.00 is 294.61% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fifth issue is whether NYSOH properly determined that you 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. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $35,000.00 is 294.61% of the 2016 FPL, NYSOH properly found you to be 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 documentation of your paystubs from your employer that shows in the month of January 2017 you received $3,200.00

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month. Since the documentation you provided shows that you earned $3,200.00 in January 2017 you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the January 11, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $179.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan it is AFFIRMED in part. However, as discussed above, your Medicaid coverage was to continue based on continuous coverage until March 31, 2017. As a result, the January 11, 2017 eligibility determination notice is MODIFIED to reflect that your eligibility for APTC is effective April 1, 2017 and that you were no longer eligible for Medicaid effective February 1, 2017 but that your coverage through Medicaid would continue until March 31, 2017.

Your case is RETURNED to NYSOH to ensure your Medicaid Managed Care plan enrollment continues through March 31, 2017.

Decision

The December 17, 2016 disenrollment notice is RESCINDED.

The January 11, 2017 eligibility determination notice is AFFIRMED in part.

The January 11, 2017 eligibility determination notice is MODIFIED to reflect that your eligibility for APTC is effective April 1, 2017 and although you were no longer eligible for Medicaid effective February 1, 2017, your coverage would continue until March 31, 2017.

Your case is RETURNED to NYSOH to enroll you into your Medicaid Managed Care plan for the months of February and March 2017.

Effective Date of this Decision: April 21, 2017

How this Decision Affects Your Eligibility

You were eligible for up to $179.00 in APTC effective April 1, 2017.

You were ineligible for cost-sharing reductions.

You were ineligible for the Essential Plan.

You were no longer eligible for Medicaid effective February 1, 2017; however, your coverage should continue until March 31, 2017.

This decision does not affect your current enrollment in a qualified health plan.

If You Disagree with this Decision (Appeal Rights)

This 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 17, 2016 disenrollment notice is RESCINDED.

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).

The January 11, 2017 eligibility determination notice is AFFIRMED in part.

The January 11, 2017 eligibility determination notice is MODIFIED to reflect that your eligibility for APTC is effective April 1, 2017 and although you were no longer eligible for Medicaid effective February 1, 2017, your coverage would continue until March 31, 2017.

Your case is RETURNED to NYSOH to enroll you into your Medicaid Managed Care plan for the months of February and March 2017.

You were eligible for up to $179.00 in APTC effective April 1, 2017.

You were ineligible for cost-sharing reductions.

You were ineligible for the Essential Plan.

You were no longer eligible for Medicaid effective February 1, 2017; however, your coverage would continue until March 31, 2017.

This decision does not affect your current enrollment in a qualified health plan.

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 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 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.

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).