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

Notice of Decision

Decision Date: June 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014942

[redacted]

Dear [redacted]

On April 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 2017 eligibility determination.

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).

nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: June 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014942

[redacted]

Issues

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

> Did NY State of Health properly determine you were eligible to receive up to $151.00 per month in advance payments of the premium tax credit, effective February 1, 2017?
>
> Did NY State of Health properly determine you were not eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine you were not eligible for the Essential Plan?
>
> Did NY State of Health properly determine you were not eligible for Medicaid?

Procedural History

On December 21, 2016, NYSOH received your updated application for financial assistance with health insurance.

On December 22, 2016, NYSOH issued an eligibility determination notice stating you were conditionally eligible for Medicaid, effective December 1, 2016. The notice directed you to provide proof of your income by January 5, 2017 to confirm the information in your application, or you might lose your insurance or receive less help paying for your health coverage.

On January 18, 2017, NYSOH issued an eligibility determination notice, based on your January 17, 2017 updated application, stating you were eligible to receive up to $151.00 in advance payments of the premium tax credit (APTC), effective February 1, 2017. That notice also stated you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid, because your income was over the allowable income limits for those programs.

Also on January 18, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibly determination, insofar as you were not eligible for Medicaid, the Essential Plan, or an increased level of APTC.

On April 20, 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 to allow you to submit supporting documents.

On April 20, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1.

On May 25, 2017, NYSOH Appeals Unit requested additional documentation. You submitted the requested documentation the same day, and it was incorporated into the record as Appellant's Exhibit #2, and the record closed thereafter.

Findings of Fact

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

1) NYSOH received your updated application for financial assistance with health insurance on December 21, 2016. That application indicated you were pregnant with an anticipated due date of [redacted]. That application listed an annual income of $21,840.00.

2) Based on the information in the December 21, 2016 application, NYSOH determined you *conditionally* eligible for Medicaid, effective December 1, 2016, and directed you to submit proof of your income to confirm the information in the application.

3) On January 13, 2017, NYSOH received income documentation consisting of your paystubs ([redacted]).

4) Before NYSOH could verify your income documentation, according to your account, you contacted NYSOH on January 17, 2017 and updated your application by increasing your attested annual income to $37,440.00. You testified this income amount was correct.

5) Based on the information in the January 17, 2017 application, NYSOH determined you eligible for $151.00 in monthly APTC and ineligible for cost-sharing reductions, the Essential Plan, and Medicaid.

6) You testified you are paid biweekly and your paycheck varies, because sometimes you work overtime.

7) You testified the monthly amount of $3,100.00 listed in the January 17, 2017 application was not accurate, and that you make less than that amount monthly.

8) You were directed to submit proof of income received in the month of January 2017.

9) On April 20, 2017, NYSOH Appeals Unit received the following documentation:

    a. Biweekly paystub with pay date January 20, 2017 in the gross amount of $1,365.54.

    b. Biweekly paystub with pay date February 3, 2017 in the gross amount of $1,464.33.

    c. Biweekly paystub with pay date February 17, 2017 in the gross amount of $1,206.39.

10) On May 25, 2017, NYSOH Appeals Unit requested additional documentation. The same day you submitted the following:

    a. Biweekly paystub with pay date January 6, 2017 in the gross amount of $1,578.07.

11) You testified that you expect to file your 2017 taxes with a tax filing status of single. You are currently pregnant and expect to give birth [redacted] and, therefore, you testified you will claim one dependent on your 2017 tax return.

12) You testified you are seeking eligibility for an increased level of financial assistance, because you cannot afford to pay your qualified health plan premiums and deductibles, due to your various monthly personal expenses such as rent.

13) You testified NYSOH should use your net income rather than your gross income in determining your eligibility because you do not actually receive the gross amount.

14) Your application states you will not be taking any deductions on your 2017 tax return.

15) Your application states that you live in Suffolk County.

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

Applicable Law and Regulations

Household Composition

For purposes of APTC and cost-sharing reductions, the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

For purposes of Medicaid eligibility, however, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Advance Payments of the 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 300% but less than 400% of the 2016 FPL, the expected contribution is 9.6% 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 $16,020.00 for a two-person household (81 Fed. Reg. 4036.).

Medicaid for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

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 $16,020.00 for a two-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).

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 finds from time 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.

Legal Analysis

The first issue is whether NYSOH properly determined you were eligible for an APTC of up to $151.00 per month.

According to your account, you contacted NYSOH on January 17, 2017 to update the income information listed on your application, and an updated application was submitted on your behalf that day. That application listed an annual household income of $37,440.00. You testified this income amount was correct and the eligibility determination relied upon that information.

During the hearing, although you testified that the income amount in your application was correct, you also testified that NYSOH should use your net income rather than your gross income when calculating your eligibility for financial assistance, because you do not actually receive the gross income amount. Pursuant to the above cited regulations, NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code. 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.

Additionally, you testified that your living expenses make paying for health insurance impossible and, therefore, such expenses should be considered in the calculation of your eligibility. However, 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 APTC purposes. Therefore, NYSOH correctly determined your household income to be $37,440.00.

According to your application, you expect to file your 2017 income taxes with a tax filing status of single. Although you testified you are currently pregnant and expect to deliver in July 2017 and, therefore, you will claim your child as a dependent on your 2017 tax return, pursuant to above cited regulations, for purposes of APTC and cost-sharing reductions, the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year. At the time of the application you were still pregnant and, therefore, you would not be allowed a deduction under 26 USC § 151 for your unborn child. Therefore, for the purposes of calculating your eligibility for APTC and cost-sharing reductions, you are in a one-person household. It is noted your application indicates you will claim no dependents.

According to your account, you reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs $453.37 per month.

An annual income of $37,440.00 is 315.15% of the 2016 FPL for a one-person household. At 315.15% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $302.33 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 ($453.37 per month) minus your expected contribution ($302.33 per month), which equals $151.14 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $151.00 per month in APTC based on your annual household income.

The second 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 $37,440.00 is 315.15% of the applicable FPL for a one-person household, 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 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. Due to your pregnancy on the date of your application you are considered to be in a two-person household for the purposes of calculating your eligibility for enrollment in the Essential Plan. On the date of your application the relevant FPL was $16,020.00 for a two-person household. Since an annual household income of $37,440.00 is 233.71% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size. Pursuant to the above cited regulations, due to your pregnancy at the time of the application, you are considered to be in a two-person household for the purposes of calculating your eligibility for Medicaid. On the date of your application, the relevant FPL was $16,020.00 for a two-person household. Since $37,440.00 is 233.71% of the applicable 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 testified that the monthly income limit of $3,100.00 listed in your January 17, 2017 application was not accurate and that you make less than that amount monthly. Accordingly, you were directed to submit documentation evidencing the amount of income you received in January 2017. You submitted two biweekly paystubs with pay dates in the month of January 2017 in the gross amount of $1,578.07 and $1,365.54. Accordingly, the evidence establishes you received gross income totaling $2,943.61 in the month of January 2017.

To be eligible for Medicaid on a monthly basis, you would need to meet the non-financial criteria and have an income no greater than 223% of the applicable FPL for a two-person household, which is $2,978.00 per month.

Since the documentation you provided shows that you earned $2,943.61 in gross income in the month of January 2017, which is less than the allowable limit of $2,978.00, it appears that you qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the January 18, 2017 eligibility determination eligibility determination stated that you did not qualify for Medicaid on the basis of your income, it is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of the date of your January 17, 2017 application, based on a two-person household (because of your pregnancy) in Suffolk County, with household income of $2,943.61 in January 2017.

Decision

The January 18, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of the date of your January 17, 2017 application, based on a two-person household (because of your pregnancy) in Suffolk County, with household income of $2,943.61 in January 2017.

Effective Date of this Decision: June 7, 2017

How this Decision Affects Your Eligibility

You will receive an updated eligibility determination from NYSOH in accordance with this decision.

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 January 18, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of the date of your January 17, 2017 application, based on a two-person household (because of your pregnancy) in Suffolk County, with household income of $2,943.61 in January 2017.

You will receive an updated eligibility determination from NYSOH in accordance with this decision.

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)

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).

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।

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)

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).

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).