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

Notice of Decision

Decision Date: September 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018274

[redacted]

Dear [redacted],

On August 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 14, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: September 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018274

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $277.00 per month in advance payments of the premium tax credit (APTC), effective May 1, 2017, and then $303.00 per month in APTC, effective June 1, 2017?
>
> Did NYSOH properly determine that you were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On April 4, 2017, you submitted an updated application for financial assistance with health insurance and attested to no income.

On April 5, 2017, NYSOH issued a notice informing you that the income information you attested to in your application did not match the information received from state and federal data sources. You were directed to provide additional information in the form of income documentation by April 19, 2017 to confirm your eligibility for financial assistance.

On April 7, 2017, a copy of your 2016 Form 1040 U.S. Individual Income Tax Return was uploaded to your NYSOH account (*see* Document [redacted]). Your income was verified by NYSOH on April 13, 2017.

On April 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $277.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective May 1, 2017. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your income of $27,952.00 was over the allowable income threshold for each of these programs.

On April 21, 2017, you spoke to NYSOH's Account Review Unit and appealed your eligibility for financial assistance.

On April 22, 2017 and May 4, 2017, NYSOH issued notices informing you that the income information in your application did not match the information received from state and federal data sources. You were directed to provide additional information in the form of income documentation by May 6, 2017 and May 18, 2017, respectively, to confirm your eligibility for financial assistance.

On May 8, 2017, NYSOH systematically updated your NYSOH account and adjusted your expected gross income on your application to $25,986.00.

On May 9, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $303.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective June 1, 2017. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your income of $25,986.00 was over the allowable income threshold for each of these programs.

On May 12, 2017, NYSOH issued a plan enrollment notice confirming your selection of a silver-level qualified health plan and start date in that plan as of May 1, 2017. The notice also stated that your monthly APTC of $303.00 would be applied to your premium as of May 1, 2017, leaving you with a premium responsibility of $153.46 per month.

On August 3, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) According to your NYSOH account, you were determined eligible for Medicaid, effective May 1, 2016, and enrolled in a Medicaid Managed Care plan as of July 1, 2016. Your 12 months of Medicaid coverage ended on April 30, 2017.

2) According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

3) You are seeking financial assistance with health insurance for yourself.

4) The application that was submitted on April 4, 2017 listed annual household income of $0.00. The application that was systematically updated on April 13, 2017, listed annual income of $27,952.00.

5) According to your 2016 Form 1040, your adjusted gross income on Line 37 was $25,986.00.

6) You testified that you are unemployed and live off of your savings and mutual fund investments. You further testified that you withdrew approximately $2,000.00 in April 2017 and probably the same amount in May 2017 from your savings.

7) You testified you have no other sources of income.

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

9) Your application states that you live in [redacted], New York.

10) You testified that you want to be redetermined eligible for Medicaid in 2017 because you remain unemployed and have no income.

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 Federal Register 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution in 2017 is between 6.43% and 8.21% 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).

<u>Cost-Sharing Reductions</u>

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).

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 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

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

Initially, it is noted that you testified to being unemployed and having no income. However, NYSOH uses a Modified Adjusted Gross Income (MAGI) standard to determine household income, which is the equivalent of an individual's adjusted gross income as reported on a federal income tax return. That consists of the amount of earned and unearned income a person expects to receive in a given tax year plus certain other income that is excluded from the adjusted gross income when a person files their tax return.

NYSOH uses attested annual income for the upcoming year when making determinations. Adjusted gross income from a previous year qualifies as attested annual income when an individual does not expect there to be any major change in their income in the current year.

Here, you submitted your 2016 Form 1040, which indicated at Line 37 that you had an adjusted gross income of $25,986.00 that year. Further, you testified that in April 2017, you withdrew from savings and/or investment accounts approximately $2,000.00, and probably withdrew the same or a similar amount in May 2017.

Therefore, your income as reported on your 2016 Form 1040 between Lines 7 and 22 applies in calculating your eligibility for financial assistance.

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $277.00 per month, and then redetermined eligible for APTC of up to $303.00 per month.

The application that was systematically updated on April 13, 2017, listed an annual household income of $27,952.00 and the preliminary eligibility determination of that date relied upon that information.

The application that was systematically updated on May 8, 2017, corrected your annual household income to $25,986.00 and the preliminary eligibility determination of that date relied upon that information.

You expect to file your 2017 income taxes as single and will claim no dependents on that tax return. Therefore, you are in a one-person household for purposes of these analyses.

You reside in New York County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $27,952.00 is 235.29% of the 2016 FPL for a one-person household. At 235.29% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.69% of income, or $179.13 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 ($179.13 per month), which equals $277.33 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $277.00 per month in APTC.

An annual income of $25,986.00, as was systematically updated on May 8, 2017, is 218.74% of the 2016 FPL for a one-person household. At 218.74% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.10% of income, or $153.75 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 ($153.75 per month), which equals $302.71 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $303.00 per month in APTC.

The second issue under review is whether you were properly found eligible 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 $27,952.00 is 235.29% of the applicable FPL and a household income

of $25,986.00 is 218.74% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were eligible 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. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $27,952.00 is 235.29% of the 2016 FPL and an annual household income of $25,986.00 is 218.74% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue under review 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. There is nothing in your NYSOH account to indicate that you would not meet the non-financial requirements such that the issue turns to whether you would meet the financial requirements for Medicaid.

On the date of your application, the relevant FPL for 2017 was $12,060.00 for a one-person household. Since $27,952.00 is 231.77% of the 2017 FPL and $25,986.00 is 215.47% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information in your April 13, 2017 and May 8, 2017 applications.

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 you withdrew approximately $2,000.00 from your savings and/or investment accounts in April 2017 and probably withdrew a similar amount in May 2017. Your testimony is supported by your 2016 Form 1040, which showed you had an adjusted gross income of $25,986.00, which equals $2,165.50 per month.

To be eligible for Medicaid, you would need to have an income no greater than 138% of the FPL, which is $1,387.00 per month. Since the documentation you provided and your testimony indicates that you had income of $2,000.00 to $2,165.50 per month in April 2017 and May 2017, you do not qualify for Medicaid on the basis of monthly income as of the date of your applications.

Since the April 14, 2017 eligibility determination notice stating that you were eligible for $277.00 in APTC per month, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it was correct when made and is AFFIRMED.

Since the May 9, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible respectively for up $303.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Also, the May 12, 2017 plan enrollment notice confirming your enrollment in a silver-level qualified health plan as of May 1, 2017, with monthly APTC of $303.00 applied as of that date, is AFFIRMED.

Decision

The April 14, 2017 and May 9, 2017 eligibility determination notices are AFFIRMED.

The May 12, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: September 1, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to $303.00 in APTC beginning as of May 1, 2017.

You remain eligible for cost-sharing reductions.

You were and remain ineligible for the Essential Plan.

You were and remain ineligible for Medicaid.

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 April 14, 2017 and May 9, 2017 eligibility determination notices are AFFIRMED.

The May 12, 2017 plan enrollment notice is AFFIRMED.

You remain eligible for up to $303.00 in APTC beginning as of May 1, 2017.

You remain eligible for cost-sharing reductions.

You were and remain ineligible for the Essential Plan.

You were and remain ineligible for Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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 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).

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).