



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

## Notice of Decision

Decision Date: November 9, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000021551

[REDACTED]

On October 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 13, 2017 disenrollment and eligibility determination notices and August 17, 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: November 9, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000021551



## Issues

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

Did NY State of Health properly determine that your and your spouse's eligibility for and enrollment in the Essential Plan ended effective August 31, 2017?

Did NY State of Health properly determine that you and your spouse were eligible for up to \$642.00 per month in advanced payments of the premium tax credit, effective October 1, 2017.

Did NY State of Health properly determine that you and your spouse were eligible for cost-sharing reductions?

Did NY State of Health properly determine that you and your spouse were ineligible for the Essential Plan?

## Procedural History

On May 8, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On May 9, 2017, NYSOH issued an eligibility determination stating in part that you and your spouse were eligible for the Essential Plan with a \$20.00 monthly premium for a limited time, effective June 1, 2017. This notice further directed you to submit income documentation to confirm your household income by August 6, 2017.

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On May 23, 2017, NYSOH issued a plan enrollment notice confirming your and your spouse's enrollment in an Essential Plan with a \$20.00 monthly premium, effective June 1, 2017.

No income documentation was received by August 6, 2017.

On August 13, 2017, NYSOH issued an eligibility determination stating that you and your spouse were eligible for qualified health plan at full cost, effective September 1, 2017. This notice stated that this was because NYSOH had not received the requested income documentation to confirm your and your spouse's eligibility within the required time frame.

Also on August 13, 2017, NYSOH issued a disenrollment notice stating that you and your spouse's coverage through your Essential Plan terminated effective August 31, 2017. This notice further stated that this was because you and your spouse were no longer eligible to enroll in the Essential Plan.

On August 16, 2017, NYSOH received your updated application for financial assistance with health insurance.

On August 17, 2017, NYSOH issued an eligibility determination notice stating in part that you and your spouse were eligible to receive up to \$642.00 per month in advanced premium tax credits (APTC) and eligible for cost-sharing reductions if enrolled in a silver-level qualified health plan, effective October 1, 2017.

Also on August 17, 2017, you spoke to NYSOH's Accounts Review Unit and appealed the eligibility determination insofar as you and your spouse were not eligible for the Essential Plan and that your Essential Plan coverage terminated as of August 31, 2017.

On September 6, 2017, NYSOH issued a plan enrollment notice, based on your August 22, 2017 plan selection, confirming your and your spouse's enrollment in a qualified health plan with the application of your APTC effective October 1, 2017.

On October 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was closed at the end of the hearing.

## **Findings of Fact**

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

- 1) Your application indicates that you receive all your notices from NYSOH via regular mail.
- 2) You testified that you did not receive any notice stating that you and your spouse's eligibility was only for a limited time and that you needed to submit income documentation to confirm your and your spouse's eligibility.
- 3) No notices that were sent to the address listed on your NYSOH account have been returned as undeliverable.
- 4) Your NYSOH account indicates that, on August 12, 2017, a system-run application redetermined you and your spouse no longer eligible for the Essential Plan as of August 31, 2017.
- 5) You are only appealing your and your spouse's eligibility.
- 6) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You testified that you will claim two dependents on that tax return.
- 7) The application that was submitted on August 16, 2017 listed your expected annual household income as \$49,000.00; which consists of \$5,000.00 you earn from your self-employment and \$44,000.00 your spouse earns from her employment. You testified that this was correct.
- 8) Your application states that you and your spouse live in [REDACTED]
- 9) You testified that you would like you and your spouse to be found eligible for the Essential Plan.
- 10) You testified that you do not think that you and your spouse should have been disenrolled from your Essential Plan because you were not aware that you had to submit additional documentation.

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

## **Applicable Law and Regulations**

### Verification of Eligibility for the 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

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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).

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 16-17, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>; 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant in order to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

### 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)).

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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 \$ 24,300.00 for a four-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 for 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).

### 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 \$24,000.00 for a three-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)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that your and your spouse's enrollment in and eligibility for the Essential Plan ended effective August 31, 2017.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to his or her household's projected annual income. For individuals seeking enrollment in the Essential Plan, NYSOH must request income data from federal data sources in order to verify an individual's income attestation.



If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on May 9, 2017, you were advised that you and your spouse were eligible for the Essential Plan for a limited time, and that you needed to confirm your and your spouse's household's income before August 6, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to provide income documentation to confirm your eligibility. Your NYSOH account confirms that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, it is concluded that NYSOH properly notified you of an inconsistency in your account and that documentation was needed to confirm the income you listed in the account.

If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine an individual's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation.

Accordingly, your and your spouse's eligibility for and enrollment in your Essential Plan terminated as of August 31, 2017, because you did not submit documentation and did not adequately demonstrate that you could not provide documentation to confirm your income.

Therefore, the August 13, 2017 disenrollment and eligibility determination notices are AFFIRMED.

The second issue under review is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to \$642.00 per month.

The application that was submitted on August 16, 2017 listed an annual household income of \$49,000.00 and the eligibility determination relied upon that information.

You and your spouse are in a four -person household. This is because you expect to file your 2017 income taxes as married filing jointly and will claim two dependents on that tax return.

You reside in Nassau County, where the second lowest cost silver plan available for a couple through NYSOH costs \$906.77 per month.

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An annual income of \$49,000.00 is 201.65% of the 2016 FPL for a four-person household. At 201.65% of the FPL, the expected contribution to the cost of the health insurance premium for 2017 is 6.49% of an appellant's income, or \$265.01 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 a couple in your county (\$906.77 per month) minus your expected contribution (\$265.01 per month), which equals \$641.76 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to \$642.00 per month in APTC, based on the information provided in your application.

The third issue under review is whether you and your spouse 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 \$49,000.00 is 201.65% of the applicable FPL, NYSOH correctly found you and your spouse to be eligible for cost sharing reductions, based on the information provided in your application.

The fourth issue under review is whether NYSOH properly determined that you and your spouse 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. On the date of your application, the relevant FPL was \$24,300.00 for a four -person household. Since an annual household income of \$49,000.00 is 201.65% of the 2016 FPL, NYSOH properly found you and your spouse to be ineligible for the Essential Plan, based on the information provided in your application.

Since the August 17,2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible for up to \$642.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

## **Decision**

The August 13, 2017 disenrollment notice is AFFIRMED.

The August 13, 2017 eligibility determination is AFFIRMED.

The August 17, 2017 eligibility determination is AFFIRMED.

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).

**Effective Date of this Decision:** November 9, 2017

## **How this Decision Affects Your Eligibility**

NYSOH properly found you and your spouse to be ineligible to enroll in the Essential Plan, effective August 31, 2017, because you did not provide documentation of your household's income by the due date.

NYSOH properly determined that you and your spouse were eligible for up to \$642.00 per month in APTC.

NYSOH properly determined that you and your spouse were eligible for cost-sharing reductions.

NYSOH properly determined that you and your spouse were ineligible for the Essential 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

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- 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 August 13, 2017 disenrollment notice is AFFIRMED.

The August 13, 2017 eligibility determination is AFFIRMED.

NYSOH properly found you and your spouse to be ineligible to enroll in the Essential Plan, effective August 31, 2017, because you did not provide documentation of your household's income by the due date.

The August 17, 2017 eligibility determination is AFFIRMED.

NYSOH properly determined that you and your spouse were eligible for up to \$642.00 per month in APTC.

NYSOH properly determined that you and your spouse were eligible for cost-sharing reductions.

NYSOH properly determined that you and your spouse were ineligible for the Essential Plan.

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## **Legal Authority**

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**A Copy of this Decision Has Been Provided To:**



## **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)**

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## **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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

## **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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

## **(Urdu) اردو**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.

## **שׂוֹדִישׁ (Yiddish)**

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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.

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