



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

### Notice of Decision

Decision Date: December 20, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022830



Dear [REDACTED]

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 15, 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: December 20, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022830



## Issues

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

Does NY State of Health have the authority to determine whether the cost of your full price qualified health plan premium is too high?

Did NY State of Health properly determine that you were not eligible for advance payments of the premium tax credit, effective October 1, 2017?

Did NY State of Health properly determine that 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 that you were not eligible for Medicaid?

## Procedural History

On September 15, 2017, NY State of Health (NYSOH) issued an eligibility determination notice, based on your September 14, 2017 updated application, stating in part that you were not eligible to receive advance payments of the premium tax credit (APTC) and not eligible to receive cost-sharing reductions, effective October 1, 2017. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your income was over the allowable income limit for those programs.

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On September 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your financial assistance.

On November 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to include an appeal of the cost of health insurance premiums was granted and testimony was received. The record was developed during the hearing and held open to December 13, 2017, to allow you to submit supporting documents.

On December 6, 2017 and December 7, 2017, you submitted four paystubs. These documents were made part of the record as "Appellant's Exhibit A" and "Appellant's Exhibit B."

No further documentation was received as of December 13, 2017, and the record closed that day.

## **Findings of Fact**

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

- 1) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim one dependent on that tax return.
- 2) You are seeking health insurance for yourself.
- 3) You testified that the cost of the health plan premiums is too high and that a bronze level qualified health plan will cost you approximately \$400.00 per month. You would like NYSOH to offer reduced and more affordable health plan premiums.
- 4) The application that was submitted on September 14, 2017 listed annual household income of \$63,700.00 in earnings from your employment. You testified that you have never earned more than \$60,000.00 in a year.
- 5) You testified that your monthly income for September 2017 was over \$5,000.00.
- 6) Your submitted documentation included paystubs dated November 10, 2017 through December 1, 2017. The necessary parts of these documents were illegible, therefore your expected 2017 modified adjusted gross income could not be determined by them (see Appellant's Exhibit A and Appellant's Exhibit B).
- 7) According to your NYSOH account and your testimony, you will not be taking any deductions on your 2017 tax return.

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- 8) According to your NYSOH account and your testimony, you live in Bronx County, New York.
- 9) You testified that you have bills including rent, clothing, and food that you think should be deducted from your household income before your eligibility is determined.

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

## **Applicable Law and Regulations**

### Appealable Issues

An applicant has the right to appeal to the Appeals Unit of NYSOH: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, and (4) a failure by NYSOH to provide timely notice of an eligibility determination (45 CFR § 155.505).

### 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 funds 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.

### 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

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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 \$16,020.00 for a two-person household (81 Federal Register 4036.).

For annual household income in the range of at least 300 % but less than 400 % of the 2016 FPL, the expected contribution in 2017 is 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 \$16,020.00 for a two-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 \$16,240.00 for a two-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).

## **Legal Analysis**

The first issue under review is whether NYSOH has the authority to determine whether the cost of your full price qualified health plan premium is too high.

You testified that the cost of the health plan premiums is too high and that a bronze level qualified plan will cost you approximately \$400.00 per month. You would like to appeal the cost of the premiums so you can find something more affordable.

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Your appeal was amended to include a request to dispute the qualified health plan premium amounts charged by the health plans. This issue relates to the cost of premiums for full rate premiums agreed upon by your health plan and New York State, which is not an issue that the Appeals Unit is authorized to address.

Since the NYSOH Appeals Unit is not given the authority to review the costs of health plan premiums, we cannot reach the merits as to whether those premiums are too high. Therefore, your request to appeal the cost of qualified health plans offered by NYSOH is **DISMISSED** as a non-appealable issue.

The second issue under review is whether NYSOH properly determined that you were not eligible for APTC.

The application that was submitted on September 14, 2017 listed an annual household income of \$63,700.00 and the eligibility determination relied upon that information. During the hearing, you testified that you have never earned more than \$60,000.00 in a year and that your current expenses, which include rent,



food, clothing and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, clothing, food, or other living expenses 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.

However, because you testified that you have never earned more than \$60,000.00 in a year, the Hearing Officer left the record open to allow you time to submit documentary proof that your modified adjusted gross income was less than what was reported in your application. Although you did submit four paystubs, because the necessary parts of these documents were illegible, your expected 2017 modified adjusted gross income could not be determined. Therefore, the 2017 annual income attested to in your September 14, 2017 application reflects the best evidence in this matter and for purposes of this analysis, your expected 2017 modified adjusted gross income remains at \$63,700.00.

You are in a two-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as head of household and will claim - one dependent on that tax return.

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

An annual income of \$63,700.00 is 397.63% of the 2016 FPL for a two-person household. At 397.63% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 9.69% of income, or \$514.38 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 (\$514.38 per month), which equals - \$57.92 per month. Since your expected contribution is higher than the lowest cost silver plan available, NYSOH correctly determined you to not be eligible to receive APTC.

The third issue under review is whether NYSOH properly determined that you were not 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 \$63,700.00 is 397.63% 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.

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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 \$16,020.00 for a two-person household. Since an annual household income of \$63,700.00 is 397.63% of the 2016 FPL, NYSOH properly found you to not be eligible for the Essential Plan.

The fifth issue under review is whether NYSOH properly determined that you were not eligible 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 \$16,240.00 for a two-person household. Since \$63,700.00 is 392.24% of the 2017 FPL, NYSOH properly found you to be not eligible 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 you received approximately \$5,000.00 in employment income in September 2017.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the 2017 FPL, which is \$1,868.00 per month. Since you testified that you earned approximately \$5,000.00 in September 2017 and there is no evidence to the contrary, it is concluded that your testimony is credible. Since \$5,000.00 monthly income exceeds the maximum allowable income limit of \$1,868.00 to be eligible for Medicaid, NYSOH properly determined that you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the September 15, 2017 eligibility determination notice properly stated that, based on the information you provided, you were not eligible to receive APTC, and not eligible for cost-sharing reductions, the Essential Plan, or Medicaid, it is correct and is AFFIRMED.

## **Decision**

Your request to have NYSOH review the cost of health care premiums is DISMISSED as a non-appealable issue.

The September 15, 2017 eligibility determination notice 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:** December 20, 2017

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

Your current eligibility does not change.

You remain ineligible for APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are 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 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 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**

Your request to have NYSOH review the costs of health care premiums is **DISMISSED** as a non-appealable issue.

The September 15, 2017 eligibility determination notice is **AFFIRMED**.

Your current eligibility does not change.

You remain ineligible for APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

You may apply for financial assistance for the 2018 insurance year by contacting NYSOH at 1-855-355-5777 or by going online to [www.nystateofhealth.ny.gov](http://www.nystateofhealth.ny.gov). A list of local certified assistance counselors or navigators can be provided to help you choose a health plan.

## **Legal Authority**

We are sending you this notice in accordance with 45 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).

**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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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 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 bɛtumi ama wo obi a okyerɛ 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.

### **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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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