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

Notice of Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026751

[redacted]

Dear [redacted]

On April 17, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 3, 2018 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026751

[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 you and your spouse were eligible to receive up to $482.00 in advance premium tax credits and your children were eligible for Child Health Plus with a $30.00 monthly premium, and not eligible for Medicaid, effective February 1, 2018?

Procedural History

On December 28, 2017, an updated application for financial assistance with health insurance was submitted on behalf of you and your family.

On December 29, 2017, NYSOH issue a notice stating you, your spouse, and your children were conditionally eligible for Medicaid, effective February 1, 2018. The notice directed you to submit proof of your household income by January 12, 2018 to confirm your family's eligibility or you might lose your insurance or receive less help paying for your coverage.

Also on December 29, 2017, NYSOH issued an enrollment notice confirming your family's enrollment in Medicaid Managed Care plans, effective February 1, 2018.

On January 2, 2018, NYSOH systematically redetermined the eligibility of your family.

On January 3, 2018, NYSOH issued an eligibility determination notice stating you and your spouse were eligible to receive up to $482.00 per month in advance payment of the premium tax credit (APTC), effective February 1, 2018. The notice further stated your children were eligible for Child Health Plus (CHP) with a $30.00 monthly premium, effective February 1, 2018.

Also on January 3, 2018, NYSOH issue a disenrollment notice stating your family's Medicaid Managed Care plan enrollments were terminated, effective February 1, 2018, because you were no longer eligible to enroll in those plans.

On January 4, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you and your family were no longer eligible for Medicaid.

On January 18, 2018, NYSOH issued an eligibility determination notice stating you and your family had been granted Aid to Continue in your Medicaid coverage pending the decision in your appeal. You and your family were reenrolled in your Medicaid Managed Care plans, effective February 1, 2018.

On April 17, 2018, 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 time to submit supporting documents.

On April 30, 2018, additional documentation was uploaded to your NYSOH account and incorporated into the record as Appellant's Exhibit #1. The record closed thereafter.

Findings of Fact

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

1) You, your spouse, and your children were determined eligible for Medicaid, effective February 1, 2017, following a January 23, 2017 application listing your annual expected household income for 2017 as $13,911.00.

2) On December 2, 2017, NYSOH automatically redetermined your family's eligibility for 2018 coverage, based on income information received from state and federal data sources. You and your spouse were found eligible for $704.10 in APTC and your children were found eligible for CHP with a 9.00 monthly premium, all effective February 1, 2018.

3) Subsequently, there were several updated applications submitted on behalf of you and your family in December 2017. Those applications

attested to expected household income for 2018 in amounts ranging from -$21,400.00 to $74,000.00.

4) The final application submitted in December 2017, on December 28, 2017, indicated you would file your 2018 tax return with a tax filing status of married and filing jointly and you would claim three dependents. You testified that information was accurate.

5) The December 28, 2017 application indicted that your spouse and children have no expected income for 2018 and attested to annual income of $33,727.16 for you.

6) The application indicated you would take a student loan interest deduction on your 2018 tax return in the amount of $2,040.00. You testified that information was accurate.

7) According to your account, NYSOH was unable to verify the income information in your application. You and your family were determined conditionally eligible for Medicaid, effective February 1, 2018, pending documentation of your income to confirm your family's eligibility.

8) On January 2, 2018, NYSOH received a biweekly paystub for you for a pay check dated December 29, 2017 showing gross biweekly earnings of $2,736.48 and year to date gross earnings of $77,963.94.

9) The paystub also showed previous deductions for [redacted]" and "[redacted]" excluded from taxable wages. There were no such deductions in the December 29, 2017 paystub.

10) According to your account, on January 2, 2018, NYSOH recalculated your annual income as $79,804.10 ($81,844.00 minus a $2,040.00 deduction for student loan interest), based on the average biweekly income in the paystubs submitted on December 2017 and January 2018.

11) NYSOH redetermined the eligibility of your family based on the recalculated income and found you and your spouse eligible for $482.00 in APTC and your children eligible for CHP with a $30.00 monthly premium, each, effective February 1, 2018.

12) You and your family were disenrolled from your Medicaid Managed Care plans, effective February 1, 2018.

13) You appealed insofar as you and your family were no longer eligible for Medicaid.

14) You and your family were granted Aid to Continue in your Medicaid coverage pending the decision in your appeal.

15) You testified that you are a [redacted] and that your biweekly pay varies with the number of hours you work.

16) You testified that you entered into a new employment contract in January 2018, but that contract was subsequently cancelled due to lack of available work. You testified that as a result, you did not work or earn income for a portion of February 2018.

17) You testified that you do not agree with NYSOH's $79,804.10 calculation of your expected annual income for 2018.

18) You testified that you only expect to earn between $60,000.00 and $65,000.00 for 2018, because you did not earn any income for a portion of February 2018 and you will not be traveling to [redacted] to work in 2018 as you did in 2017.

19) You testified that aside from your hourly wages, you also receive a stipend for travel, meals, and incidental costs. You testified that the stipend is only deducted from your taxable income when you travel more than 50 miles from your home base.

20) You testified that you cannot afford to pay for health insurance premiums, because you have various personal expenses such as housing, utilities, insurance, and property taxes. You testified these expenses should be considered when determining your ability to pay for health insurance.

21) On April 30, 2018, you uploaded recent paystubs to your NYSOH account, including a paystub for a pay date of April 20, 2018. That paystub showed gross biweekly taxable earnings of $1,314.23, year to date gross earnings of $21,550.14, and no year to date deductions from taxable wages.

22) According to your account, you and your family reside in Nassau County.

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

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is $28,780.00 for a five-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.43% and 8.10% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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 are available to a person who (1) is eligible to enroll in a qualified health plan 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 qualified health plan (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 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 2017 FPL, which is $28,780.00 for a five-person household (82 Fed. Reg. 8831).

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/downloads/ny-blueprint.pdf).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage; therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise

eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2018 FPL, which is $29,420.00 for a five-person household (83 Fed. Reg. 2642).

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 (*id*.).

Legal Analysis

The issue is whether NYSOH properly determined properly you and your spouse were eligible to receive up to $482.00 in APTC and your children were eligible for CHP with a $30.00 monthly premium, and not eligible for Medicaid, effective February 1, 2018.

On December 29, 2017, you and your family were determined conditionally eligible for Medicaid, effective February 1, 2018, following a December 28, 2017 application wherein you attested to annual expected income for 2018 of

$33,727.16, including a $2,040.00 deduction for student loan interest. You were directed to submit proof of your income to confirm your family's eligibility.

According to your account, on January 2, 2018, NYSOH recalculated your annual income for 2018 as $81,844.00, based on the average gross biweekly income amount in the December 2017 paystubs you submitted. NYSOH redetermined your family's eligibility based on an annual expected income of $79,804.10, the $81,844.00 recalculated annual income amount minus the $2,040.00 student loan interest deduction attested to in your application. NYSOH found you and your spouse eligible to receive up to $428.00 in APTC and your children eligible for CHP with a $30.00 monthly premium, each, effective February 1, 2018. You appealed insofar as you and your family were no longer eligible for Medicaid.

You testified that you do not agree with NYSOH's calculation of your expected income for 2018. You testified that you will file your 2018 tax return with a tax filing status of married filing jointly and you would claim your three children as dependents. You further testified that you are the only member of your household with expected income for 2018.

You testified that you are a [redacted] and that your biweekly pay varies with the number of hours you work. You testified you expect to earn between $60,000.00 and $65,000.00 in 2018, less than you did in 2017, because you did not earn income for a portion of February 2018 and you will not be traveling to [redacted] to work in 2018 as you did in 2017.

On April 30, 2018, you uploaded recent paystubs to your NYSOH account, including a paystub for a pay date of April 20, 2018. That paystub showed gross biweekly taxable earnings of $1,314.23, year to date gross earnings of $21,550.14, and no year to date deductions from taxable wages. Based on the evidence establishing that your biweekly earnings vary with the number of hours you work and your testimony that you did not earn income for a portion of February 2018, it is concluded that your year to date income, rather than your average biweekly earnings, is the best indicator of your annual expected income for 2018.

As discussed above, the recent paystubs submitted show that you received $21,550.14 in gross federal taxable income through the first eight pay checks of 2018. Based on that evidence, your average biweekly federal taxable earnings would be $2,693.77 which results in an annual expected income of $70,037.96. Allowing for the $2,040.00 student loan interest deduction you testified you will take on your 2018 tax return, it is concluded that the credible evidence of record supports a finding that your federal taxable income for 2018 will be $67,997.96. Thus, your family's eligibility for financial assistance with health insurance should be redetermined based on that income amount.

It is noted that you testified you have various personal expenses that should be considered when determine your family's eligibility for financial assistance with health insurance. However, according to the above cited regulations, eligibility for financial assistance through NYSOH is based on modified adjusted gross income as defined in the federal tax code. Since 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 NYSOH computes your modified adjusted gross income for APTC purposes.

Therefore, your family's eligibility for financial assistance with health insurance should be based on the record establishing your annual expected household income for 2018 is $67,997.96

Accordingly, based on the above, your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance, based on the evidence establishing you, your spouse, and your children are in a five-person household with expected annual household income for 2018 of $67,997.96.

Decision

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance, based on a five-person household with expected annual household income for 2018 of $67,997.96.

Effective Date of this Decision: May 21, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your family's eligibility.

Your case is being sent back to NYSOH to redetermine your family's eligibility based on the new evidence, in accordance with this decision.

You will receive an updated determination of your family's eligibility.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your

request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance, based on a five-person household with expected annual household income for 2018 of $67,997.96.

This is not a final determination of your family's eligibility.

Your case is being sent back to NYSOH to redetermine your family's eligibility based on the new evidence, in accordance with this decision.

You will receive an updated determination of your family's eligibility.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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)

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).