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

Notice of Decision

Decision Date: May 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029920

[redacted]

Dear [redacted],

On May 7, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 8, 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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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).

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

Decision

Decision Date: May 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029920

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you, your spouse, and your child were eligible to receive up to $1,094.00 per month in advance payments of the premium tax credit, effective April 1, 2018?

Procedural History

On December 4, 2017, you applied for health insurance and financial assistance through NYSOH.

On December 5, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your child were eligible for the Essential Plan for a limited time, effective January 1, 2018. This notice directed you to submit documentation of your household's income by March 4, 2018 in order to confirm your eligibility for financial assistance.

Also on December 5, 2017, NYSOH issued a notice of enrollment confirmation stating that you, your spouse, and your child were enrolled in an Essential Plan with a plan enrollment start date of January 1, 2018.

On February 26, 2018, you faxed income documentation to NYSOH.

On March 7, 2018, your income documentation was uploaded to your NYSOH.

Also on March 7, 2018, NYSOH reviewed the income documentation you submitted, determined that this was insufficient to resolve the inconsistency in your account, updated your and your spouse's income based on this documentation, and submitted an application on your household's behalf.

On March 8, 2018, NYSOH issued an eligibility determination notice stating that you, your spouse, and your child were eligible to receive up to $1,094.00 in advance payments of the premium tax credit (APTC) for a limited time, effective April 1, 2018. That notice also stated that you, your spouse, and your child were not eligible for cost-sharing reductions or the Essential Plan because your annual household income was over the allowable income limits for those programs. This notice further directed you to produce proof of your household income by June 5, 2018 in order to confirm your eligibility for financial assistance.

Also on March 8, 2018, NYSOH issued a disenrollment notice stating that your, your spouse's, and your child's coverage in your Essential Plan would end on March 31, 2018. This was because you, your spouse, and your child were no longer eligible to enroll in the Essential Plan.

Additionally, on March 8, 2018, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional documentation was due by June 5, 2018.

Also on March 8, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you, your spouse, and your child were not eligible for the Essential Plan.

On March 16, 2018, NYSOH issued a notice stating that you, your spouse, and your child were eligible for the Essential Plan for a limited time, effective April 1, 2018. This was because you, your spouse, and your child had been granted Aid to Continue pending the outcome of your appeal.

Also on March 16, 2018, NYSOH issued an enrollment confirmation notice stating that you, your spouse, and your child were enrolled in the Essential Plan, effective April 1, 2018.

On May 7, 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 until May 21, 2018, to allow you time to submit supporting documents.

On May 10, 2018, NYSOH received your supporting documents by fax. The documents were incorporated into the record as Appellant's [redacted] and the record was closed.

Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of married filing jointly. You will claim one dependent, your child, on that tax return.

2) You testified that your child will not file a tax return for 2018.

3) You are seeking insurance for yourself, your spouse, and your child.

4) The application that was submitted on December 4, 2017 listed annual household income of $36,500.00 consisting of wages your spouse earns from his employment.

5) You testified that you were laid off as of November 29, 2017 and began collecting unemployment insurance benefits in December 2017, from which you receive a weekly net benefit of $327.00. You explained that this will be ending in approximately one month. You testified that your only income for 2018 has consisted of unemployment insurance benefits.

6) You testified that your spouse earns commission, and that his pay is considered a draw against commission, so if he does not earn enough commission in a given week to cover his base pay, he is required to pay this back when he does receive commission. You testified that your spouse is paid each Friday.

7) You testified that your child stopped working in the summer of 2017 and recently began working 2 days per week at 7-8 hours per shift in a part time job. You stated that he makes minimum wage and is paid on a biweekly basis. You explained that your child is a full-time student.

8) You testified that on your 2017 tax return you claimed $360.00 in student loan interest deductions. You explained that you believe you will also claim a deduction for student loan interest in 2018, but you are not sure if it will be the same amount as 2018.

9) On February 26, 2018 you faxed income documentation to NYSOH consisting of:

    a. Your 2017 1099-G from the New York State Department of Labor showing that in 2017 you received a gross of $1,122.00 in unemployment insurance benefits;
    b. Four of your spouse's paystubs, the first is for pay date January 26, 2018 for a gross pay amount of $1,196.83; the second is for pay

date February 2, 2018 for a gross pay amount of $725.48; the third is for pay date February 9, 2018 for a gross pay amount of $657.51; the fourth is for pay date February 16, 2018 for a gross pay amount of $666.33 and a gross year to date amount of $6,098.63;

c. A letter signed by yourself indicating that your child is a full-time college student who does not work and does not have any income.

10) On March 7, 2018, NYOSH reviewed the income documentation you submitted and recalculated your annual expected income to be $9,724.00, recalculated your spouse's annual expected income to be $42,342.95, and determined that the income documentation you submitted for your child was insufficient to resolve the income inconsistency in the application.

11) The application that was submitted on March 7, 2018 listed annual household income of $52,066.95, consisting of $374.00 for 26 weeks you would receive in unemployment benefits and $42,342.95 your spouse receives in wages from his employment.

12) You testified that the paystubs you submitted for your spouse did not reflect his typical wages as his commission was uncharacteristically high for some of those paystubs.

13) On May 10, 2018, you submitted additional income documentation consisting of:

a. Your unemployment insurance benefit history which indicates that your claim was effective November 27, 2017, that your weekly benefit is $374.00, and that as of May 8, 2018 you had 16 effective days remaining on your claim;
b. You submitted four of your spouse's paystubs, the first is for pay date April 20, 2018 for a gross pay amount of $737.89; the second is for pay date April 27, 2018 for a gross pay amount of $700.58; the third is for pay date May 5, 2018 for a gross pay amount of $622.84; the fourth is for pay date May 11, 2018 for a gross pay amount of $626.41 and a gross year to date amount of $15,640.70;
c. You submitted your child's first paystub from his new job for pay date April 26, 2018 for a gross pay amount of $250.51 for 19.27 hours worked and a gross year to date amount of $250.51;
d. You submitted a letter dated May 8, 2018 signed by your child stating that his last employment ended [redacted] and he began his current job on [redacted].

14) Your application states, and you confirmed, that you live in Queens 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 $20,420.00 for a three-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.10% and 9.56% 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 $20,420.00 for a three-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)).

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)).

With regard to eligibility for financial assistance through the Marketplace, a tax filer's household income includes the MAGI of all the individuals in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(1)(A)). For the 2018 year, a dependent who had yearly gross earned income greater than $6,500.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2017-58).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The issue under review is whether NYSOH properly determined that you, your spouse, and your child were eligible for up to $1,094.00 per month in APTC.

You expect to file your 2018 income tax return as married filing jointly and will claim your one child as a dependent on that tax return. Therefore, you, your spouse, and your child are in a three-person household.

The application that was submitted on December 4, 2017 listed an annual household income of $36,500.00. Following submission of this application, NYSOH requested that you submit documentation of your household income.

On February 26, 2018 you submitted your 2017 1099-G from the New York State Department of Labor which shows that in 2017 you received $1,122.00 in unemployment insurance benefits, four of your spouse's weekly paystubs, and a letter indicating that your child had stopped working and was not currently employed or receiving any income.

On March 7, 2018, NYSOH verified your and your spouse's income documentation, however, NYSOH determined that the income documentation you had submitted for your child was insufficient, and an application for financial assistance was run on your household's behalf by an NYSOH representative. The NYSOH representative entered into your application unemployment insurance benefit income for you of be $9,724.00, and earned income for your spouse of $42,342.95.

The record reflects that NYSOH calculated your annual expected income based on a weekly unemployment insurance benefit rate of $374.00 for 26 weeks for a total of $9,724.00. However, the documentation you submitted shows that you had already received $1,122.00 in unemployment insurance benefits, therefore your annual expected income for 2018 is only $8,602.00.

The NYSOH representative calculated your spouse's annual expected income to be $42,342.95, however, based on the paystubs that you submitted on February 26, 2018, your spouse's annual expected income as of that time was $42,199.95 (four week gross income of $3,246.15 yields a weekly average of $811.54 multiplied by 52 weeks).

As the income amount that was relied upon in the March 8, 2018 eligibility determination notice is not supported by the record, the eligibility determination is RESCINDED.

You have submitted additional documentation and testimony that shows that your spouse's annual expected income is $34,440.36 (four week gross income of $2,687.72 yields a weekly average of $671.93 multiplied by 52 weeks), and that your child's annual expected income is $7,488.00 ($13.00 per hour multiplied by 16 hours per week for 36 weeks). As noted above, your annual expected income is $8,602.00. You testified to deductions of $360.00. Therefore, your household's annual expected income for 2018 is $50,170.36.

Therefore, based on your testimony as well as the documentation you submitted, your case is RETURNED to NYSOH to redetermine your, your spouse's, and your child's eligibility for financial assistance as of March 7, 2018 based on a

household of three with an annual expected income of $50,170.36 residing in Queens County.

Decision

The March 8, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your, your spouse's, and your child's eligibility for financial assistance as of March 7, 2018 based on a household of three with an annual expected income of $50,170.36 residing in Queens County.

Effective Date of this Decision: May 25, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your, your spouse's, and your child's eligibility.

Your case is being sent back to NYSOH to redetermine your, your spouse's, and your child's eligibility for financial assistance based on the income documentation you submitted and your testimony.

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

The March 8, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your, your spouse's, and your child's eligibility for financial assistance as of March 7, 2018 based on a

household of three with an annual expected income of $50,170.36 residing in Queens County.

This is not a final determination of your, your spouse's, and your child's eligibility.

Your case is being sent back to NYSOH to redetermine your, your spouse's, and your child's eligibility for financial assistance based on the income documentation you submitted and your testimony.

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).