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

Notice of Decision

Decision Date: March 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013190 and AP000000014153

[redacted]

Dear [redacted]

On February 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 11, 2016 and December 6, 2016 eligibility redetermination notices.

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: March 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013190 and AP000000014153

[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 on November 11, 2016, that you were eligible to purchase a qualified health plan at full cost, effective December 1, 2016.
>
> Did NYSOH properly determine on December 6, 2016, that you were eligible to receive up to $308.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2017?
>
> Did NYSOH properly determine on December 6, 2016, that you were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?

Procedural History

Per your NY State of Health (NYSOH) account, you were determined eligible for Medicaid effective December 1, 2015 and were enrolled in a Medicaid Managed Care plan with coverage through August 31, 2016.

On July 19, 2016, NYSOH issued an eligibility redetermination based on your July 18, 2016 updated application that stated that you remained eligible for Medicaid, effective July 1, 2016. This was because your attested household income of $0.00 was less that the allowable income limit for Medicaid.

On July 19, 2016, NYSOH you updated application for health insurance. That day a preliminary eligibility determination was prepared finding you not applying for health care coverage through NYSOH. No eligibility redetermination was issued because of that update.

On July 20, 2016, NYSOH issued a disenrollment notice stating that your Medicaid Managed Care coverage would end effective August 31, 2016. This was because you were no longer eligible to enroll in health insurance through NYSOH.

On July 25, 2016, August 4, 2016, August 5, 2016, August 31, 2016, and September 1, 2016, you updated you NYSOH account and on each occasion stated that you did not need health insurance.

On October 5, 2016, NYSOH received your updated application for health insurance. That day, a preliminary eligibility redetermination was prepared finding you eligible to enroll in a qualified health plan and that you were eligible to receive APTC of up to $240.00 per month, as well as newly eligible to receive cost sharing reductions, effective November 1, 2016. You were further found ineligible for Medicaid. This determination was based on your attested household income of $25,200.00.

On October 7, 2016, NYSOH issued an enrollment confirmation notice based upon your October 6, 2016 bronze-level qualified health plan selection with a plan enrollment start date of November 1, 2016. The notice further stated that your APTC of $240.00 would be applied to your monthly premium effective November 1, 2016.

On October 9, 2016, NYSOH issued an eligibility redetermination notice based on the information contained in your updated October 5, 2016 application, stating that you were eligible for a limited time to enroll in a qualified health plan with APTC of up to $240.00 per month, effective September 1, 2016 and that you were eligible for cost sharing reductions if you selected a silver-level health plan effective November 1, 2016. That notice stated you needed to provide proof of income by January 3, 2017.

On October 27, 2016, NYSOH issued a renewal notice stating that, based on information from federal and state data sources, a decision could not be made about whether you qualified for financial assistance to help pay for your health coverage. You were asked to update the information in your account by

December 15, 2016 or risk losing the financial assistance you were currently receiving.

On November 3, 2016, you uploaded to your NYSOH account a copy of a letter from the Social Security Administration, dated November 2, 2016, regarding your monthly benefits.

On November 10, 2016, NYSOH issued an eligibility redetermination notice, based on your November 9, 2016 updated application, that stated you were eligible for a limited time for APTC of up to $239.00 per and eligible for cost sharing reductions if you selected a silver-level health plan, both effective December 1, 2016. You were further found ineligible for Medicaid. This determination was based on your attested household income of $25,284.00.

On November 10, 2016, NYSOH issued an enrollment confirmation notice based upon your November 9, 2016 silver-level qualified health plan selection with a plan enrollment start date of December 1, 2016. The notice further stated that your APTC of $239.00 would be applied to your monthly premium effective December 1, 2016.

Also on November 10, 2016, NYSOH issued a disenrollment notice stating that your bronze-level qualified health plan would end effective November 30, 2016.

Also on November 10, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to your ineligibility for Medicaid.

On November 11, 2016, NYSOH issued an eligibility redetermination notice, based on your updated November 10, 2016 application, that stated you were newly eligible to purchase a qualified health plan at full cost through NYSOH, effective December 1, 2016. The notice further stated that you were not eligible for Medicaid, Child Health Plus, the Essential Plan or for tax credits and cost sharing reductions. This was because your application stated you did not plan on filing a federal tax return. The notice also stated that NYSOH would send your information to your local Department of Social Services to determine your eligibility for Medicaid on a different basis.

On November 11, 2016, NYSOH issued an enrollment confirmation notice based upon the system update of November 10, 2016 stating that you were enrolled in a silver-level qualified health plan at full cost, effective December 1, 2016.

On December 6, 2016, NYSOH issued an eligibility redetermination notice, based on your December 5, 2016 updated application, that stated you were eligible for a limited time for APTC of up to $308.00 per month and eligible for cost sharing reductions if you selected a silver-level health plan, both effective January 1, 2017. You were further found ineligible for Medicaid or the Essential

Plan because your household income was over the allowable income limits for those programs. This determination was based on your attested household income of $25,284.00.

On December 19, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of December 6, 2016 eligibility determination as it related to your level of APTC and ineligibility for Medicaid.

On February 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) Your application states that you will not be taking any deductions on your 2016 tax return.

3) You testified that you last filed a federal income tax return in 2014 for the 2013 tax year. You testified that you did not think it was necessary to file taxes the last couple of years because of your income level.

4) You are seeking insurance for yourself.

5) Per your NYSOH account and your testimony, you have a disability.

6) Per your NYSOH account and your testimony, your expected household income of $25,284.00 is based on your receiving $2,107.00 each month in Social Security Disability benefits.

7) Per your NYSOH account and your testimony, on November 3, 2016, you uploaded a copy of a letter from Social Security Administration dated, November 2, 2016, which confirmed that you were receiving $2,107.00 per month in disability benefits (see Document [redacted].

8) Per your NYSOH account, on the applications submitted on July 19, 2016, July 25, 2016, August 4, 2016, August 5, 2016 August 31, 2016 and September 1, 2016, you indicated that you did not need health insurance.

9) Per your NYSOH account, the application that you submitted on November 10, 2016 stated that you were not going to be filing income taxes.

10) Per your NYSOH account, your information has been submitted to your local Department of Social Services because you may be eligible for Medicaid on a different basis.

11) You testified that you have high living expenses such as rent, utilities and food. You testified that without Medicaid you will not be able to afford health insurance, even with APTC, because health plans are not affordable.

12) You testified that you do not have any outstanding medical bills but you do have some out of pocket prescription costs.

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

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

Applicable Law and Regulations

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.

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (45 CFR §155.335(h)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b); Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13 ADM-03(III)(F)).

Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

minus

2) the taxpayer's expected contribution amount

(*see* 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 2015 FPL, which is $11,770.00 for a one-person household (80 Federal Register 3236, 3237). For 2017 eligibility determinations, the applicable FPL was from 2016, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution is between 6.41% and 8.18% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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).

NY State of Health may authorize APTC only when it obtains certain necessary attestations from the tax filer, including an attestation that he or she will file an income tax return for the benefit year (45 CFR § 155.310(d)(2)(ii)(A)). A tax filer who is married must generally file a joint return with his or her spouse to qualify for APTC (45 CFR §§ 155.305(f), 155.310(d); 26 CFR § 1.36B-2).

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)).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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).

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), N.Y. Soc. Serv. Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL for 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 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

Affordability Exemption

Under some circumstances, a person may receive an exemption from paying a penalty for not purchasing health insurance coverage. Such an exemption may be granted if that person can show that he or she experienced a financial hardship or has domestic circumstances that (1) caused an unexpected increase in essential expenses that prevented that person from obtaining health coverage under a QHP; (2) would have caused the person to experience serious deprivation of food, shelter, clothing, or other necessities, as a result of the

expense of purchasing health coverage under a QHP; or (3) prevented that person from obtaining coverage under a QHP (45 CFR § 155.605(a), (g)).

NYSOH has deferred to the U.S. Department of Health and Human Services (HHS) on the matter of hardship exemptions (see 45 CFR § 155.505(c)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to purchase a qualified health plan at full cost, effective December 1, 2016, as stated in the November 11, 2016 eligibility redetermination notice.

The application that was submitted on November 10, 2016 listed an annual household income of $25,284.00 and that you did not plan on filing a tax return. The eligibility determination issued on November 11, 2016 relied upon that information.

To be eligible for APTC to help pay for the cost of health insurance during the tax year, a person must attest to planning on filing a tax return. You testified that you have not filed a tax return since 2014 because you thought you were not required to do so. Since your November 10, 2016 application stated that you did not plan on filing a tax return for 2016, NYSOH could not approve an advance premium tax credit as of that time.

Therefore, the November 11, 2016 eligibility redetermination notice stating you were qualified to purchase a qualified health plan at full cost, effective December 1, 2016, is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $308.00 per month, effective January 1, 2017.

The application that was submitted on December 5, 2016 listed an annual household income of $25,284.00 and the eligibility determination relied upon that information. During the hearing, you testified that you live in [redacted] County, New York and have very high living expenses such as rent, utilities and food. You further testified that, even with APTC, health insurance plans are just not affordable for you. Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, and other living expenses 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, the household income amount of $25,284.00 that was used in calculating your eligibility for APTC was correct.

You are in a one-person household for purposes of this analysis. This is because you testified that you now expect to file your 2016 income taxes as single and will

claim no dependents on that tax return. You testified that your only source of income is the $2,107.00 in monthly Social Security Disability benefits that you receive.

You reside in [redacted] County, where the second lowest cost silver plan available for an individual through NYSOH costs $453.36 per month.

An annual income of $25,284.00 is 212.83% of the 2016 FPL for a one-person household. At 212.83% of the FPL, the expected contribution to the cost of the health insurance premium is 6.84% of income, or $144.54 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 ($453.36 per month) minus your expected contribution ($144.54 per month), which equals $308.82 per month. Therefore, rounding down to the nearest dollar, NYSOH correctly determined you to be eligible for up to $308.00 per month in APTC.

The third issue is whether you were properly found eligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $25,284.00 is 212.83% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The fourth issue is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $25,284.00 is 212.83% of the 2016 FPL, NYSOH properly found you to be ineligible 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 submitted a letter from Social Security Administration that shows you received $2,107.00 a month in Social Security Disability benefits each month.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month (138% of $11,880/12 months). Since the documentation you provided shows that

you receive $2,107.00 each month, including during December 2016, you do not qualify for Medicaid based on monthly income as of the date of your application.

In addition, you testified and your NYSOH account confirms that you have a disability. The December 6, 2016 eligibility redetermination states that your eligibility for Medicaid can be determined on a different basis that considers both your income and certain deductions that were not applied by NYSOH. That notice stated that NYSOH will send your information to your local Department of Social Services to determine your eligibility for Medicaid on a difference basis, which NYSOH indicated it had. You can contact your Local DSS office for additional information in this regard.

The final issue is whether NYSOH properly determined that you 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 (MAGI) that is between 138% and 200% of the Federal Poverty Level (FPL) for the applicable family size. On the date of your December 5, 2016 application, the relevant FPL was $11,770.00 for a one-person household. Since an annual household income of $25,284.00 is 214.82% of the 2015 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the December 6, 2016 eligibility redetermination notice properly stated that, based on the information you provided, you were eligible for up to $308.00 per month in APTC, eligible for cost-sharing reductions, ineligible for Medicaid, and ineligible for the Essential Plan, it is correct and must be AFFIRMED.

If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2016 or 2017, you can check the Federal Marketplace website (www.healthcare.gov) for direction.

Decision

The November 11, 2016 eligibility redetermination notice is AFFIRMED.

The December 6, 2016 eligibility redetermination notice is AFFIRMED.

This decision does not affect any subsequent eligible redeterminations made or notices issued by NYSOH.

Effective Date of this Decision: March 30, 2017

How this Decision Affects Your Eligibility

You were eligible for up to $308.00 per month of APTC effective January 1, 2017.

You were eligible for cost-sharing reductions effective January 1, 2017.

You are ineligible for Medicaid.

NYSOH has sent your information to your local Department of Social Services to determine your eligibility for Medicaid on a different basis.

You are 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

- 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 November 11, 2016 eligibility redetermination notice is AFFIRMED.

The December 6, 2016 eligibility redetermination notice is AFFIRMED.

This decision does not affect any subsequent eligible redeterminations made or notices issued by NYSOH.

You were eligible for up to $308.00 per month of APTC effective January 1, 2017.

You were eligible for cost-sharing reductions effective January 1, 2017.

You are ineligible for Medicaid.

NYSOH has sent your information to your local Department of Social Services to determine your eligibility for Medicaid on a different basis.

You are ineligible for the Essential Plan.

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.

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