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

Notice of Decision

Decision Date: June 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015727

[redacted]

Dear [redacted],

On May 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 13, 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 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: June 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015727

[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 that you were disenrolled from your Medicaid Managed Care plan coverage effective October 31, 2016?
>
> Did NYSOH properly determine that you were eligible to enroll in the Essential Plan with a monthly premium of $20.00, effective February 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On November 25, 2015, NYSOH issued an eligibility determination stating that you were eligible for Medicaid effective November 1, 2015. You were then enrolled in a Medicaid Managed Care plan with coverage start date of January 1, 2016.

On September 3, 2016, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not decide whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by October 15, 2016 or you might lose the financial assistance you were currently receiving.

On September 4, 2016, NYSOH issued an eligibility determination notice that stated that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until October 31, 2016 because certain individuals who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined eligible.

No updates were made to your account by October 15, 2016.

On October 17, 2016, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid, Child Health Plus, the Essential Plan or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility would end November 1, 2016.

Also on October 17, 2016, NYSOH issued a disenrollment notice that stated your Medicaid Managed Care plan would end effective October 31, 2016. This was because you did not renew your health insurance coverage and, therefore, were no longer eligible to remain enrolled in health insurance through NYSOH.

On October 24, 2016, NYSOH received your updated application for financial assistance.

On October 25, 2016, NYSOH issued a notice stating that your October 24, 2016 application had been reviewed, and the information in that application did not match the information NYSOH received from state and federal sources. The notice further stated that you needed to provide income documentation by November 8, 2016. The notice warned that if you missed the due date, NYSOH would not be able to determine your eligibility for health coverage.

On November 18, 2016, you uploaded to your NYSOH account five pay advices and a letter from your employer (*see* Documents [redacted], [redacted] and [redacted]).

On December 4, 2016, NYSOH updated your application for financial assistance.

On December 5, 2016, NYSOH issued an eligibility determination notice that stated you were eligible to purchase a qualified health plan (QHP) at full cost effective January 1, 2017. This was because NYSOH had not received the requested information to verify your income by the due date.

On December 9, 2016, NYSOH received your updated application for financial assistance.

On December 10, 2016, NYSOH issued a notice stating that your December 9, 2016 application had been reviewed, and the information in that application did not match the information NYSOH received from state and federal sources. The notice further stated that you needed to provide income documentation by December 24, 2016. The notice warned that if you missed the due date, NYSOH would not be able to determine your eligibility for health coverage.

On December 22, 2016, you uploaded to your NYSOH account four pay advices (*see* Documents [redacted], [redacted], [redacted] and [redacted].

On January 6, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a QHP at full cost effective February 1, 2017. This was because NYSOH did not receive the income documentation needed to verify the income listed in your application.

On January 12, 2017, NYSOH received your updated application for financial assistance.

Also on January 12, 2017, NYSOH reviewed and validated the pay advices that you submitted on November 18, 2016.

On January 13, 2017, NYSOH issued an eligibility determination notice based on the January 12, 2017, updated application, that stated you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017.

On February 10, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the January 13, 2017 eligibility determination insofar as you were not eligible for Medicaid.

On February 17, 2017, NYSOH issued an enrollment notice confirming your February 10, 2017 selection of Essential Plan 1 with a $20.00 per month premium and a plan enrollment start date of March 1, 2017.

On May 18, 2017, 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 June 1, 2017 to allow you to submit your 2016 U.S. Individual Income Tax Return and copies of pay advices for the months of November 2016 and December 2016.

On May 31, 2017, you uploaded to your NYSOH account a copy of your 2016 US Individual Income Tax Return (*see* Document [redacted]). That document was made part of the record as "Appellant's Exhibit # 1." The record is now closed.

Findings of Fact

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

1) You are applying for health insurance for only yourself.

2) According to your NYSOH account, you were found eligible for Medicaid effective November 1, 2015 and were enrolled in a Medicaid Managed Care plan as of January 1, 2016.

3) According to your NYSOH account and your testimony, you receive your notices from NYSOH by regular mail. You testified that you do not recall receiving any notice in September 2016 informing you that you needed to update the information in your NYSOH account for your eligibility to be confirmed.

4) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

5) According to your NYSOH account and your testimony, you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.

6) You testified that you work at [redacted] and your work hours vary by the season.

7) You testified that, after receiving the October 17, 2016 disenrollment notice, you then called NYSOH on October 24, 2016 to update your account.

8) Based on the information you provided in your October 24, 2016 application, NYSOH issued a notice on October 25, 2016 requesting income documentation by November 8, 2016 to confirm that the information contained in your account was accurate.

9) According to your NYSOH account and your testimony, on November 18, 2016, you uploaded five pay advices and a letter from your employer.

10) According to you NYSOH account, on December 4, 2016 without reviewing the pay advices you submitted on November 18, 2016, NYSOH reran your eligibility and you were found eligible to enroll in a QHP at full cost, effective December 1, 2016.

11) According to your NYSOH account, on December 6, 2016, NYSOH reviewed and verified your proof of income, but did not update your account with this income information or rerun your eligibility at this time.

12) According to your NYSOH account, on December 9, 2016 and January 12, 2017, you updated your application for health insurance. On January 12, 2017, NYSOH reviewed and verified the pay advices you submitted on November 18, 2016 and your eligibility was reran based on the updated validated income of $20,132.06. You were found eligible for the Essential Plan with a $20.00 monthly premium effective February 1, 2017.

13) According to your NYSOH account and your testimony, you selected an Essential Plan 1 on February 10, 2017 with an enrollment start date of March 1, 2017.

14) On May 31, 2017, you uploaded a copy of your 2016 Individual income Tax Return. This document reflects an adjusted gross income of $22,280.00 consisting of $21,601.00 in wages and tips and $679.00 in dividends and capital gains (*see* Appellant's Exhibit # 1).

15) You testified that you went to the emergency room in November 2016 and have a large unpaid bill for that medical treatment.

16) You testified that you want to be recertified for Medicaid and that there be no lapse in your Medicaid coverage.

17) Your application states that you live in Orange County, New York.

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

Applicable Law and Regulations

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 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 Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H(6)(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019, NY Social Services Law § 364-j(1)(c); 18 NYCRR § 360-10.3(h)).

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 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

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

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

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).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were disenrolled from your Medicaid coverage as of October 31, 2016.

You were originally found eligible for Medicaid effective November 1, 2015.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months 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. NYSOH's September 3, 2016 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health

insurance, and that you needed to supply additional information by October 15, 2016, or your financial assistance might end.

You testified that you do not recall receiving any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified and your NYSOH account confirms, that you receive notifications by regular mal There is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Because there was no timely response to this notice, you were terminated from your Medicaid Managed Care plan effective October 31, 2016.

Therefore, NYSOH's October 17, 2016 eligibility redetermination and disenrollment notices are AFFIRMED.

The second issued under review is whether NYSOH properly determine that you were eligible to enroll in the Essential Plan with a monthly premium of $20.00, effective February 1, 2017.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

According to your NYSOH account and your testimony, on November 18, 2016, you uploaded five pay advices and a letter from your employer. These documents were reviewed and verified by NYSOH on December 6, 2016 but no further action was taken by NYSOH and your eligibility was not rerun based on this verified information.

You next updated your application for health insurance on December 9, 2016 and January 12, 2017. No determination was made on December 9, 2016 because NYSOH requested additional proof of income. The January 12, 2017 eligibility redetermination was based on the verified income documentation you uploaded to your account on November 18, 2016.

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 FPL for the applicable family size. NYSOH verified your income on December 6, 2016, but took no further action at that time although your application was complete as of that date. No explanation has been provided as to why your eligibility was not run then.

Therefore, this analysis turns to your eligibility as of December 6, 2016, on which date the relevant FPL was $11,770.00 for a one-person household. The annual income that was ascertained on January 12, 2017, based on the income documentation you submitted on November 18, 2016, was calculated to be $20,132.06. Since an annual household income of $20,132.06 is 171.05% of the 2015 FPL as of that date, NYSOH should have determined you eligible for the Essential Plan with a $20.00 monthly premium.

Therefore, had NYSOH properly run your eligibility based on the information contained in your NYSOH account on December 6, 2016 you would have been determined eligible to enroll in the Essential Plan at a $20.00 monthly premium, effective January 1, 2017.

Therefore, the January 6, 2017 and January 13, 2017 eligibility determination notices are MODIFIED to state that you are eligible for the Essential Plan with a $20.00 monthly premium effective January 1, 2017.

NYSOH will assist you, at your option, in enrolling in an Essential Plan with a $20.00 monthly premium, effective January 1, 2017.

You will be responsible for any monthly premiums due.

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

You testified that you had a medical issue that required you to go to the emergency room in November 2016. As your Medicaid Managed Care plan ended effective October 31, 2016, that emergency room bill remains unpaid and you requested your eligibility for Medicaid redetermined for the month of November 2016.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter if that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual’s initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking Medicaid from November 1, 2016 through November 30, 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in November 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during November 2016.

On November 18, 2016 and December 22, 2016, you submitted a total of nine pay advices for various months in November 2016 and December2016. Also, the Hearing Officer held the record open until June 1, 2017, for you to submit a copy of your 2016 US Individual Income Tax Return and copies of all pay advices you received for the months of November and December 2016.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the 2016 FPL, which is $1,367.00 per month. Your 2016 US Individual Income Tax Return indicates that your adjusted gross income for 2016 was $22,280.00. Since your tax return indicates that on a monthly basis ($22,280.00/12 months), you would have earned an average of $1,856.67 in income per month, which exceeds the maximum allowable monthly income limit of $1,367.00. Therefore, you do not qualify for Medicaid based on monthly income in November 2016.

Decision

The October 17, 2016 eligibility redetermination notice is AFFIRMED.

The October 17, 2016 disenrollment notice is AFFIRMED.

The January 6, 2017 and January 13, 2017 eligibility redeterminations are MODIFIED to state that you are eligible for the Essential Plan with a $20.00 monthly premium effective January 1, 2017.

Your case is RETURNED to NYSOH to assist you, at your option, in enrolling in an Essential Plan 1 with a $20.00 monthly premium effective January 1, 2017.

Effective Date of this Decision: June 16, 2017

How this Decision Affects Your Eligibility

Your Medicaid Managed Care plan ended effective October 31, 2016.

You do not qualify for Medicaid based on monthly income in November 2016, and did not have health insurance coverage through NYSOH that month.

By this Decision, you are determined to be fully eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2017.

Your case is RETURNED to NYSOH to assist you, at your option, in enrolling in an Essential Plan 1 with a $20.00 monthly premium effective January 1, 2017.

You will be responsible for any monthly premiums due.

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 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 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 October 17, 2016 eligibility redetermination notice is AFFIRMED.

The October 17, 2016 disenrollment notice is AFFIRMED.

The January 6, 2017 and January 13, 2017 eligibility redeterminations are MODIFIED to state that you are eligible for the Essential Plan with a $20.00 monthly premium effective January 1, 2017.

Your case is RETURNED to NYSOH to assist you, at your option, in enrolling in an Essential Plan 1 with a $20.00 monthly premium effective January 1, 2017.

Your Medicaid Managed Care plan ended effective October 31, 2016.

You do not qualify for Medicaid based on monthly income in November 2016, and did not have health insurance coverage through NYSOH that month.

By this Decision, you are determined to be fully eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2017.

Your case is RETURNED to NYSOH to assist you, at your option, in enrolling in an Essential Plan 1 with a $20.00 monthly premium effective January 1, 2017.

You will be responsible for any monthly premiums due.

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:

[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 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 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).