



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

## Notice of Decision

Decision Date: November 3, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020547

[REDACTED]

Dear [REDACTED],

On October 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 19, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

### Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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

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

## Decision

Decision Date: November 3, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020547

[REDACTED]

## Issues

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

Did NY State of Health properly determine that you and your child were eligible to receive up to \$566.00 per month in advance payments of the premium tax credit, effective August 1, 2017?

Did NY State of Health properly determine that you and your child were eligible for cost-sharing reductions?

Did NY State of Health properly determine that you and your child were ineligible for the Essential Plan?

Did NY State of Health properly determine that you and your child were ineligible for Medicaid?

## Procedural History

On April 16, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you and your child were eligible to enroll in the Essential Plan, effective May 1, 2016.

Also on April 16, 2016, NYSOH issue a notice of enrollment confirmation stating that you and your child were enrolled in an Essential Plan with a plan enrollment start date of May 1, 2016.

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On March 3, 2017, NYSOH issued a renewal notice stating that based on federal and state data sources you and your child were eligible to receive up to \$566.11 in advance payments of the premium tax credit (APTC) and cost-sharing reductions if you enrolled in a silver level qualified health plan, effective May 1, 2017.

On March 17, 2017, NYSOH issued a disenrollment notice stating that your and your child's enrollment in your Essential Plan would end on April 30, 2017. This was because you and your child were no longer eligible to enroll in the Essential Plan.

On March 22, 2017, you submitted an application for your household for financial assistance.

On March 23, 2017, NYSOH issued a notice of eligibility determination stating that you and your child were eligible to receive up to \$595.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective May 1, 2017.

On April 4, 2017, you updated your household's application for financial assistance.

On April 5, 2017, NYSOH issued a notice of eligibility determination stating that you and your child were eligible for the Essential Plan for a limited time, effective May 1, 2017. This notice directed you to submit income documentation by July 3, 2017 in order to confirm your and your child's eligibility for financial assistance.

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

No income documentation was submitted by July 3, 2017.

On July 8, 2017, NYSOH redetermined your and your child's eligibility for financial assistance.

On July 9, 2017, NYSOH issued a notice of eligibility determination stating you and your child were eligible to receive up to \$566.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017. That notice also stated that you and your child were not eligible for the Essential Plan or Medicaid because state and federal data sources show that your household income was over the allowable income limits for those programs.

On July 10, 2017, NYSOH issued a notice of disenrollment stating that your and your child's coverage in your Essential Plan would end on July 31, 2017. This

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was because you and your child were no longer eligible to enroll in the Essential Plan.

On July 18, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your child were not found eligible for additional financial assistance.

On July 19, 2017, NYSOH issued a notice of eligibility determination stating that you and your child were eligible for the Essential Plan for a limited time, effective August 1, 2017. This was because you and your child had been granted Aid to Continue until a decision was made on your appeal.

Also on July 19, 2017, NYSOH issued a notice of enrollment confirmation stating that you and your child were enrolled in an Essential Plan with a plan enrollment start date of August 1, 2017.

On October 2, 2017, you were scheduled for a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that day that the hearing be adjourned to a later date.

On October 16, 2017, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the hearing. The record was developed during the hearing and left open for fourteen days to allow you the opportunity to submit additional income documentation. Specifically, the Hearing Officer requested all your paystubs for pay dates in July 2017, all your child's paystubs for pay dates in July 2017, your 2016 tax return, your child's final paystub from his employer, and your two most recent paystubs from your employer.

On October 25, 2017, the Appeals Unit received via fax a copy of your 2016 tax return, your 2016 W-2, your child's paystubs from July 2017, and your child's final paystub from his employer. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

## **Findings of Fact**

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

- 1) You testified that you expect to file your 2017 tax return with a tax filing status of single. You will claim one dependent, your child, on that tax return.
- 2) You are seeking insurance for yourself and your child.

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- 3) The application that you submitted on April 4, 2017 listed annual household income of \$28,262.00, consisting of wages you earn from your employment at the [REDACTED].
- 4) Following submission of the April 4, 2017, NYSOH issued the April 5, 2017 eligibility determination notice, which requested that you submit income documentation by July 3, 2017 in order to confirm your and your child's eligibility for financial assistance.
- 5) No income documentation was submitted by July 3, 2017.
- 6) On July 8, 2017, NYSOH redetermined your eligibility for financial assistance based on wage information from state and federal data sources.
- 7) NYSOH has not supplied information regarding the household income amount that it received from state and federal data sources.
- 8) You testified that your annual expected income is currently around \$33,000.00, consisting of wages you receive from your only employer.
- 9) You testified that your monthly income for July 2017 was \$2,500.00.
- 10) You testified that your child will not file a tax return for 2017.
- 11) You testified that your child is a full-time student. You further testified that he had a part-time job which ended in September 2017.
- 12) Your application states that you will not be taking any deductions on your 2017 tax return. You testified that you are not sure if you will be able to take any deductions associated with your child's tuition on your 2017 tax return.
- 13) Your application states, and you confirmed, that you live in Nassau County.
- 14) You submitted your 2016 tax return which shows total income of \$39,728.00, and adjusted gross income of \$39,728.00. No deductions for student loan interest or tuition and fees are listed on this tax return.
- 15) You submitted your 2016 W-2 from the [REDACTED] which shows gross income of \$39,728.30.
- 16) You submitted three of your child's paystubs; the first is for pay date July 14, 2017 for a gross pay amount of \$627.00; the second is for pay date July 28, 2017 for a gross pay amount of \$666.00; the third is for pay date

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October 6, 2017 for a gross pay amount of \$78.68 and a gross year to date amount of \$5,499.51.

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

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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is \$16,020.00 for a two-person household (81 Federal Register 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the

household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

### Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

### Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036).

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 2017 FPL, which is \$16,240.00 for a two-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

### Modified Adjusted Gross Income

The Marketplace bases its eligibility determinations on modified adjusted gross income (MAGI) as defined in the federal tax code (45 CFR § 155.300(a), 42 CFR § 603(e), see 26 USC § 36B(d)(2)(B)).

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 2017 year, a dependent who had

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yearly gross earned income greater than \$6,300.00 or gross unearned income greater than \$1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2014-61).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including the taxable part of Social Security and pension payments (IRS Publication 929, pg. 15).

For the purposes of determining a person's eligibility for financial assistance for health insurance through the Marketplace, the term "MAGI" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

## **Legal Analysis**

The first issue is whether NYSOH properly determined that you and your child were eligible for an APTC of up to \$566.00 per month.

You expect to file your 2017 tax return as single and will claim one dependent, your child, on that tax return. Therefore, you and your child are in a two-person household.

The June 8, 2017 eligibility redetermination relied upon income information received from state and federal data sources. NYSOH has not provided information as to the income amount that was relied upon when issuing the June 9, 2017 eligibility determination notice.

However, you have provided documentation that your 2016 income was \$39,728.00. The record reflects that you continue to work for the same employer with no change in your employment status. You testified that your annual expected income for 2017 is only \$33,000.00. The Hearing Officer directed you to submit recent paystubs in support of your testimony. You did not produce any of your recent paystubs, rather, you submitted your 2016 W-2. Therefore, based on the current record, we must assume that your 2017 income will be similar to your 2016 income.

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A dependent will be required to file a tax return in 2017 if their earned income is greater than \$6,300.00.

You testified that your child stopped working in September 2017 and you produced your child's last paystub from his employer for 2017 which shows a gross year to date income of \$5,499.51.

Since your child has earned income less than \$6,300.00, he is not required to file a tax return on the basis of his earned income. As the record reflects that your child is not required to file a tax return for 2017, his income will not be included in determining your household's annual expected income for 2017.

You reside in Nassau County, where the second lowest cost silver plan available for an individual and one dependent through NYSOH costs \$770.75 per month.

An annual income of \$39,728.00 is 247.99% of the 2016 FPL for a two-person household. At 247.99% of the FPL, the expected contribution to the cost of the health insurance premium is 8.14% of income, or \$269.44 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 and one dependent in your county (\$770.75 per month) minus your expected contribution (\$269.44 per month), which equals \$501.31 per month. Therefore, rounding to the nearest dollar, based on the information you provided, you and your child would only have been eligible for up to \$501.00 per month in APTC.

The second issue is whether you and your child 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 \$39,728.00 is 247.99% of the applicable FPL, NYSOH correctly found you and your child to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your child 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 that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$16,020.00 for a two-person household. Since an annual household income of \$39,782.00 is 247.99% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you and your child 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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$16,240.00 for a two-person household. Since \$39,782.00 is 244.96% of the 2017 FPL, NYSOH properly found you and your child 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 testified that in July 2017 you received \$2,500.00.

To be eligible for Medicaid, you and your child would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,868.00 per month. Since the testimony you provided shows that you earned \$2,500.00 in July 2017 you and your child do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the July 9, 2017 eligibility determination properly stated that, based on the information provided to NYSOH by state and federal data sources, you and your child were eligible for up to \$566.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Based on the income documentation you produced, you and your child would be eligible for less APTC than that which NYSOH determined based on state and federal data sources. However, it is unclear from the record what the amount of your household income was as reported by those state and federal data sources. Therefore, there is insufficient information to disturb the July 9, 2017 eligibility determination.

If you have used APTC to help pay health insurance premiums for 2017, you must file a federal tax return. Your APTC, regardless of whether correctly or incorrectly determined by NYSOH, will be reconciled on your 2017 tax return by the IRS.

## **Decision**

The July 9, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** November 3, 2017

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).

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

You and your child remain eligible for up to \$566.00 per month in APTC.

You and your child are eligible for cost-sharing reductions.

You and your child are ineligible for the Essential Plan.

You and your child are ineligible for Medicaid.

If you have used APTC to help pay health insurance premiums for 2017, you must file a federal tax return. Your APTC, regardless of whether correctly or incorrectly determined by NYSOH, will be reconciled on your 2017 tax return by the IRS.

## **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

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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 July 9, 2017 eligibility determination notice is AFFIRMED.

You and your child remain eligible for up to \$566.00 per month in APTC.

You and your child are eligible for cost-sharing reductions.

You and your child are ineligible for the Essential Plan.

You and your child are ineligible for Medicaid.

If you have used APTC to help pay health insurance premiums for 2017, you must file a federal tax return. Your APTC, regardless of whether correctly or incorrectly determined by NYSOH, will be reconciled on your 2017 tax return by the IRS.

## **Legal Authority**

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

**A Copy of this Decision Has Been Provided To:**



## **Getting Help in a Language Other than English**

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

### **Español (Spanish)**

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

### **中文 (Traditional Chinese)**

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

### **Kreyòl Ayisyen (Haitian Creole)**

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

### **中文 (Simplified Chinese)**

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

### **Italiano (Italian)**

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

### **한국어 (Korean)**

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

### **Русский (Russian)**

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

### **العربية (Arabic)**

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

### **বাংলা (Bengali)**

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### **Français (French)**

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

### **हिंदी (Hindi)**

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

### **日本語 (Japanese)**

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

### **नेपाली (Nepali)**

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

### **Polski (Polish)**

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

### **Twi (Twi)**

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. yeb&tumi ama wo obi a okyer& kasa a woka no ase ama wo kwa a wontua hwee.

### **(Urdu) اردو**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

### **Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

### **שׂוֹדֵיִשׁ (Yiddish)**

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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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