



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

## Notice of Decision

Decision Date: December 22, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022569

[REDACTED]

Dear [REDACTED] [REDACTED]

On December 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 19, 2017 eligibility determination and August 14, 2017 eligibility determination 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).

This page intentionally left blank.



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

## Decision

Decision Date: December 22, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022569



## 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 were eligible for the Essential Plan with a \$20.00 monthly premium, effective September 1, 2017?

Did NY State of Health properly determine that your spouse and your child was eligible for a full price qualified health plan and not eligible for Medicaid, or the Essential Plan because you did not submit sufficient documentation of your household income, effective September 1, 2017?

## Procedural History

On June 3, 2017, NY State of Health (NYSOH) issued an eligibility determination notice stating that it was time for you to renew your NYSOH coverage. This notice stated that if the information in your application was still accurate, that NYSOH had reenrolled you into an Essential Plan with a \$0.00 monthly premium, and your daughter and your spouse into a Medicaid Managed Care plan, effective August 1, 2017. This notice further directed you to update your account between June 16, 2017 and July 15, 2017 if any household information had changed which may affect your family's eligibility, including a change in income.

On June 18, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in your Essential Plan with a \$0.00 monthly premium, effective August 1, 2017 and your spouse and your daughter's enrollment in their Medicaid Managed Care plans, effective September 1, 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).

On July 3, 2017, NYSOH received your updated application for financial assistance with health insurance, which included an updated expected household annual income.

On July 4, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with no monthly premium, for a limited time, effective August 1, 2017. This notice further directed you to submit income documentation to confirm your eligibility by October 1, 2017.

On July 4, 2017, NYSOH issued a notice stating that the income information listed on your application did not match what NYSOH received from state and federal data sources and more information was needed to confirm your eligibility. This notice further directed you to submit income documentation for your spouse and your child by July 18, 2017 and for yourself by October 1, 2017.

Also on July 4, 2017, NYSOH issued a plan disenrollment notice confirming your spouse and child's disenrollment from their Medicaid Managed Care coverage, effective July 31, 2017.

On July 18, 2017, you uploaded six documents to your NYSOH account.

Also on July 18, 2017, NYSOH validated the income documentation and submitted an updated application on your family's behalf.

On July 19, 2017, NYSOH issued an eligibility determination stating that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective September 1, 2017.

On July 19, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan with a \$20.00 monthly premium, effective September 1, 2017.

Also on July 19, 2017, NYSOH issued a notice stating that the income information listed in your application did not match what NYSOH received from state and federal data sources and that more information was needed to confirm the information listed in your account. This notice further directed you to submit additional income documentation for your spouse and child by July 18, 2017.

No further income documentation was received between July 18, 2017 and August 13, 2017.

On August 13, 2017, the system ran an application on your family's behalf.

On August 14, 2017, NYSOH issued an eligibility determination notice stating that you remained eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective September 1, 2017. This notice further stated that your

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).

spouse and child were eligible to purchase a qualified health plan at full cost through NYSOH, effective September 1, 2017, because they failed to complete the requirements for obtaining Medicaid and they could not receive tax credits or cost sharing reductions to help pay for the cost of insurance if their eligibility for Medicaid cannot be determined.

On September 7, 2017, NYSOH received your updated application for financial assistance with health insurance.

On September 8, 2017, NYSOH issued an eligibility determination stating that you and your spouse were eligible to enroll in the Essential Plan with no monthly premium, effective October 1, 2017, and that your child was eligible for Medicaid, effective September 1, 2017.

Also on September 8, 2017, NYSOH issued a plan enrollment notice confirming your and your spouse's enrollment in the Essential Plan, effective October 1, 2017, and your child's enrollment in her Medicaid Managed Care plan, effective October 1, 2017.

On September 23, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your family's health insurance coverage for the month of September 2017.

On December 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Spanish Interpreter [REDACTED] assisted with the hearing. The record was developed during the hearing and was closed at the end of the proceeding.

## **Findings of Fact**

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

- 1) The record indicates that, on June 4, 2017, NYSOH issued a renewal notice stating that, based on state and federal data sources, you were eligible for the Essential Plan with a \$0.00 monthly premium and your child and your spouse were eligible for Medicaid, effective August 1, 2017.
- 2) The June 4, 2017 renewal notice indicated that if anything had changed in your household that would affect your household's eligibility, to update your NYSOH account between June 16, 2017 and July 15, 2017, including if your household's income had changed.
- 3) The record indicates that, on July 3, 2017, an updated application for financial assistance was submitted on your behalf; which included a change in income.

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).

- 4) The application that was submitted on July 3, 2017 listed an annual household income of \$27,000.00, consisting of \$21,000.00 you earn from your employment and \$6,000.00 your spouse received from his self-employment.
- 5) You uploaded six documents to your NYSOH account on July 18, 2017.
- 6) Also on July 18, 2017, a NYSOH representative validated the income documentation you submitted. The income documentation was used to update your annual expected income from \$21,000.00 to \$23,069.54 and your child's annual expected income from \$6,000.00 to \$8,552.05. Your spouse's income remained the same.
- 7) The application that was submitted on July 18, 2017 stated that your spouse plans on taking a self-employment tax deduction of \$254.00 on your 2017 federal tax return.
- 8) The application that was submitted on July 18, 2017 listed a total expected annual household income of \$37,367.59.
- 9) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim one dependent on that tax return.
- 10) You testified that, in 2016, you and your spouse filed separate federal tax returns.
- 11) You are seeking health insurance for yourself, your spouse and your child.
- 12) Your application states, and you confirmed, that you are an immigrant non-citizen with a permanent resident card and that your date of entry was [REDACTED].
- 13) Your application states, and you confirmed, that your child is an immigrant non-citizen with a permanent resident card and that her date of entry was [REDACTED].
- 14) Your application states that your child's birthdate is [REDACTED]. She was the age [REDACTED] when you submitted your July 3, 2017 application.
- 15) Your application states that your child is a full-time student, and you will be claiming her as a dependent on your 2017 federal tax return.

- 16) Your application states, and you confirmed, that your spouse is a naturalized citizen and has been throughout at all times relevant.
- 17) You testified that you are unsure as to what happened and why your family lost coverage for the month of September 2017, but you are seeking coverage for the month of September 2017 because you have unpaid medical bills from that month.

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

## **Applicable Law and Regulations**

### Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

### 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 \$20,160.00 for a three-person household (81 Federal Register 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

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).

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)).

A child aged 19 or 20, whose primary residence is with their parents, is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 155% of the federal poverty level (FPL) for the applicable family size (NY Social Services Law § 366)(b)(7); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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 \$20,420.00 for a three-person household (82 Fed. Reg. 8831).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan with a \$20.00 monthly premium, effective September 1, 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).



On June 6, 2017, NYSOH issued an eligibility determination notice stating that it was time for you to renew your NYSOH coverage. This notice stated that, if the information in your application was still accurate, NYSOH had enrolled you into an Essential Plan with a \$0.00 monthly premium, effective August 1, 2017. This notice also directed you to update your NYSOH account between June 16, 2017 and July 15, 2017 if any information had changed which may affect your eligibility; including a change in income.

The record indicates that, on July 3, 2017, NYSOH received your updated application for financial assistance with health insurance; which included an updated expected household annual income of \$27,000.00.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to his or her household's projected annual income. For individuals seeking enrollment in the Essential Plan, NYSOH must request income data from federal data sources in order to verify an individual's income attestation.

If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on July 4, 2017, you were advised that you were eligible for the Essential Plan for a limited time, and that you needed to confirm your household's income before July 18, 2017.

The record reflects that, on July 18, 2017, you uploaded six documents to your NYSOH account. This income documentation included two biweekly paystubs for yourself; which were dated June 20, 2017 and July 3, 2017; two biweekly paystubs for your child dated June 20, 2017 and July 3, 2017; and your spouse's signed 2016 Federal Income Tax Return. The record reflects that on July 18, 2017, NYSOH validated the income documentation that was uploaded. Using the income information provided, NYSOH updated your expected annual income from \$27,000.00 to \$37,367.59 and a new application was submitted on your behalf.

Therefore, the application that was submitted on July 18, 2017 listed an annual expected household income of \$37,367.59 and the eligibility determination relied upon this information.

On the date of your July 18, 2017, you were in a three-person household. You expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return.

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 \$20,160.00 for a three-person household. Since an annual household income of \$37,367.59 is 185.36% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan with a \$20.00 monthly premium.

Therefore, the July 19, 2017 eligibility determination notice, stating that you were eligible for the Essential Plan with a \$20.00 monthly premium is correct, and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that your spouse and your child was eligible for a full price qualified health plan and not eligible for Medicaid or the Essential Plan, effective September 1, 2017.

On June 6, 2017, NYSOH issued an eligibility determination notice stating that it was time to renew your family's NYSOH coverage. This notice stated that, if the information in your application was still accurate, NYSOH had reenrolled your spouse and your child into a Medicaid Managed Care plan, effective August 1, 2017. This notice directed you to update your NYSOH account between June 16, 2017 and July 15, 2017, if any information had changed that may affect your spouse's and your child's eligibility, including a change in income.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

The record indicates that, on July 3, 2017, NYSOH received your updated family's application for financial assistance with health insurance. The income amount that was entered into that application did not match federal and state data sources. As a result, NYSOH asked that you submit documentation to confirm your child's and your spouse's income by July 18, 2017.

The record reflects that, on July 18, 2017, you uploaded six documents to your NYSOH account. This income documentation included two biweekly paystubs for yourself; which were dated June 20, 2017 and July 3, 2017; two biweekly paystubs for your child dated June 20, 2017 and July 3, 2017; and your spouse's signed 2016 Federal Income Tax Return.

The record indicates that, on July 19, 2017, NYSOH issued a notice stating that the income documentation you submitted was not sufficient to confirm the information listed in your application. This notice directed you to submit additional income information to confirm your spouse and child's eligibility. No additional

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).

income documentation was submitted. As a result, NYSOH issued an eligibility determination, on August 14, 2017, stating that your spouse and your child were eligible to purchase a qualified health plan at full cost through NYSOH, effective September 1, 2017. This notice further stated that this was because your spouse and your child had failed to complete the requirements for obtaining Medicaid and they could not receive tax credits or cost sharing reductions to help pay for the cost of insurance if their eligibility for Medicaid could not first be determined.

However, after review of the record, your spouse and child's household income was ascertainable with the documents that were uploaded to your NYSOH account on July 18, 2017.

Therefore, the August 14, 2017 eligibility determination is RESCINDED, in part, as it pertains to your spouse and child's eligibility.

Your case is being RETURNED to NYSOH to redetermine your child's and your spouse's eligibility, as of July 18, 2017, based on a household of three people, residing in Westchester County. NYSOH is directed to determine your household's annual expected income based on the documentation that was uploaded on July 18, 2017 (see Document [REDACTED] and to notify you accordingly.

## **Decision**

The July 19, 2017 eligibility determination notice is AFFIRMED.

The August 14, 2017 eligibility determination is RESCINDED, in part, as it pertains to your spouse and child's eligibility.

Your case is being RETURNED to NYSOH to redetermine your child's and your spouse's eligibility, as of July 18, 2017, based on a household of three people, residing in Westchester County. NYSOH is directed to determine your household's annual expected income based on the documentation that was uploaded on July 18, 2017 (see Document [REDACTED]), and to notify you accordingly.

This Decision has no effect on your, your spouse and your child's current eligibility.

**Effective Date of this Decision: December 22, 2017**

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

NYSOH properly determined that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective September 1, 2017.

NYSOH improperly determined that your child and your spouse were eligible to purchase a qualified health plan at full cost, effective September 1, 2017, because you failed to submit sufficient income documentation.

Your case is being sent back to NYSOH to redetermine your spouse and child's eligibility, as of July 18, 2017, and to notify you accordingly.

## **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

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).

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 19, 2017 eligibility determination notice is AFFIRMED.

The August 14, 2017 eligibility determination is RESCINDED, in part, as it pertains to your spouse and child's eligibility.

Your case is being RETURNED to NYSOH to redetermine your child's and your spouse's eligibility, as of July 18, 2017, based on a household of three people, residing in Westchester County. NYSOH is directed to determine your household's annual expected income based on the documentation that was uploaded on July 18, 2017 (see Document [REDACTED]), and to notify you accordingly.

This Decision has no effect on your, your spouse and your child's current eligibility.

NYSOH properly determined that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective September 1, 2017.

NYSOH improperly determined that your child and your spouse were eligible to purchase a qualified health plan at full cost, effective September 1, 2017, because you failed to submit sufficient income documentation.

Your case is being sent back to NYSOH to redetermine your spouse and child's eligibility, as of July 18, 2017, and to notify you accordingly.

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).

## **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:**



## **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)**

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).



0000 00 0000000000000000 0000 000 000000 000000 000 0000000000 0000000000 00 000000,  
00000000 0000 1-855-355-5777 00000000 00 000000 000000 00 00000000 0000 000000000000 000000  
00000000 000000 00000000 000000 000000

## **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. ye b&tumi ama wo obi a okyerE 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.

## **שׂוֹדֵשׂ (Yiddish)**

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).

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).