



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

## Notice of Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022633

[REDACTED]

Dear [REDACTED],

On November 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 13, 2017 eligibility determination notice, September 13, 2017 disenrollment notice, and the September 30, 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.

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

## Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022633

[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 your eligibility for the Essential Plan ended effective September 30, 2017?

Did NY State of Health properly determine that you were eligible to receive up to \$208.00 per month in advance payments of the premium tax credit, effective November 1, 2017?

Did NY State of Health properly determine that you were ineligible for cost-sharing reductions?

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

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

## Procedural History

On June 9, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan for a limited time, effective July 1, 2017. The notice directed you to provide documentation confirming your income before September 6, 2017.

On June 14, 2017, NYSOH issued a notice confirming your enrollment in an Essential Plan, effective July 1, 2017.

On September 13, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost. The notice stated that you were not eligible to enroll in the Essential Plan because NYSOH did not receive the income documentation needed to verify the income listed in your application. This eligibility was effective October 1, 2017.

Also on September 13, 2017, NYSOH issued a disenrollment notice stating that your enrollment in the Essential Plan would end as of September 30, 2017, because you were no longer eligible to remain in your plan.

On September 20, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to \$208.00 per month in advance payments of the premium tax credit (APTC), effective November 1, 2017.

Also on September 20, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your Essential Plan.

On September 30, 2017, NYSOH issued a notice of eligibility determination, based on the September 20, 2017 application, stating that you were eligible to receive up to \$208.00 per month in APTC, effective November 1, 2017. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

Also on September 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective October 1, 2017. This was because you had been granted Aid to Continue until a decision was made on your appeal.

On November 30, 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 December 18, 2017, you had an adjourned 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 held open until January 2, 2018 to allow you to submit supporting documents.

On January 2, 2018, the Appeals Unit received via fax copies of your final two checks from your employer, a payment advice statement for [REDACTED], and your NYS Department of Labor unemployment insurance benefit payment history. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

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## Findings of Fact

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

- 1) You testified, and your application indicates, that you receive all of your notices from NYSOH via regular mail.
- 2) You testified that you did not receive any notices stating that your eligibility was only conditional and that you needed to provide documentation of your household's income.
- 3) No notices that were sent to the address listed on your NYSOH account have been returned as undeliverable.
- 4) You testified that you did not know that you needed to submit documentation of your income until you received the disenrollment notice from NYSOH.
- 5) Your NYSOH account indicates that on September 12, 2017 your application was run and you were found no longer eligible for the Essential Plan as of September 30, 2017.
- 6) You updated the income information in your NYSOH account on September 20, 2017.
- 7) You testified that you expect to file your 2017 taxes with a tax filing status of single and will not claim any dependents on that return.
- 8) You are seeking insurance for yourself.
- 9) The application that was submitted on September 20, 2017, listed annual household income of \$33,000.00, consisting of wages you earn from your employment. You testified that this amount was your projected income for 2017 as of that time, however, you have since become unemployed.
- 10) You testified that you last worked for your employer on November 10, 2017. You do not yet know when you will be returning to work.
- 11) You testified that you [REDACTED] work in 2017 from which you were paid \$600.00 by the [REDACTED] and approximately \$600.00 from [REDACTED].

- 12) You testified that your gross monthly income for September 2017 was \$4,200.00.
- 13) Your September 20, 2017 application states that you will not be taking any deductions on your 2017 tax return. You testified that you believe you will be taking deductions for business expenses on your 2017 tax return, but you are not sure what the amount of these deductions will be. You testified that you also have outstanding student loans. However, you did not know if you would be claiming a deduction for student loan interest.
- 14) Your application states, and you confirmed, that you live in Kings County.
- 15) Following the hearing, you submitted income documentation consisting of:
  - a. copies of two paychecks from your former employer, the first is for pay date November 9, 2017 for a net amount of \$734.03 and the second is for pay date November 16, 2017 for a net amount of \$734.03
  - b. one payment advice statement for [REDACTED] your performed for the [REDACTED] showing that on November 29, 2017 you were paid a gross amount of \$600.00
  - c. your NYS Department of Labor unemployment insurance benefit payment history showing that your claim began as of November 13, 2017, that your weekly benefit amount is \$435.00, that you have four effective days per week and eighty-eight days remaining on your claim for a maximum amount of \$11,310.00. This payment history also shows that on November 26, 2017, December 3, 2017, December 10, 2017, and December 17, 2017 you received gross payments of \$435.00.

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

## **Applicable Law and Regulations**

### Verification of Eligibility for the 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

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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).

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 15-18, as approved January 2017; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>; 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant in order to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); see also 42 CFR § 600.320(c)). For updates received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR § 155.420(b)(1)(ii); see also 42 CFR § 600.320(c)).

### 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

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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 \$11,880.00 for a one-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% 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,

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(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 \$11,880.00 for a one-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. 23-24, as approved January 2017; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a \$20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2017).

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

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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 \$12,060.00 for a one-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).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that your eligibility for the Essential Plan ended effective September 30, 2017.

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 June 9, 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 September 8, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to provide income documentation to confirm your eligibility. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, NYSOH properly notified you of an inconsistency in your account and that documentation was needed to confirm the income you listed in the account.

If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine an individual's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation.

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Accordingly, your eligibility for the Essential Plan terminated as of September 30, 2017 because you did not submit documentation and did not adequately demonstrate that you could not provide documentation to confirm your income.

Therefore, the September 13, 2017 eligibility determination notice and the September 13, 2017 disenrollment notice are AFFIRMED.

The second issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$208.00 per month.

The application that was submitted on September 20, 2017 listed an annual household income of \$33,000.00 and the eligibility determination relied upon that information.

You expect to file your 2017 income taxes as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

You reside in Kings County, where the second lowest cost silver plan available for an individual through NYSOH costs \$456.46 per month.

An annual income of \$33,000.00 is 277.78% of the 2016 FPL for a one-person household. At 277.78% of the FPL, the expected contribution to the cost of the health insurance premium is 9.03% of income, or \$248.39 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county (\$456.46 per month) minus your expected contribution (\$248.39 per month), which equals \$208.07 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$208.00 per month in APTC.

The third issue is whether you were properly found ineligible 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 \$33,000.00 is 277.78% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The fourth issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$11,880.00 for a one-person

household. Since an annual household income of \$33,000.00 is 277.78% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

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

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$12,060.00 for a two-person household. Since \$33,000.00 is 273.63% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You testified that in September 2017 you received gross earnings of \$4,200.00.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,387.00 per month. Since the testimony you provided indicates that you earned \$4,200.00 in September 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the September 30, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$208.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

However, this eligibility is only effective for 2017. You testified that your 2018 income has changed as a result of your loss of employment. Therefore, your case is RETURNED to NYSOH to conduct outreach to assist you in updating your application to reflect your annual expected income for 2018.

## **Decision**

The September 13, 2017 notice of eligibility determination is AFFIRMED.

The September 13, 2017 disenrollment notice is AFFIRMED.

The September 30, 2017 notice of eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to conduct outreach to assist you in updating your application to reflect your annual expected income for 2018.

**Effective Date of this Decision:** January 9, 2018

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

NYSOH properly found you ineligible to enroll in the Essential Plan effective September 30, 2017 because you did not provide documentation of your household's income.

NYSOH properly found you eligible for up to \$208.00 per month in APTC and ineligible for cost-sharing reductions and the Essential Plan based on the application you submitted on September 20, 2017.

Your case is being sent back to NYSOH to assist you with updating the income information in your application to reflect your 2018 annual expected income.

### **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

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London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

## **If You Have Questions about this Decision (Customer Service Resources):**

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **Summary**

The September 13, 2017 notice of eligibility determination is AFFIRMED.

The September 13, 2017 disenrollment notice is AFFIRMED.

NYSOH properly found you ineligible to enroll in the Essential Plan effective September 30, 2017 because you did not provide documentation of your household's income.

The September 20, 2017 notice of eligibility determination is AFFIRMED.

NYSOH properly found you eligible for up to \$208.00 per month in APTC and ineligible for cost-sharing reductions and the Essential Plan based on the application you submitted on September 20, 2017.

Your case is RETURNED to NYSOH to conduct outreach to assist you in updating your application to reflect your annual expected income for 2018.

## **Legal Authority**

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).

We are issuing this determination in accordance with 45 CFR § 155.545.

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**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. 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.

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