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

Notice of Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026772

On March 28, 2018, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's April 6, 2017 eligibility determination and enrollment notices, and the January 30, 2018 disenrollment 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 Account ID at the top of this notice.

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 Code of Federal Regulations (CFR) § 155.545.

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

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

Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026772

Issues

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

> Was your appeal of NY State of Health's eligibility and enrollment notices stating that you were eligible for and enrolled in a qualified health plan at full cost, effective May 1, 2017, timely?
>
> Did NY State of Health properly determine that you were enrolled in a full pay qualified health plan for the month of January 2018?
>
> Can the Appeals Unit of NY State of Health consider your request for reimbursement of your health insurance premiums and out of pocket medical expenses?

Procedural History

On April 5, 2017, NY State of Health (NYSOH) received your initial application for health insurance. That application did not request for you to be evaluated for financial assistance for help with paying for your health insurance.

On April 6, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective May 1, 2017. That notice stated that if you think a mistake was made, you should

contact NYSOH. The notice also contained appeal rights and that you could appeal a decision that you do not qualify for Medicaid.

Also on April 6, 2017, NYSOH issued an enrollment notice confirming your enrollment in a qualified health plan effective May 1, 2017.

On October 17, 2017, NYSOH issued a notice of renewal stating that you remained eligible to purchase a qualified health plan at full cost, effective January 1, 2018. The notice further directed you to choose a health plan between November 16, 2017 and December 15, 2017.

On November 18, 2017, NYSOH issued a disenrollment notice indicating that coverage in your qualified health plan would end on December 31, 2017. This was because your health plan was being discontinued for the 2018 year.

On January 3, 2018, your Authorized Representative contacted NYSOH to update your account on your behalf. That day, a non-financial assistance application was submitted.

On January 4, 2018, NYSOH issued an eligibility determination notice based on the January 3, 2018 update, stating you were eligible to purchase a qualified health plan at full cost, effective February 1, 2018. That notice stated that if you think a mistake was made, you should contact NYSOH. The notice also contained appeal rights and that you could appeal a decision that you do not qualify for Medicaid.

Also on January 4, 2018, NYSOH issued an enrollment notice confirming your selection of a qualified health plan effective February 1, 2018.

Additionally, on January 4, 2018, your Authorized Representative spoke with the NYSOH Account Review Unit and appealed the start date of your qualified health plan, requesting the enrollment be made effective January 1, 2018. As a result of this request, Incident ████████ was created.

On January 8, 2018, Incident ████████ was created. That incident also requested that your enrollment in a qualified health plan be backdated to January 1, 2018.

Also on January 8, 2018, two applications were submitted on your behalf. The first application was for financial assistance, that application resulted in a preliminary eligibility determination stating that you were eligible for Medicaid as of January 1, 2018. Immediately thereafter, a second application was filed for non-financial assistance.

On January 9, 2018, NYSOH issued an eligibility determination notice based on your second January 8, 2018 application, stating you were newly eligible to

purchase a qualified health plan at full cost, effective February 1, 2018. The notice further stated that you were no longer qualified for Medicaid through NYSOH as of January 31, 2018. That notice stated that if you think a mistake was made, you should contact NYSOH. The notice also contained appeal rights and that you could appeal a decision that you do not qualify for Medicaid.

On January 12, 2018, your request to backdate your qualified health plan in Incident [redacted] and Incident #[redacted] was approved and your qualified health plan was backdated to January 1, 2018.

On January 13, 2018, NYSOH issued a notice of enrollment confirming that your qualified health plan was backdated to begin on January 1, 2018.

On January 16, 2018, NYSOH contacted you about your request to backdate your coverage. That day, you were informed that your request for a new enrollment start date was granted.

On January 22, 2018, NYSOH contacted you to confirm that your health plan was backdated as you requested. Notes in Incident #[redacted] and Incident [redacted] reflect that you withdrew your appeal, therefore you hearing request was cancelled.

On January 29, 2018, you updated your NYSOH account. Specifically, you changed your account from non-financial to financial and submitted an application requesting financial assistance with your health insurance. That application also requested help in paying for medical bills in October, November, and December 2017.

On January 30, 2018, NYSOH issued an eligibility determination notice, based on your January 29, 2018 application, stating that you were eligible for Medicaid effective January 1, 2018.

Also on January 30, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for October 1, 2017 through December 31, 2017.

Additionally, on January 30, 2018, NYSOH issued a disenrollment notice indicating that your coverage in your qualified health plan would end effective January 31, 2018.

On January 31, 2018, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care plan, effective March 1, 2018.

On February 12, 2018, your Authorized Representative contacted the NYSOH Account Review Unit and informed them that you wished to reopen your appeal (Incident [redacted]).

On March 27, 2018, NYSOH contacted your Authorized Representative. She informed NYSOH that you were appealing for reimbursement of the premiums paid for your qualified health plan for the month of January 2018.

On March 28, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. During the hearing, [redacted] acted as your Authorized Representative and assisted you with your testimony. The Hearing Officer established and you both agreed that you originally requested an appeal of NYSOH's January 4, 2018 enrollment confirmation notice which stated you were enrolled in a qualified health plan at full cost, effective February 1, 2018. You initially sought a January 1, 2018 start date of your qualified health plan through this appeal however, this issue was moot at the time of the hearing because NYSOH had backdated your plan as you requested. You and your authorized representative agreed that you were currently seeking to be disenrolled from your qualified health plan as of December 31, 2017. However, you later testified that you were seeking to be completely disenrolled from your qualified health plan for April 2017 through January 2018, so that you can receive a refund of all the premium costs and out of pocket medical expenses paid during that time period because you should have been eligible for Medicaid. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

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

1) When applying for assistance through NYSOH, you can choose to apply for health insurance with no financial assistance or you can apply for financial assistance to help pay for the cost of your health insurance. The record reflects that a non-financial assistance application was submitted by you ([redacted] on April 5, 2017. No other applications were submitted by you or anyone else on your behalf in 2017.

2) The record reflects that you were enrolled in a qualified health plan through NYSOH and that your coverage was effective as of May 1, 2017.

3) You testified that you paid premiums to your health plan for the months of April 2017 through January 2018. You also uploaded a handwritten summary of the amount of premiums and out of pocket medical expenses paid for those months (document [redacted]

4) The record reflects that your Authorized Representative, contacted NYSOH on January 3, 2018 (Incident [redacted]). A non-financial assistance application was run on that day and you were determined

eligible to purchase a qualified health plan at full cost and a plan was chosen on your behalf, effective February 1, 2018.

5) On January 4, 2018, your Authorized Representative appealed the start date of your plan insofar as your plan did not start on January 1, 2018. Your Authorized Representative testified and the record reflects that your request to backdate the start of your qualified health plan was granted on January 12, 2018.

6) You and your Authorized Representative testified that you were not aware of your Medicaid eligibility until January 2018.

7) The record indicates that your application was updated requesting financial assistance on January 29, 2018, and at that time, you were found eligible for Medicaid effective January 1, 2018.

8) You also requested assistance with paying medical bills for the previous three months on your January 29, 2018 application. Based on the information submitted on your application, you were also found eligible for retroactive Medicaid for October, November, and December 2017.

9) You and your Authorized Representative testified that you are seeking an earlier disenrollment date because you were eligible for Medicaid coverage through NYSOH for the months of April 2017 through January 2018, when you were still enrolled in your qualified health plan.

10) You and your Authorized Representative testified that NYSOH should have informed you that you were eligible for Medicaid prior to January 2018 and therefore you should receive a refund of all of the premiums and out of pocket medical expenses paid for the entire period that you were enrolled in a qualified health plan.

11) Your NYSOH account does not reflect that you were eligible for Medicaid for the months of April 2017 through September 2017.

12) You testified you paid for and you used your insurance through your qualified health plan for April 2017 through January 2018.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Termination of a Qualified Health Plan

NYSOH must permit an enrollee to terminate his or her coverage with a qualified health plan coverage, with appropriate notice to the NYSOH or qualified health plan (45 CFR § 155.430(b)(1)(i)).

If an enrollee is newly eligible for Medicaid, the last day of coverage for the qualified health plan is the day before the Medicaid coverage begins (45 CFR § 155.430(d)(2)(iv)).

For enrollee-initiated terminations, the last day of coverage is either:

1) The termination date specified by the enrollee, if the enrollee provides reasonable notice (at least 14 days before the requested termination date);

2) Fourteen days after the enrollee requests the termination, if they do not provide reasonable notice; or

3) On a date on or after the date the enrollee requests the termination, if the enrollee's qualified health plan issuer and the enrollee agree to such a date

(45 CFR § 155.430(d)(2)(i)-(iii)).

NYSOH must permit an enrollee to retroactively terminate or cancel their enrollment in a qualified health plan if:

1) The enrollee demonstrates that they attempted to terminate their coverage and experienced a technical error that did not allow the coverage to be terminated, and requests retroactive termination within 60 days after they discovered the technical error.

2) The enrollment in the qualified health plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH or HHS, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment.

3) The enrollee was enrolled in a qualified health plan without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(45 CFR § 155.430(b)(2)(iv)(A-C)).

NYSOH permits a qualified health plan to terminate an individual's coverage if (1) the enrollee is no longer eligible for coverage or (2) non-payment of the premiums by the enrollee (45 CFR § 155.430(b)(2)(i)-(ii)).

Medicaid Fee for Service Start Date

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

Legal Analysis

The first issue under review is whether your appeal of the April 6, 2017 eligibility and enrollment notices stating that you were eligible for and enrolled in a qualified health plan effective May 1, 2017, was timely.

On April 6, 2017, NYSOH issued an eligibility determination stating you were eligible for a qualified health plan at full cost, effective May 1, 2017. The enrollment notice issued on that same day confirmed your enrollment in a qualified health plan, effective May 1, 2017.

You and your Authorized Representative testified that you are seeking to be disenrolled from your qualified health plan as of the date it started in 2017 because you should have been eligible for Medicaid.

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your eligibility and enrollment in a full pay qualified health plan, effective May 1, 2017, as stated in the April 6, 2017 eligibility determination and enrollment notices, an appeal should have been filed by June 5, 2017. The record reflects that the appeal for this issue was not made until the day of hearing on March 28, 2018, well after the 60-day timeframe to appeal the April 6, 2017 eligibility determination had expired. Even if your initial appeal date of January 4, 2018 was considered for this analysis, your appeal would remain untimely.

Where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

You and your Authorized Representative testified that NYSOH should have informed you that you were eligible for Medicaid prior to January 2018.

However, the April 6, 2017 eligibility determination notice finding you eligible for a full pay qualified health plan contains appeal rights and those rights outline that you could appeal a decision that you do not qualify for Medicaid. You testified, and provided proof, that you paid your full pay qualified health plan premiums every month in which you were enrolled. Furthermore, you did not submit a financial assistance application to NYSOH prior to January 2018 and therefore, NYSOH was not required to make a determination on your eligibility for Medicaid prior to that date because you did not request it.

Therefore, NYSOH provided you with adequate notice of your eligibility based on the type of assistance you requested and informed you of your appeal rights if you did not agree with that eligibility. Thus, there are no exceptional circumstances present to toll the deadline in which to appeal that determination.

Since there has been no timely appeal of the April 6, 2017 eligibility determination and enrollment notices, your appeal of your full cost qualified health plan eligibility and enrollment, effective May 1, 2017, must be DISMISSED.

The second issue under review is whether NYSOH properly determined that you were enrolled in a full pay qualified health plan for the month of January 2018.

On January 3, 2018, your Authorized Representative contacted NYSOH to update your account on your behalf. As a result, you were enrolled into a qualified health plan at full cost-effective February 1, 2018.

Your authorized representative then contacted NYSOH on January 4, 2018, and filed a formal appeal requesting an earlier start date for your qualified health plan of January 1, 2018.

On January 12, 2018, your request to backdate your qualified health plan was approved and your qualified health plan was backdated to January 1, 2018. A notice was issued on January 13, 2018 confirming that your enrollment was backdated.

On January 16, 2018, you were informed by NYSOH that your request for a new enrollment start date was granted. On January 22, 2018, NYSOH contacted you to confirm that your health plan was backdated as you requested and you withdrew your appeal request on this issue.

You subsequently updated your NYSOH application on January 29, 2018 and were found eligible for Medicaid, effective January 1, 2018. This is because an individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month. Since you submitted your initial application for financial assistance with health insurance on January 29, 2018, any resulting Medicaid eligibility would be effective the first of the month of January.

You and your Authorized Representative testified that you are now seeking retroactive disenrollment from your qualified health plan as of December 31, 2017 because you became Medicaid eligible.

If an enrollee is newly eligible for Medicaid, the last day of coverage through their qualified health plan is the day before the Medicaid coverage begins. Since you were determined eligible for Medicaid on January 29, 2018 under the regulations your qualified health plan should have terminated that day. However, NYSOH does not allow for prorated or partial premiums based on the amount of days in a month you were enrolled in a qualified health plan and as such your plan was terminated at the end of the calendar month in which you became eligible for Medicaid.

Since NYSOH's determination that you were enrolled in a full pay qualified health plan for the month of January 2018 was granted at your request, the January 30, 2018 notice which disenrolled you from your qualified health plan as of January 31, 2018, which is the end of the month in which you were first found eligible for Medicaid, it is AFFIRMED.

The third issue under review is whether NYSOH's Appeals Unit can consider your appeal to seek reimbursement of your health insurance premiums and out of pocket medical expenses.

You and your authorized representative testified that you are seeking to be reimbursed for your qualified health plan insurance premiums and out of pocket medical costs for April 1, 2017 through January 31, 2018 because you feel that NYSOH should have informed you that you were eligible for Medicaid prior to January 2018 and therefore you should receive a refund of all of the premiums and out of pocket medical expenses paid for the entire period that you were enrolled in a qualified health plan.

Although you testified that you were eligible for Medicaid coverage through NYSOH for the months of April 2017 to January 2018, this is not supported by the record. Your NYSOH account does not reflect that you were eligible for Medicaid for the months of April 2017 through September 2017. Your account reflects that you were determined eligible for Medicaid, January 1, 2018 based on your January 29, 2018 application. You were also determined eligible for retroactive Medicaid for the months of October, November, and December 2017 based on your January 29, 2018 request for financial assistance to pay for medical bills incurred during the three months prior to your January 29, 2018 application.

You testified that you paid premiums to your health plan for the months of April 2017 through January 2018 and uploaded a handwritten summary of the amount of premiums and out of pocket medical expenses paid for those months (document # [redacted]).

NYSOH Appeals Unit only has the authority to review issues related to the following: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination; and (4) a denial of a request for a special enrollment period.

The Appeals Unit does not have the authority to review whether an individual should be reimbursed for a qualified health plan premium, co-pays, or out of pocket medical expenses paid. We cannot reach the merits as to whether you are entitled to be reimbursed for those payments. Therefore, your request for the NYSOH Appeals Unit to consider reimbursement for your qualified health plan premiums and out of pocket medical expenses paid is DISMISSED as a non-appealable issue.

Decision

Your appeal of NYSOH's April 6, 2017 eligibility determination and disenrollment notices is DISMISSED.

The January 30, 2018 disenrollment notice is AFFIRMED.

Your request for the NYSOH Appeals Unit to consider reimbursement for your qualified health plan premiums and out of pocket medical expenses paid is DISMISSED.

Effective Date of this Decision: April 10, 2018

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of January 31, 2018.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

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

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

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

Your appeal of NYSOH’s April 6, 2017 eligibility determination and disenrollment notices is DISMISSED.

The January 30, 2018 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of January 31, 2018.

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).

Your request for the NYSOH to consider reimbursement for your qualified health plan premiums and out of pocket medical expenses paid for the months of April 2017 to January 2018 is DISMISSED.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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

Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية(Arabic)

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

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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

Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu)اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

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