



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

Notice of Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027747



Dear [REDACTED]

On March 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 28, 2017 and February 8, 2018 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).

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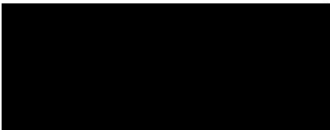


STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027747



Issues

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

Was your appeal of the October 28, 2017 automatic renewal notice timely?

Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to \$335.00 per month in advance payments of the premium tax credit, effective March 1, 2018?

Did NYSOH properly determine that you were eligible for cost-sharing reductions, effective March 1, 2018?

Did NYSOH properly determine that you were not eligible for the Essential Plan, effective March 1, 2018?

Procedural History

On May 4, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$326.00 in advance payments of the premium tax credit (APTC) as well as cost-sharing reductions if you enrolled in a silver-level qualified health plan, both effective June 1, 2017. You were subsequently enrolled in a platinum-level qualified health plan with a plan enrollment and APTC start date of June 1, 2017.

On October 28, 2017, NYSOH issued a renewal eligibility determination notice stating your coverage was being automatically renewed for the upcoming coverage year. That notice also stated that based on income information

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received from state and federal data sources, you were eligible to receive up to \$335.10 in APTC and cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective January 1, 2018. The notice also stated you were not eligible for Medicaid or the Essential Plan because your income was over the allowable income limits for those programs. The notice indicates that you were being reenrolled in your same health plan for 2018. The notice further stated that if you wanted to make changes to your account, you must do so between November 16, 2017 and December 15, 2017.

On November 18, 2017, NYSOH issued an enrollment notice based on the system automatically renewing your enrollment in the same platinum-level qualified health plan that you were in previously, effective January 1, 2018, with a monthly premium of \$441.75 after \$326.00 in APTC was deducted.

On January 24, 2018, you spoke to NYSOH's Account Review Unit and appealed the October 28, 2017 eligibility determination notice insofar as you were not eligible for an increased amount of financial assistance.

On February 7, 2018, you submitted an updated application for financial assistance with health insurance. In that application you attested to an expected annual income of \$28,000.00.

On February 8, 2018, NYSOH issued an eligibility determination notice, based on the updated February 7, 2018 application, stating that you were eligible to receive up to \$335.00 in APTC as well as cost-sharing reductions if you enrolled in a silver-level qualified health plan, both effective March 1, 2018. That notice stated that you were not eligible for Medicaid or the Essential Plan because your household income of \$28,000.00 was over the allowable income limits for those programs. The notice stated that you may be able to enroll in coverage if you qualified for a special enrollment period.

On March 15, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. In that hearing the Hearing Officer agreed to amend your appeal to include the February 8, 2018 eligibility determination notice. The record was developed during the hearing and held open up to March 22, 2018, to allow you time to submit supporting documents.

On March 16, 2018, NYSOH Appeals Unit received your supporting documents by secure facsimile. The documents were incorporated into the record as Appellant's [REDACTED] and the record was closed.

Findings of Fact

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

- 1) You were determined eligible to receive up to \$326.00 in APTC, effective June 1, 2017, following a May 3, 2017 application requesting automatic renewal of your coverage for five years.
- 2) You testified that you expect to file your tax return for 2018 with a tax filing status of single. You will claim no dependents on that tax return.
- 3) You are seeking insurance for yourself.
- 4) The October 28, 2017 renewal notice indicated that your coverage for 2018 was being automatically renewed and that based on income information from state and federal data sources received on October 8, 2017, you were eligible to receive up to \$335.10 in APTC, effective January 1, 2018.
- 5) The October 28, 2017 automatic renewal notice stated that if you wanted to make changes to your account, you must do so between November 16, 2017 and December 15, 2017.
- 6) NYSOH issued an enrollment notice on November 18, 2017 confirming your reenrollment in your platinum-level qualified health plan for 2018 with a monthly premium of \$441.75 after application of \$326.00 in APTC, effective January 1, 2018.
- 7) You filed an appeal on January 24, 2018 and requested additional financial assistance.
- 8) There is no record on any activity on your account between the automatic renewal of October 28, 2017 and your request for an appeal on January 24, 2018.
- 9) On February 7, 2018 you submitted an updated application for financial assistance with your health insurance. In that application you listed an expected annual income for 2018 of \$28,000.00.
- 10) On February 8, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for \$335.00 in APTC effective March 1, 2018.
- 11) You testified that you are employed as [REDACTED], are paid bi-weekly based on an annual salary. You testified that your gross pay is approximately \$1,200.00 per pay check.

- 12) After the hearing, you submitted two earning statements. The first is dated February 2, 2018 for pay period January 20, 2018 to February 2, 2018 with gross pay of \$1,277.46 with year-to-date earnings of \$3,822.38. The second statement is dated March 2, 2018 for pay period February 17, 2018 to March 2, 2018 with gross pay of \$1,277.46 and year-to-date earnings of \$6,387.30.
- 13) Your application states that you will not be taking any deductions on your 2018 tax return.
- 14) According to your NYSOH account and your testimony, you live in Queens County.
- 15) You testified that you are not able to keep paying health insurance premiums, even with APTC applied, because of the many bills and high living expenses with residing in New York City area, such as rent, utilities and transportation. You testified that you want to be considered for a higher level of financial assistance including more APTC or the Essential Plan to help pay for your health insurance.

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)).

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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

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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 are available to a person who (1) is eligible to enroll in a qualified health plan through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level qualified health plan (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 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 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

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)).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term “modified adjusted gross income” means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

“Adjusted gross income” means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of funds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id.*).

Legal Analysis

The first issue under review is whether your appeal of NYSOH’s October 28, 2017 eligibility determination notice was timely.

On May 4, 2017, you submitted an updated application for financial assistance with health insurance to NYSOH. As a result of that application you were determined eligible for \$326.00 in APTC and were enrolled in a platinum-level qualified health plan with plan enrollment and application of APTC starting June 1, 2017.

On October 28, 2017, NYSOH issued a renewal eligibility determination notice based on a system run application using income information received from state and federal data sources. That eligibility determination stated you were eligible for \$335.10 in APTC effective January 1, 2018 and you were automatically re-enrolled in the same plan you were in at that time. That notice stated that if you wanted to make changes to your account, you must do so between November 16, 2017 and December 15, 2017. Your account confirms that no changes were made to your account by December 15, 2017; therefore, the eligibility was implemented January 1, 2018.

On January 24, 2018, you contacted NYSOH and formally requested an appeal on the October 28, 2017 eligibility determination.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH. For an appeal to have been valid on the issue of the amount of APTC as stated in the October 28, 2017 eligibility determination notice, an appeal should have been filed by December 28, 2017. The record reflects that you filed a formal appeal on January 24, 2018, which is well outside the 60-day deadline for an appeal to be timely. Further, the record reflects that there are no exceptional circumstances that would warrant a finding that the 60-day deadline should be extended.

Therefore, as there has been no timely appeal of the October 28, 2017 eligibility determination notice, your appeal of that eligibility determination notice is **DISMISSED**.

On February 7, 2018, you submitted an updated application for financial assistance with health insurance with NYSOH. As a result of that application, NYSOH issued an eligibility determination notice dated February 8, 2018, stating you were eligible for \$335.00 in APTC and cost-sharing reductions effective March 1, 2018, if you qualified for a special enrollment period. The hearing officer agreed to your request, made at the March 15, 2018 hearing, to amend your appeal to include the February 8, 2018 eligibility determination notice.

Therefore, the second issue is whether NYSOH properly determined that you were eligible for up to \$335.00 per month in APTC, effective March 1, 2018.

The application that was submitted on February 7, 2018 listed an annual household income of \$28,000.00 and the eligibility determination relied upon that information.

During the hearing, you testified that you are not able to keep paying health insurance premiums, even with APTC applied because of the many bills and high living expenses with residing in New York City area. You asked that your current expenses, such as rent, utilities and transportation, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, and transportation to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be \$28,000.00.

You are in a one-person household. You expect to file your 2018 income tax return as single and will claim no dependents on that tax return.

You reside in Queens County, where the second lowest cost silver-level plan available for an individual through NYSOH costs \$509.30 per month.

An annual income of \$28,000.00 is 232.17% of the 2017 FPL for a one-person household. At 232.17% of the FPL, the expected contribution to the cost of the health insurance premium is 7.47% of income, or \$174.30 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver-level plan available through NYSOH for an individual in your county (\$509.30 per month) minus your expected contribution (\$174.30 per month), which equals \$335.00 per month. Therefore, NYSOH correctly determined you to be eligible for up to \$335.00 per month in APTC.

The third issue is whether you were properly determined eligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income

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of \$28,000.00 is 232.17% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

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

The Essential Plan is generally 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 \$12,060.00 for a one-person household. Since an annual household income of \$28,000.00 is 232.17% of the 2017 FPL, NYSOH correctly found you to be ineligible for the Essential Plan.

However, at the hearing you testified that you are presently employed full time as [REDACTED] and are paid bi-weekly with gross pay of about \$1,200.00 per pay check. You testified that your pay is based on a yearly salary. After the hearing, you submitted two earning statements. The first is dated February 2, 2018 for pay period January 20, 2018 to February 2, 2018 with gross pay of \$1,277.46 with year-to-date earnings of \$3,822.38. The second statement is dated March 2, 2018 for pay period February 17, 2018 to March 2, 2018 with gross pay of \$1,277.46 and year-to-date earnings of \$6,387.30. Therefore, the record reflects that you are paid \$1,277.46 on a bi-weekly basis. Averaging that amount over 26 paychecks equals annual earnings from that employment of \$33,213.96.

The Appeals Unit finds, based on your income documentation, that your expected annual household income for 2018 is therefore \$33,213.96, and your case is returned to NYSOH to make a final determination as to your financial eligibility for the remainder of 2018.

Decision

Your appeal of the October 28, 2017 eligibility determination notice is untimely and is DISMISSED.

The February 8, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of February 7, 2018, using a one-person household residing in Queens County, with expected 2018 annual income of \$33,213.96, and to notify you accordingly.

This decision does not affect any eligibility determination notices issued after February 8, 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).

Effective Date of this Decision: May 24, 2018

How this Decision Affects Your Eligibility

You remain temporarily eligible to receive up to \$335.00 per month in APTC. HOWEVER, your case is being returned to NYSOH for a redetermination of your eligibility based on your income documentation, and this level of assistance may change.

PLEASE NOTE: Any APTC you receive for 2018 must be reconciled on your 2018 federal income tax return. Be advised that enrollees who take more tax credit in advance than they eventually can claim on their tax return for that year will owe the difference as additional income tax.

You remain temporarily eligible for cost-sharing reductions and ineligible for the Essential Plan.

This decision does not affect any eligibility determination notices issued after February 8, 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

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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 the October 28, 2017 eligibility determination notice is untimely and is DISMISSED.

The February 8, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of February 7, 2018, using a one-person household residing in

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Queens County, with expected 2018 annual income of \$33,213.96, and to notify you accordingly.

You remain temporarily eligible to receive up to \$335.00 per month in APTC. HOWEVER, your case is being returned to NYSOH for a redetermination of your eligibility based on your income documentation, and this level of assistance may change.

PLEASE NOTE: Any APTC you receive for 2018 must be reconciled on your 2018 federal income tax return. Be advised that enrollees who take more tax credit in advance than they eventually can claim on their tax return for that year will owe the difference as additional income tax.

You remain temporarily eligible for cost-sharing reductions and ineligible for the Essential Plan.

This decision does not affect any eligibility determination notices issued after February 8, 2018.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您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।

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Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

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

(Urdu) اردو

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

Tiếng Việt (Vietnamese)

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

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.