The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call <u>1-855-OSCAR-55</u> or visit <u>https://www.hioscar.com/forms/2023/il</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-OSCAR-55 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$7,750 individual / \$15,500 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive</u> care, Pre- and post-natal care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$9,100 individual / \$18,200 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums, balance billing</u> charges, and healthcare this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.hioscar.com/care-options</u> or call <u>1-855-OSCAR-55</u> for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services, but only if you have a <u>referral</u> before you see the <u>specialist</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

	Services You	What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information*
	Primary care visit to treat an injury or illness	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	Cost share applies to both in-person and virtual services. Virtual <u>urgent</u> <u>care</u> services from Oscar designated telemedicine <u>providers</u> are covered in full. One (1) non- <u>preventive</u> visit is \$50 and not subject to the <u>deductible</u> .
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	Cost share applies to both in-person and virtual services.
	Preventive care/ <u>screening</u> / immunization	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay. Well Woman and Well Man exams are limited to one (1) visit per Benefit Period.
lf you have a test	<u>Diagnostic test</u> (x- ray, blood work)	50% <u>coinsurance</u> subject to <u>deductible</u> (<i>x-ray</i>), \$10 <u>copayment</u> / visit subject to <u>deductible</u> (lab work, Preferred), \$50 <u>copayment</u> /visit subject to <u>deductible</u> (lab work, Non- Preferred)	Not Covered	none
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u> subject to <u>deductible</u> (Office/Ind facility/other outpatient facility)	Not Covered	none
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hioscar.com/search/IL /drugs?year=2023	Generic drugs (Tier 1)	\$3 <u>copayment</u> /prescription <u>Deductible</u> does not apply (retail, Tier 1A), \$30 <u>copayment</u> /prescription <u>Deductible</u> does not apply (retail, Tier 1B)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail <u>cost-sharing</u> amount. 90-day supply for Maintenance Drugs is subject to 3x retail <u>cost-sharing</u> amount.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2023/il

	Services You	What You Will Pay		Limitations Evapations ? Other
Common Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you need drugs to treat your illness or condition	Preferred brand drugs (Tier 2)	\$250 <u>copayment</u> /prescription subject to <u>deductible</u> (retail), \$625 <u>copayment</u> / prescription subject to <u>deductible</u> (mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail <u>cost-sharing</u> amount. 90-day supply for Maintenance Drugs is subject to 3x retail <u>cost-sharing</u> amount.
More information about prescription drug coverage is available at www.hioscar.com/search/IL /drugs?year=2023	Non-preferred brand drugs (Tier 3)	50% <u>coinsurance</u> subject to <u>deductible</u> (retail/mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail <u>cost-sharing</u> amount. 90-day supply for Maintenance Drugs is subject to 3x retail <u>cost-sharing</u> amount.
	<u>Specialty drugs</u> (Tier 4)	50% <u>coinsurance</u> subject to <u>deductible</u> (retail/mail order)	Not Covered	Limited to a 30-day supply.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$1,200 <u>copayment</u> /visit subject to <u>deductible</u> (surgical and non-surgical services)	Not Covered	none
surgery	Physician/surgeon fees	\$350 <u>copayment</u> /visit subject to <u>deductible</u>	Not Covered	none
	<u>Emergency room</u> <u>care</u>	50% <u>coinsurance</u> subject to <u>deductible</u> (ER Facility Fee)	50% <u>coinsurance</u> subject to <u>deductible</u> (ER Facility Fee)	Emergency Room care by an Out-of- Network provider is covered if the services are for an emergency condition.
If you need immediate medical attention	<u>Emergency</u> <u>medical</u> <u>transportation</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	Emergency Transportation services by an <u>Out-of-Network provider</u> are covered if the services are for an emergency condition.
	<u>Urgent care</u>	\$75 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	When temporarily out of the Service Area, <u>Out-of-Network Urgent Care</u> services are covered. In addition to applicable cost share, you may be responsible for <u>balance billing</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	none

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2023/il

	Services You	What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information*
If you have a hospital stay	Physician/surgeon fees	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	none
If you need mental health, behavioral health, or substance abuse	Outpatient services	50% <u>coinsurance</u> subject to <u>deductible</u> (office visit), \$350 <u>copayment</u> /visit subject to <u>deductible</u> (other outpatient services)	Not Covered	none
services	Inpatient services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	none
	Office Visits	No charge	Not Covered	Depending on the type of services (such as Primary Care Office Visits, <u>Specialist</u> Office Visits, Diagnostic Imaging Services, etc.), the applicable <u>cost-sharing</u> will apply.
If you are pregnant	Childbirth/delivery professional services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	none
	Childbirth/delivery facility services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	Covers 48-hour hospital stay for uncomplicated vaginal birth and 96- hour hospital stay for uncomplicated caesarean section.
If you need help	Home health care	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	Benefit limits do not apply to services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a substance use disorder.
If you need help recovering or have other special health needs	<u>Rehabilitation</u> services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	60 visits per benefit period combined for physical, occupational, and speech therapies. Benefit limits do not apply to services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a substance use disorder.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2023/il

	Services You	What You Will Pay		Limitationa Exampliana 8 Other
Common Medical Event	May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
	<u>Habilitation</u> services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	60 visits per benefit period combined for physical, occupational, and speech therapies. Benefit limits do not apply to services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a substance use disorder.
	<u>Skilled nursing</u> care	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	Benefit limits do not apply to services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a substance use disorder.
	<u>Durable medical</u> equipment	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	none
	Hospice services	50% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	none
	Children's eye exam	No charge	Not Covered	One (1) exam per benefit period for children up to age 19.
If your child needs dental or eye care	Children's glasses	50% <u>coinsurance</u> <u>Deductible</u> does not apply	Not Covered	One (1) prescribed lenses and frames per Benefit Period. Contacts covered in lieu of glasses. \$150 allowance for Lenses and Frames, or Contact Lenses.
	Children's dental check-up	Not Covered	Not Covered	none

 Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

 • Acupuncture
 • Non-emergency care when traveling outside the U.S.
 • Weight loss programs

 • Long-term care
 • Routine eye care (Adult)
 • Weight loss programs

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2023/il

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Hearing aids

- Abortion
- Bariatric surgery
- Chiropractic Care (Limited to 25 visits per Benefit Period)
- Cosmetic surgery (correction of congenital deformities and conditions resulting from accidental • Private-duty nursing injuries, scars, tumors or disease)
 - Infertility treatment

 - Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Illinois Department of Insurance, 320 W. Washington Street, Springfield, IL 62767 at 877-527-9431 or https://insurance.illinois.gov/consumer/consumerMain.html or contact Oscar at 1-855-OSCAR-55. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: https://insurance.illinois.gov/consumer/consumerMain.html

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-OSCAR-55. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa <u>1-855-OSCAR-55</u>. Chinese (中文): 如果需要中文的帮助,请拨打这个号码 <u>1-855-OSCAR-55</u>. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' <u>1-855-OSCAR-55</u>.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

(9 months of in-network pre-natal care a hospital delivery)	and a
 The <u>plan</u>'s overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other coinsurance 	\$7,750 50% 50%
Specialist coinsurance	

Deg is Having a Rahy

This EXAMPLE event includes services like:

<u>Specialist</u> office visits (prenatal care) Childbirth/delivery professional services Childbirth/delivery facility services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing		
Deductibles	\$7,750	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$1,400	
What isn't covered		
Limits or exclusions	\$0	
The total Peg would pay is	\$9,150	

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well- controlled condition)

\$7,750

\$1.200

50%

50%

The <u>plan</u> 's overall <u>deductible</u>	
Specialist coinsurance	
Hospital (facility) <u>copayment</u>	
Other <u>coinsurance</u>	

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits *(including disease education)* <u>Diagnostic tests</u> *(blood work)* <u>Prescription drugs</u> <u>Durable medical equipment</u> *(glucose meter)*

In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$5,100	
<u>Copayments</u>	\$80	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$5,180	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall <u>deductible</u>	\$7,750
Specialist coinsurance	50%
Hospital (facility) <u>copayment</u>	\$1,200
Other coinsurance	50%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing		
Deductibles	\$2,800	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

Notice of Non-Discrimination: Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Oscar will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Oscar will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters

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Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CA Members: Oscar Health Plan of California, Attention Grievances, PO Box 66550, Los Angeles, CA 90066

All other Members: Oscar Insurance, Attention: Grievances, PO Box 52146, Phoenix, AZ 85072

All Members: Phone: 1-855-OSCAR-55 (TTY: 7-1-1), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

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Cherokee: Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-855-OSCAR-55 (TTY: 711)

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-OSCAR-55.

繁體中文 (Chinese): 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-OSCAR-55.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-OSCAR-55.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-OSCAR-55.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-OSCAR-55 번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-OSCAR-55.

.1-855-OSCAR-55 אידיש (Yiddish): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (Yiddish) אידיש

বাংলা (Bengali): লক্ষ্য করুল: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিংথরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুল ১-855-OSCAR-55.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-OSCAR-55.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–558–RACSO–558.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-OSCAR-55.

اُ**ردُوُ (Urdu):** خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 55-OSCAR -1-855

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-OSCAR-55.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-OSCAR-55.

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-OSCAR-55.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-OSCAR-55.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-OSCAR-55 पर कॉल करें।

فارسسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید ت OSCAR-55-1-855-1

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-OSCAR-55.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો ^{1-855-OSCAR-55.}

日本語 (Japanese): 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-855-OSCAR-55 まで、お電話にてご連絡ください。

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ຫ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ຫ່ານ. ໂຫຣ 1-855-OSCAR-55.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-OSCAR-55.

አማርኛ (Amharic): ማስታወሻ: የሚና7ሩት ቋንቋ ኣማርኛ ከሆነ የትርፖም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

Հայերեն (Armenian)։ ՈՒՇԱԴՐՈՒԹՅՈՒԾ ԵԹե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ։ Զանգահարեք 1-855-OSCAR-55.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤਹਾਡੇ ਲਈ ਮਫਤ ਉਪਲਬਧ ਹੈ। 1-855-OSCAR-55. 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនកិតឈ្នួល គឺអាចមានសំរាប់ប៉េរីអ្នក។ ចូរ ទូរស័ព្ទ 1-855-OSCAR-55. ។ Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-OSCAR-55. ภาษาไทย (Thai): តំ ។ คุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเลือทางภาษาได้ ฟรี โทร 1-855-OSCAR-55.

Deitsch (Pennsylvania Dutch): Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf

selli Nummer uff: Call 1-855-OSCAR-55.

Oroomiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-OSCAR-55.

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-OSCAR-55.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-OSCAR-55.

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-OSCAR-55.

Navajo Diné Bizaad: Díí baa akó nínízin: Díí saad bee yánilti'go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-855-OSCAR-55 (TTY: 711.)

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-OSCAR-55

Burmese: သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-855-OSCAR-55 (TTY: 711) သို့ ခေါ်ဆိုပါ။

OSC-NDN Bronze Classic (Select) Off-Ex Individual IL 2023 SBC

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