**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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 1-855-OSCAR-55 or visit https://www.hioscar.com/forms/2023/oh. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, 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 deductible?** | $0 individual / $0 family | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, Pre- and post-natal care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $6,500 individual / $13,000 family for prescription drug coverage. No other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $9,100 individual / $18,200 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges, and healthcare this plan 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 network provider?** | Yes. See www.hioscar.com/care-options or call 1-855-OSCAR-55 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40 copayment/visit Deductible does not apply | Not Covered | Cost share applies to both in-person and virtual services. One (1) non-preventive visit is $50 and not subject to the deductible. |
| | Specialist visit | $125 copayment/visit Deductible does not apply | Not Covered | Cost share applies to both in-person and virtual services. |
| | Preventive care/ screening/ immunization | No charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $125 copayment/visit Deductible does not apply *(x-ray)*, $25 copayment/visit Deductible does not apply (lab work, Preferred), $50 copayment/visit Deductible does not apply (lab work, Non-Preferred) | Not Covered | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | $750 copayment/visit Deductible does not apply (Office/Ind facility/other outpatient facility) | Not Covered | ——————none—————— |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.hioscar.com/search/OH/drugs?year=2023 | Generic drugs (Tier 1) | $3 copayment/prescription Deductible does not apply (retail, Tier 1A), $30 copayment/prescription Deductible 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 cost-sharing amount. 90-day supply for Maintenance Drugs is subject to 3x retail cost-sharing amount. |
| | Preferred brand drugs (Tier 2) | $50 copayment/prescription subject to deductible (retail), $125 copayment/ prescription subject to deductible (mail order) | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | 50% coinsurance subject to deductible (retail/mail order) | Not Covered | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.hioscar.com/search/OH/drugs?year=2023 | Specialty drugs (Tier 4) | 50% coinsurance subject to deductible (retail/mail order) | Not Covered | Limited to a 30-day supply. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $1,200 copayment/visit Deductible does not apply (surgical and non-surgical services) | Not Covered | ——————none—————— |
| | Physician/surgeon fees | $350 copayment/visit Deductible does not apply | Not Covered | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | $1,500 copayment/visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee) | $1,500 copayment/visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee) | Emergency Room care by an Out-of-Network provider is covered if the services are for an emergency condition. |
| | Emergency medical transportation | $1,500 copayment/visit Deductible does not apply | $1,500 copayment/visit Deductible does not apply | Emergency Transportation services by an Out-of-Network provider are covered if the services are for an emergency condition. |
| | Urgent care | $75 copayment/visit Deductible does not apply | Not Covered | When temporarily out of the Service Area, Out-of-Network Urgent Care services are covered. In addition to applicable cost share, you may be responsible for balance billing. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $3,000 copayment/day | Not Covered | The per day copayment will apply for a maximum of 2 days. |
| | Physician/surgeon fees | $350 copayment/visit Deductible does not apply | Not Covered | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $125 copayment/visit Deductible does not apply (office visit), $350 copayment/visit Deductible does not apply (other outpatient services) | 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/oh

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Inpatient services | $3,000 copayment/day Deductible does not apply | Not Covered | The per day copayment will apply for a maximum of 2 days. |
| **If you are pregnant** | Office Visits | No charge | Not Covered | Depending on the type of services (such as Primary Care Office Visits, Specialist Office Visits, Diagnostic Imaging Services, etc.), the applicable cost-sharing will apply. |
| | Childbirth/delivery professional services | $350 copayment/visit Deductible does not apply | Not Covered | ——————none—————— |
| | Childbirth/delivery facility services | $3,000 copayment | Not Covered | Covers 48-hour hospital stay for uncomplicated vaginal birth and 96-hour hospital stay for uncomplicated caesarean section. |
| **If you need help recovering or have other special health needs** | Home health care | $125 copayment/visit Deductible does not apply | Not Covered | 100 visits per Benefit Period. Limit does not apply to Private Duty Nursing; Private Duty Nursing is limited to 90 visits per Benefit Period. 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. |
| | Rehabilitation services | $125 copayment/visit Deductible does not apply | Not Covered | 20 visits per Benefit Period per therapy for Physical, Speech, Occupational and Pulmonary therapies (Pulmonary therapy is only limited when rendered as part of Physical therapy). 36 visits per Benefit Period for Cardiac Rehabilitation. 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/oh

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Habilitation services | $125 copayment/visit Deductible does not apply | Not Covered | 20 visits per therapy per Benefit Period. 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. |
| | Skilled nursing care | $3,000 copayment/day | Not Covered | The per day copayment will apply for a maximum of 2 days. 90 days per Benefit Period. 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. |
| | Durable medical equipment | 50% coinsurance Deductible does not apply | Not Covered | ——————none—————— |
| | Hospice services | 50% coinsurance Deductible does not apply | Not Covered | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not Covered | ——————none—————— |
| | Children's glasses | 50% coinsurance Deductible 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—————— |

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

## Excluded Services & Other Covered Services:

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

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult and Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Private-duty nursing

**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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, OH 43215 at 1-800-686-1526 or http://www.insurance.ohio.gov/Pages/default.aspx 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: http://www.insurance.ohio.gov/Pages/default.aspx

**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 1-855-OSCAR-55.Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-OSCAR-55.Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-OSCAR-55.

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

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

## About these Coverage Examples:

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

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $125 |
| Hospital (facility) | |
| Other coinsurance | 50% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $4,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,100** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $125 |
| Hospital (facility) copayment | $1,200 |
| Other coinsurance | 50% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles * | $4,200 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$4,800** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $125 |
| Hospital (facility) copayment | $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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $2,100 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,200** |

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan 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
  - 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.

**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.

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

**বাংলা (Bengali):** লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 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 1–855–OSCAR–55.

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

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

**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.

**Ελληνικά (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।

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

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

**ગુજરાતી (Gujarati):** સૂચના: 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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

**Հայերեն (Armenian):** ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-OSCAR-55.

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

**ខ្មែរ (Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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):** ถ้ า คุ ณพู ดภา ษาไทยคุณสามารถใช้ บริการช่ วยเหลือท างภาษาได้ 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 yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' 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။