Oscar Classic Silver Plan

Coverage for: Individual + Family **Plan Type:** EPO

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/?planYear=2018&planState=NJ. 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.dol.gov/ebsa/healthreform or call 1-855-OSCAR-55 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** individual / **$5,000** family	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care**, pre- and post-natal care, blood work by Quest and telemedicine.	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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$7,350** individual / **$14,700** 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 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	$50.00 copay/visit	Not Covered	**Deductible** does not apply.
	Specialist visit	$75.00 copay/visit	Not Covered	**Deductible** does not apply.
	Preventive care / **screening** /immunization	$0.00 copay/visit	Not Covered	**Deductible** does not apply. You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	50% coinsurance (x-ray/blood work)	Not Covered	Blood work provided by Quest is covered at no charge. Blood work provided by **in-network** labs other than Quest is subject to **in-network** cost sharing.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not Covered	**Preauthorization** is required.

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 More information about **prescription drug coverage** is available at **www.hioscar.com/search/NJ/drugs?year=2018**	Generic drugs (Tier 1)	$20.00 copay/prescription (retail), $50.00 copay/prescription (mail order)	Not Covered	Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization** may be required. **Deductible** does not apply.
	Preferred brand drugs (Tier 2)	50% coinsurance (retail/mail order)	Not Covered	Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization** may be required.
	Non-preferred brand drugs (Tier 3)	50% coinsurance (retail/mail order)	Not Covered	Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization** may be required.
	Specialty drugs (Tier 4)	50% coinsurance (retail/mail order)	Not Covered	Covers up to 90 day supply through Oscar Specialty Pharmacy. **Preauthorization** may be required. Please contact Oscar Concierge at 1-855-OSCAR-55 for more information about obtaining **specialty drugs** .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not Covered	**Preauthorization** may be required.
	Physician/surgeon fees	50% coinsurance	Not Covered	**Preauthorization** may be required.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	**Emergency room care**	50% coinsurance	Covered at in-network level	None.
	Emergency medical transportation	50% coinsurance	Covered at in-network level	None.
	Urgent care	$50.00 copay/visit	Covered at in-network level	**Deductible** does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not Covered	**Preauthorization** is required for inpatient stays, except for emergency admissions.
	Physician/surgeon fees	50% coinsurance	Not Covered	**Preauthorization** is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75.00 copay/visit	Not Covered	**Deductible** does not apply.
	Inpatient services	50% coinsurance	Not Covered	**Preauthorization** is required for inpatient stays, except for emergency admissions, and the first 180 days of inpatient care for substance use disorders.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office Visit	$0.00 copay/visit	Not Covered	Deductible does not apply to office visits. cost sharing does not apply to certain preventive services. Depending on the type of services, cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% coinsurance	Not Covered	
	Childbirth/delivery facility services	50% coinsurance	Not Covered	None.
If you need help recovering or have other special health needs	**Home health care**	$50.00 copay/visit	Not Covered	**Preauthorization** is required. **Deductible** does not apply.
	Rehabilitation services	$50.00 copay/visit	Not Covered	Up to 30 visits/year each for Physical, Occupational, Speech, and Cognitive Therapy. **Preauthorization** is required. **Deductible** does not apply.
	Habilitation services	$50.00 copay/visit	Not Covered	Up to 30 visits/year each for Physical, Occupational, Speech, and Cognitive Therapy, subject to **preauthorization** . Visit limits and **preauthorization** do not apply to **habilitation services** for the treatment of autism. **Deductible** does not apply.
	Skilled nursing care	50% coinsurance	Not Covered	**Preauthorization** is required.
	Durable medical equipment	50% coinsurance	Not Covered	**Preauthorization** is required for purchases and rentals >$500.

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	**Hospice services**	50% coinsurance	Not Covered	Inpatient hospice care is subject to the inpatient hospital cost sharing. **Preauthorization** is required.
If your child needs dental or eye care	Children's eye exam	$75.00 copay/visit	Not Covered	1 exam in a 12 month period. **Deductible** does not apply.
	Children's glasses	50% coinsurance	Not Covered	1 pair of glasses or contact lenses in a 12 month period.
	Children's dental check-up	$0.00 copay/visit	Not Covered	Limited to 2 dental check-ups/year. **Deductible** does not apply.

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**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- 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.)

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids (covered for members 15 and younger)
- Infertility treatment (limited to artificial insemination; requires preauthorization)
- Private-duty nursing (covered under Home Health Care)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. To contact Oscar call **1-855-OSCAR-55**, or the contact information for those agencies is: New Jersey Department of Banking and Insurance at 1-609-292-7272 or **http://www.state.nj.us/dobi/consumer.htm**. 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: **1-855-OSCAR-55** or **www.hioscar.com**; or New Jersey Department of Banking and Insurance Consumer Protection Services at **1-888-393-1062**.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.

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**.

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

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:** $2,500
- **Specialist:** $75.00 copay/visit
- **Hospital (facility):** 50% coinsurance
- **Other:** 50% coinsurance

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	**$7,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copays	$300
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$200
The total Peg would pay is	**$4,600**

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

- **The plan's overall deductible:** $2,500
- **Specialist:** $75.00 copay/visit
- **Hospital (facility):** 50% coinsurance
- **Other:** 50% coinsurance

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	**$5,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copays	$800
Coinsurance	$300
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$3,680**

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

- **The plan's overall deductible:** $2,500
- **Specialist:** $75.00 copay/visit
- **Hospital (facility):** 50% coinsurance
- **Other:** 50% coinsurance

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copays	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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:

NY/NJ/TX/OH/TN Members: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072

CA Members: Oscar Health Plan of California, Attention Grievances 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), 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.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Oscar, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-855-OSCAR-55.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Oscar، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أية تكلفة. للتحدث مع مترجم، اتصل بالرقم 1-855-OSCAR-55.

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Oscar մասին, Դուք իրավունք ունեք ստանալ անվճար օգնություն և տեղեկություն Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 1-855-OSCAR-55

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, Oscar, সম্পর্কে প্রশ্ন আছে আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন ১-৮৫৫-অস্কার-৫৫.

如果您，或是您正在協助的對象，有關於 Oscar 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-855-OSCAR-55。

اگر شما، یا فردی که شما به او کمک می کنید ، سوالی در مورد Oscar داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره 1-855-OSCAR-55 تماس بگیرید.

Si vous, ou une personne que vous aidez, a des questions à propos d'Oscar, vous avez le droit d'obtenir de l'aide et des informations dans votre langue gratuitement. Pour parler à un interprète, appelez le 1-855-OSCAR-55.

Falls Sie oder jemand, dem Sie helfen, Fragen zu Oscar haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-855-OSCAR-55 an.

Εάν εσείς ή κάποιος που βοηθάτε έχετε απορίες σχετικά με την Oscar, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς καμία χρέωση. Για να μιλήσετε με έναν διερμηνέα, καλέστε στον αριθμό 1-855-OSCAR-55.

જો તમે અથવા તમે મદદ કરી રહ્યા હો તેમાંથી કોઈને Oscar વિશે પ્રશ્નો હોય તો, તમને તમારી ભાષામાં નિશૂલ્ક મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-855-OSCAR-55 પર ફોન કરો.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Oscar, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-855-OSCAR-55.

यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के पास Oscar के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दोभाषिए से बात करने के लिए, 1-855-OSCAR-55 पर कॉल करें।

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Oscar, koj muaj cai kom lawv muab cov ntsiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-855-OSCAR-55.

Se tu o qualcuno che stai aiutando avete domande su Oscar, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-OSCAR-55.

貴殿または貴殿の援助されている方でも、Oscarについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話をされる場合、1-855-OSCAR-55までお電話ください。

ប្រសិនបើលោកអ្នក ឬនរណាម្នាក់ដែលលោកអ្នកកំពុងជួយ មានសំណួរនានាអំពី Oscar លោកអ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសារបស់លោកអ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរសព្ទទៅលេខ 1-855-OSCAR-55 ។

귀하 또는 귀하가 돕고 있는 사람이Oscar에 관해서 문의사항이 있는 경우, 귀하에게는 이러한 도움과 정보를 귀하의 언어로 비용 부담없이 제공받을 권리가 있습니다. 통역 서비스를 원하시면1-855-OSCAR-55번으로 전화해 주십시오.

ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອຢູ່ມີຄຳຖາມກ່ຽວກັບ Oscar, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໃຫ້ໂທຫາ 1-855-OSCAR-55.

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Oscar, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-855-OSCAR-55.

ਜੇ ਤੁਹਾਡੇ ਕੋਲ, ਜਾਂ ਤੁਸੀ ਜਸਿ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Oscar ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਨਿਾਂ ਕਸਿ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Oscar, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-OSCAR-55.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Oscar, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-OSCAR-55.

Kung ikaw o ang iyong tinutulungan ay may mga tanong tungkol sa Oscar, may karapatan kang makatanggap ng libreng tulong at impormasyon nang nasa iyong wika. Upang makipag-usap sa isang tagasalin, tumawag sa 1-855-OSCAR-55.

หากคุณหรือคนที่คุณก าลังช่วยเหลือมีค าถามเกี่ยวกับ Oscar
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-855-OSCAR-55.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про програму OSCAR, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв’язатись з перекладачем, задзвоніть за номером 1-855-OSCAR-55.

اگر آپ یا آپ کسی کی مدد کر رہے /رہی ہیں ان کو Oscar کے بارے سوالات پوچھنے ہیں ، تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے 1-855-OSCAR-55 پر کال کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Oscar, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-OSCAR-55.

אויב איר, אודר עמצער איר העלפסט, האט פראגעס וועגן Oscar, איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך אומזיסט. צו רעדן מיט דער אייבערזעצער, קלונג 1-855-OSCAR-55