Coverage Period: 01/01/2022 - 12/31/2022

Coverage for: Individual + Family | Plan Type: EPO

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 https://www.hioscar.com/forms/2022/ne. 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 <u>underlined</u> terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call <u>1-855-OSCAR-55</u> 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 <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and preand 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</u> <u>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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$600 individual / \$1,200 family for prescription drug coverage. There are 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 <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 individual / \$5,000 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?	Premiums, balance billing charges, healthcare this plan does not cover, and penalties for failure to obtain preauthorization for services.	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 <u>www.hioscar.com</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</u> <u>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> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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	Limitationa Evacationa & 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
	Primary care visit to treat an injury or illness	\$10 <u>copayment</u> /visit <u>Deductible</u> does not apply	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.
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$25 <u>copayment</u> /visit <u>Deductible</u> 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)	\$25 <u>copayment</u> /visit <u>Deductible</u> does not apply (<i>x-ray</i>), \$10 <u>copayment</u> /visit <u>Deductible</u> does not apply (lab work, Preferred), \$20 <u>copayment</u> /visit <u>Deductible</u> does not apply (lab work, Non-Preferred)	Not Covered	none
	Imaging (CT/PET scans, MRIs)	\$75 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	none
If you need drugs to treat your illness or condition		\$3 <u>copayment</u> / prescription <u>Deductible</u> does not apply (retail, Tier 1A), \$20 <u>copayment</u> / prescription <u>Deductible</u> does not apply (retail, Tier 1B)	Not Covered	Retail is limited to a 30-day supply.
More information about prescription drug coverage is available at www.hioscar.com/search/NE/drugs?year=2022	Preferred brand drugs (Tier 2)	\$60 <u>copayment</u> /prescription <u>Deductible</u> does not apply (retail), \$150 <u>copayment</u> /prescription <u>Deductible</u> does not apply (mail order)	Not Covered	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.
	Non-preferred brand drugs (Tier 3)	50% <u>coinsurance</u> subject to <u>deductible</u> (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/2022/ne.

	Services You	What You	Limitations Everytions 9 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 More information about	Specialty drugs	50% coinsurance subject to	Not Covered	Limited to a 30 day cumply
prescription drug coverage is available at www.hioscar.com/search /NE/drugs?year=2022	(Tier 4)	deductible (retail/mail order)	Not Covered	Limited to a 30-day supply.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$200 copayment/visit Deductible does not apply	Not Covered	none
surgery	Physician/surgeon fees	\$75 copayment /visit Deductible does not apply	Not Covered	none-
	Emergency room care	\$300 copayment/visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee)	\$300 copayment/visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee)	Cost-share waived if admitted. <u>Out-of-Network</u> Emergency Room services are covered if the services are for an emergency condition.
If you need immediate medical attention	Emergency medical transportation	\$300 <u>copayment</u> /visit <u>Deductible</u> does not apply	\$300 <u>copayment</u> /visit <u>Deductible</u> does not apply	Emergency Transportation services by an Out-of-Network provider are covered if the services are for an emergency condition.
	Urgent care	\$15 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	none
If you have a hospital	Facility fee (e.g., hospital room)	\$300 copayment/day Deductible does not apply	Not Covered	The per day copayment will apply for a maximum of 2 days.
stay	Physician/surgeon fees	\$75 copayment /visit Deductible does not apply	Not Covered	none-
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copayment</u> /visit <u>Deductible</u> does not apply (office visit), \$75 <u>copayment</u> /visit <u>Deductible</u> does not apply (for other outpatient services)	Not Covered	none
	Inpatient services	\$300 <u>copayment</u> /day <u>Deductible</u> does not apply	Not Covered	The per day copayment will apply for a maximum of 2 days.

^{*}For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2022/ne.

Services You		What You	Limitationa Evacutiona 9 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
	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.
If you are pregnant	Childbirth/delivery professional services	\$75 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	none
	Childbirth/delivery facility services	\$300 <u>copayment</u> /day <u>Deductible</u> does not apply	Not Covered	The per day copayment will apply for a maximum of 2 days.
If you need help recovering or have other special health needs	Home health care	\$25 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	60 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.
	Rehabilitation services	\$25 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	45 treatments per Benefit Period combined for Osteopathic Physiotherapy, Occupational, Physical, Speech Therapy. 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.
	Habilitation services	\$25 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	45 treatments per Benefit Period combined for Osteopathic Physiotherapy, Occupational, Physical, Speech Therapy. 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/2022/ne.

	Services You	What You Will Pay		Limitations Eventions & 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 help recovering or have other special health needs	Skilled nursing care	\$300 <u>copayment</u> /day <u>Deductible</u> does not apply	Not Covered	The per day <u>copayment</u> will apply for a maximum of 2 days. 60 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% <u>coinsurance</u> <u>Deductible</u> does not apply	Not Covered	none
	Hospice services	50% <u>coinsurance</u> <u>Deductible</u> does not apply	Not Covered	none
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One (1) per Benefit Period.
	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	No charge	Not Covered	One (1) visit per 6 months.

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 surgeryCosmetic surgery

- Dental care (Adult)Infertility treatment
- Long-term carePrivate-duty nursing

- Routine eye care (Adult)Routine foot care
- · Weight loss programs

^{*}For more information about limitations, exceptions, and prior authorization, see the plan or policy document at https://www.hioscar.com/forms/2022/ne.

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

- · Chiropractic care
- Hearing aids

Non-emergency care when traveling outside the U.S.

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: Nebraska Department of Insurance, P.O. Box 82089, Lincoln, NE 68501 at <u>402-471-2201</u> or <u>https://doi.nebraska.gov/consumer/consumer-assistance</u> or contact Oscar at <u>1-855-OSCAR-55</u>. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call <u>1-800-318-2596</u>.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

https://doi.nebraska.gov/consumer/consumer-assistance

Does this plan provide Minimum Essential Coverage? Yes.

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

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/2022/ne.

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	\$25
Hospital (facility) copayment	\$300
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			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$600		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Peg would pay is	\$600		

I he <u>plan</u> 's overall <u>deductible</u>	\$0
Specialist copayment	\$25
Hospital (facility) copayment	\$200
Other coinsurance	50%

This EXAMPLE event includes services like: Primary care physician office visits (including

disease education)

Diagnostic tests (blood work)

Prescription drugs

Managi	ing Joe's	Type 2	Diabetes
(a year of	routine in-r	network ca	are of a well-
	controlled	I conditior	1)

<u>eductible</u>	\$0	The plan's overall deductible
<u>ıt</u>	\$25	Specialist copayment
<u>payment</u>	\$200	Hospital (facility) copayment
-	50%	Other coinsurance

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Mia's Simple Fracture

(in-network emergency room visit and follow up

care)

Diagnostic test (x-ray)

Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$5,600		
In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$1,500		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Joe would pay is	\$1,500		

\$2,800
\$0
\$900
\$100
\$0
\$1,000

\$0 \$25 \$200 50%

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.

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

বাংলা (Bengali): লক্ষ্য করুলঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:থরচায় তাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুল ১-৪55-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 1-558–8ACSO-558.

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

اُرِدُو (Urdu): خبر دار: اگر آپ ار دو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 55-855-0SCAR

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।

فارسىي (Farsi): توجه: اگر به زبان فارسىي گفتگو مي كنيد، تسميلات زباني بصورت رايگان براي شما .بگيريد ت OSCAR-55-.

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

ગુજરાતી (Gujarati): સુયના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહ્યુય 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, ໂດຍບໍ່ເສັຽຄ່າ, 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): ማስተወሻ: የማና7ረት ቋንቋ አማርኛ ከሆነ የትርንም እርዳት ድርጅቶች፣ በነጻ ስ የግዝዎት ተዘገጀተዋል፡ ወደ ማከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանդահարեք 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 ដោយមិនកិតឈ្នល 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 ดภาษาไทยคุณสามารถใช้ 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 yánílti go Diné Bizaad, saad bee áká ánída áwo déé, t'áá jiik'eh, éí ná hóló, koji hódíílnih 1-855-OSCAR-55 (TTY: 711.)

Srpsko-hrvatski (Serbo-Croatian): OBAV|EŠTEN|E: 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 ခေါ် ဆိုပါ။