



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/2022/ga>. 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 <u>deductible</u> ? | \$1,000 individual / \$2,000 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 care</u> , pre-and post-natal care, PCP/ <u>Specialist</u> visits, <u>urgent care</u> , outpatient mental health/substance use disorders office visits, home health, LifeSource Transplant Services, T1-T2 drugs, Pediatric Vision, and Pediatric Dental. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| 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> ? | \$2,900 individual / \$5,800 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 <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance billing</u> charges, healthcare this <u>plan</u> does not cover, and penalties for failure to obtain <u>preauthorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.hioscar.com or call 1-855-OSCAR-55 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's 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's</u> 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> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 | No charge | Not Covered | Cost share applies to both in-person and virtual services. Virtual urgent care services from Oscar designated telemedicine providers are covered in full. |
| | Specialist visit | \$20 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) | \$50 copayment /visit Deductible does not apply (x-ray), \$10 copayment /visit Deductible does not apply (lab work, Preferred), \$30 copayment /visit Deductible does not apply (lab work, Non-Preferred) | Not Covered | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | \$75 copayment /visit Deductible does not apply | 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/GA/drugs?year=2022 | Generic drugs (Tier 1) | No charge (retail, Tier 1A), \$10 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 3x retail cost-sharing amount. |
| | Preferred brand drugs (Tier 2) | \$75 copayment /prescription Deductible does not apply (retail), \$225 copayment /prescription Deductible does not apply (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/2022/ga>.

| 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/GA/drugs?year=2022 | 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) | \$100 copayment /visit Deductible does not apply | Not Covered | _____none_____ |
| | Physician/surgeon fees | \$50 copayment /visit Deductible does not apply | Not Covered | _____none_____ |
| If you need immediate medical attention | Emergency room care | \$150 copayment /visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee) | \$150 copayment /visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee) | Cost-share waived if admitted. Out-of-Network Emergency Room services are covered if the services are for an emergency condition. |
| | Emergency medical transportation | \$150 copayment /visit Deductible does not apply | \$150 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 | \$50 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) | \$200 copayment /day subject to deductible | Not Covered | The per day copayment will apply for a maximum of 3 days. |
| | Physician/surgeon fees | \$50 copayment /visit Deductible does not apply | Not Covered | _____none_____ |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 copayment /visit Deductible does not apply (office visit), \$50 copayment /visit Deductible does not apply (for 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/2022/ga>.

| 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 | \$200 <u>copayment</u> /day subject to <u>deductible</u> | Not Covered | The per day <u>copayment</u> will apply for a maximum of 3 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 <u>cost-sharing</u> will apply. |
| | Childbirth/delivery professional services | \$50 <u>copayment</u> /visit <u>Deductible</u> does not apply | Not Covered | _____none_____ |
| | Childbirth/delivery facility services | \$200 <u>copayment</u> /day subject to <u>deductible</u> | Not Covered | The per day <u>copayment</u> will apply for a maximum of 3 days. 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 | <u>Home health care</u> | \$20 <u>copayment</u> /visit <u>Deductible</u> does not apply | Not Covered | 120 visits per Benefit Period. |
| | <u>Rehabilitation services</u> | \$20 <u>copayment</u> /visit <u>Deductible</u> does not apply | Not Covered | 40 visits per benefit period combined for physical therapy, occupational therapy, spinal manipulation, speech therapy or speech pathology services, and audiology services. |
| | <u>Habilitation services</u> | \$20 <u>copayment</u> /visit <u>Deductible</u> does not apply | Not Covered | 40 visits per benefit period. |
| | <u>Skilled nursing care</u> | \$200 <u>copayment</u> /day subject to <u>deductible</u> | Not Covered | The per day <u>copayment</u> will apply for a maximum of 3 days. 60 days per Benefit Period. |
| | <u>Durable medical equipment</u> | 50% <u>coinsurance</u> subject to <u>deductible</u> | Not Covered | _____none_____ |
| | <u>Hospice services</u> | 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/2022/ga>.

| 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 your child needs dental or eye care | Children's eye exam | No charge | Not Covered | One (1) per Benefit Period. |
| | 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 | 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 surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (see Evidence of Coverage for complete details)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Weight loss programs (limits apply)

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: Georgia Office of Insurance and Safety Fire Commissioner, 2 Martin Luther King Jr. Dr., Atlanta, GA 30334 at **404-656-2070** or <http://www.oci.ga.gov/ConsumerService> 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.oci.ga.gov/ConsumerService>

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/ga>.

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, kwijigo holne' **1-855-OSCAR-55**.

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 **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 | \$1,000 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$200 |
| ■ 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 | \$1,000 |
| Copayments | \$500 |
| Coinsurance | \$0 |

| | |
|--------------------|--|
| What isn't covered | |
|--------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|----------------------------|---------|
| The total Peg would pay is | \$1,500 |
|----------------------------|---------|

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|----------------------------------------|---------|
| ■ The plan's overall deductible | \$1,000 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$100 |
| ■ Other coinsurance | 50% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs

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

In this example, Joe would pay:

| | |
|--------------|--|
| Cost Sharing | |
|--------------|--|

| | |
|--------------------|---------|
| Deductibles | \$0 |
| Copayments | \$1,600 |
| Coinsurance | \$0 |

| | |
|--------------------|--|
| What isn't covered | |
|--------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|----------------------------|---------|
| The total Joe would pay is | \$1,600 |
|----------------------------|---------|

Mia's Simple Fracture

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

| | |
|----------------------------------------|---------|
| ■ The plan's overall deductible | \$1,000 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) copayment | \$100 |
| ■ 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 | \$200 |
| Copayments | \$500 |
| Coinsurance | \$0 |

| | |
|--------------------|--|
| What isn't covered | |
|--------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|----------------------------|-------|
| The total Mia would pay is | \$700 |
|----------------------------|-------|

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. 1-855-OSCAR-55 רופט.

বাংলা (Bengali): লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিসেবা 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 انكر 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.

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।

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید 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): 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): ໂປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 አገልግሎት ድርጅቶቻችን በየዓለሙ ለሚገኙት ተዘጋጅተዋል፡ ወደ ሚክላው ቁጥር 1-855-OSCAR-55.

Հայերեն (Armenian): Ուշադրություն: Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցություններ: Ձանդահարեք 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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, លេខជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ ក៏អាចមានសំណប់ផងដែរ។ 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): ถ้าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่วยเหลือทางภาษาได้ 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 niederlands 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: Dii baa akó nínizín: Dii saad bee yáníłti'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။