Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Oscar: AI/AN Limited Cost Sharing

Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual + Family | Plan Type: PPO

⚠️ 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/ok**. 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 at Indian Health Care **Provider** (IHCP) or with IHCP **referral** at non-IHCP; or $3,500 individual / $7,000 family for **in-network** and $10,500 individual / $21,000 family for **out-of-network**	Generally, you must pay all of 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, and Primary Care office visits.	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?	$7,500 individual / $15,000 family for **in-network** / Unlimited for **out-of-network**	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**).
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
		Indian Health Care Provider (IHCP) (You will pay the least)	**Non-IHCP In-Network Provider (You will pay more)**	**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	No charge	50% **coinsurance** subject to **deductible**	Cost share applies to both in-person and virtual services. Virtual **urgent care** services from Oscar designated telemedicine **providers** are covered in full. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Specialist visit	No charge	$60 **copayment**/visit **Deductible** does not apply	50% **coinsurance** subject to **deductible**	Cost share applies to both in-person and virtual services. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Preventive care/ **screening**/ immunization	No charge	No charge	50% **coinsurance** subject to **deductible**	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)	No charge	$75 **copayment**/visit subject to **deductible** *(x-ray)*, $10 **copayment**/visit **Deductible** does not apply (lab work, Preferred), $50 **copayment**/visit **Deductible** does not apply (lab work, Non-Preferred)	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Imaging (CT/PET scans, MRIs)	No charge	$200 **copayment**/ visit subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	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/OK/drugs?year=2022**	Generic drugs (Tier 1)	No charge	No charge (retail, Tier 1A), $25 **copayment**/prescription **Deductible** does not apply (retail, Tier 1B)	50% **coinsurance** subject to **deductible**	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x the retail **cost-sharing** amount. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization**/step therapy may be required. If you don't get **preauthorization** payment for care may be denied.
	Preferred brand drugs (Tier 2)	No charge	$100 **copayment**/prescription subject to **deductible** (retail), $300 **copayment**/prescription subject to **deductible** (mail order)	50% **coinsurance** subject to **deductible**	
	Non-preferred brand drugs (Tier 3)	No charge	50% **coinsurance** subject to **deductible** (retail/mail order)	50% **coinsurance** subject to **deductible**	
	Specialty drugs (Tier 4)	No charge	50% **coinsurance** subject to **deductible** (retail/mail order)	50% **coinsurance** subject to **deductible**	Limited to a 30-day supply. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization**/step therapy may be required. If you don't get **preauthorization** payment for care may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$350 **copayment**/visit subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** may be required.
	Physician/surgeon fees	No charge	$150 **copayment**/visit subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** may be required.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	**Non-IHCP In-Network Provider (You will pay more)**	**Out-of-Network Provider (You will pay the most)**	
If you need immediate medical attention	**Emergency room care**	No charge	$650 **copayment**/visit subject to **deductible** (ER Facility Fee), $0 **copayment**/visit subject to **deductible** (ER Physician Fee)	$650 **copayment**/visit subject to **deductible** (ER Facility Fee), $0 **copayment**/visit subject to **deductible** (ER Physician Fee)	Cost-share waived if admitted. **Out-of-Network** Emergency Room services are covered if the services are for an emergency condition. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Emergency medical transportation	No charge	$650 **copayment**/visit subject to **deductible**	$650 **copayment**/visit subject to **deductible**	Emergency Transportation services by an **Out-of-Network provider** are covered if the services are for an emergency condition. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Urgent care	No charge	$75 **copayment**/visit **Deductible** does not apply	50% **coinsurance** subject to **deductible**	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**. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$500 **copayment**/day subject to **deductible**	50% **coinsurance** subject to **deductible**	The per day **copayment** will apply for a maximum of 3 days. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Physician/surgeon fees	No charge	$150 **copayment**/ visit subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$60 **copayment**/visit **Deductible** does not apply (office visit), $150 **copayment**/ visit **Deductible** does not apply (for other outpatient services)	50% **coinsurance** subject to **deductible**	**Preauthorization** may be required for outpatient non-office services. Outpatient Mental Health Office Visit **cost-sharing** applies to services to treat Autism. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Inpatient services	No charge	$500 **copayment**/ day subject to **deductible**	50% **coinsurance** subject to **deductible**	The per day **copayment** will apply for a maximum of 3 days. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
If you are pregnant	Office Visits	No charge	No charge	50% **coinsurance** subject to **deductible**	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. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).
	Childbirth/delivery professional services	No charge	$150 **copayment**/ visit subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**).

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	No charge	$500 **copayment**/day subject to **deductible**	50% **coinsurance** subject to **deductible**	The per day **copayment** will apply for a maximum of 3 days. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** is not required if patient stay <48 hours (<96 hours for a cesarean). If you do not get **preauthorization**, payment for care may be denied.
If you need help recovering or have other special health needs	**Home health care**	No charge	$60 **copayment**/visit **Deductible** does not apply	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). 30 visits per Benefit Period. Limit does not apply to Private Duty Nursing; Private Duty Nursing is limited to 85 visits per Benefit Period.
	Rehabilitation services	No charge	$75 **copayment**/visit **Deductible** does not apply	50% **coinsurance** subject to **deductible**	30 visits per Benefit Period combined for Physical, Occupational, and 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. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Habilitation services	No charge	$75 **copayment**/visit **Deductible** does not apply	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). 30 visits per Benefit Period combined for Physical, Occupational, and 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. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	**Non-IHCP In-Network Provider (You will pay more)**	**Out-of-Network Provider (You will pay the most)**	
If you need help recovering or have other special health needs	**Skilled nursing care**	No charge	$500 **copayment**/day subject to **deductible**	50% **coinsurance** subject to **deductible**	The per day **copayment** will apply for a maximum of 3 days. **Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). 30 days per Benefit Period. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Durable medical equipment	No charge	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** may be required.
	Hospice services	No charge	50% **coinsurance** subject to **deductible**	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). One (1) per Benefit Period.
	Children's glasses	No charge	50% **coinsurance** **Deductible** does not apply	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). One (1) prescribed lenses and frames per Benefit Period. Contacts covered in lieu of glasses. $150 allowance for Lenses and Frames, or Contact Lenses.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	No charge	No charge	50% **coinsurance** subject to **deductible**	**Cost sharing** waived at non-IHCP with IHCP **referral**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference (**balance billing**). One (1) preventive 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 (except in the case or rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery

- Dental care (Adult)
- Infertility treatment (except for diagnostic and exploratory procedures)
- 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

- Hearing aids (one hearing aid per ear every 48 months)

- Private-duty nursing (85 visits per Benefit Period)

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: Oklahoma Insurance Department , 400 NE 50th Street, Oklahoma City,, OK 73105 at **800-522-0071** or **https://www.oid.ok.gov/** or contact Oscar at **1-855-OSCAR-55**. Other coverage options may be available to you too, including buying individual insurance coverage through the **Health Insurance Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights:

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

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**.

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

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/ok.

⚠ **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)		**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The **plan's** overall **deductible**	$3,500	■ The **plan's** overall **deductible**	$3,500	■ The **plan's** overall **deductible**	$3,500
■ Specialist **copayment**	$60	■ Specialist **copayment**	$60	■ Specialist **copayment**	$60
■ Hospital (facility) **copayment**	$500	■ Hospital (facility) **copayment**	$350	■ Hospital (facility) **copayment**	$350
■ Other **coinsurance**	50%	■ Other **coinsurance**	50%	■ Other **coinsurance**	50%

This EXAMPLE event includes services like:	This EXAMPLE event includes services like:	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)*	**Primary care physician** office visits *(including disease education)* **Diagnostic tests** *(blood work)* **Prescription drugs** **Durable medical equipment** *(glucose meter)*	**Emergency room care** *(including medical supplies)* **Diagnostic test** *(x-ray)* **Durable medical equipment** *(crutches)* **Rehabilitation services** *(physical therapy)*

Total Example Cost	$12,700	Total Example Cost	$5,600	Total Example Cost	$2,800

In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$0	Copayments	$0	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$0	Limits or exclusions	$0
The total Peg would pay is	**$0**	**The total Joe would pay is**	**$0**	**The total Mia would pay is**	**$0**

Note: These numbers assume the patient received care from an IHCP **provider** or with IHCP **referral** at a non-IHCP. If you receive care from a non-IHCP **provider** without a **referral** from an IHCP your costs may be higher.

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.

Oscar hioscar.com

OSC-NDN

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 1–558–RACSO–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 ت 855–OSCAR-55–1.

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

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

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

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ຽຄ່າ, 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 ተዘጋጅተዋል፡ 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): 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 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 nínizin: Díí saad bee yáníłti'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): 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။

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