



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthnet.com or by calling 1-888-802-7001.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$2,500 member / \$5,000 family through PPO and \$7,500 member / \$15,000 family through OON per calendar year.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$6,850 member / \$13,700 family through PPO and \$20,550 member / \$41,100 family through OON per calendar year. Deductible included in OOPL.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of preferred providers , see www.healthnet.com or call 1-888-802-7001.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call the number on your Health Net ID card (current members) or 1-888-802-7001 or visit us at www.healthnet.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://ccio.cms.gov> or call 1-888-802-7001 or the number on your Health Net ID card to request a copy.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use CommunityCare Network (Level 1)	Your Cost If You Use an Out-of-network Provider (Level 2)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35	75% co-ins after ded	—————none—————
	Specialist visit	\$70	75% co-ins after ded	—————none—————
	Other practitioner office visit	Chiropractic-\$35 Acupuncture-Not Covered	Not covered	No limits apply to chiropractic care. Nurse/physician assistant is covered at the primary care visit cost share.
	Preventive care/screening/immunization	No charge deductible waived	75% coinsurance deductible waived	Some preventive health services require you to pay a cost share. For a complete list of preventive services covered with no cost-sharing visit www.healthnet.com/preventivecare or call member services at 1-888-802-7001.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins after ded	75% co-ins after ded	—————none—————
	Imaging (CT/PET scans, MRIs)	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.
If you need drugs to treat your illness or condition	Preferred generic drugs	\$15 per 30 day retail order; \$30/mail order	Not covered	Supply/order: 30-90 day (retail); 60 and 90 day supplies available for additional charge; 35-90 day (mail

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Health Net Oregon Standard Silver Plan

Coverage Period: Beginning on or after 01/01/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | Coverage for: Individual/Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use CommunityCare Network (Level 1)	Your Cost If You Use an Out-of-network Provider (Level 2)	Limitations & Exceptions
More information about prescription drug coverage is available at www.healthnet.com .	Preferred brand drugs	\$50 per 30 day retail order; \$100/mail order	Not covered	order). May require prior authorization. Anti-cancer drugs at 30% coinsurance.
	Non-preferred brand or generic drugs	50% coinsurance retail/mail order	Not covered	
	Specialty drugs	50% coinsurance	Not covered	Supply/order: 30-90 day supply filled by a specialty pharmacy. May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins after ded	75% co-ins after ded	Requires prior authorization. Coverage includes abortion services.
	Physician/surgeon fees	30% co-ins after ded	75% co-ins after ded	May require prior authorization.
If you need immediate medical attention	Emergency room services	30% co-ins after ded	30% co-ins after ded	—————none—————
	Emergency medical transportation	30% co-ins after ded	30% co-ins after ded	—————none—————
	Urgent care	\$70	\$70	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.
	Physician/surgeon fee	30% co-ins after ded	75% co-ins after ded	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office-\$35 deductible waived Other than office-30% co-ins after ded	75% co-ins after ded	Requires prior authorization except for office visits.
	Mental/Behavioral health inpatient services	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.
	Substance use disorder outpatient services	Office-\$35 deductible waived Other than office-30% co-ins after ded	75% co-ins after ded	Requires prior authorization except for office visits.
	Substance use disorder inpatient services	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.

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Common Medical Event	Services You May Need	Your Cost If You Use CommunityCare Network (Level 1)	Your Cost If You Use an Out-of-network Provider (Level 2)	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	30% co-ins after ded	75% co-ins after ded	—————none—————
	Delivery and all inpatient services	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.
	Rehabilitation services	Outpatient-\$35 Inpatient-30% co-ins after ded	75% co-ins after ded	Outpatient-Max 30 visits combined for all rehab visits per cal year / Inpatient-Max 30 days per cal year (Level 1/2 combined). May require prior authorization.
	Habilitation services	Outpatient-\$35 Inpatient-30% co-ins after ded	75% co-ins after ded	Outpatient-Max 30 visits combined for all rehab visits per cal year / Inpatient-Max 30 days per cal year (Level 1/2 combined). May require prior authorization.
	Skilled nursing care	30% co-ins after ded	75% co-ins after ded	Max 60 days per calendar year (Level 1/2 combined). Requires prior authorization.
	Durable medical equipment	30% co-ins after ded	75% co-ins after ded	May require prior authorization.
	Hospice service	30% co-ins after ded	75% co-ins after ded	Requires prior authorization.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Eye exams are limited to 1 visit per year.
	Glasses	No charge	Not covered	Glasses are limited to 1 pair per year. Health Net vision benefits are provided through Eyemed. Eyemed providers can be found using provider search on www.healthnet.com or by calling 1-866-392-6058.
	Dental check-up	Not covered	Not covered	—————none—————

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-------------------------------|--|----------------------------|
| • Acupuncture | • Infertility treatment | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Child & Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|--|--|
| • Abortion services – All terminations of pregnancy (abortion) services provided by a licensed provider, including those for which federal funding is prohibited, are covered by this plan. | • Chiropractic care | • Routine foot care (In connection with the treatment of diabetes) |
| | • Cosmetic surgery (Medically necessary) | |
| | • Hearing aids | |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-888-802-7001. You may also contact your state insurance department by calling (503) 947-7984 or the toll free message line at (888) 877-4894; by writing to the Division of Financial Regulation, Department of Consumer and Business Services, Insurance Division, 350 Winter Street NE, Salem, OR 97301-3838; through the internet at <http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx>; or by e-mail at: cp.ins@state.or.us.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Net's Customer Contact Center at 1-888-802-7001, submit a grievance form through www.healthnet.com, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. You have the right at any time to file a complaint with or seek assistance from the Division of Financial Regulation. If you choose to do so, assistance is available. Contact the Division of Financial Regulation at PO Box 14480, Salem, OR 97309-0405. Contact them by phone at 1-503-947-7984 or toll free at 1-888-877-4894, by email at cp.ins@state.or.us or online at www.cbs.state.or.us/ins/consumer/consumer.html. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform/>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-802-7001.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-802-7001.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-802-7001.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-888-802-7001.

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$3,420**
- **Patient pays \$4,120**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,500
Copays	\$20
Coinsurance	\$1,400
Limits or exclusions	\$200
Total	\$4,120

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,120**
- **Patient pays \$3,280**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,500
Copays	\$500
Coinsurance	\$200
Limits or exclusions	\$80
Total	\$3,280

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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DHK/WSA/W7K/C0L/7G/D0

Health Net Health Plan of Oregon, Inc. (“Health Net”) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-802-7001 (TTY: 711).

If you believe that Health Net 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 by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center 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, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Employer group members please call 1-888-802-7001 (TTY: 711).

Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-888-802-7001 (TTY: 711).

Chinese

免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。雇主團體的會員請致電 1-888-802-7001 (TTY: 711)。

Cushite (Oromo)

Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha lagu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Xubnaha kooxda badrooniga fadlan soo wac 1-888-802-7001 (TTY: 711).

French

Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Membres du groupe employeur veuillez composer le 1-888-802-7001 (TTY: 711).

German

Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-888-802-7001 (TTY: 711) an.

Japanese

無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。雇用主を通じた団体保険のメンバーの方は、1-888-802-7001 (TTY: 711) までお電話ください。

Korean

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 고용주 그룹 가입자분은 1-888-802-7001 (TTY: 711)번으로 전화해 주십시오.

Khmer

សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ បេក្ខជន សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

Romanian

Servicii lingvistice gratuite. Puteți obține un interpret. Puteți avea documente citite pentru dvs. Pentru asistență telefonați-ne la numărul indicat pe cardul de membru. Membrii grupului angajatorilor să telefoneze la 1-888-802-7001 (TTY: 711).

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. اعضای گروه کارفرما لطفاً با شماره (TTY: 711) 1-888-802-7001 تماس بگیرید.

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочесть документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы участник коллективного плана, предоставляемого работодателем, звоните по телефону 1-888-802-7001 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados del grupo del empleador deben llamar al 1-888-802-7001 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกกลุ่มนายจ้าง กรุณาโทร 1-888-802-7001 (TTY: 711)

Ukrainian

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