


! 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, visit aspirushealthplan.com or call 866-631-4611. 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 <https://www.healthcare.gov/sbc-glossary> /or call 866-631-4611 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | For participating <u>providers</u> : \$4,350 / Covered Person or \$8,700 / 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 deductible? | Yes. <u>Preventive care</u> services, office visits and prescription drugs, other than <u>specialty drugs</u> , purchased from a pharmacy are covered before you meet your <u>deductible</u> . | 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 deductibles for specific services? | Yes. \$750 / Covered Person or \$1,500 / Family for <u>specialty drugs</u> . There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For participating <u>providers</u> : \$6,500 / Covered Person or \$13,000 / 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? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | 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 network provider? | Yes. See https://p1.aspirushealthplan.com/find-a-doctor/ or call 866-631-4611 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 referral to see a specialist? | Yes. | This plan will pay some or all of the costs to see a non-participating or tertiary specialist for covered services, but only if you have a referral before you see the specialist. |

 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 |
|---|--|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | \$35 <u>copayment</u> / office visit and 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the office visit charge | Not covered | <u>Copayment</u> waived for the first three visits with a primary care practitioner. \$0 <u>copayment</u> / telehealth visit charge with our approved telehealth provider \$10 <u>copayment</u> / office visit charge for a convenient care clinic visit \$35 <u>copayment</u> / visit for chiropractor |
| | <u>Specialist</u> visit | \$70 <u>copayment</u> / office visit and 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the office visit charge | Not covered | None |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | Not covered | Certain genetic tests and high-technology imaging may require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | Not covered | |
| If you need drugs to treat your illness or condition | Tier 1 drugs | Retail: \$20 <u>copayment</u> / prescription (30-day supply) & 2.5 times the retail <u>copayment</u> / prescription (90-day supply) for retail and home delivery | Not covered | Preferred generic drugs are no charge. The <u>deductible</u> does not apply to generic and brand name drugs which are not <u>specialty drugs</u> . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| <p>More information about <u>prescription drug coverage</u> is available at https://www.aspirushealthplan.com/group-individual/Aspirus_Drug_Formulary/AspirusDrugFormulary2021.pdf</p> | Tier 2 drugs | Retail: \$40 <u>copayment</u> / prescription (30-day supply) & 2.5 times the retail <u>copayment</u> / prescription (90-day supply) for retail and home delivery | Not covered | <p>Covers up to a 90-day supply.</p> <p>If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which does not count toward your <u>out-of-pocket limit</u>. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization.</p> <p><u>Specialty drugs</u> are subject to a separate <u>deductible</u> amount and are always limited to a 30-day supply. <u>Specialty drugs</u> require prior authorization. Benefits may not be payable if you do not obtain prior authorization.</p> |
| | Tier 3 drugs | Retail: \$70 <u>copayment</u> / prescription (30-day supply) & 2.5 times the retail <u>copayment</u> / prescription (90-day supply) for retail and home delivery | Not covered | |
| | <u>Specialty drugs</u> | 40% <u>coinsurance</u> / prescription (retail & home delivery) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$450 <u>copayment</u> / emergency room charge and 20% <u>coinsurance</u> for other emergency room services; <u>deductible</u> does not apply to the emergency room charge | \$450 <u>copayment</u> / emergency room charge and 20% <u>coinsurance</u> for other emergency room services; <u>deductible</u> does not apply to the emergency room charge | <p>Urgent care professional charges may be subject to the \$70 <u>specialist</u> office visit <u>copayment</u> depending on the specialty of the physician providing treatment.</p> |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| | <u>Urgent care</u> | \$35 <u>copayment</u> / urgent office visit and 20% <u>coinsurance</u> for other urgent care services; <u>deductible</u> does not apply | \$35 <u>copayment</u> / urgent office visit and 20% <u>coinsurance</u> for other urgent care services; <u>deductible</u> does not apply | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | Not covered | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not covered | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 <u>copayment</u> / therapy office visit and 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the therapy office visit charge | Not covered | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Inpatient services | 20% <u>coinsurance</u> | Not covered | |
| If you are pregnant | Office visits | \$35 <u>copayment</u> / office visit and 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the office visit charge | Not covered | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 60 visits/year |
| | <u>Rehabilitation services</u> | \$35 <u>copayment</u> / therapy office visit and 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the therapy office visit charge | Not covered | Rehabilitation services: Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy. Habilitation services: |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|--|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | <u>Habilitation services</u> | \$35 <u>copayment</u> / therapy office visit and 20% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the therapy office visit charge | Not covered | Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 30 days per confinement in a skilled nursing facility. Non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to a single purchase of a type of <u>durable medical equipment</u> every three years. Prior authorization required for: <ul style="list-style-type: none"> • All CPAP purchases and rentals • Purchases over \$1,000 • All other rentals as stated on our website Benefits may not be payable if you do not obtain prior authorization. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | Not covered | <u>Hospice services</u> require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge | Not covered | Coverage limited to one pair of glasses/year. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups. |

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.) | | |
|---|---|--|
| <ul style="list-style-type: none">• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)• Acupuncture• Bariatric Surgery• Cosmetic Surgery | <ul style="list-style-type: none">• Dental Care• Infertility Treatment• Long Term Care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private Duty Nursing• 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.) | | |
| <ul style="list-style-type: none">• Chiropractic Care | <ul style="list-style-type: none">• Hearing Aids | |

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: for the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517; or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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: Aspirus at 866-631-4611. You may also contact your state insurance department at 1-800-236-8517.

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 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 866-631-4611.

Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu 866-631-4611.

Traditional Chinese (傳統中文): 有關中文協助,請致電 866-631-4611.

German (Deutsch): Für Hilfe in deutscher Sprache rufen 866-631-4611.

————— *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 <u>plan's</u> overall <u>deductible</u> | \$4,350 |
| ■ <u>Specialist copayment</u> | \$70 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% |

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 | \$4,350 |
| Copayments | \$60 |
| Coinsurance | \$1,060 |
| What isn't covered | |
| Limits or exclusions | \$30 |
| The total Peg would pay is | \$5,500 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,350 |
| ■ <u>Specialist copayment</u> | \$70 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

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

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$310 |
| Copayments | \$1,425 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,735 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,350 |
| ■ <u>Specialist copayment</u> | \$70 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% |

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 | \$1,860 |
| Copayments | \$650 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,510 |



Non-Discrimination and Language Access Policy

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

Aspirus Health Plan:

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, call us at the phone number on the attached correspondence, your ID card, or the number listed on AspirusHealthPlan.com.

If you believe that Aspirus Health Plan 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:

Aspirus Health Plan
Attn: Nondiscrimination Grievance Coordinator
PO Box 1062
Minneapolis, MN 55440
Emails: G&A@AspirusHealthPlan.com

You can file a grievance in person, by mail, or by email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019, TTY: 1-800-537-7697. Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Albanian VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Na telefononi në numrin e telefonit që gjendet në korrespondencën e bashkëngjitur, në pjesën e përparme të kartës suaj ID ose në numrin e renditur në adresën www.aspirushealthplan.com (TTY: 711).

الهاتف المتواجد بالرسالة المرفقة أو بالجهة الاتصال بنا على رقم الهاتف الموجود بالرسالة المرفقة لك مجاناً. فإن خدمات المساعدة اللغوية متاحة لك مجاناً. www.aspirushealthplan.com (الهاتف النصي: 711).

French À NOTER : Si vous parlez le français, des services d'assistance linguistique gratuits sont à votre disposition.

Appelez-nous au numéro de téléphone indiqué sur le courrier joint, au recto de votre carte d'identité ou au numéro indiqué sur le site Internet www.aspirushealthplan.com (ATS : 711).

German HINWEIS: Wenn Sie Deutsch sprechen, stehen für Sie kostenlos Sprachassistenzen zur Verfügung. Rufen Sie uns an. Sie finden die Telefonnummer auf dem beigefügten Schreiben, auf der Vorderseite Ihrer ID-Karte oder unter www.aspirushealthplan.com (TTY: 711).

Hindi ध्यान दें: अगर आप हинदी बोलते हैं तो आपको लिए भाषा सहायता सेवाएँ www.aspirushealthplan.com पर दिए गए फोन नंबर या आपकेहपचान पत्र (आईडी कार्ड) केसामने केपृष्ठ पर दिए गए फोन नंबर या www.aspirushealthplan.com पर दिए गए नंबर पर कॉल करें (TTY: 711)

Hmong TSHWJ XEEB: Yog hais tias koj hais lus Hmoob, peb muaj cov kev pab cuam hais ua koj hom lus pub rau koj yam tsis xam tus nqi hlo li. Hu rau peb tus nab nrawb xov tooj nyob rau ntawm daim ntawv, sab hauv ntej ntawm koj daim id lossis nab nrawb xov tooj nyob rau hauv www.aspirushealthplan.com (TTY: 711).

Korean 주목해 주세요: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 첨부된 서신, ID 카드 앞면 또는 www.aspirushealthplan.com에 나와 있는 전화번호로 연락해 주십시오(TTY: 711).

Polish UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany w załączonej korespondencji, z przodu karty identyfikacyjnej lub numer podany na stronie www.aspirushealthplan.com (TTY: 711).

Russian ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами переводчика. Позвоните по любому номеру, указанному: в прикрепленном письме, на лицевой стороне Вашей идентификационной карты или на сайте www.aspirushealthplan.com (телефайп: 711).

Spanish ATENCIÓN: Si habla español, los servicios de asistencia de idioma están disponibles para usted, sin ningún costo para usted. Llámenos al número de teléfono que se encuentra en la correspondencia adjunta, en la parte de adelante de su tarjeta de identificación o en el número indicado en www.aspirushealthplan.com (TTY: 711).

Tagalog BIGYANG-PANSIN: Kung Tagalog ang ginagamit mong wika, may mga serbisyong tulong sa wika na makukuha mo nang walang babayaran. Tawagan kami sa numero ng telepono na nasa nakalakip na sulat, nasa harapang bahagi ng iyong id card o nakalintang numero sa www.aspirushealthplan.com (TTY: 711).

Traditional 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。請撥打隨附之通訊上、ID 卡正面或以下網址：www.aspirushealthplan.com 列出的電話號碼與我們聯絡 (TTY: 711)。

Vietnamese CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi cho chúng tôi theo số điện thoại có trên thư từ đính kèm, mặt trước thẻ id của quý vị hoặc số điện thoại được niêm yết trên www.aspirushealthplan.com (TTY: 711).

Pennsylvania Dutch GEB ACHT: Wann du Deitsch schwetzst, du kannscht Schprooch Services griege, mitaus Koschd. Ruf uns mit der Nummer uff die attached correspondence, die vonne Seide vun dei ID Kaarde odder die Nummer uff www.aspirushealthplan.com(TTY: 711).

Lao ສຳລັບທ່ານທີ່ສົນໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຄິດຄ່າໃຊ້ຈ່າຍ ສຳລັບທ່ານ. ທ່ານສາມາດໂທຫາພວກເຮົາໄດ້ທີ່ໝາຍເລກຢູ່ເທິງຈົດໝາຍຕິດຕໍ່ທີ່ຕິດຄັດມາ, ດ້ານໜ້າບັດປະຈຳຕົວຂອງທ່ານ ຫຼື ໝາຍເລກທີ່ລະບຸໄວ້ໃນ www.aspirushealthplan.com (TTY: 711).