

This is your Summary of Benefits.

2019

Allwell Medicare (PPO) H6348:002

Allen, Elkhart, St. Joseph, Wells, and Whitley counties,
IN

This booklet provides you with a summary of what we cover and your cost-sharing responsibilities. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at allwell.mhsindiana.com.

You are eligible to enroll in Allwell Medicare (PPO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.
- You permanently reside in the service area of the plan (in other words, your permanent residence is within one of the Allwell Medicare (PPO) service area counties). Our service areas include the following counties in Indiana: Allen, Elkhart, St. Joseph, Wells, and Whitley.
- You do not have end-stage renal disease (ESRD). (Exceptions may apply for individuals who develop ESRD while enrolled in a Allwell commercial or group health plan, or a Medicaid plan.)

With Allwell Medicare (PPO) Medicare Advantage plan, you'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use contracting providers in our network. Either way, doctor visits, hospital stays and many other services have a simple copayment, which helps make health care costs more predictable.

You can see our plan's provider directory at our website at allwell.mhsindiana.com.

This Allwell Medicare (PPO) plan also includes prescription drug coverage and access to our large network of pharmacies. Our drug plan is designed specifically for Medicare beneficiaries and includes a comprehensive selection of affordable generic and brand-name drugs.

Summary of Benefits

JANUARY 1, 2019–DECEMBER 31, 2019

Benefits	Allwell Medicare (PPO) H6348: 002 Premiums / Copays / Coinsurance	
	In-network	Out-of-network
Monthly Plan Premium	\$0 You must continue to pay your Medicare Part B premium.	
Deductible	This plan does not have a medical or Part D prescription deductible.	
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$5,500 in-network annually \$9,000 combined in- and out-of-network annually This is the most you will pay in copays and coinsurance for medical services for the year.	
Inpatient Hospital Coverage*	<ul style="list-style-type: none"> \$300 copay per day, days 1 through 6 \$0 copay per day, days 7 and beyond 	<ul style="list-style-type: none"> 40% coinsurance per stay
Outpatient Hospital*	<ul style="list-style-type: none"> Outpatient Hospital: \$300 copay per visit Observation Services: \$300 copay per visit Ambulatory Surgical Center: \$275 copay per visit 	<ul style="list-style-type: none"> Outpatient Hospital (includes ambulatory surgical center and observation services): 40% coinsurance per visit

Services with an * (asterisk) may require prior authorization and / or a referral from your doctor.

Benefits	Allwell Medicare (PPO) H6348: 002 Premiums / Copays / Coinsurance	
	In-network	Out-of-network
Doctor Visits*	<ul style="list-style-type: none"> Primary Care: \$5 copay per visit Specialist: \$40 copay per visit 	<ul style="list-style-type: none"> Primary Care: 40% coinsurance per visit Specialist: 40% coinsurance per visit
Preventive Care* <i>(e.g., flu vaccine, diabetic screening)</i>	<ul style="list-style-type: none"> \$0 copay 	<ul style="list-style-type: none"> 40% coinsurance
	Other preventive services are available. Cost-sharing may apply when other services are received in addition to the preventive service.	
Emergency Care	\$90 copay per visit	\$90 copay per visit
	You do not have to pay the copay if admitted to the hospital immediately.	
Urgently Needed Services	<ul style="list-style-type: none"> \$40 copay per visit 	<ul style="list-style-type: none"> \$40 copay per visit
	Copay is not waived if admitted to hospital.	
Diagnostic Services/ Labs/Imaging*	<ul style="list-style-type: none"> Lab services: \$5 copay Diagnostic tests and procedures: \$5 copay X-ray services: \$35 copay 	<ul style="list-style-type: none"> Lab services: 40% coinsurance Diagnostic tests and procedures: 40% coinsurance X-ray services: 40% coinsurance
Hearing Services	<ul style="list-style-type: none"> Hearing exam (Medicare-covered): \$40 copay per visit Routine hearing exam: \$0 copay (1 every calendar year) Hearing aid: \$0-\$995 copay (2 hearing aids every year) 	<ul style="list-style-type: none"> Hearing exam (Medicare-covered): 40% coinsurance per visit Routine hearing exam: 40% coinsurance Hearing aid: 40% coinsurance
Dental Services	<ul style="list-style-type: none"> Dental services (Medicare-covered): \$40 copay Preventive Dental Services: \$0 copay (including oral exams, cleanings, and X-rays) 	<ul style="list-style-type: none"> Dental services (Medicare-covered): 40% coinsurance Preventive Dental Services: \$0 copay (including oral exams, cleanings, and X-rays)

Services with an * (asterisk) may require prior authorization and / or a referral from your doctor.

Benefits	Allwell Medicare (PPO) H6348: 002 Premiums / Copays / Coinsurance	
	In-network	Out-of-network
Vision Services	<ul style="list-style-type: none"> • Vision exam (Medicare-covered): \$40 copay per visit • Routine eye exam: \$0 copay per visit • Routine eyewear: \$0 copay <p>Our plan pays up to \$150 every calendar year for routine (non-Medicare covered) eyewear for in-network and out-of-network services combined.</p>	<ul style="list-style-type: none"> • Vision exam (Medicare-covered): 40% coinsurance • Routine eye exam: 40% coinsurance per visit • Routine eyewear: 40% coinsurance <p>Our plan pays up to \$150 every calendar year for routine (non-Medicare covered) eyewear for in-network and out-of-network services combined.</p>
Mental Health Services*	Individual and group therapy: \$40 copay per visit	Individual and group therapy: 40% coinsurance per visit
Skilled Nursing Facility*	For each benefit period, you pay: <ul style="list-style-type: none"> • \$0 copay per day, days 1 through 20 • \$170 copay per day, days 21 through 100 	For each benefit period, you pay: <ul style="list-style-type: none"> • 40% coinsurance per stay
Physical Therapy*	\$35 copay per visit	40% coinsurance per visit
Ambulance*	\$295 copay (per one-way trip)	40% coinsurance (per one-way trip)
Transportation	Not Covered	
Medicare Part B Drugs*	<ul style="list-style-type: none"> • Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance 	<ul style="list-style-type: none"> • Chemotherapy drugs: 40% coinsurance • Other Part B drugs: 40% coinsurance

Services with an * (asterisk) may require prior authorization and / or a referral from your doctor.

Part D Prescription Drugs

Deductible Phase	This plan does not have a Part D deductible.		
Initial Coverage Phase <i>(after you pay your Part D deductible, if applicable)</i>	Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply	Mail-Order Rx 90-day supply
Tier 1: Preferred Generic	\$0 copay	\$5 copay	\$0 copay
Tier 2: Generic	\$5 copay	\$10 copay	\$15 copay
Tier 3: Preferred Brand	\$37 copay	\$47 copay	\$111 copay
Tier 4: Non-Preferred Drug	\$90 copay	\$100 copay	\$270 copay
Tier 5: Specialty	33% coinsurance	33% coinsurance	Not available
Tier 6: Select Care Drugs	\$0 copay	\$0 copay	\$0 copay
Important Info:	<p>Cost-sharing may change depending on the pharmacy you choose (such as Preferred Retail, Standard Retail, Mail-Order, Long-Term Care or Home Infusion) and when you enter another of the four phases of the Part D benefit. For more information about the costs for Long-Term Supply, Home Infusion, or additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our EOC online.</p>		

Additional Covered Benefits		
Benefits	Allwell Medicare (PPO) H6348: 002 Premiums / Copays / Coinsurance	
	In-network	Out-of-network
Over-the-Counter (OTC) Items	\$0 copay (\$65 allowance every quarter for items available via mail order)	\$0 copay (\$65 allowance every quarter for items available via mail order)
	Please visit the plan's website to see the list of covered over-the-counter items.	
Chiropractic Care*	Chiropractic services (Medicare-covered): \$20 copay per visit	<ul style="list-style-type: none"> Chiropractic services (Medicare-covered): 40% coinsurance per visit
Medical Equipment/Supplies*	<ul style="list-style-type: none"> Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance Prosthetics (e.g., braces, artificial limbs): 20% coinsurance Diabetic supplies: \$0 copay 	<ul style="list-style-type: none"> Durable Medical Equipment (e.g., wheelchairs, oxygen): 40% coinsurance Prosthetics (e.g., braces, artificial limbs): 40% coinsurance Diabetic supplies: 40% coinsurance
Foot Care * (Podiatry Services)	<ul style="list-style-type: none"> Foot exams and treatment (Medicare-covered): \$40 copay per visit Routine foot care: \$35 copay per visit (6 visits per year.) 	<ul style="list-style-type: none"> Foot exams and treatment (Medicare-covered): 40% coinsurance per visit Routine foot care: 40% coinsurance per visit
Virtual Visits	Teladoc offers 24 hours a day/7days a week/365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions	
Wellness Programs	<ul style="list-style-type: none"> Fitness program: \$0 copay 24-hour nurse advice line: \$0 copay Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): \$0 copay 	<ul style="list-style-type: none"> Fitness program: \$0 copay 24-hour nurse advice line: 40% coinsurance Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): \$0 copay
	For a detailed list of wellness program benefits offered, please refer to the EOC.	For a detailed list of wellness program benefits offered, please refer to the EOC.

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Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

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

Allwell:

- 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 Allwell’s Member Services telephone number listed for your state on the Member Services Telephone Numbers by State Chart. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Allwell 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 in the chart below and telling them you need help filing a grievance; Allwell’s Member Services 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 (TTY: 1-800-537-7697).

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

Member Services Telephone Numbers by State Chart

State	Telephone Number and Plan Type
Arizona	1-800-977-7522/1-877-935-8020 (HMO and HMO SNP) (TTY: 711)
Arkansas	1-855-565-9518 (HMO) (TTY: 711)
Florida	1-844-293-2636 (HMO); 1-877-935-8022 (HMO SNP) (TTY: 711)
Georgia	1-844-890-2326 (HMO); 1-877-725-7748 (HMO SNP) (TTY: 711)
Illinois	1-855-766-1736 (HMO) (TTY: 711)
Indiana	1-855-766-1541 (HMO and PPO); 1-833-202-4704 (HMO SNP) (TTY: 711)
Kansas	1-855-565-9519 (HMO); 1-833-402-6707 (HMO SNP) (TTY: 711)
Louisiana	1-855-766-1572 (HMO) (TTY: 711)
Mississippi	1-844-786-7711 (HMO); 1-833-260-4124 (HMO SNP) (TTY: 711)
Missouri	1-855-766-1452 (HMO); 1-833-298-3361 (HMO SNP) (TTY: 711)
New Mexico	1-844-810-7965 (HMO SNP) (TTY: 711)
Ohio	1-855-766-1851 (HMO); 1-866-389-7690 (HMO SNP) (TTY: 711)
Pennsylvania	1-855-766-1456 (HMO); 1-866-330-9368 (HMO SNP) (TTY: 711)
South Carolina	1-855-766-1497 (HMO and HMO SNP) (TTY: 711)
Texas	1-844-796-6811 (HMO); 1-877-935-8023 (HMO SNP) (TTY: 711)
Wisconsin	1-877-935-8024 (HMO SNP) (TTY: 711)

Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the Member Services number listed for your state in the Member Services Telephone Number Chart.

SPANISH: ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al número del Departamento de Servicios al Afiliado que se enumera para su estado en la Ficha de Números de Teléfono del Departamento de Servicios al Afiliado.

VIETNAMESE: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số điện thoại phục vụ hội viên dành cho tiểu bang của quý vị trong Bảng số điện thoại dịch vụ hội viên.

CHINESE: 請注意: 如果您使用中文，您可以免費獲得語言援助服務。請撥會員服務部電話號碼表所列的您所在州的會員服務部號碼。

FRENCH CREOLE (HAITIAN CREOLE): ATANSYON: Si w pale kreyòl ayisyen, ou ka resewwa sèvis gratis ki la pou ede w nan lang pa w. Rele nimewo sèvis manm pou eta kote w rete a. W ap jwenn li nan tablo nimewo telefòn sèvis manm yo.

ARABIC:

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل برقم خدمات الأعضاء المُدرج في لائحة رقم هاتف خدمات الأعضاء الخاص بالولاية المقيم فيها.

FRENCH: ATTENTION : Si vous parlez français, un service d'aide linguistique vous est proposé gratuitement. Veuillez appeler le numéro de téléphone du Service aux membres spécifique à votre État qui se trouve dans le tableau de numéros de téléphone du Service aux membres.

RUSSIAN: ВНИМАНИЕ! Если Вы говорите на русском языке, мы можем предложить Вам бесплатные услуги переводчика. Позвоните в Отдел обслуживания участников по указанному для Вашего штата номеру в телефонном справочнике Отдела обслуживания участников

GERMAN: ACHTUNG: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie bitte die für Ihren Bundesstaat zuständige Rufnummer des Mitgliederkundendienstes an, die im Telefonverzeichnis des Mitgliederkundendienstes angegeben ist.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuha ka na mga libreng serbisyong pantulong sa wika. Tawagan ang numero ng Mga Serbisyo ng Miyembro na nakalista para sa iyong estado sa Tsart ng Numero ng mga Serbisyo ng Miyembro.

PORTUGUESE: ATENÇÃO: Se falar português, estão disponíveis, gratuitamente, serviços de assistência linguística. Ligue para o número dos Serviços aos Membros indicado para o seu estado na Tabela de números de telefone destes serviços.

PENNSYLVANIAN DUTCH: Geb Acht: Wann du Deitsch schwetze kannscht, un Hilf in dei eegni Schprooch brauchst, kannscht du es Koschdefrei griege. Ruf die Glieder Nummer von dei Staat, ass iss uff die Lischd an die Glieder Hilf Telefon Nummer Kaart.

GUJARATI: સાવધાન: જો તમે ગુજરાતી બોલતા હો તો, ભાષા સહાય સેવાઓ, નિશુલ્ક, તમારા માટે ઉપલબ્ધ છે. સભ્ય સેવા ટેલેફોન નંબર ચાર્ટમાં તમારા રાજ્ય માટે સૂચવિધ સભ્ય સેવાઓ નંબર પર કોલ કરો.

JAPANESE: 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。メンバーサービス電話番号チャートに記載されているお住まいの州のメンバーサービスまでお電話ください。

ITALIAN: ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Consulti la Tabella dei Numeri Telefonici dei Servizi per i Membri e chiami il numero dei Servizi per i Membri del Suo stato.

MARSHALLESE: LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin eo am ilo ejjelok wōñāān ñan kwe. Kallok nōm̄ba in telpon in Jermal in Jipañ ñan ro Uwaan eo ej jeje ñan state eo am ilo Jaat in Nōm̄ba in Telpon in Jermal in Jipañ ñan ro Uwaan.

LAOTIAN: ເອົາໃຈໃສ່ ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບັນທຶກສູນຊ່ວຍເຫຼືອດ້ານພາສາໄວ້ອ້ອຍຖ້າບໍ່ວ່າການທ່ານ ໂດຍບໍ່ຄ່າ. ກະລຸນາໃຫ້ຫາເວກໜາຍບໍ່ວ່າການສະມາຊິກທົ່ວປະເທດໃນວັດຂອງທ່ານໃນເວັບໜ້າເວກໜາຍໃຫວະສັບ ບໍ່ວ່າການສະມາຊິກ.

HMONG: CEEV FAJ: Yog koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau tus xov tooj ntawm Lub Chaw Pab Cuam Tswv Cuab ntawm koj lub xeev ntawm Tus Xov Tooj Ntawm Lub Chaw Pab Cuam Tswv Cuab Hauv Daim Ntawv No.

KOREAN: 알림 사항: 귀하가 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 받으실 수 있습니다. 가입자 서비스 전화번호 표에 있는 귀하의 주 가입자 서비스 안내번호로 전화하십시오.

HINDI: ध्यान दें: यदि आप हिन्दी भाषी हैं, तो आपके लिए, भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। सदस्य सेवा टेलीफोन नंबर चार्ट में अपने राज्य के लिए सूचीबद्ध सदस्य सेवा नंबर पर कॉल करें।

POLISH: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług tłumaczeniowych. Zadzwoń pod numer działu obsługi klienta odpowiedni dla twojego stanu, dostępny w Wypisie numerów telefonu działu obsługi klienta.

THAI: โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถขอรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย โทรไปยัง หมายเลขบริการสมาชิกที่ระบุไว้ในรัฐของคุณในแผนภูมิหมายเลขโทรศัพท์สำหรับบริการสมาชิก

AMHARIC: ማሳሰቢያ: አማርኛ የሚያውቁ ከሆን፣ የቋንቋ እገዛ አገልግሎቶች ያለክፍያ አለገልግሎት። በ አባላት አገልግሎት የስልክ ቻርት ላይ ባለው በአባላት አገልግሎት ቁጥር ይደውሉ።

PERSIAN:

توجه: اگر به زبان فارسی صحبت می کنید، خدمات امداد زبانی به طور رایگان در اختیار شما می باشند. با شماره تلفن خدمات اعضا برای ایالت خود که در جدول شماره تلفن های خدمات اعضا ذکر شده تماس بگیرید.

BURMESE: သတိပုဂ္ဂိုလ်: ဗမာစကားပြောလျှင်၊ သင့်အတွက် ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများ အခမဲ့ ရရှိနိုင်ပါသည်။ အဖွဲ့ဝင်ဝန်ဆောင်မှုများ တယ်လီဖုန်းနံပါတ်ဇယားထဲ၌ သင့်ပြည်နယ်အတွက် စာရင်းသွင်းထားသည့် အဖွဲ့ဝင်ဝန်ဆောင်မှုများနံပါတ်ကို ဖုန်းခေါ်ပါ။

DUTCH: GRAAG UW AANDACHT: Indien u Nederlands spreekt, zijn taaldiensten gratis voor u beschikbaar. Gelieve de Ledendienstenummer vermeld voor uw staat in de Ledendiensten Telefoonnummer Tabel op te bellen.

PUNJABI: ਧਿਆਨ ਦੇਵੇ: ਜੇਕਰ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਬਨਿ ਕਸਿ ਮੁੱਲ ਦੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲੱਬਧ ਹਨ। ਮੈਬਰ ਸੇਵਾਵਾਂ ਦੇ ਟੈਲੀਫੋਨ ਨੰਬਰ ਚਾਰਟ ਵੱਚਿ ਤੁਹਾਡੀ ਸਟੇਟ ਦੇ ਲਈ ਦੱਤਿ ਗਏ ਮੈਬਰ ਸੇਵਾਵਾਂ ਦੇ ਨੰਬਰ ਉੱਤੇ ਫੋਨ ਕਰੋ।

SWAHILI: TAHADHARI: Kama unazungumza Kiswahili, huduma ya msaada wa lugha, bure, zinapatikana kwa ajili yako. Piga Nambari ya Huduma ya Mwanachama iliyoorodheshwa ya jimbo lako kwenye hiyo Chati ya Nambari za Simu za Huduma ya Mwanachama.

For more information, please contact:

Allwell Medicare (PPO)
550 N. Meridian Street
Suite 101
Indianapolis, IN 46204

allwell.mhsindiana.com

Current members should call: 1-855-766-1541 (TTY: 711)

Prospective members should call: 1-877-891-6093 (TTY: 711)

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-855-766-1541 (TTY: 711) for more information.

“Coinsurance” is the percentage you pay of the total cost of certain medical and prescription drug services.

This document is available in other formats such as Braille, large print or audio.

The provider network may change at any time. You will receive notice when necessary.

Allwell is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Allwell depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Allwell members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.