



OAK  
STREET  
HEALTH

# Summary of Benefits

JANUARY 1, 2023 - DECEMBER 31, 2023

## INDIANA (HMO-POS DSNP)

H4624-018 Zing Dual Platinum Plus IN (HMO-POS DSNP)

**Service Area:** Marion County

Y0149\_2023-SB-018-Platinum-HMO-POS-DSNP-IN\_M

## Important Plan Information

Zing Health is a HMO-DSNP with a Medicare contract. Enrollment in Zing Health depends on contract renewal.

This easy-to-use guide helps you to understand what benefits are covered by Zing Dual Platinum Plus IN (HMO-POS DSNP). The benefit information provided is a summary of what we cover and what you can expect to pay. It does not list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, call us to request the “Evidence of Coverage” booklet or you can access and download the booklet from our website ([www.myzinghealth.com](http://www.myzinghealth.com)).

For more information, please call us at **1-866-946-4458 (TTY users should call 711)**, between 8 a.m. and 8 p.m. Monday through Friday (from April 1 through September 30) and 8 a.m. to 8 p.m. 7 days a week (from October 1 through March 31) or **visit us at [www.myzinghealth.com](http://www.myzinghealth.com)**.

## Who can join?

To join **Zing Dual Platinum Plus IN (HMO-POS DSNP)**, you must:

- Be entitled to Medicare Part A,
- Be enrolled in Medicare Part B,
- Be eligible for enrollment in the State’s Medicaid program, and
- Live in our service area.

The service area includes the following county: Marion.

## Definitions

**Health Maintenance Organizations (HMOs)** are health-care plans offered by an insurance provider with a network of contracted healthcare providers and facilities. HMOs generally require members to select a primary care doctor to coordinate care. Some plans also include giveback of some or all of the Part B premium.

**Dual Eligible Special Needs Plan (DSNPs)** are specialized Medicare Advantage plans that provide healthcare benefits for beneficiaries that have both Medicare and Medicaid coverage. Beneficiaries must meet certain income and resource requirements with eligibility and scope of benefits offered determined by the state where the plan is offered.

**Dual Eligible Special Needs Plan - Point of Service (DSNP-POS)** plans are DSNPs which, under certain circumstances, allow members to get care out-of-network, often at a higher cost-share than those provided from network providers.

## This is a Dual Eligible Special Needs Plan (D-SNP)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. What you pay for covered services may depend on your level of Medicaid eligibility.

Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people may also get coverage for additional services and drugs that are covered under Medicaid but not by Medicare.

## Medicaid Eligibility Requirements

Zing Dual Platinum Plus IN (HMO-POS DSNP) is available to anyone with both Medicare Parts A and B and who receive some level of Medical Assistance from the Indiana Family and Social Services Administration (FSSA) (the state Medicaid program) as described below:

- Plan members with full Medicaid coverage (**Full Benefit Dual Eligible (FBDE)**) status are eligible for the Indiana Medicaid program, which may be responsible for payment of their Medicare cost sharing. These members are also eligible to receive the full Medicaid benefits.
- Plan members with Qualified Medicare Beneficiary (**QMB**) status are eligible for the Indiana Medicaid program, which is responsible for payment of their Medicare Part B premium, deductibles and cost sharing.
- Plan members with Qualified Medicare Beneficiary Plus (**QMB+**) status are eligible for full benefits under the Indiana Medicaid program, which is also responsible for payment of their Medicare Part A (if any) and Medicare Part B premiums, deductibles and cost sharing.
- Plan members with Specified Low-Income Medicare Beneficiary Plus (**SLMB+**) status are eligible for the Indiana Medicaid program, which is responsible for payment of their Medicare Part B premium. Members are also eligible to receive full Medicaid benefits.

## Cost sharing and cost-sharing protections

You pay no cost sharing for the Medicare-covered benefits described later in this Summary of Benefits. You will pay no or small copayments for prescriptions covered under the Part D prescription drug benefit. When you receive health services, the provider should bill the plan for the cost of Medicare services and bill the Indiana Medicaid program for the Medicare cost-sharing amounts. **The provider should not bill you for services or cost sharing. Please be sure to present both your Zing Health Member ID card and your Indiana FSSA Member ID card at the time services are rendered.**

## What is “Extra Help?”

A Low Income Subsidy (LIS), also referred to as “Extra Help,” may be available to help you with Part D out-of-pocket expenses such as premiums, deductibles, co-insurance or co-pays. Many people qualify for the “Extra Help” Program and don’t even know it. Keep in mind that assistance may also depend on your dual eligible status.

For each benefit listed, you can see what our plan covers in addition to what your state covers. No matter what your level of Medicaid eligibility is, our plan will cover the benefits as described in the plan’s column. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call: **1-866-946-4458** (TTY users should call 711).

## How will I determine my drug costs?

You will generally have to use one of our network pharmacies to fill your prescriptions covered by Part D. You will need to use our plan’s formulary (list of covered drugs) to locate what tier your drug is on to determine how much it will cost you. Each medication will be grouped into one of the five tiers. The amount you pay depends on the drug’s tier, what stage of the benefit you have reached and your level of “Extra Help.”

## What providers can I use?

**Zing Dual Platinum Plus IN (HMO-POS DSNP)**, has a network of doctors, hospitals, pharmacies, and other providers. Our plan does not require a referral to see a specialist. In some instances, a prior authorization may be required for some services you receive. Except in emergency situations, if you use providers that are not in our network, the plan may not pay for these services.

Members of this plan will have access to nurses who are called Care Managers. Care Managers work with members and their healthcare providers to close gaps in care and support individualized care plans developed to address members' specific needs geared toward improving health related outcomes.

## What are our hours of operation?

Hours of operation are between 8 a.m. and 8 p.m. Monday through Friday (from April 1 through September 30) and 8 a.m. to 8 p.m. 7 days a week (from October 1 through March 31).

- If you are a member of this plan, call toll free **1-866-946-4458 (TTY users should call 711) or visit us at [www.myzinghealth.com](http://www.myzinghealth.com).**
- If you are not a member of this plan, call toll-free **1-866-946-4458**.

## Medicare coverage that goes beyond Original Medicare

- Like all Medicare Advantage health plans, our plans cover everything that Original Medicare covers — Part A (hospital services) and Part B (medical services). Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are covered in this Summary of Benefits.
- Our plans cover Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider).

## What does Original Medicare cover?

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](http://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 document is available in other formats such as braille, large print or audio. For additional information, call us at **1-866-946-4458**, (TTY users should call 711).

# Monthly Premium, Deductible, and Limits on How Much you Pay for Covered Services


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## MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS

|   |   |
|---|---|
| <b>Monthly Part C Premium</b>   | <b>\$0</b><br><br>You must continue to pay your Medicare Part B premium. If you meet certain eligibility requirements for both Medicare and Medicaid, your Part B premiums may be covered in full. <b>See the Prescription Drug Benefits section of this document for Part D Premium information.</b>   |
| <b>Plan Deductible</b>  | <b>\$0</b> Deductible<br><br>See the Prescription Drug Benefits section of this document for Part D Prescription Drug Deductible information.   |
| <b>Yearly Maximum Out-of-pocket responsibility (Does not include prescription drugs).</b> | <b>\$8,300</b> is the most you'll pay for covered services you receive from in-network providers.<br><br>Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. These limits are the most you pay for co-pays, coinsurance and other costs for hospital and medical services. Depending on your level of Indiana Family and Social Services Administration (FSSA) eligibility, you may pay nothing for Medicare-covered services.<br><br>Refer to the "Medicare & You" handbook for Medicare-covered services. For Indiana Family and Social Services Administration (FSSA)-covered services, refer to the Medicaid Coverage section in this document. Please note that you may still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs, depending on your level of "Extra Help." |

## Covered Medical and Hospital Benefits

You will see this icon  under the column describing our plan's coverage of select benefits. This icon means that the service is a part of the plan's Point of Service (POS) program. POS means that you can receive services outside of our provider network at the same cost as using a network provider. For more information on the POS program, please refer to your "Evidence of Coverage" booklet or call Customer Service.

|   |  |  |
|---|--|--|
| <b>Benefit Coverage</b><br><b>Services with a <sup>1</sup> may require prior authorization.</b> | <b>H4624-018</b><br><b>Zing Dual Platinum Plus IN (HMO-POS DSNP)</b><br><i>Marion County</i>   |  <b>OAK STREET HEALTH</b> |
| <b>HOSPITAL COVERAGE</b>  |  |  |
| <b>Inpatient Hospital Coverage <sup>1</sup></b>   | <b>In-Network:</b><br>\$0<br><b>Out-of-Network:</b><br>\$0<br>Our plan covers unlimited days for an inpatient hospital stay. Once discharged from an inpatient hospital stay, talk to one of our care managers. Our care managers can help make sure you stay healthy and out of the hospital. Refer to the Evidence of Coverage for more plan specific information. |                           |
| <b>Outpatient Hospital Coverage <sup>1</sup></b>  | <b>In-Network:</b><br>\$0<br><b>Out-of-Network:</b><br>\$0<br>Outpatient hospital services may include approved procedures like observation services, diagnostic procedures, casts, stitches, or outpatient surgery. For a complete list of services, please refer to the Evidence of Coverage.  |                         |
| <b>Ambulatory Surgical Center <sup>1</sup></b>  | <b>In-Network:</b><br>\$0 for Outpatient Surgery at an Ambulatory Surgical Center.<br><b>Out-of-Network:</b><br>\$0  |                         |
| <b>Primary Care Physician (PCP)</b>   | <b>In-Network:</b><br>\$0<br>Not covered out-of-network.   |  |
| <b>Specialists</b>  | <b>In-Network:</b><br>\$0<br><b>Out-of-Network:</b><br>\$0   |                         |

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## PREVENTIVE CARE

### Preventive Services

- Abdominal aortic aneurysm screening
  - Alcohol misuse counseling
  - Bone mass measurement
  - Breast cancer screening (mammogram)
  - Cardiovascular disease (behavioral therapy)
  - Cardiovascular screenings
  - Cervical and vaginal cancer screening
  - Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
  - Depression screening
  - Diabetes screenings
  - Glaucoma tests
  - Hepatitis B shots and screening
  - Hepatitis C screening test
  - HIV screening
  - Lung cancer screening
  - Medical nutrition therapy
- Services**
- Obesity screening and counseling
  - Prostate cancer screenings (PSA)
  - Sexually transmitted infections screening and counseling
  - Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
  - Vaccines, including Flu shots
  - “Welcome to Medicare” preventive visit (one time)
  - Annual Wellness visit

### In-Network:



\$0 for Original Medicare preventive services

\$0 for screening exams and/or diagnostic tests received in preparation for your Annual Physical Exam or ordered as a result of this visit

### Out-of-Network:

\$0 for Original Medicare preventive services

\$0 for screening exams and/or diagnostic tests received in preparation for your Annual Physical Exam or ordered as a result of this visit.

Any additional preventive services approved by Medicare during the contract year will be covered.

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## EMERGENCY CARE

|                          |     |
|--------------------------|-----|
| Emergency Care Services  | \$0 |
| Worldwide Emergency Care | \$0 |


## URGENTLY NEEDED SERVICES

|                      |                        |
|----------------------|------------------------|
| Urgent Care Services | <b>In-Network:</b>     |
|                      | \$0                    |
|                      | <b>Out-of-Network:</b> |
|                      | \$0                    |

## OUTPATIENT DIAGNOSTIC PROCEDURES, TESTS AND LAB SERVICE

|  |                        |  |
|--|------------------------|--|
| Diagnostic Tests and Procedures <sup>1</sup> | <b>In-Network:</b>     |  |
|  | \$0                    |  |
|  | <b>Out-of-Network:</b> |  |
|  | \$0                    |  |

|                           |                        |   |
|---------------------------|------------------------|---|
| Lab Services <sup>1</sup> | <b>In-Network:</b>     |  |
|                           | \$0                    |   |
|                           | <b>Out-of-Network:</b> |   |
|                           | \$0                    |   |

|  |   |   |
|--|---|---|
| Diagnostic Radiological Services <sup>1</sup> (e.g., MRIs and CTR Scans) | <b>In-Network:</b>                          |  |
|  | \$0   |   |
|  | <b>Out-of-Network:</b>                      |   |
|  | \$0<br>Prior authorization may be required. |   |

|   |                        |   |
|---|------------------------|---|
| Therapeutic Radiological Services <sup>1</sup> (e.g., radiation treatment for cancer) | <b>In-Network:</b>     |  |
|   | \$0                    |   |
|   | <b>Out-of-Network:</b> |   |
|   | \$0                    |   |



## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## HEARING SERVICES

Hearing Exam  
 (Medicare Covered)

**In-Network:**

\$0 for Medicare covered diagnostic hearing exam.

**Out-of-Network:**

\$0



Routine Hearing Exam

**In-Network:**

\$0 copay for one (1) routine hearing exam per year.

Not covered out-of-network.

Hearing Aid Evaluation/  
 Fitting

**In-Network:**

\$0 for one (1) hearing aid evaluation/fitting every three (3) years

Not covered out-of-network.

Hearing Aids

**In-Network:**

**\$750** benefit allowance towards hearing aids per ear every three (3) years.

You are responsible for all costs beyond the maximum allowed amount. Three follow-up visits, 3-year repair warranty and 3 years of batteries included. One-time replacement coverage for lost, stolen or damaged hearing aids. For more information, call Nations Hearing or Customer Service.

Not covered out-of-network.

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## DENTAL SERVICES

### Preventive Dental Benefits

#### **In-Network:**

\$0 for oral exams up to one (1) every six (6) months

\$0 for prophylaxis (cleaning) up to one (1) every six (6) months

\$0 for a fluoride treatment for up to one (1) every year

\$0 for x-rays up to one (1) set per year

\$0 for panoramic x-rays for up to one (1) every five (5) years

**\$3,500** benefit allowance every year for preventive and comprehensive dental benefits combined.

You are responsible for all cost beyond the maximum allowed amount.

Not covered out-of-network.

### Comprehensive Dental Benefits

#### **In-Network:**

You pay \$0 for Medicare-covered services

You pay \$0 for comprehensive dental services

Unlimited benefit for:

- Non-routine Services (other services)
- Diagnostic Services (exams, x-rays)
- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/root planning)
- Prosthodontics, Other Oral/Maxillofacial Surgery (dentures or fixed prosthetics and partials)
- Extractions (1 per tooth per year)

**\$3,500** benefit allowance every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount.

Not covered out-of-network.

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## VISION SERVICES

Eye Exams  
(Medicare-covered)

**In-Network:**

\$0 for a Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).

POS

**Out-of-Network:**

\$0

Routine Eye Exam

**In-Network:**

\$0 for (1) routine eye exam/refraction up to (1) per year

Not covered out-of-network.

Eyewear (Medicare Covered)

**In-Network:**

\$0 for one (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery.

POS

**Out-of-Network:**

\$0

Routine Eyewear

**In-Network:**

**\$285** benefit allowance towards eyewear (contact lenses, eyeglasses (frames and lenses), eyeglass lenses, eyeglass frames) one (1) per year.

You are responsible for all cost exceeding the maximum benefit amount for routine eyewear.

Not covered out-of-network.

## MENTAL HEALTH SERVICES

Inpatient Mental Health  
Services

**In-Network:**

\$0

POS

**Out-of-Network:**

\$0

Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

Prior authorization may be required

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## MENTAL HEALTH SERVICES *(continued)*

Outpatient Mental Health Services (including psychiatric services)

**In-Network:**

\$0 for Medicare-covered individual therapy visits.

\$0 for Medicare-covered group therapy visits

**Out-of-Network:**

\$0 for Medicare-covered individual therapy visits.

\$0 for Medicare-covered group therapy visits.

Prior authorization may be required.

POS

Outpatient Substance Abuse Services <sup>1</sup>

**In-Network:**

\$0 for Medicare-covered individual therapy visits.

\$0 for Medicare-covered group therapy visits

**Out-of-Network:**

\$0 for Medicare-covered individual therapy visits.

\$0 for Medicare-covered group therapy visits.

POS

## SKILLED NURSING

Skilled Nursing Facility (SNF)<sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Our plan covers up to 100 days per benefit period.

Prior authorization may be required.

POS

## THERAPY AND REHABILITATION SERVICES

Occupational Therapy Services <sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Prior authorization may be required.

POS

Physical Therapy and Speech-Language Therapy <sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Prior authorization may be required.

POS

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## THERAPY AND REHABILITATION SERVICES *(continued)*

### Cardiac and Pulmonary Rehabilitation Services <sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Services include Medicare-covered: cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation services, supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) services.



## AMBULANCE AND TRANSPORTATION SERVICES

### Ground Service

\$0

Prior authorization may be required for nonemergency Medicare services.

### Air Service (one-way trip)

\$0

Prior authorization may be required for nonemergency Medicare services.

### Non-Emergency Transportation Services

**In-Network:**

\$0 for **unlimited** one-way trips per year to plan approved health-related locations.

The first step to staying healthy is getting to your doctor. That's why we cover these shared trips to plan approved health care providers. We want to make sure you get the care you need when you need it. Call Customer Service in advance to reserve a ride for your appointment.

## ADDITIONAL DRUG COVERAGE

### Medicare Part B Drugs <sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Includes Medicare Part B Chemotherapy and Radiation Drugs and other Medicare Part B Drugs



# Part D Prescription Drugs

## Benefit Coverage

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## PART D PRESCRIPTION DRUGS

|  |  |
|--|--|
| <b>Stage 1: Deductible Stage</b>                 | <p><b>\$0 Deductible.</b></p> <p>Because your plan does not have a deductible, this stage does not apply to you. You start the Initial Coverage Stage when you fill your first prescription.</p>   |
| <b>Stage 2: Initial Coverage Stage</b>           | <p>You are in the Initial Coverage Stage until your total yearly drug cost reach <b>\$4,660</b>. Total yearly drug cost are the total drug costs paid both you and the plan.</p> <p>Once you've reached this amount, you enter the coverage gap.</p> |
| <b>Standard Retail Cost-Sharing</b>              | <b>30-day Supply</b>   |
| <b>Tier 1: Preferred Generic Select Insulins</b> | \$0<br>\$0   |
| <b>Tier 2: Generic</b>                           | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35  |
| <b>Tier 3: Preferred Brand</b>                   | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35  |
| <b>Tier 4: Non-Preferred Drug</b>                | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35  |
| <b>Tier 5: Specialty Tier</b>                    | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35<br><br>Specialty drugs are limited to a 30 day-supply  |
| <b>Standard Mail Order Cost-Sharing</b>          | <b>100-day Supply</b>  |
| <b>Tier 1: Preferred Generic Select Insulins</b> | \$0<br>\$0   |
| <b>Tier 2: Generic</b>                           | \$0  |
| <b>Tier 3: Preferred Brand</b>                   | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35  |
| <b>Tier 4: Non-Preferred Drug</b>                | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35  |
| <b>Tier 5: Specialty Tier</b>                    | <b>Generics:</b> \$0 / \$1.45 / \$4.15<br><b>Brands:</b> \$0 / \$4.30 / \$10.35<br><br>Specialty drugs are limited to a 30 day-supply  |

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## PART D PRESCRIPTION DRUGS (continued)

### Coverage Gap Stage

Most Medicare drug plans have a Coverage Gap Stage (also called the “donut hole”). The Coverage Gap Stage begins after you and your drug plan together have spent **\$4,660** for covered drugs.

After you enter the coverage gap, you pay **25%** of the plan’s costs for covered brand name drugs and **25%** of the plan’s cost for generic drugs until your cost total **\$7,400**.

For generic drugs, the amount paid by the plan (**75%**) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. You will remain in the coverage gap stage until your drug costs total **\$7,400**, which is the end of the coverage gap.

During this stage, you will continue to pay **\$0** cost-share for select insulins.

Not everyone will enter the coverage gap.

### Catastrophic Coverage Stage

The Catastrophic Coverage Stage begins after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$7,400**, you pay the greater of:

#### Drug Type

#### Cost-Share Information

#### Generic/Preferred Multi-Source Drugs

- **5%** of the cost, or
- **\$4.15** copay (including brand drugs treated as generic)

#### Brand Name and Other Drugs

- **\$10.35** copay for all other drugs

Cost-Sharing may change depending on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, the pharmacy you choose and when you enter a new phase of the drug stages.

**Important Message About What You Pay for Insulin** - You won’t pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on.

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for “Extra Help.” To find out if you qualify for “Extra Help,” please contact the Social Security Office at 1-800-772-1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1-800-325-0778.

For more information on additional pharmacy specific cost-share and the drug coverage stages, please call our Customer Service department or access our “Evidence of Coverage” online or request one by mail.

## Additional Benefits, Care and Services

### Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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### FOOT CARE (PODIATRY SERVICES)

Podiatry Services  
(Medicare-covered)

**In-Network:**

\$0

**Out-of-Network:**

\$0

Prior authorization may be required.

POS

Routine Podiatry Services

**In-Network:**

\$0 for six (6) routine visits per year

Not covered out-of-network.

### MEDICAL EQUIPMENT AND SUPPLIES

Durable Medical Equipment  
(wheelchairs, oxygen, etc.) <sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Prior authorization required on any durable medical equipment (DME) costs greater than \$1,500.

Zing Health has preferred vendors or manufacturers for DME. Contact Customer Service for more information.

POS

Prosthetic Devices (braces,  
artificial limbs, etc.) and  
Related Medical Supplies <sup>1</sup>

**In-Network:**

\$0

**Out-of-Network:**

\$0

Prior authorization required for prosthetic device costs greater than \$1,500.

POS



## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## MEDICAL EQUIPMENT AND SUPPLIES *(continued)*

### Diabetes Supplies and Services

**In-Network:**

\$0 for diabetic supplies  
\$0 for diabetic therapeutic shoes or inserts

**Out-of-Network:**

\$0  
Prior authorization may be required.



## CHIROPRACTIC CARE

### Chiropractic Services (Medicare Covered)

**In-Network:**

\$0 for manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position).

**Out-of-Network:**

\$0  
Prior authorization may be required.



### Acupuncture (Medicare-covered)

**In-Network:**

\$0 copay per visit for up to (12) visits in 90 days for chronic low back pain. No more than 20 acupuncture treatments may be administered annually for chronic low back pain.

**Out-of-Network:**

\$0

## HOME HEALTH CARE

### Home Health Care (Medicare-covered)

**In-Network:**

\$0

**Out-of-Network:**

\$0  
Prior authorization may be required.



## HOSPICE

### Hospice Care

You must get your care from a Medicare-certified hospice provider.

You pay part of the cost for outpatient drugs.

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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**OAK  
STREET  
HEALTH**

## RENAL DIALYSIS

### Renal Dialysis

#### **In-Network:**

\$0 for Medicare-covered dialysis treatments.

\$0 for kidney disease education services.

Not covered out-of-network.

## TELEHEALTH

### Telehealth

\$0 copay per telehealth visit.

You can access board certified doctors and behavioral health specialist via phone and/or video technology for diagnosis and treatment of certain non-emergency medical services.

Doctors can diagnose and prescribe medications if medically necessary.

Please call us for more details.

## POINT OF SERVICE (POS) FLEX CARD

### Flex Card

**\$500** Flex Card benefit allowance

#### **What you should know**

The Flex Card benefit is a debit card that may be used to reduce the cost-sharing for items and services beyond what are provided by the plan as supplemental benefits for hearing exams/hearing aids, eye exams/eyewear, and dental services at any provider that accepts VISA. The debit card is prepaid by the plan; it is not a credit card. You cannot convert the card to cash or loan it to other people. Cosmetic procedures are not covered under this benefit.

Any unused allocated money will revert to the plan at the end of the year or when you leave the plan.

## Wellness Programs

### Additional Covered Benefits

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## OVER-THE-COUNTER (OTC) ITEMS

### Over-the-Counter (OTC)

**\$300** every (3) months for OTC items.

#### What you should know

The OTC benefit includes nicotine replacement therapy (NRT).

The OTC debit card allows members to purchase health related items from retail pharmacies as well as mail order purchases.

If you do not use all your quarterly OTC benefit amount when you order, the remaining balance will not accumulate to the next OTC benefit period.

You can order:

- Online – visit [NationsOTC.com/ZingHealth](https://NationsOTC.com/ZingHealth)
- By Phone – call a NationsOTC Member Experience Advisor at 1-877-273-3381 (TTY: 711), 24 hours a day, seven days a week, 365 days a year.
- By Mail – Fill out and return the order form in the NationsOTC/Zing Health product catalog.
- Retail – through an approved, in network retailer

Please visit our website at [www.myzinghealth.com](https://www.myzinghealth.com) to see our list of covered over-the-counter items.

## Additional Covered Benefits

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### MEAL BENEFIT

#### Re-admission Prevention Meals

You pay nothing for meals immediately following an Inpatient Acute Hospital stay to aid in recovery with a maximum of 10 meals (limitations and exclusions apply).

#### Special Supplemental Benefits for the Chronically Ill

##### Healthy Foods Card (Grocery Debit Card)

Members must have one or more of the following chronic condition categories:

1. Chronic alcohol and other drug dependence
2. Autoimmune disorders
3. Cancer, excluding pre-cancer conditions or in-situ status
4. Cardiovascular disorders
5. Chronic heart failure
6. Dementia
7. Diabetes mellitus
8. End-stage liver disease
9. End-stage renal disease (ESRD) requiring dialysis
10. Severe hematologic disorders
11. HIV/AIDS
12. Chronic lung disorders
13. Chronic and disabling mental health conditions
14. Neurologic disorders
15. Stroke

Members receive a **\$50** monthly allowance to buy healthy foods and produce.

#### What you should know

Members with a qualifying chronic condition can purchase plan-approved food products through a mail order solution or at participating retail locations using their physical card.

For a complete list of qualifying chronic conditions, please call Customer Service or reference your Evidence of Coverage booklet.

## Additional Covered Benefits

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### IN-HOME SUPPORT SERVICES

#### In-Home Senior Assistance

\$0 copay

Members are eligible for **60 hours** per year of PAPA services.

PAPA combats loneliness and social isolation by connecting PAPA Pals with our members for companionship and help with Instrumental Activities of Daily Living (IADL). PAPA Pals assist members with services including but not limited to grocery shopping, medication pick up, doctor's appointments, technical guidance, reminders, light house help, light exercise and activity. PAPA Pals can support our members either in their homes or virtually.

#### Personal Emergency Response System (PERS)

\$0 copay

Members may sign up for the PERS benefit to receive emergency alert services from ADT Security Services (ADT). Members will have access to a customizable PERS offering, including three (3) emergency alert solutions:

- Medical Alert Basic (PERS Basic): an in-home unit with range of up to 300-feet
- Medical Alert Plus (PERS Plus): an in-home unit with 600-foot pendant range
- On-The-Go (PERS On-The-Go): Mobile base unit with optional Fall Detection

All solutions feature:

- Two-way voice communication to ADT monitoring center
- Water resistant pendants or wristbands
- 24/7/365 monitoring service

The optional Fall Detection system pairs with the Medical Alert Plus and On-The-Go solutions and enables members to send an alert to ADT's customer monitoring center automatically when a fall is detected, even if the button is not pressed as well as when the help button is pressed.

## Additional Covered Benefits

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### HEALTH CLUB MEMBERSHIPS

#### Silver & Fit Fitness®

\$0 copay

Silver & Fit Fitness® membership is available at no cost while you are a member of our plan.

You can find a list of participating clubs on our website at [www.myzinghealth.com](http://www.myzinghealth.com) or call Customer Service.

#### Weight Management Program

\$0 copay

Zing Health's weight loss and long-term weight maintenance program is achieved through changes in diet, eating-related behaviors and physical activity. At no cost to you, a team of dietitians and exercise staff will tailor a program to meet members' weight loss goals.

Your plan also provides complimentary vouchers for membership in the Weight Watchers program.

Weight Watchers meals are not covered.

### NURSING HOTLINE

#### 24/7 Nurse Advice Line

\$0 copay

Members may call the Nurse Advice Line with questions about health-related issues, symptoms you may be experiencing, and to get advice about seeing a doctor or going to the hospital.

A Nurse is available at no cost to you 24 hours a day, 7 days a week by phone at:

1-855-4-ZHNURSE  
(1-855-494-6877)

## Additional Covered Benefits

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### SAFETY DEVICES

#### In-Home Safety Devices

\$0 copay

For plan-approved in-home safety devices of the following items: grab bar, handheld shower wand, toilet safety rail, bathtub assist bar, raised toilet seat, bedside commode, bath bench, bath transfer bench.

Your plan does not cover any assembly or installation costs. Plan is not held liable for improper assembly, installation, repairs, or other modifications. Members are responsible for any, and all costs associated with assembly, installation and repairs.


For a complete listing of your plan benefits and coverage, please refer to your Evidence of Coverage document or contact the plan for more detail.

## Medicaid Benefits

In addition to the Medicare Advantage services described in the sections above, Zing Dual Platinum Plus IN (HMO-POS DSNP) provides the following Medicaid benefits based on the level of your Medicaid coverage. For eligibility rules and additional information about these services, please visit:

<https://www.in.gov/medicaid/>

There may be instances when the Medicaid limit is greater than the Medicare Advantage limit. In those instances where the Medicare Advantage limit has been exhausted, you may be eligible for coverage under the Indiana Medicaid program. **Be sure to show your Medicaid ID card to your provider when receiving services.**

|   |  |   |
|---|--|---|
| <h3>Benefit Coverage</h3>   | <p><b>H4624-018</b><br/>Zing Dual Platinum Plus IN (HMO-POS DSNP)<br/>Marion County</p>  |  <p><b>OAK STREET HEALTH</b></p> |
| <h3>INSTITUTIONAL AND CLINIC SERVICES</h3>  |  |   |
| <h4>Free-standing Ambulatory Service Center</h4>                                  | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p>  |   |
| <h4>Public Health and Mental Health Clinics</h4>                                  | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p>  |   |
| <h4>Federally Qualified Health Center (FQHC) services</h4>                        | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p>  |   |
| <h4>Inpatient Hospital services (excluding institutions for mental diseases)</h4> | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p> <p>Prior authorization may be required, including to rehab and burn centers. Benefit limits may apply.</p> |   |
| <h4>Outpatient Hospital services</h4>   | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$3 for Medicaid non-emergency visit in Emergency Room</p>  |   |



## Benefit Coverage

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### INSTITUTIONAL AND CLINIC SERVICES *(continued)*

#### Rehabilitation Services: Mental Health & Substance Abuse

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

#### Rural Health Clinic services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

### PRACTITIONER SERVICES

#### Certified Registered Nurse Anesthetist services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

#### Chiropractic services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services. Benefit limits may apply.

Prior authorization may be required.

#### Dental services

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

#### Medical/surgical services of a Dentist

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for medically necessary Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

#### Nurse Midwife services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

## Benefit Coverage

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### PRACTITIONER SERVICES *(continued)*

|   |   |
|---|---|
| <p><b>Nurse Practitioner services</b></p> | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p>   |
| <p><b>Optometrist services</b></p>        | <p>\$0 for Medicaid-covered services. Benefit limits may apply.</p>   |
| <p><b>Physician services</b></p>          | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p> <p>Prior authorization may be required. Benefit limits may apply.</p> |
| <p><b>Podiatrist services</b></p>         | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p> <p>Prior authorization may be required. Benefit limits may apply.</p> |
| <p><b>Psychologist services</b></p>       | <p>For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.</p> <p>\$0 for Medicaid-covered services.</p> <p>Prior authorization may be required. Benefit limits may apply.</p> |

### PRESCRIPTION DRUGS

|                                |   |
|--------------------------------|---|
| <p><b>Non-Part D drugs</b></p> | <p>\$3 for Medicaid covered prescription drugs.</p> <p>Prior authorization may be required.</p> |
|--------------------------------|---|

## Benefit Coverage

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### PHYSICAL THERAPY AND OTHER SERVICES

#### Occupational Therapy services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

#### Physical Therapy services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

#### Services for Speech, Hearing and Language Disorders

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

### PRODUCTS AND DEVICES

#### Dentures

\$0 for Medicaid-covered services.

Prior authorization may be required. Medicaid benefit limits may apply.

#### Eyeglasses

\$0 for Medicaid-covered services.

Medicaid benefit limits may apply.

#### Hearing Aids

\$0 for Medicaid-covered services.

Prior authorization may be required. Medicaid benefit limits may apply.

#### Medical Equipment and Supplies

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Benefit limits may apply.

## Benefit Coverage

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### PRODUCTS AND DEVICES *(continued)*

#### Prosthetic and Orthotic Devices

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required.

### TRANSPORTATION SERVICES

#### Ambulance services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0.50 - \$2.00 for Medicaid-covered non-emergency transport services (depending on payment).

Prior authorization may be required.

#### Non-Emergency Medical Transportation services

\$0.50 - \$2.00 for Medicaid-covered non-emergency transport services (depending on payment).

Prior authorization may be required. Benefit limits may apply.

### OTHER SERVICES

#### Diagnostic, Screening and Preventive services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

#### Laboratory and X-ray services (outside of hospital or clinic)

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

#### Targeted Case Management

\$0 copay for Medicaid-covered services.

Medicaid benefit limits may apply.

# Long-Term Case Services

## Benefit Coverage

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### COMMUNITY BASED CARE

#### Home & Community Based Services Waiver

\$0 for Medicaid-covered services.  
 Prior authorization may be required. Medicaid benefit limits may apply.

#### Home Health Services (includes nursing services, home health aides and medical supplies/equipment)

\$0 for Medicaid-covered services.  
 Medicaid benefit limits may apply.

#### Hospice Care

Medicare hospice services are covered under Fee-for-Service Medicare.  
 \$0 for Medicaid-covered hospice services.  
 Prior authorization may be required.

### INSTITUTIONAL CARE

#### Inpatient Hospital, Nursing Facility and Intermediate Care Facility services in institutions for Mental Diseases (age 65 and older)

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.  
 \$0 for Medicaid-covered services.  
 Prior authorization may be required. Medicaid benefit limits may apply.

#### Inpatient Psychiatric Services (under age 21)

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.  
 \$0 for Medicaid-covered services.  
 Prior authorization may be required. Medicaid benefit limits may apply.

## Benefit Coverage

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### INSTITUTIONAL CARE *(continued)*

#### Intermediate Care Facility Services (for mentally retarded)

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Medicaid benefit limits may apply.

#### Nursing Facility Services (other than in an institution for mental diseases)

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Prior authorization may be required. Medicaid benefit limits may apply.

#### Religious Non-medical Health Care Institution and Practitioner Services

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

\$0 for Medicaid-covered services.

Practitioner services are not covered.

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-946-4458 (TTY users should call 711).

## Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [www.myzinghealth.com](http://www.myzinghealth.com) or call 1-866-946-4458 (TTY users should call 711) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- For our Health Maintenance Organization (HMO) plans only, these plans except in emergency or urgent situations, do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- For our Health Maintenance Organization Point of Service (HMO-POS) plans only, these plans allow you to see providers outside of our network (non-contracted providers). However, while we pay for certain covered services provided by a non-contractee provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- For our Chronic Condition Special Needs plans (CSNP) only, your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- For our Dual Eligible Special Needs plans (DSNP) only, your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Zing Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

# Notice of Non-Discrimination

## **Discrimination is against the law.**

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

Zing Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Customer Service at 1-866-946-4458 (TTY 711).

If you believe that Zing Health 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:

Zing Health  
Civil Rights Coordinator  
225 W. Washington Street, Suite 450  
Chicago, Illinois 60606  
Phone: 1-866-946-4458, TTY number 711  
Fax: 1-866-946-4458  
Email: [civilrightscoordinator@myzinghealth.com](mailto:civilrightscoordinator@myzinghealth.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Zing Health Civil Rights 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 <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>



# Aviso de no discriminación

## La discriminación es ilegal.

Zing Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Zing Health no excluye a las personas ni las trata de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

Zing Health:

- Brinda asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen efectivamente con nosotros, tales como:
  - o Intérpretes calificados en el lenguaje de signos
  - o Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Brinda servicios gratuitos de idiomas a personas cuyo idioma principal no es el inglés, como:
  - o Intérpretes calificados
  - o Información escrita en otros idiomas.

Si necesita estos servicios, comuníquese con Servicio al Cliente al 1-866-946-4458 (TTY 711).

Si cree que Zing Health no ha brindado estos servicios o ha discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante:

Zing Health  
Civil Rights Coordinator  
225 W. Washington Street, Suite 450  
Chicago, Illinois 60606  
Teléfono: 1-866-946-4458, número TTY 711  
Fax: 1-866-946-4458

Correo electrónico: [civilrightscordinator@myzinghealth.com](mailto:civilrightscordinator@myzinghealth.com)

Puede presentar una queja por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja, un Coordinador de Derechos Civiles de Zing Health está disponible para ayudarlo.

También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los EE. UU., Oficina de Derechos Civiles, electrónicamente a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o teléfono a:

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)

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

# Multi-language Interpreter Services / Servicios de interpretación multilingüe

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-946-4458 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-946-4458 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-946-4458 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-946-4458 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-946-4458 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-946-4458 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-946-4458 (TTY: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-946-4458 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-946-4458 (TTY: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-946-4458 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة. 1-866-946-4458 (TTY: 711) فوري، ليس عليك سوى الاتصال بنا على مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-946-4458 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-946-4458 (TTY: 711). Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-946-4458 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-946-4458 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-866-946-4458 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。