Zing HEALTH™
MEDICARE REIMAGINED

Summary of Benefits

JANUARY 1, 2024 – DECEMBER 31, 2024

INDIANA

H4624-003 Zing Select Care IN (HMO)
Service Area: Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties

H4624-026 Zing Elite Select IN (HMO)
Service Area: Lake and Marion Counties

H6876-004 Zing Open Choice IN (PPO)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties

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Zing Health contracts with Medicare to offer Medicare Advantage HMO, HMO SNP, PPO, and PPO SNP plans in select states, and with select State Medicaid programs. Enrollment in Zing Health depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-866-946-4458 (TTY 711) and request the "Evidence of Coverage" or access it online at www.myzinghealth.com.

To join Zing Health, you must be entitled to Medicare Part A, be enrolled in Part B, and live in the plans service area. The service area includes the counties listed in the first row of the chart below for each plan.

For HMO plans, except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

For 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), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

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

For more information, please call us at 1-866-946-4458 (TTY users should call 711) 7 days a week, 8 a.m. to 8 p.m. or visit us at www.myzinghealth.com.

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

Benefit Coverage **Services with a [1] may require prior authorization.**	**H4624-003** **Zing Select Care IN (HMO)** *Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*	**H4624-026** **Zing Elite Select IN (HMO)** *Lake and Marion Counties* *Uses a Provider-Specific Network+*	**H6876-004** **Zing Open Choice IN (PPO)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*
PREMIUMS, DEDUCTIBLES & MOOP			
Monthly Plan Premium *(includes both medical and drugs)*	You pay $0	You pay $0	You pay $0
Deductible	No deductible for medical. See Part D prescription drugs section for Part D deductible.	No deductible for medical. See Part D prescription drugs section for Part D deductible.	No deductible for medical. See Part D prescription drugs section for Part D deductible.
Maximum Out-of-Pocket Responsibility (In-Network) *(does not include Part D prescription drugs)*	You pay no more than $4,500 annually for in-network services.	You pay no more than $3,900 annually for in-network services.	You pay no more than $6,350 annually for in-network and out-of-network services combined.

+Zing Elite Select IN (HMO) is a Provider Specific Plan (PSP) and has a network of doctors, hospitals, pharmacies, and other providers that have agreed to participate in the network for this plan. As a member of a PSP, you must select a Primary Care Physician (PCP) from a subset of PCPs within this designated network. Except in emergency situations or out-of-area urgently needed services, if you use providers that are not associated with Zing Elite Select IN (HMO)'s PSP specific network, the plan may not pay for these services.

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INPATIENT & OUTPATIENT HOSPITAL COVERAGE			
Inpatient Hospital[1]	You pay $350 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay.	You pay $325 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay.	In-Network and Out-of-Network: You pay $395 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay.
Outpatient Hospital[1]	You pay $300 per visit	You pay $250 per visit	In-Network and Out-of-Network: You pay $350 per visit
Ambulatory Surgical Center (ASC)[1]	You pay $200 per visit	You pay $195 per visit	In-Network and Out-of-Network: You pay $250 per visit
DOCTOR VISITS			
Doctor Visits			In-Network and Out-of-Network:
• Primary Care Provider	You pay $0 per visit	You pay $0 per visit	You pay $0 per visit
• Specialists	You pay $30 per visit	You pay $25 per visit	You pay $35 per visit
PREVENTIVE CARE			
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing Other preventive services are available. There are some covered services that have a cost.	You pay nothing Other preventive services are available. There are some covered services that have a cost.	In-Network and Out-of-Network: You pay nothing Other preventive services are available. There are some covered services that have a cost.

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EMERGENCY CARE			
Emergency Care	You pay $120; If you are admitted to the hospital within 24 hours, then you do not have to pay $120	You pay $120; If you are admitted to the hospital within 24 hours, then you do not have to pay $120	You pay $120; If you are admitted to the hospital within 24 hours, then you do not have to pay $120
Worldwide Emergency and Urgent Care	You pay $0 for emergency and urgent care services received outside of the United States and its, territories. Our plan will reimburse up to a $50,000 maximum benefit amount per year. Emergency transportation is not included.	You pay $0 for emergency and urgent care services received outside of the United States and its, territories. Our plan will reimburse up to a $100,000 maximum benefit amount per year. Emergency transportation is not included.	You pay $0 for emergency and urgent care services received outside of the United States and its, territories. Our plan will reimburse up to a $50,000 maximum benefit amount per year. Emergency transportation is not included.
Urgently Needed Services	You pay $0 per visit at a PCP office; You pay $10 per visit at other locations	You pay $0 per visit at a PCP office; You pay $5 per visit at other locations	You pay $0 per visit at a PCP office; You pay $40 per visit at other locations

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DIAGNOSTIC SERVICES / LABS / IMAGING			
Diagnostic Services/ Labs/Imaging If a member receives multiple services on the same day, only the maximum copay applies.			In-Network:
• **Diagnostic Tests and Procedures[1]**	You pay $0 for outpatient COVID Tests; You pay $25 for all other Medicare-covered diagnostic tests and procedures	You pay $0 for outpatient COVID Tests; You pay $25 for all other Medicare-covered diagnostic tests and procedures	You pay $0 for outpatient COVID Tests; You pay $30 for all other Medicare-covered diagnostic tests and procedures
• **Lab Services[1]**	You pay $0 for Lab services	You pay $0 for Lab services	You pay $0 for Lab services
• **MRI, CAT Scan[1]**	You pay $50 for CT, MRI, PET Scan at a doctor's office; You pay $150 at a facility	You pay $50 for CT, MRI, PET Scan at a doctor's office; You pay $150 at a facility	You pay $50 for CT, MRI, PET Scan at a doctor's office; You pay $150 at a facility
• **X-Rays**	You pay $0 for X-rays	You pay $0 for X-rays	You pay $25 for X-rays
• **Therapeutic Radiology[1]** (radiation, chemotherapy)	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services Out-of-Network: You pay the same as In-Network for diagnostic tests and procedures, diagnostic radiology, x-rays, and therapeutic radiology.

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HEARING SERVICES			
Hearing Services			In-Network
• Medicare-Covered Hearing Exams	You pay $35 for Medicare-covered hearing exams	You pay $25 for Medicare-covered hearing exams	You pay $40 for Medicare-covered hearing exams
• Routine Hearing Exam	You pay $0 for one (1) routine hearing exam per year.	You pay $0 for one (1) routine hearing exam per year.	You pay $0 for one (1) routine hearing exam per year.
• Hearing Aid Fitting and Evaluation	You pay $0 for one (1) hearing aid fitting and evaluation every three (3) years	You pay $0 for one (1) hearing aid fitting and evaluation every three (3) years	You pay $0 for one (1) hearing aid fitting and evaluation every three (3) years
• Hearing Aids	You receive a $750 benefit allowance towards hearing aids per ear every three (3) years.	You receive a $750 benefit allowance towards hearing aids per ear every three (3) years.	You receive a $750 benefit allowance towards hearing aids per ear every three (3) years. Out-of-Network: You pay $40 for Medicare-covered hearing exams You pay 50% coinsurance for hearing aids. You receive a $750 benefit allowance towards hearing aids per ear every three (3) years. You pay 50% coinsurance for routine hearing services, up to one (1) routine hearing exam per year and one (1) hearing aid fitting and evaluation every three (3) years.
DENTAL SERVICES			
Dental Services	You receive a $2,000 benefit allowance every year for preventive and comprehensive dental benefits combined.	You receive a $2,000 benefit allowance every year for preventive and comprehensive dental benefits combined.	In-Network: You receive a $1,500 benefit allowance every year for preventive and comprehensive dental benefits combined.

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• Routine (Preventive) Dental Services	You pay a $0 copay for routine dental services. • Oral exams up to one (1) every six (6) months • $0 copay for prophylaxis (cleaning) up to one (1) every six (6) months • $0 copay for a fluoride treatment for up to one (1) every year • $0 copay for x-rays up to one (1) set per year	You pay a $0 copay for routine dental services. • Oral exams up to one (1) every six (6) months • $0 copay for prophylaxis (cleaning) up to one (1) every six (6) months • $0 copay for a fluoride treatment for up to one (1) every year • $0 copay for x-rays up to one (1) set per year	You pay a $0 copay for routine dental services. • Oral exams up to one (1) every six (6) months • $0 copay for prophylaxis (cleaning) up to one (1) every six (6) months • $0 copay for a fluoride treatment for up to one (1) every year • $0 copay for x-rays up to one (1) set per year
• Comprehensive Dental Services[1]	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)	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)	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) Out-of-Network: You pay $0 for Medicare-covered comprehensive dental services. You pay 50% coinsurance for non-Medicare-covered dental services (preventive and comprehensive) up to $1,500 benefit allowance every year.

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VISION SERVICES			
Vision Services			In-Network:
• Medicare-Covered Eye Exams	You pay $35 for Medicare-covered eye exams	You pay $25 for Medicare-covered eye exams	You pay $40 for Medicare-covered eye exams
• Routine Eye Exams	You pay $0 for one (1) routine vision exam per year.	You pay $0 for one (1) routine vision exam per year.	You pay $0 for one (1) routine vision exam per year.
• Medicare-Covered Eyewear	You pay $0 for Medicare-covered eyewear	You pay $0 for Medicare-covered eyewear	You pay $0 for Medicare-covered eyewear
• Routine Eyewear	You pay $0 for routine eyewear; You receive a $350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year	You pay $0 for routine eyewear; You receive a $250 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year	You pay $0 for routine eyewear; You receive a $300 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year Out-of-Network: You pay $40 for Medicare-covered eye exams You pay 50% coinsurance for non-Medicare-covered eye exams You pay $0 for Medicare-covered and non-Medicare-covered eyewear, with a $300 benefit allowance towards non-Medicare-covered eyeglass (lenses and frames), eyeglass lenses, eyeglass frames, contact lenses)

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MENTAL HEALTH SERVICES			
Inpatient Mental Health Services[1]	You pay $350 for days 1-6; $0 copay for days 7 through 90 for each Medicare-covered stay Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.	You pay $325 for days 1-6; $0 copay for days 7 through 90 for each Medicare-covered stay Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.	In-Network and Out-of-Network: You pay $363 for days 1-6; $0 copay for days 7 through 90 for each Medicare-covered stay Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.
Outpatient Mental Health Services[1] • Outpatient Group Therapy/Individual Therapy Visit[1]	You pay $35 per Medicare-covered session	You pay $25 per Medicare-covered session	In-Network and Out-of-Network: You pay $40 per Medicare-covered session
SKILLED NURSING			
Skilled Nursing Facility[1]	You pay nothing for days 1 through 20 You pay $203 per day for days 21 through 100 of each Medicare-covered stay	You pay nothing for days 1 through 20 You pay $203 per day for days 21 through 100 of each Medicare-covered stay	In-Network and Out-of-Network: You pay nothing for days 1 through 20 You pay $203 per day for days 21 through 100 of each Medicare-covered stay
REHABILITATION SERVICES			
Physical Therapy / Speech Therapy[1]	You pay $20 per visit	You pay $30 per visit	In-Network and Out-of-Network: You pay $40 per visit
Occupational Therapy[1]	You pay $20 per visit	You pay $30 per visit	In-Network and Out-of-Network: You pay $40
Cardiac Rehabilitation[1] • Intensive Cardiac Rehabilitation[1]	You pay $0 per visit	You pay $0 per visit	In-Network and Out-of-Network: You pay $0 per visit

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AMBULANCE			
Ambulance (Ground)[1]	You pay $200 for Medicare-covered services	You pay $200 for Medicare-covered services	In-Network and Out-of-Network: You pay $250 for Medicare-covered services
Ambulance (Air)[1]	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services	In-Network and Out-of-Network: You pay 20% of the cost for Medicare-covered services
TRANSPORTATION			
Transportation (Non-Emergency)[1]	You pay $0 for 24 one-way trips per year to plan approved health-related locations.	You pay $0 for 24 one-way trips per year to plan approved health-related locations. Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease	You pay $0 for 12 one-way trips per year to plan approved health-related locations.
MEDICARE PART B DRUGS			
Medicare Part B Drugs[1]			In-Network and Out-of-Network:
• Insulin[1]	You pay 0% to 20% coinsurance for insulin not to exceed $35	You pay 0% to 20% coinsurance for insulin not to exceed $35	You pay 0% to 20% coinsurance for insulin not to exceed $35
• Chemotherapy and Other Drugs[1] Step Therapy may be required	You pay 20% coinsurance for chemotherapy and other Part B drugs	You pay 20% coinsurance for chemotherapy and other Part B drugs	You pay 20% coinsurance for chemotherapy and other Part B drugs
FOOT CARE			
Podiatry Visit (Medicare-Covered)	You pay $35 per visit	You pay $25 per visit	In-Network and Out-of-Network You pay $35
Podiatry Visit (Routine Foot Care)	You pay $20 per visit; up to 4 visits / year	You pay $0 per visit; up to 6 visits / year	In-Network and Out-of-Network You pay $0 per visit; up to 4 visits / year

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MEDICAL EQUIPMENT/SUPPLIES			
Durable Medical Equipment[1] • Prosthetics[1] Prior authorization required for items/ supplies over $1,500	You pay 20% for Medicare-covered benefits	You pay 20% for Medicare-covered benefits	In-Network and Out-of-Network: You pay 20% for Medicare-covered benefits
Diabetes Supplies and Services	You pay 0% - 20%	You pay 0% - 20%	In-Network and Out-of-Network: You pay 0% - 20%
• Diabetic Therapeutic Shoes or Inserts	You pay 20%	You pay 20%	You pay 20%
• Diabetes Self-Management Training	You pay $0	You pay $0	You pay $0
CHIROPRACTIC CARE & ACUPUNCTURE			
Chiropractic Visit (Medicare-Covered)	You pay $20 per visit	You pay $15 per visit	In-Network and Out-of-Network: You pay $15 per visit
Acupuncture Visit (Medicare-Covered)	You pay $0 per visit	You pay $0 per visit	In-Network and Out-of-Network: You pay $0 per visit
HOME HEALTH CARE			
Home Health Care (Medicare-covered)	You pay $0 per visit	You pay $0 per visit	In-Network and Out-of-Network: You pay $0
HOSPICE			
Hospice Care	You must get your care from a Medicare-certified hospice provider. You pay part of the cost for outpatient drugs.	You must get your care from a Medicare-certified hospice provider. You pay part of the cost for outpatient drugs.	You must get your care from a Medicare-certified hospice provider. You pay part of the cost for outpatient drugs.

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OUTPATIENT SUBSTANCE ABUSE			
Individual and Group Therapy Visit[1]	You pay $35 per visit	You pay $20 per visit	In-Network and Out-of-Network: You pay $25
Opioid Treatment Visit[1]	You pay $35 per visit	You pay $25 per visit	In-Network and Out-of-Network: You pay $40
RENAL DIALYSIS			
Renal Dialysis	You pay 20% for Medicare-covered benefits	You pay 20% for Medicare-covered benefits	In-Network and Out-of-Network: You pay 20% for Medicare-covered benefits
Kidney Disease Education Services	You pay $0 for Medicare-covered benefits	You pay $0 for Medicare-covered benefits	In-Network and Out-of-Network: You pay $0 for Medicare-covered benefits
IN-HOME SUPPORT SERVICES			
In-Home Support Services	You pay $0 for 30 hours per year of Papa Pals services	You pay $0 for 30 hours per year of Papa Pals services	You pay $0 for 30 hours per year of Papa Pals services
FITNESS			
Fitness - Health Club Membership and At-home Fitness Kit	You pay $0	You pay $0	You pay $0
Weight Management Program	You pay $0	You pay $0	You pay $0
24 / 7 NURSING HOTLINE			
24 / 7 Nurse Hotline	You pay $0	You pay $0	You pay $0
MEAL BENEFITS			
Post Discharge Meals	You pay $0 for 10 meals after each inpatient facility discharge or surgery	You pay $0 for 10 meals after each inpatient facility discharge or surgery	You pay $0 for 10 meals after each inpatient hospital discharge

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OVER-THE-COUNTER ITEMS / HEALTHY FOODS / UTILITY			
Over-the-Counter Items Allowance	You pay $0 for **$120** / quarter to use for over-the-counter items, unused funds do not roll-over to next quarter	You pay $0 for **$198** / quarter to use for over-the-counter items, unused funds do not roll-over to next quarter	You pay $0 for **$197** / quarter to use for over-the-counter items, unused funds do not roll-over to next quarter
Healthy Food and Utilities Allowance	Healthy Choices Allowance - If you receive "Extra Help" to pay your Medicare prescription drug program costs, you are eligible to receive a **$55** allowance every month automatically loaded on a prepaid card to use toward plan-approved food items and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.	Healthy Choices Allowance - If you receive "Extra Help" to pay your Medicare prescription drug program costs, you are eligible to receive a **$60** allowance every month automatically loaded on a prepaid card to use toward plan-approved food items and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.	Healthy Choices Allowance - If you receive "Extra Help" to pay your Medicare prescription drug program costs, you are eligible to receive a **$55** allowance every month automatically loaded on a prepaid card to use toward plan-approved food items and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.
FLEX CARD BENEFIT			
Flex Card	You receive a $700 debit card every year to apply towards the following non-Medicare covered benefits at your discretion: • Hearing • Dental (preventive and comprehensive) • Vision (routine and eyewear)	You receive a $900 debit card every year to apply towards the following non-Medicare covered benefits at your discretion: • Hearing • Dental (preventive and comprehensive) • Vision (routine and eyewear)	You receive a $700 debit card every year to apply towards the following non-Medicare covered benefits at your discretion: • Hearing • Dental (preventive and comprehensive) • Vision (routine and eyewear)

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PART D PRESCRIPTION DRUGS			
Phase 1: Deductible Stage	You pay $0	You pay $0	You pay $0
Phase 2: Initial Coverage Stage	You are in the Initial Coverage Stage until your total yearly drug cost reach $5,030. Total yearly drug costs are the total drug costs paid both by you and the plan. Once you've reached this amount, you enter the coverage gap.		
Standard Retail Benefits (30 days /60 days /100 days)			
Tier 1 - Preferred Generic (includes insulins)	$0 / $0 / $0	$0 / $0 / $0	$0 / $0 / $0
Tier 2 - Generic (includes excluded drugs)	$8 / $16 / $24	$8 / $16 / $24	$15 / $30 / $45
Tier 3 - Preferred Brand	$47 / $94 / $141	$47 / $94 / $141	$47 / $94 / $141
Tier 4 - Non-Preferred Drug	$100 / $200 / $300	$100 / $200 / $300	$100 / $200 / $300
Tier 5 - Specialty Tier (30-day supply only)	33%	33%	33%
Mail Order Copay (30 days / 60 days / 100 days)			
Tier 1 - Preferred Generic (includes insulins)	$0 / $0 / $0	$0 / $0 / $0	$0 / $0 / $0
Tier 2 - Generic (includes excluded drugs)	$0 / $0 / $0	$0 / $0 / $0	$0 / $0 / $0
Tier 3 - Preferred Brand	$47 / $94 / $94	$47 / $94 / $94	$47 / $94 / $94
Tier 4 - Non-Preferred Drug	$100 / $200 / $200	$100 / $200 / $200	$100 / $200 / $200
Tier 5 - Specialty Tier (30-day supply only)	33%	33%	33%
Phase 3: Gap Coverage	During this phase, you will pay 25% for generic or brand-name drugs. During this stage, you will continue to pay $0 cost-share for select insulins and tier 1 drugs.		
Phase 4: Catastrophic Coverage Stage	The plan pays the full cost for your covered Part D drugs. You pay nothing.		
Additional Drug Coverage			
Erectile Dysfunction (ED Drugs) - sildenafil	Covered at Tier 2 cost-share amount		

Benefit Coverage **Services with a [1] may require prior authorization.**	**H4624-003** **Zing Select Care IN (HMO)** *Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*	**H4624-026** **Zing Elite Select IN (HMO)** *Lake and Marion Counties* *Uses a Provider-Specific Network+*	**H6876-004** **Zing Open Choice IN (PPO)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*
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.			

+Zing Elite Select IN (HMO) is a Provider Specific Plan (PSP) and has a network of doctors, hospitals, pharmacies, and other providers that have agreed to participate in the network for this plan. As a member of a PSP, you must select a Primary Care Physician (PCP) from a subset of PCPs within this designated network. Except in emergency situations or out-of-area urgently needed services, if you use providers that are not associated with Zing Elite Select IN (HMO)'s PSP specific network, the plan may not pay for these services.