Zing HEALTH™
MEDICARE REIMAGINED

Summary of Benefits

JANUARY 1, 2024 – DECEMBER 31, 2024

MICHIGAN (HMO & PPO)

H4624-006 Zing Select Care MI (HMO)
Service Area: Genesee, Oakland, and Wayne Counties

H4624-022 Zing Elite Select MI (HMO)
Service Area: Wayne County

H6876-001 Zing Open Choice MI (PPO)
Service Area: Wayne County

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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.**	**H4624-006** **Zing Select Care MI (HMO)** *Genesee, Oakland, and Wayne Counties*	**H4624-022** **Zing Elite Select MI (HMO)** *Wayne County* *Uses a Provider-Specific Network**	**H6876-001** **Zing Open Choice MI (PPO)** *Wayne County*
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	You pay no more than $4,500 annually	You pay no more than $4,950 annually for in-network services. You pay no more than $8,950 annually for in-network and out-of-network services combined.

*Zing Elite Select MI (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 MI (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 $300 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay	You pay $295 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 $310 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 $275 per visit	You pay $250 per visit	In-Network and Out-of-Network: You pay $300
Ambulatory Surgical Center (ASC)[1]	You pay $175 per visit	You pay $175 per visit	In-Network and Out-of-Network: You pay $275
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 $30 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 $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 $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 $20 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 and Out-of-Network:
• **Diagnostic tests and procedures[1]**	You pay $0 for outpatient COVID Tests; You pay $25 for all other diagnostic tests and procedures	You pay $0 for outpatient COVID Tests; You pay $25 for all other diagnostic tests and procedures	You pay $0 for outpatient COVID Tests; You pay $85 for all other 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 $40 for CT, MRI, PET Scan at a doctor's office; You pay $125 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 $15 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

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HEARING SERVICES			
Hearing Services • Medicare-Covered Hearing Exams	You pay $35 for Medicare-covered hearing exams	You pay $30 for Medicare-covered hearing exams	In-Network: You pay $35 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 $35 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.

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DENTAL SERVICES			
Dental Services	You receive a $2,500 benefit allowance every year for preventive and comprehensive dental benefits combined.	You receive a $2,500 benefit allowance every year for preventive and comprehensive dental benefits combined.	In-Network: You receive a $2,000 benefit allowance every year for preventive and comprehensive dental benefits combined.
• 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

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• **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)	In-Network: 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 (routine or comprehensive) up to the maximum benefit allowance of $2,000 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 $30 for Medicare-covered eye exams	You pay $35 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 eywear; 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 eywear; You receive a $300 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year	You pay $0 for routine eywear; You receive a $200 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year Out-of-Network: You pay $35 for Medicare-covered eye exams You pay 50% coinsurance for non- Medicare-covered vision services . You pay $0 for Medicare-covered and non-Medicare-covered eyewear; You receive a $200 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year.

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MENTAL HEALTH SERVICES			
Inpatient Mental Health Services[1]	You pay $300 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 $295 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 $310 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 $30 per Medicare-covered session	In-Network and Out-of-Network: You pay $35 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 $20 per visit	In-Network and Out-of-Network: You pay $40 per visit
Occupational Therapy[1]	You pay $20 per visit	You pay $20 per visit	In-Network and Out-of-Network: You pay $40 per visit
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 $225 for Medicare-covered services
Ambulance (Air)[1]	You pay 20% for Medicare-covered services	You pay 20% for Medicare-covered services	In-Network and Out-of-Network: You pay 20% for Medicare-covered services
TRANSPORTATION			
Transportation (Non-Emergency)[1]	You pay $0 for 48 one-way trips per year to plan approved locations.	You pay $0 for 48 one-way trips per year to plan approved locations. Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease	You pay $0 for 36 one-way trips per year to plan approved locations. Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease
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
• Chemotheraphy and Other Drugs[1] Step Therapy may be required	You pay 20% coinsurance for chemotherapthy and other Part B drugs	You pay 20% coinsurance for chemotherapthy and other Part B drugs	You pay 20% coinsurance for chemotherapthy and other Part B drugs
FOOT CARE			
Podiatry Visit (Medicare-Covered)	You Pay $30 per visit	You Pay $30 per visit	In-Network and Out-of-Network: You Pay $30 per visit
Podiatry Visit (Routine Foot Care)	You pay $20 per visit; up to 4 visits / year	You pay $30 per visit; up to 4 visits / year	In-Network and Out-of-Network: You pay $30 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%	You pay 20%	In-Network and Out-of-Network: You pay 20%
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	You pay $20	In-Network and Out-of-Network: You pay $20
Acupuncture Visit (Medicare-Covered)	You pay $0	You pay $0	In-Network and Out-of-Network: You pay $0
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 per visit
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 $30 per visit	In-Network and Out-of-Network: You pay $40 per visit
Opioid Treatment Visit[1]	You pay $35 per visit	You pay $30 per visit	In-Network and Out-of-Network: You pay $35 per visit
RENAL DIALYSIS			
Renal Dialysis	You pay 20%	You pay 20%	In-Network and Out-of-Network: You pay 20%
Kidney Disease Education Services	You pay $0	You pay $0	In-Network and Out-of-Network: You pay $0
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 facility discharge or surgery

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OVER-THE-COUNTER ITEMS / HEALTHY FOODS / UTILITY			
Over-the-Counter Items Allowance	You pay $0 for **$132** / quarter to use for over-the-counter items, unused funds do not roll-over to next quarter	You pay $0 for **$168** / quarter to use for over-the-counter items, unused funds do not roll-over to next quarter	You pay $0 for **$174** / 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, sanitary or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period. You must receive "Extra Help" to qualify for the Healthy Choices 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, sanitary or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period. You must receive "Extra Help" to qualify for the Healthy Choices Allowance.	Healthy Choices Allowance - If you receive "Extra Help" to pay your Medicare prescription drug program costs, you are eligible to receive a **$50** allowance every month automatically loaded on a prepaid card to use toward plan-approved food items and/or utilities (electric, gas, heating oil, sanitary or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period. You must receive "Extra Help" to qualify for the Healthy Choices Allowance.
FLEX CARD BENEFIT			
Flex Card	You receive a $300 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 $500 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 $1,100 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)	$5 / $10 / $15	$5 / $10 / $15	$8 / $16 / $24
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%
Tier 6 - Select Care Drugs	Non-Covered	Non-Covered	Non-Covered
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%
Tier 6 - Select Care Drugs	Non-Covered	Non-Covered	Non-Covered
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.	H4624-006 Zing Select Care MI (HMO) *Genesee, Oakland, and Wayne Counties*	H4624-022 Zing Elite Select MI (HMO) *Wayne County* *Uses a Provider-Specific Network**	H6876-001 Zing Open Choice MI (PPO) *Wayne County*
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 MI (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 MI (HMO)'s PSP specific network, the plan may not pay for these services.