

Summary of Benefits

January 1, 2025 - December 31, 2025

Illinois HMO C-SNP

H4624-010 Zing Essential Wellness Diabetes & Heart IL (HMO C-SNP)
Service Area: Boone, Cook, DeKalb, DuPage, Kane, Kankakee,
Kendall, Lake, McHenry, Ogle, Will, and Winnebago Counties

H4624-028 Zing Elite Diabetes & Heart IL (HMO C-SNP)
Service Area: Boone, Cook, Kane, Will, and Winnebago Counties

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 plan's 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.

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PREMIUMS, DEDUCTIBLES, AND MOOP

	H4624-010	H4624-028
Monthly Plan Premium (medical and drugs)	\$0. You must continue to pay your Medicare Part B premium unless paid on your behalf by Medicaid.	\$0. You must continue to pay your Medicare Part B premium unless paid on your behalf by Medicaid.
Deductible (medical)	\$0 Medicare-defined Part B Deductible Amount Applies to All In-Network Medicare-Covered Services. See outpatient prescription drugs section for Part D deductible.	\$0 Medicare-defined Part B Deductible Amount Applies to All In-Network Medicare-Covered Services. See outpatient prescription drugs section for Part D deductible.
Maximum Out-of-Pocket Responsibility (medical)	You pay no more than \$3,650 annually.	You pay no more than \$3,200 annually.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital¹

You pay \$275 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

You pay \$275 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

Outpatient Hospital¹

You pay \$300 per visit.

You pay \$225 per visit.

Ambulatory Surgical Center (ASC)¹

You pay \$200 per visit.

You pay \$125 per visit.

DOCTOR VISITS

Doctor Visits

- **Primary Care Provider**
- **Specialists**

You pay \$0 per visit.

You pay \$0 per visit.

You pay \$0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, Pulmonologist; You pay \$15 for all other Specialists.

You pay \$0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, Pulmonologist; You pay \$10 for all other Specialists.

PREVENTIVE CARE

Preventive Care (e.g., flu vaccine, diabetic screenings)

\$0 copay. Other preventive services are available. There are some covered services that have a cost.

\$0 copay. Other preventive services are available. There are some covered services that have a cost.

EMERGENCY CARE

Emergency Care

You pay \$135; If you are admitted to the hospital within 24 hours, then you do not have to pay \$135.

You pay \$140; If you are admitted to the hospital within 24 hours, then you do not have to pay \$140.

Worldwide Emergency and Urgent Care (Emergency Transportation not covered)

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.

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.

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 \$10 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.

- **Diagnostic tests and procedures¹**
- **Lab services¹**
- **MRI, CAT Scan¹**
- **X-Rays**
- **Therapeutic Radiology¹** (radiation, chemotherapy)

You pay \$0 for outpatient COVID tests; You pay \$25 for all other Medicare-covered diagnostic tests and procedures.

You pay \$0 for Lab services.

You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$150 at a facility.

You pay \$0 for X-rays.

You pay 20% of the cost for Medicare-covered services.

You pay \$0 for outpatient COVID tests; You pay \$25 for all other Medicare-covered diagnostic tests and procedures.

You pay \$0 for Lab services.

You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$150 at a facility.

You pay \$0 for X-rays.

You pay 20% of the cost for Medicare-covered services.

HEARING SERVICES

Hearing Services

- **Medicare-Covered Hearing Exams**
- **Routine Hearing Exam**
- **Fitting and Evaluation for Hearing Aid**
- **Hearing Aids**

You pay \$20 for Medicare-covered hearing exams.

You pay \$0 for 1 routine hearing exam per year.

You pay \$0 for 1 fitting and evaluation every 3 years.

You receive a \$750 benefit allowance towards hearing aids per ear every 3 years.

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You pay \$0 for 1 routine hearing exam per year.

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DENTAL SERVICES

Dental Services

You receive a \$2,500 benefit allowance every year for preventive, diagnostic, and comprehensive dental benefits combined.

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• **Medicare Dental Services**

You pay \$0 for certain emergent or complicated dental services received when in the hospital.

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• **Diagnostic and Preventive Dental Services**

You pay a \$0 copay for diagnostic and preventive dental services.

- 1 Oral exam every 6 months
- 1 Prophylaxis (cleaning) every 6 months
- 1 Fluoride treatment every year
- 1 X-ray set per year

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- 1 Oral exam every 6 months
- 1 Prophylaxis (cleaning) every 6 months
- 1 Fluoride treatment every year
- 1 X-ray set per year

• **Comprehensive Dental Services**

You pay \$0 for comprehensive dental services.

- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/root planing)
- Prosthodontics, fixed and removable (dentures, partials)
- Oral and Maxillofacial Surgery (extractions)
- Adjunctive General Services

You pay \$0 for comprehensive dental services.

- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/root planing)
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VISION SERVICES

Vision Services

- **Medicare-Covered Eye Exams**
- **Routine Eye Exams**
- **Medicare-Covered Eyewear**
- **Routine Eyewear**

Diabetic Retinopathy: \$0.
All Other: \$20.

You pay \$0 for 1 routine vision exam per year.

You pay \$0 for Medicare-covered eyewear.

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.

Diabetic Retinopathy: \$0.
All Other: \$20.

You pay \$0 for 1 routine vision exam per year.

You pay \$0 for Medicare-covered 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.

MENTAL HEALTH SERVICES

Inpatient Mental Health Services¹

You pay \$275 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

You pay \$275 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

Outpatient Mental Health Services¹

- **Outpatient Group Therapy/Individual Therapy Visit¹**

You pay \$0 per Medicare-covered session.

You pay \$0 per Medicare-covered session.

SKILLED NURSING

Skilled Nursing Facility¹

You pay:

- \$0 for days 1 through 20.
- \$214 for days 21 through 100.
- All costs for each day after day 100 of the benefit period.

You pay:

- \$0 for days 1 through 20
- \$214 for days 21 through 100.
- All costs for each day after day 100 of the benefit period.

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REHABILITATION SERVICES

Physical Therapy/ Speech Therapy¹

You pay \$20 per visit.

You pay \$20 per visit.

Occupational Therapy¹

You pay \$20 per visit.

You pay \$20 per visit.

Cardiac Rehabilitation¹

- **Intensive Cardiac Rehabilitation¹**

You pay \$0 per visit.

You pay \$0 per visit.

AMBULANCE

Ambulance (Ground)¹

You pay \$175 per Medicare-covered services.

You pay \$200 per 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.

TRANSPORTATION

Transportation (Non-Emergency)

You pay \$0 for 30 one-way trips per year to plan approved locations.

You pay \$0 for 30 one-way trips per year to plan approved locations.

MEDICARE PART B DRUGS

Medicare Part B Drugs¹

- **Insulin¹**
- **Chemotherapy and Other Drugs¹**

Step Therapy may be required.

You pay 0% to 20% coinsurance for insulin not to exceed \$35.

You pay 20% coinsurance for chemotherapy and other Part B drugs.

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FOOT CARE

Podiatry Visit (Medicare-Covered)

You pay \$10 per visit.

You pay \$10 per visit.

Podiatry Visit (Routine Foot Care)

You pay \$0; up to 6 visits/year.

You pay \$0; up to 12 visits/year.

MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment¹

- **Prosthetics¹**

Prior authorization required for items/supplies over \$1,500.

You pay 20% for Medicare-covered benefits.

You pay 20% for Medicare-covered benefits.

Diabetes Supplies and Services

- **Diabetic Therapeutic Shoes or Inserts**
- **Diabetes Self-Management Training**

You pay 0%-20%.

You pay 0%.

You pay \$0.

You pay 0%-20%.

You pay 0%.

You pay \$0.

CHIROPRACTIC CARE AND ACUPUNCTURE

Chiropractic Visit (Medicare-Covered)

You pay \$20 per visit.

You pay \$20 per visit.

Acupuncture Visit (Medicare-Covered)

You pay \$0 per visit.

You pay \$0 per visit.

HOME HEALTH CARE

Home Health Care (Medicare-Covered)¹

You pay \$0 per visit.

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.

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OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit¹

You pay \$0 per visit.

You pay \$0 per visit.

Opioid Treatment Visit¹

You pay \$20 per visit.

You pay \$20 per visit.

RENAL DIALYSIS

Renal Dialysis

You pay 20% for Medicare-covered benefits.

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-HOME SUPPORT SERVICES

In-Home Support Services

You pay \$0 for 60 hours per year of Papa Pals services.

You pay \$0 for 60 hours per year of Papa Pals services.

FITNESS

Fitness - Health Club Membership and At-Home Fitness Kit

You pay \$0.

You pay \$0.

Weight Management Program

You pay \$0.

You pay \$0.

24/7 NURSING HOTLINE

24/7 Nurse Hotline

You pay \$0.

You pay \$0.

PERSONAL EMERGENCY RESPONSE SYSTEM

Personal Emergency Response System

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.

Chronic Condition Meals

You pay \$0 for 28 meals if you have a qualifying chronic condition and participate in a lifestyle transition program.

You pay \$0 for 28 meals if you have a qualifying chronic condition and participate in a lifestyle transition program.

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OVER-THE-COUNTER ITEMS/HEALTHY FOODS/UTILITY

Over-the-Counter Items Allowance

You pay \$0 for \$161/month to use for over-the-counter items, unused funds do not roll-over to next month.

You pay \$0 for \$181/month to use for over-the-counter items, unused funds do not roll-over to next month.

Healthy Food and Utilities Allowance

Any unused balances cannot be converted to cash or rolled over to the next benefit period.

Members with Cardiovascular Disorders, Chronic Heart Failure, and Diabetes who have a high risk of hospitalization or other adverse health outcome, and require intensive care coordination are eligible for this benefit. Eligible members will receive this benefit for the first 90 days of their effective date. In order to continue to receive this benefit, you must complete a health risk assessment (HRA) within 90 days of your effective date and then annually. The over-the-counter (OTC) allowance can also be used for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water).

The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

Members with Cardiovascular Disorders, Chronic Heart Failure, and Diabetes who have a high risk of hospitalization or other adverse health outcome, and require intensive care coordination are eligible for this benefit. Eligible members will receive this benefit for the first 90 days of their effective date. In order to continue to receive this benefit, you must complete a health risk assessment (HRA) within 90 days of your effective date and then annually. The over-the-counter (OTC) allowance can also be used for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water).

The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

FLEX CARD BENEFIT

Flex Card

You receive a \$490 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 \$250 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.

Phase 2: Out-of-Pocket Threshold

\$2,000.

The maximum that you will pay each year for Medicare Part D prescription drugs covered by the plan.

Once you've reached this amount, you enter the catastrophic coverage phase.

\$2,000.

The maximum that you will pay each year for Medicare Part D prescription drugs covered by the plan.

Once you've reached this amount, you enter the catastrophic coverage phase.

Standard Retail Benefits (30 days/60 days/100 days)

Insulins (30 days): T1, T3, T5, T6-\$0, T4-\$35

Tier 1 - Preferred Generic

\$0/\$0/\$0

\$0/\$0/\$0

Tier 2 - Generic (includes excluded drugs)

\$5/\$10/\$15

\$5/\$10/\$15

Tier 3 - Preferred Brand

\$47/\$94/\$141

\$47/\$94/\$141

Tier 4 - Non-Preferred Drug

33%/33%/33%

33%/33%/33%

Tier 5 - Specialty Tier (30-day supply only)

33%

33%

Tier 6 - Select Care Drugs

\$0/\$0/\$0

\$0/\$0/\$0

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Mail Order Copay (30 days/60 days/100 days)

Insulins (30 days): T1, T3, T5, T6-\$0, T4-\$35

Tier 1 - Preferred Generic	\$0/\$0/\$0	\$0/\$0/\$0
Tier 2 - Generic (includes excluded drugs)	\$0/\$0/\$0	\$0/\$0/\$0
Tier 3 - Preferred Brand	\$47/\$94/\$94	\$47/\$94/\$94
Tier 4 - Non-Preferred Drug	33%/33%/33%	33%/33%/33%
Tier 5 - Specialty Tier (30-day supply only)	33%	33%
Tier 6 - Select Care Drugs	\$0/\$0/\$0	\$0/\$0/\$0

Phase 3: 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.

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 Member Services or access our "Evidence of Coverage" online or request one by mail.

⁽²⁾ If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay \$0 for your Medicare-covered services as noted by the cost sharing in this chart.