Zing HEALTH™

Summary of Benefits

January 1, 2025 - December 31, 2025

Indiana HMO/PPO

H4624-003 Zing Select Care IN (HMO)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, 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, Madison, Marion, Morgan, Porter, and Shelby 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.	**H4624-003** **Zing Select Care IN (HMO)** *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, AND MOOP			
Monthly Plan Premium (medical and drugs)	$0. You must continue to pay your Medicare Part B premium unless paid on your behalf.	$0. You must continue to pay your Medicare Part B premium unless paid on your behalf.	$0. You must continue to pay your Medicare Part B premium unless paid on your behalf.
Deductible (medical)	$0. See Part D prescription drugs section for Part D deductible.	$0. See Part D prescription drugs section for Part D deductible.	In-Network and Out-of-Network: $0. See Part D prescription drugs section for Part D deductible.
Maximum Out-of-Pocket Responsibility (medical)	You pay no more than $4,500 annually for in-network Medicare-covered services.	You pay no more than $3,900 annually for in-network Medicare-covered services.	You pay no more than $6,350 annually for in-network and out-of-network Medicare-covered services combined.

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INPATIENT AND 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 $339 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 $175 per visit.	In-Network and Out-of-Network: You pay $275 per visit.
Ambulatory Surgical Center (ASC)[1]	You pay $200 per visit.	You pay $120 per visit.	In-Network and Out-of-Network: You pay $175 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 $15 per visit.	You pay $10 per visit.	You pay $30 per visit.
PREVENTIVE CARE			
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay $0 per service. Other preventive services are available that have a cost.	You pay $0 per service. Other preventive services are available that have a cost.	In-Network and Out-of-Network: You pay $0 per service. Other preventive services are available that have a cost.

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EMERGENCY CARE			
Emergency Care	You pay $125; If you are admitted to the hospital within 24 hours, then you do not have to pay $125.	You pay $125; If you are admitted to the hospital within 24 hours, then you do not have to pay $125.	In-Network and Out-of-Network: You pay $110; If you are admitted to the hospital within 24 hours, then you do not have to pay $110.
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 $50,000 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.	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.
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.	In-Network and Out-of-Network: 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 and Out-of-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.

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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 1 routine hearing exam per year.	You pay $0 for 1 routine hearing exam per year.	You pay $0 for 1 routine hearing exam per year.
• **Hearing Aid Fitting and Evaluation**	You pay $0 for 1 hearing aid fitting and evaluation every 3 years.	You pay $0 for 1 hearing aid fitting and evaluation every 3 years.	You pay $0 for 1 hearing aid fitting and evaluation every 3 years. Out-of-Network: You pay $40 for Medicare-covered hearing exams. You pay 50% coinsurance for routine hearing exam and hearing aid fitting and evaluation.
• **Hearing Aids**	You receive a $750 benefit allowance towards hearing aids per ear every 3 years.	You receive a $750 benefit allowance towards hearing aids per ear every 3 years.	In-Network and Out-of-Network: You receive a $750 benefit allowance towards hearing aids per ear every 3 years.

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DENTAL SERVICES			
Dental Services	You receive a $2,000 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined.	You receive a $2,000 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined.	In-Network and Out-of-Network: You receive a $1,500 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined in-network or out-of-network.
• **Medicare Dental Services[1]**	You pay $0 for certain emergent or complicated dental services received when in the hospital.	You pay $0 for certain emergent or complicated dental services received when in the hospital.	In-Network: You pay $0 for certain emergent or complicated dental services received when in the hospital.
• **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	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	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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• **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) • Prosthodontics, fixed and removable (dentures, partials) • Oral and Maxillofacial Surgery (extractions) • Adjunctive General Services	In-Network: 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 Out-of-Network: You pay $0 for Medicare dental services. You pay 50% coinsurance for non-Medicare-covered dental services (diagnostic, preventive, and comprehensive).

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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 1 routine exam per year.	You pay $0 for 1 routine exam per year.	You pay $0 for 1 routine 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 $300 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 $0 for routine eye exams. You pay 50% coinsurance for Medicare-covered and routine eyewear, with a $300 benefit allowance towards routine 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 7-90 for each Medicare-covered stay.	You pay $325 for days 1-6; $0 copay for days 7-90 for each Medicare-covered stay.	In-Network and Out-of-Network: You pay $339 for days 1-6; $0 copay for days 7-90 for each Medicare-covered stay.
Outpatient Mental Health Services[1] • **Outpatient Group Therapy/Individual Therapy Visit[1]**	You pay $0 per Medicare-covered session.	You pay $0 per Medicare-covered session.	In-Network and Out-of-Network: You pay $0 per Medicare-covered session.
SKILLED NURSING			
Skilled Nursing Facility[1]	You pay nothing for days 1-20. You pay $214 per day for days 21-100 of each Medicare-covered stay.	You pay nothing for days 1-20. You pay $214 per day for days 21-100 of each Medicare-covered stay.	In-Network and Out-of-Network: You pay nothing for days 1-20. You pay $214 per day for days 21-100 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 $35 per visit.
Occupational Therapy[1]	You pay $20 per visit.	You pay $30 per visit.	In-Network and Out-of-Network: You pay $35.
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)	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.	Non-Covered.
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 for a 1-month supply.	You pay 0% to 20% coinsurance for insulin not to exceed $35 for a 1-month supply.	You pay 0% to 20% coinsurance for insulin not to exceed $35 for a 1-month supply.
• **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 AND 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)[1]	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 $0 per visit.	You pay $0 per visit.	In-Network and Out-of-Network: You pay $0.
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.	In-Network and Out-of-Network: You pay $0 for 30 hours per year of Papa Pals services.
FITNESS			
Fitness - Health Club Membership or At-Home Fitness Kit	You pay $0.	You pay $0.	In-Network and Out-of-Network: You pay $0.
Weight Management Program	You pay $0.	You pay $0.	Non-Covered.
24/7 NURSING HOTLINE			
24/7 Nurse Hotline	You pay $0.	You pay $0.	You pay $0.

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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.	In-Network: You pay $0 for 10 meals after each inpatient hospital discharge. Out-of-Network: You pay 50% coinsurance for 10 meals after each inpatient facility discharge.
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.	In-Network and Out-of-Network: You pay $0 for $190/ quarter to use for over-the-counter items, unused funds do not roll-over to next quarter.

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Healthy Food and Utilities Allowance 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 $75 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). Eligibility for the Model benefits or RI Programs under the VBID Model is not assured and will be determined by the Zing Health after enrollment, based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).	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). Eligibility for the Model benefits or RI Programs under the VBID Model is not assured and will be determined by the Zing Health after enrollment, based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).	In-Network: 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). Eligibility for the Model benefits or RI Programs under the VBID Model is not assured and will be determined by the Zing Health after enrollment, based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).

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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 $385 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)	In-Network: You receive a $200 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)
PART D PRESCRIPTION DRUGS			
Phase 1: Deductible Stage	You pay $0.	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.		
Standard Retail Benefits (30 days/60 days/100 days) Insulins (30 days): T1, T3, T5-$0, T4-$35			
Tier 1 - Preferred Generic	$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	33%/33%/33%	33%/33%/33%	33%/33%/33%
Tier 5 - Specialty Tier (30-day supply only)	33%	33%	33%

Benefit Coverage Services with a [1] may require prior authorization.	**H4624-003** **Zing Select Care IN (HMO)** *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*
Mail Order Copay (30 days/60 days/100 days) Insulins (30 days): T1, T3, T5-$0, T4-$35			
Tier 1 - Preferred Generic	$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	33%/33%/33%	33%/33%/33%	33%/33%/33%
Tier 5 - Specialty Tier (30-day supply only)	33%	33%	33%
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.

+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.