

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

HMO/PPO

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
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Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

H4624-026
Zing Elite Select IN (HMO)
Lake and Marion Counties
Uses a Provider-Specific Network+

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PREMIUMS, DEDUCTIBLES, AND MOOP

	H4624-003	H4624-026	H6876-004
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.	\$0. You must continue to pay your Medicare Part B premium unless paid on your behalf by Medicaid.
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 Hospital¹

You pay \$350 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

You pay \$325 per day for days 1-6; You pay \$0 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 \$0 per day for days 7 and beyond per admission or stay.

Outpatient Hospital¹

You pay \$225 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 \$125 per visit.

You pay \$120 per visit.

In-Network and Out-of-Network:
You pay \$175 per visit.

DOCTOR VISITS

Doctor Visits

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

You pay \$0 per visit.

You pay \$15 per visit.

You pay \$0 per visit.

You pay \$10 per visit.

In-Network and Out-of-Network:
You pay \$0 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.

• **Diagnostic Tests and Procedures¹**

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.

In-Network and Out-of-Network:

You pay \$0 for outpatient COVID Tests; You pay \$30 for all other Medicare-covered diagnostic tests and procedures.

• **Lab Services¹**

You pay \$0 for Lab services.

You pay \$0 for Lab services.

You pay \$0 for Lab services.

• **MRI, CAT Scan¹**

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

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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 Radiology¹**
(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**
- **Routine Hearing Exam**
- **Hearing Aid Fitting and Evaluation**

- **Hearing Aids**

You pay \$35 for Medicare-covered hearing exams.

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

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

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

You pay \$25 for Medicare-covered hearing exams.

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

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

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

In-Network:

You pay \$40 for Medicare-covered hearing exams.

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

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.

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 Services¹**

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 \$0 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 \$0 for diagnostic and preventive dental services.

- 1 Oral exam every 6 months
- 1 Prophylaxis (cleaning) every 6 months
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You pay \$0 for diagnostic and preventive dental services.

- 1 Oral exam every 6 months
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Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

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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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H4624-026

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VISION SERVICES

Vision Services

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

You pay \$35 for Medicare-covered eye exams.

You pay \$0 for 1 routine eye 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.

You pay \$25 for Medicare-covered eye exams.

You pay \$0 for 1 routine eye 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.

In-Network:

You pay \$40 for Medicare-covered eye exams.

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

You pay \$0 for Medicare-covered and routine eyewear.

Out-of-Network:

You pay \$40 for Medicare-covered eye exams.

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

You pay 50% coinsurance for Medicare-covered and routine eyewear.

In-Network and Out-of-Network:

Our plan covers up to a \$300 maximum benefit amount in-network or out-of-network towards 1 pair of covered contact lenses, eyeglasses (lenses and frames), eyeglass lenses, and eyeglass frames.

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H4624-003

Zing Select Care IN (HMO)

Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

H4624-026

Zing Elite Select IN (HMO)

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Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

MENTAL HEALTH SERVICES

Inpatient Mental Health Services¹

You pay \$350 per day for days 1-6; You pay \$0 per day for days 7 to 90 per admission or stay.

You pay \$325 per day for days 1-6; You pay \$0 per day for days 7 to 90 per admission or stay.

In-Network and Out-of-Network:

You pay \$339 per day for days 1-6; You pay \$0 per day for days 7 to 90 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.

In-Network and Out-of-Network:

You pay \$0 per Medicare-covered session.

SKILLED NURSING

Skilled Nursing Facility¹

You pay \$0 for days 1-20.
You pay \$214 per day for days 21-100 of each Medicare-covered stay.

You pay \$0 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 \$0 for days 1-20.
You pay \$214 per day for days 21-100 of each Medicare-covered stay.

REHABILITATION SERVICES

Physical Therapy/Speech Therapy¹

You pay \$20 per visit.

You pay \$30 per visit.

In-Network and Out-of-Network:

You pay \$35 per visit.

Occupational Therapy¹

You pay \$20 per visit.

You pay \$30 per visit.

In-Network and Out-of-Network:

You pay \$35 per visit.

Cardiac Rehabilitation¹

- Intensive Cardiac Rehabilitation¹

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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H4624-026

Zing Elite Select IN (HMO)

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H6876-004

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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.

Not Covered.

MEDICARE PART B DRUGS

Medicare Part B Drugs¹

- **Insulin¹**

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.

In-Network and Out-of-Network:

You pay 0% to 20% coinsurance for insulin not to exceed \$35 for a 1-month supply.

- **Chemotherapy and Other Drugs¹**

Step Therapy may be required.

You pay 0% to 20% coinsurance for chemotherapy and other Part B drugs.

You pay 0% to 20% coinsurance for chemotherapy and other Part B drugs.

You pay 0% to 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 per visit.

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 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.

In-Network and Out-of-Network:

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 20%.

You pay \$0.

You pay 0%-20%.

You pay 20%.

You pay \$0.

In-Network and Out-of-Network:

You pay 0%-20%.

You pay 20%.

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 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.

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H4624-026
Zing Elite Select IN (HMO)
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OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit¹

You pay \$0 per visit.

You pay \$0 per visit.

In-Network and Out-of-Network:
 You pay \$0 per visit.

Opioid Treatment Visit¹

You pay \$35 per visit.

You pay \$25 per visit.

In-Network and Out-of-Network:
 You pay \$40 per visit.

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.

Not Covered.

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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.	<p>In-Network: You pay \$0 for 10 meals after each inpatient hospital discharge.</p> <p>Out-of-Network: You pay 50% coinsurance for 10 meals after each inpatient facility discharge.</p>
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OVER-THE-COUNTER ITEMS/HEALTHY FOODS/UTILITY

Over-the-Counter Items Allowance

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

You receive \$120/quarter for over-the-counter items.

You receive \$198/quarter for over-the-counter items.

In-Network and Out-of-Network:

You receive \$190/quarter for over-the-counter items.

Healthy Foods and Utilities Allowance

Allowance is 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 (verified by Zing Health after enrollment), you are eligible to receive \$75/month.

Healthy Choices Allowance - If you receive "Extra Help" to pay your Medicare prescription drug program costs (verified by Zing Health after enrollment), you are eligible to receive \$60/month.

In-Network:

Healthy Choices Allowance - If you receive "Extra Help" to pay your Medicare prescription drug program costs (verified by Zing Health after enrollment), you are eligible to receive \$55/month.

Medicare approved Zing Health to provide this benefit as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

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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)

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H4624-003
Zing Select Care IN (HMO)
Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, 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, Madison, Marion, Morgan, Porter, and Shelby Counties

PART D PRESCRIPTION DRUGS

Deductible Stage	You pay \$0.	You pay \$0.	You pay \$0.
Initial Coverage Stage	You are in the Initial Coverage Stage until your total yearly drug cost reaches \$2,000. This is 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 Stage.	You are in the Initial Coverage Stage until your total yearly drug cost reaches \$2,000. This is 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 Stage.	You are in the Initial Coverage Stage until your total yearly drug cost reaches \$2,000. This is 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 Stage.

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

Insulins (30 days): Tiers 1, 3, & 5: \$0; Tier 4: \$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, Madison, Marion, Morgan, 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, Madison, Marion, Morgan, Porter, and Shelby Counties

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

Insulins (100 days): Tiers 1, 3, & 5: \$0; Tier 4: \$70

Tier	H4624-003	H4624-026	H6876-004
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%

Catastrophic Coverage Stage

The plan pays the full cost for your covered Part D drugs. You pay \$0.

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.