Zing HEALTH™

Summary of Benefits

January 1, 2025 - December 31, 2025

Indiana
HMO/PPO C-SNP

H4624-011 Zing Select Diabetes & Heart IN (HMO C-SNP)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

H6876-005 Zing Open Choice Diabetes & Heart IN (PPO C-SNP)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

H4624-031 Zing Elite Diabetes & Heart IN (HMO C-SNP)
Service Area: Lake and Marion 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. These plans are specifically for someone who has been diagnosed with Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes.

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.	**H4624-011** **Zing Select Diabetes & Heart IN** **(HMO C-SNP)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties*	**H6876-005** **Zing Open Choice Diabetes & Heart IN (PPO C-SNP)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties*	**H4624-031** **Zing Elite Diabetes & Heart IN (HMO C-SNP)** *Lake and Marion Counties* *Uses a Provider-Specific Network+*
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 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 drug section for Part D deductible.	In-Network and Out-of-Network: $0. See Part D prescription drug section for Part D deductible.	$0. See Part D prescription drug 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 $6,350 annually for in-network and out-of-network Medicare-covered services combined.	You pay no more than $4,500 annually for in-network Medicare-covered services.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE			
Inpatient Hospital[1]	You pay $350 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.	You pay $350 per day for days 1-6; You pay $0 per day for days 7 and beyond per admission or stay.
Outpatient Hospital[1]	You pay $225 per visit.	In-Network and Out-of-Network: You pay $225 per visit.	You pay $225 per visit.
Ambulatory Surgical Center (ASC)[1]	You pay $125 per visit.	In-Network and Out-of-Network: You pay $125 per visit.	You pay $125 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 $0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, Pulmonologists; You pay $15 for all other Specialists.	You pay $0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, Pulmonologists; You pay $30 for all other Specialists.	You pay $0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, Pulmonologists; You pay $10 for all other Specialists.
PREVENTIVE CARE			
Preventive Care (e.g., flu vaccine, diabetic screenings)	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.	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.	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.	You pay $125; If you are admitted to the hospital within 24 hours, then you do not have to pay $125.
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.	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.	In-Network and Out-of-Network: 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 for services.		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 $25 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 $0 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 $30 for Medicare-covered hearing exams.	You pay $45 for Medicare-covered hearing exams.	You pay $30 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. Out-of-Network: You pay $45 for Medicare-covered hearing exams. You pay 50% coinsurance for a routine hearing exam and hearing aid fitting and evaluation.	You pay $0 for 1 hearing aid fitting and evaluation every 3 years.
• **Hearing Aids**	You receive a $750 benefit allowance towards hearing aids per ear every 3 years.	In-Network and Out-of-Network: You receive a $750 maximum benefit amount per ear every 3 years towards hearing aids.	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.	In-Network and Out-of-Network: You receive a $1,500 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined.	You receive a $2,500 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined.
• **Medicare Dental Services**[1]	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.	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 • 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 • 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	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) up to the $1,500 benefit allowance every year.	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
VISION SERVICES			

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Vision Services		In-Network:	
• **Medicare-Covered Eye Exams**	You pay $0 for diabetic retinopathy exams; you pay $30 for all other Medicare-covered eye exams.	You pay $0 for diabetic retinopathy exams; you pay $45 for all other Medicare-covered eye exams.	You pay $0 for diabetic retinopathy exams; you pay $30 for all other Medicare-covered eye exams.
• **Routine Eye Exams**	You pay $0 for 1 routine eye exam per year.	You pay $0 for 1 routine eye exam per year.	You pay $0 for 1 routine eye 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 $300 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year.	Out-of-Network: You pay $0 for diabetic retinopathy exams; $45 for all other 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 $200 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.	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			

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Inpatient Mental Health Services[1]	You pay $350 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.	You pay $350 per day for days 1-6; You pay $0 per day for days 7 to 90 per admission or stay.
Outpatient Mental Health Services[1] • **Outpatient Group Therapy/Individual Therapy Visit[1]**	You pay $0 per Medicare-covered session.	In-Network and Out-of-Network: You pay $0 per Medicare-covered session.	You pay $0 per Medicare-covered session.
SKILLED NURSING			
Skilled Nursing Facility[1]	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.	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 Therapy[1]	You pay $20 per visit.	In-Network and Out-of-Network: You pay $20 per visit.	You pay $20 per visit.
Occupational Therapy[1]	You pay $20 per visit.	In-Network and Out-of-Network: You pay $20 per visit.	You pay $20 per visit.
Cardiac Rehabilitation[1] • **Intensive Cardiac Rehabilitation[1]**	You pay $0 per visit.	In-Network and Out-of-Network: You pay $0 per visit.	You pay $0 per visit.
AMBULANCE			

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Ambulance (Ground)[1]	You pay $200 for Medicare-covered services.	In-Network and Out-of-Network: You pay $200 for Medicare-covered services.	You pay $200 for Medicare-covered services.
Ambulance (Air)[1]	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.	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 health-related locations.	Not Covered.	You pay $0 for 30 one-way trips per year to plan approved health-related locations.
MEDICARE PART B DRUGS			
Medicare Part B Drugs[1]		In-Network and Out-of-Network:	
• **Insulin[1]**	You pay 0% to 20% coinsurance for insulin not to exceed $35 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 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 $15 per visit.	In-Network and Out-of-Network: You pay $20 per visit.	You pay $15 per visit.
Podiatry Visit (Routine Foot Care)	You pay $0 per visit; up to 12 visits/year.	In-Network and Out-of-Network: You pay $0 per visit; up to 12 visits/year.	You pay $0 per visit; up to 12 visits/year.
MEDICAL EQUIPMENT/SUPPLIES			

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Durable Medical Equipment[1]		In-Network and Out-of-Network:	
• **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.	You pay 20% for Medicare-covered benefits.
Diabetes Supplies and Services		In-Network and Out-of-Network:	
	You pay 0%-20%.	You pay 0%-20%.	You pay 0%-20%.
• **Diabetic Therapeutic Shoes or Inserts**	You pay $0.	You pay $0.	You pay $0.
• **Diabetes Self-Management Training**	You pay $0.	You pay $0.	You pay $0.
CHIROPRACTIC CARE AND ACUPUNCTURE			
Chiropractic Visit (Medicare-Covered)		In-Network and Out-of-Network:	
	You pay $20 per visit.	You pay $15 per visit.	You pay $20 per visit.
Acupuncture Visit (Medicare-Covered)		In-Network and Out-of-Network:	
	You pay $0 per visit.	You pay $0 per visit.	You pay $0 per visit.
HOME HEALTH CARE			
Home Health Care (Medicare-Covered)[1]		In-Network and Out-of-Network:	
	You pay $0 per visit.	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.	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.
OUTPATIENT SUBSTANCE ABUSE			

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Individual and Group Therapy Visit[1]	You pay $0 per visit.	In-Network and Out-of-Network: You pay $0 per visit.	You pay $0 per visit.
Opioid Treatment Visit[1]	You pay $30 per visit.	In-Network and Out-of-Network: You pay $30 visit.	You pay $30 per visit.
RENAL DIALYSIS			
Renal Dialysis	You pay 20% for Medicare-covered benefits.	In-Network and Out-of-Network: 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.	In-Network and Out-of-Network: 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.	In-Network and Out-of-Network: 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.	In-Network and Out-of-Network: You pay $0.	You pay $0.
Weight Management Program	You pay $0.	In-Network and Out-of-Network: You pay $0.	You pay $0.
24/7 NURSING HOTLINE			

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24/7 Nurse Hotline	You pay $0.	You pay $0.	You pay $0.
PERSONAL EMERGENCY RESPONSE SYSTEM			
Personal Emergency Response System	You pay $0.	In-Network and Out-of-Network: You pay $0.	You pay $0.
MEAL BENEFITS			
Post Discharge Meals	You pay $0 for 10 meals after each inpatient facility discharge or surgery.	In-Network and Out-of-Network: 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.	In-Network and Out-of-Network: 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 (OTC) ALLOWANCE AND SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)			
Over-the-Counter (OTC) Allowance Unused funds do not roll-over to next month.	You may receive $172/ month for over-the-counter items.	In-Network and Out-of-Network: You may receive $167/ month for over-the-counter items.	You may receive $174/ month for over-the-counter items.
Special Supplemental Benefits for the Chronically Ill (SSBCI) Healthy Foods, Produce, and Utilities Unused funds do not roll-over to next month.	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). 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.	In-Network: 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). 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). 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.

Benefit Coverage Services with a [1] may require prior authorization.	**H4624-011** **Zing Select Diabetes & Heart IN** **(HMO C-SNP)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties*	**H6876-005** **Zing Open Choice Diabetes & Heart IN (PPO C-SNP)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties*	**H4624-031** **Zing Elite Diabetes & Heart IN (HMO C-SNP)** *Lake and Marion Counties* *Uses a Provider-Specific Network+*
FLEX CARD BENEFIT			
Flex Card	Not Covered.	Not Covered.	You receive a $245 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			
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, & 6: $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	$8 /$16/$24
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%
Tier 6 - Select Care Drugs	$0/$0/$0	$0/$0/$0	$0/$0/$0

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Mail Order Copay (30 days/60 days/100 days) Insulins (100 days): Tiers 1, 3, 5, & 6: $0; Tier 4: $70			
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%
Tier 6 - Select Care Drugs	$0 / $0 / $0	$0 / $0 / $0	$0 / $0 / $0
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 Diabetes & Heart IN (HMO C-SNP) 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 Diabetes & Heart IN (HMO C-SNP)'s PSP specific network, the plan may not pay for these services.