

Summary of Benefits

January 1, 2025 - December 31, 2025

Indiana HMO/PPO C-SNP (Duals Focused)

H4624-024 Zing Select Diabetes & Heart Complete IN (HMO C-SNP)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake,
Madison, Marion, Morgan, Porter, and Shelby Counties

H6876-006 Zing Choice Diabetes & Heart Complete IN (PPO C-SNP)
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.

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PREMIUMS, DEDUCTIBLES, AND MOOP

<p>Monthly Plan Premium (medical and drugs)</p>	<p>\$0. You must continue to pay your Medicare Part B premium unless paid on your behalf.</p>	<p>\$4.40. If you receive "Extra Help," you may pay \$0.² You must continue to pay your Medicare Part B premium unless paid on your behalf.</p>
<p>Deductible (medical)</p>	<p>\$240², except for insulin furnished through an item of durable medical equipment. This is the 2024 cost-sharing amount and may change for 2025. Zing Health will provide the updated rate as soon as it is released. See Part D Prescription Drug section for Part D deductible.</p>	<p>In-Network and Out-of-Network: \$240², except for insulin furnished through an item of durable medical equipment. This is the 2024 cost-sharing amount and may change for 2025. Zing Health will provide the updated rate as soon as it is released. See Part D Prescription Drug section for Part D deductible.</p>

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Maximum Out-of-Pocket Responsibility (medical)

You pay no more than \$9,350 annually for in-network Medicare-covered services.

You pay no more than \$9,350 annually for in-network Medicare-covered services.

You pay no more than \$14,000 annually for in-network and out-of-network Medicare-covered services combined.

INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital¹

You pay a \$1,632² deductible per benefit period.

You pay:

- \$0 for days 1-60.
- \$408² copay per day for days 61-90.
- \$0 per day after day 90 while using your 60 lifetime reserve days.
- 100% of all costs beyond the lifetime reserve days.

These are 2024 cost-sharing amounts and may change for 2025. Zing Health will update these rates on its website

(www.myzinghealth.com) once available.

If you have Medicaid benefits, your costs could be less.²

In-Network and Out-of-Network:

You pay a \$1,632² deductible per benefit period.

You pay:

- \$0 for days 1-60.
- \$408² copay per day for days 61-90.
- \$0 per day after day 90 while using your 60 lifetime reserve days.
- 100% of all costs beyond the lifetime reserve days.

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If you have Medicaid benefits, your costs could be less.²

Outpatient Hospital¹

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

Ambulatory Surgical Center (ASC)¹

You may pay 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

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DOCTOR VISITS

Doctor Visits

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

You may pay \$0 or up to 20%² coinsurance per visit.

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

You may pay \$0 or up to 20%² coinsurance per visit.

PREVENTIVE CARE

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

You pay \$0. Other preventive services are available that may have a cost².

In-Network and Out-of-Network:

You pay \$0. Other preventive services are available that may have a cost².

EMERGENCY CARE

Emergency Care

You may pay \$0 or up to 20%² coinsurance with a maximum limit of \$110 per visit.
If admitted to the hospital within 24 hours of ER visit, the emergency cost share is waived.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance with a maximum limit of \$110 per visit.
If admitted to the hospital within 24 hours of ER visit, the emergency cost share is waived.

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 may pay \$0 or up to 20%² coinsurance with a maximum limit of \$45 per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance with a maximum limit of \$45 per visit.

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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 may pay \$0 or up to 20%² coinsurance for all services listed.

In-Network and Out-of-Network:
You pay \$0 for X-Rays.
You may pay \$0 or up to 20%² coinsurance for all services listed.

HEARING SERVICES

Hearing Services

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

You may pay \$0 or up to 20%² coinsurance 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.

In-Network:

You may pay \$0 or up to \$30² 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.

Out-of-Network:

You pay \$0 for Medicare-covered hearing exams.

You pay 50% coinsurance for a routine hearing exam and fitting and evaluation for hearing aids.

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

• **Medicare Dental Services¹**

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

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

• **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 and Out-of-Network:

You receive a \$2,000 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined in-network or out-of-network.

In-Network:

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

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 \$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.

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VISION SERVICES

Vision Services

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

You may pay 20%² coinsurance for Medicare-covered eye exams.

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.

In-Network:

You pay \$0 copay for Medicare-covered eye exams.

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 \$250 benefit allowance towards in-network or out-of-network Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year.

Out-of-Network:

You may pay \$0 for Medicare-covered and routine eye exams.

You pay 50% coinsurance for Medicare-covered and routine eyewear with up to a \$250 benefit allowance for routine eyewear towards in-network or out-of-network Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year.

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MENTAL HEALTH SERVICES

Inpatient Mental Health Services¹

You pay a \$1,632² deductible per benefit period.

You pay:

- \$0 for days 1-60.
- \$408² copay per day for days 61-90.
- \$816² copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- 20%² of the cost for mental health services from providers during the stay.
- Part A only pays for up to 190 days of inpatient psychiatric care for a lifetime.

These are 2024 cost-sharing amounts and may change for 2025. Zing Health will provide updated rates on its website (www.myzinghealth) once available.

If you have Medicaid benefits, your costs could be less.²

In-Network and Out-of-Network:
You pay a \$1,632² deductible per benefit period.

You pay:

- \$0 for days 1-60.
- \$408² copay per day for days 61-90.
- \$816² copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- 20%² of the cost for mental health services from providers during the stay.
- Part A only pays for up to 190 days of inpatient psychiatric care for a lifetime.

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If you have Medicaid benefits, your costs could be less.²

Outpatient Mental Health Services¹

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

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:
You may pay \$0 or up to 20%² coinsurance per visit.

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SKILLED NURSING

Skilled Nursing Facility¹

You pay:

- \$0 for days 1-20.
- \$204² for days 21-100.
- All costs for each day after day 100 of the benefit period.

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If you have Medicaid benefits, your costs could be less.²

In-Network and Out-of-Network:

You pay:

- \$0 for days 1-20.
- \$204² for days 21-100.
- All costs for each day after day 100 of the benefit period.

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If you have Medicaid benefits, your costs could be less.²

REHABILITATION SERVICES

Physical Therapy/ Speech Therapy¹

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

Occupational Therapy¹

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

Cardiac Rehabilitation¹

- Intensive Cardiac Rehabilitation¹

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

AMBULANCE

Ambulance (Ground)¹

You may pay \$0 or up to 20%² coinsurance.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance.

Ambulance (Air)¹

You may pay \$0 or up to 20%² coinsurance.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance.

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TRANSPORTATION

Transportation (Non-Emergency)

You pay \$0 for 36 one-way trips per year to plan approved health-related locations.

Not Covered.

MEDICARE PART B DRUGS

Medicare Part B Drugs¹

- **Insulin¹**
 - **Chemotherapy and Other drugs¹**
- Step Therapy may be required.

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

You pay \$0 or up to 20%² coinsurance for chemotherapy and other Part B drugs.

In-Network and Out-of-Network:

You pay 0%-20%² coinsurance for insulin not to exceed \$35 for a 1-month supply.

You pay \$0 or up to 20%² coinsurance for chemotherapy and other Part B drugs.

FOOT CARE

Podiatry Visit (Medicare-Covered)

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network:
You may pay \$0 or up to 20%² coinsurance per visit.

Podiatry Visit (Routine Foot Care)

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

In-Network:
You pay \$0; up to 12 visits/year.

Out-of-Network:
You pay 20% coinsurance; up to 12 visits per year.

MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment¹

- **Prosthetics¹**
- Prior authorization required for items/supplies over \$1,500.

You may pay \$0 or up to 20%² coinsurance.

In-Network and Out-of-Network:
You may pay \$0 or up to 20%² coinsurance.

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Diabetes Supplies and Services

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

You may pay \$0 or up to 20%² coinsurance.

You may pay \$0 or up to 20%² coinsurance.

You pay \$0.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance.

You may pay \$0 or up to 20%² coinsurance.

You pay \$0.

CHIROPRACTIC CARE AND ACUPUNCTURE
Chiropractic Visit (Medicare-Covered)

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

Acupuncture Visit (Medicare-Covered)

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.

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.

OUTPATIENT SUBSTANCE ABUSE
Individual and Group Therapy Visit¹

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

Opioid Treatment Visit¹

You may pay \$0 or up to 20%² coinsurance per visit.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance per visit.

RENAL DIALYSIS
Renal Dialysis

You may pay \$0 or up to 20%² coinsurance.

In-Network and Out-of-Network:

You may pay \$0 or up to 20%² coinsurance.

Kidney Disease Education Services

You pay \$0.

In-Network and Out-of-Network:

You pay \$0.

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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.

FITNESS

Fitness - Health Club Membership or At-Home Fitness Kit*

You pay \$0.

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

Weight Management Program*

You pay \$0.

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

24/7 NURSING HOTLINE

24/7 Nurse Hotline*

You pay \$0.

In-Network:
You pay \$0.

PERSONAL EMERGENCY RESPONSE SYSTEM

Personal Emergency Response System*

You pay \$0.

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

MEAL BENEFITS

Post Discharge Meals*

You pay \$0 for 10 meals after each inpatient facility discharge or surgery.

In-Network:
You pay \$0 for 10 meals after each inpatient facility discharge or surgery.
Out-of-Network:
You pay 50% coinsurance for 10 meals after each inpatient facility discharge.

Chronic Condition Meals*

You pay \$0 for 28 meals (limited to 1 event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program.

In-Network:
You pay \$0 for 28 meals (limited to 1 event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program.
Out-of-Network:
You pay 50% coinsurance for 28 meals (limited to 1 event per year) if you have a qualifying condition.

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OVER-THE-COUNTER ITEMS/HEALTHY FOODS/UTILITY

Over-the-Counter Items Allowance*

You pay \$0 for \$172/month to use for over-the-counter items, unused funds do not roll-over to next month.

In-Network and Out-of-Network: You pay \$0 for \$130/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).

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: 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).

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).

FLEX CARD BENEFIT

Flex Card

Not Covered.

Not Covered.

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PART D PRESCRIPTION DRUGS

Phase 1: Deductible Stage	You pay \$590. (T1 and T6 Excluded) If you get Extra Help paying for your prescription drugs, your deductible may be paid by Extra Help.	You pay \$590. (T1 and T6 Excluded) If you get Extra Help paying for your prescription drugs, your deductible may be paid by Extra Help.
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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.	
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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)	25%/25%/25%	25%/25%/25%
Tier 3 - Preferred Brand	25% / 25% / 25%	25%/25%/25%
Tier 4 - Non-Preferred Drug	25%/25%/25%	25%/25%/25%
Tier 5 - Specialty Tier (30-day supply only)	25%	25%
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	25%/25%/25%	25%/25%/25%
Tier 4 - Non-Preferred Drug	25%/25%/25%	25%/25%/25%
Tier 5 - Specialty Tier (30-day supply only)	25%	25%
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.

*You must see a In-Network provider to use this benefit. Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Zing to the provider.

²If 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.