

Summary of Benefits

January 1, 2025 - December 31, 2025

Michigan HMO/PPO C-SNP

H4624-012 Zing Select Diabetes & Heart MI (HMO C-SNP)

Service Area: Genesee, Livingston, Macomb, Oakland, Washtenaw, and Wayne Counties

H6876-003 Zing Open Choice Diabetes & Heart MI (PPO C-SNP)

Service Area: Livingston, Macomb, Oakland, Washtenaw, and Wayne Counties

H4624-032 Zing Elite Diabetes & Heart MI (HMO C-SNP)

Service Area: Macomb, Oakland, and Wayne 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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Uses a Provider-Specific Network+

PREMIUMS, DEDUCTIBLES, AND MOOP

	H4624-012	H6876-003	H4624-032
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.

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Maximum Out-of-Pocket Responsibility (medical)

You pay no more than \$4,500 annually.

You pay no more than \$4,950 annually for in-network Medicare-covered services.
 You pay no more than \$8,950 annually for in-network and out-of-network services combined.

You pay no more than \$4,500 annually.

INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital¹

You pay \$300 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 \$310 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay.

You pay \$300 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

Outpatient Hospital¹

You pay \$175 per visit.

In-Network and Out-of-Network:
 You pay \$200.

You pay \$175.

Ambulatory Surgical Center (ASC)¹

You pay \$100 per visit.

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

You pay \$100.

DOCTOR VISITS

Doctor Visits

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

You pay \$0 per visit.

You pay \$0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, and Pulmonologists; You pay \$20 per visit for all other Specialists.

In-Network and Out-of-Network:

You pay \$0 per visit.

You pay \$0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, and Pulmonologists; You pay \$20 per visit for all other Specialists.

You pay \$0 per visit.

You pay \$0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, and Pulmonologists; You pay \$20 per visit for all other Specialists.

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PREVENTIVE CARE

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

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

In-Network and Out-of-Network:
 \$0 copay. Other preventive services are available that have a cost.

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

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 \$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.

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.

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Urgently Needed Services

You pay \$0 at a PCP office; You pay \$25 at other locations.

In-Network and Out-of-Network:
 You pay \$0 at a PCP office; You pay \$20 at other locations.

You pay \$0 per visit at a PCP office; You pay \$25 per visit at other locations.

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DIAGNOSTIC SERVICES/LABS/IMAGING

Diagnostic Services/Labs/Imaging

If a member receives multiple services on the same day, only the maximum copay applies.

- **Diagnostic Tests and Procedures¹**
- **Lab Services¹**
- **MRI, CAT Scan¹**
- **X-Rays**
- **Therapeutic Radiology¹** (radiation, chemotherapy)

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

You pay \$0 for Lab services.

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

You pay \$0 for X-rays.

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

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.

You pay \$0 for Lab services.

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

You pay \$0 for X-rays.

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

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

You pay \$0 for Lab services.

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

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HEARING SERVICES

Hearing Services

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

You pay \$30 for Medicare-covered hearing exams.

You pay \$0 for one 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 pay \$30 for Medicare-covered hearing exams.

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

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

Out-of-Network:

You pay \$30 for Medicare-covered hearing exams.

You pay 50% coinsurance for routine hearing services and hearing aids.

In-Network and Out-of-Network:

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

You pay \$30 for Medicare-covered hearing exams

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

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

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

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DENTAL SERVICES

Dental Services

You receive a \$2,000 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.

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

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.

- **Medicare Dental Services¹**

- **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

In-Network:
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
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<p>• Comprehensive Dental Services</p>	<p>You pay \$0 for comprehensive dental services.</p> <ul style="list-style-type: none"> • Restorative Services (crowns) • Endodontics (root canals) • Periodontics (scaling/ root planing) • Prosthodontics, fixed and removable (dentures, partials) • Oral and Maxillofacial Surgery (extractions) • Adjunctive General Services 	<p>In-Network: You pay \$0 for comprehensive dental services.</p> <ul style="list-style-type: none"> • Restorative Services (crowns) • Endodontics (root canals) • Periodontics (scaling/ root planing) • Prosthodontics, fixed and removable (dentures, partials) • Oral and Maxillofacial Surgery (extractions) • Adjunctive General Services <p>Out-of-Network: You pay \$0 for Medicare dental services. You pay 50% coinsurance for non-Medicare-covered dental services (routine and comprehensive) up to the maximum benefit limit of \$1,500 every year.</p>	<p>You pay \$0 for comprehensive dental services.</p> <ul style="list-style-type: none"> • Restorative Services (crowns) • Endodontics (root canals) • Periodontics (scaling/ root planing) • Prosthodontics, fixed and removable (dentures, partials) • Oral and Maxillofacial Surgery (extractions) • Adjunctive General Services
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VISION SERVICES

Vision Services

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

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams.

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

You pay \$0 for Medicare-covered eyewear.

You pay \$0 for routine eyewear; You receive a \$300 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year.

In-Network:

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams.

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

You pay \$0 for Medicare-covered eyewear.

You pay \$0 for routine eyewear; You receive a \$250 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year in-network or out-of-network.

Out-of-Network:

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams.

You pay \$0 copay for routine eye exams.

You pay 50% coinsurance Medicare-covered and non-Medicare-covered eyewear, with a \$250 benefit allowance towards non-Medicare-covered Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, Contact lenses in-network or out-of-network.

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams.

You pay \$0 for 1 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.

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MENTAL HEALTH SERVICES

Inpatient Mental Health Services¹

You pay \$300 for days 1-6; \$0 copay for days 7 through 90 for each Medicare-covered stay.

In-Network and Out-of-Network:

You pay \$310 for days 1-6; \$0 copay for days 7 through 90 for each Medicare-covered stay.

You pay \$300 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

Outpatient Mental Health Services¹

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

You pay \$0 per Medicare-covered session.

In-Network and Out-of-Network:

You pay \$0 per Medicare-covered session.

You pay \$0 per Medicare-covered session.

SKILLED NURSING

Skilled Nursing Facility¹

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.

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 Therapy¹

You pay \$20 per visit.

In-Network and Out-of-Network:

You pay \$25 per visit.

You pay \$20 per visit.

Occupational Therapy¹

You pay \$20 per visit.

In-Network and Out-of-Network:

You pay \$25.

You pay \$20 per visit.

Cardiac Rehabilitation¹

- **Intensive Cardiac Rehabilitation¹**

You pay \$0 per service.

In-Network and Out-of-Network:

You pay \$0 per service.

You may pay \$0 per service.

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AMBULANCE
Ambulance (Ground)¹

You pay \$200 for Medicare-covered services.

In-Network and Out-of-Network:

You pay \$225.

You pay \$200 for Medicare-covered services.

Ambulance (Air)¹

You pay 20% for Medicare-covered services.

In-Network and Out-of-Network:

You pay 20%.

You pay 20% for Medicare-covered services.

TRANSPORTATION
Transportation (Non-Emergency)

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

Non-Covered.

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

MEDICARE PART B DRUGS
Medicare Part B Drugs¹

- Insulin¹**

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

In-Network and Out-of-Network:

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

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

- Chemotherapy and Other drugs¹**

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 \$0 copay or 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 \$15 per visit.

You pay \$15 per visit.

Podiatry Visit (Routine Foot Care)

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

In-Network and Out-of-Network:

You pay \$15 per visit; up to 12 visits/year.

You pay \$0; up to 6 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%.

In-Network and Out-of-Network:

You pay 20%.

You pay 20%.

Diabetes Supplies and Services

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

You pay 0%-20%.

You pay \$0.

You pay \$0.

In-Network and Out-of-Network:

You pay 0%-20%.

You pay \$0.

You pay \$0.

You pay 0%-20%.

You pay \$0.

You pay \$0.

CHIROPRACTIC CARE AND ACUPUNCTURE

Chiropractic Visit (Medicare-Covered)

You pay \$20 per visit.

In-Network and Out-of-Network:

You pay \$15 per visit.

You pay \$20 per visit.

Acupuncture Visit (Medicare-Covered)

You pay \$0 per visit.

In-Network and Out-of-Network:

You pay \$0 per visit.

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.

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.

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OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit¹	You pay \$0 per visit.	In-Network and Out-of-Network: You pay \$0 per visit.	You pay \$0 per visit.
Opioid Treatment Visit¹	You pay \$30 per visit.	In-Network and Out-of-Network: You pay \$30 per visit.	You pay \$30 per visit.

RENAL DIALYSIS

Renal Dialysis	You pay 20%.	In-Network and Out-of-Network: You pay 20%.	You pay 20%.
Kidney Disease Education Services	You pay \$0.	In-Network and Out-of-Network: You pay \$0.	You pay \$0.

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.
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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

24/7 Nurse Hotline	You pay \$0.	You pay \$0.	You pay \$0.
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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.

In-Network and Out-of-Network:

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

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

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 and Out-of-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.

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

OVER-THE-COUNTER ITEMS/HEALTHY FOODS/UTILITY

Over-the-Counter Items Allowance

You pay \$0 for \$125/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 \$166/month to use for over-the-counter items, unused funds do not roll-over to next month.

You pay \$0 for \$174/month to use for over-the-counter items, unused funds do not roll-over to next month.

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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.

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

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

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).

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

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

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

Benefit Coverage

Services with a ¹ may require prior authorization.

H4624-012
Zing Select Diabetes & Heart MI (HMO C-SNP)
Genesee, Livingston, Macomb, Oakland, Washtenaw, and Wayne Counties

H6876-003
Zing Open Choice Diabetes & Heart MI (PPO C-SNP)
Livingston, Macomb, Oakland, Washtenaw, and Wayne Counties

H4624-032
Zing Elite Diabetes & Heart MI (HMO C-SNP)
Macomb, Oakland, and Wayne Counties
Uses a Provider-Specific Network+

FLEX CARD BENEFIT

Flex Card

You receive a \$750 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)

Non-Covered

You receive a \$350 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, T6-\$0, T4-\$35

Tier 1 - Preferred Generic

\$0/\$0/\$0

\$0/\$0/\$0

\$0/\$0/\$0

Tier 2 - Generic (includes excluded drugs)

\$5/\$10/\$15

\$5/\$10/\$15

\$5/\$10/\$15

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 (30 days): T1, T3, T5, T6-\$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%
Tier 6 - Select Care Drugs	\$0/\$0/\$0	\$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.

+Zing Elite Diabetes & Heart MI (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 MI (HMO C-SNP)'s PSP specific network, the plan may not pay for these services.