Zing HEALTH™

Summary of Benefits

January 1, 2025 - December 31, 2025

Tennessee-Mississippi HMO/PPO C-SNP (Duals Focused)

H4624-041 Zing Select Diabetes & Heart Complete TN-MS (HMO C-SNP)
TN Service Area: Davidson, Fayette, and Shelby Counties
MS Service Area: DeSoto, Marshall, Tate, and Tunica Counties

H6876-008 Zing Choice Diabetes & Heart Complete TN (PPO C-SNP)
TN Service Area: Davidson, Fayette, and Shelby Counties
This plan available only in TN

Y0149_0056626_M SB25TNMS56626E

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.	**H4624-041** **Zing Select Diabetes & Heart Complete TN-MS (HMO C-SNP)** *TN: Davidson, Fayette, and Shelby Counties* *MS: DeSoto, Marshall, Tate, and Tunica Counties*	**H6876-008** **Zing Choice Diabetes & Heart Complete TN (PPO C-SNP)** *Davidson, Fayette, and Shelby Counties* *Only available in TN.*
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.
Deductible (medical)	$240[2], 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.	In-Network and Out-of-Network: $240[2], 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.
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 services combined.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE		
Inpatient Hospital[1]	You pay a $1,632 deductible per benefit period. You pay: • $0 for days 1-60. • $408 copay per day for days 61-90. • $0 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • 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 $1,632 deductible per benefit period. You pay: • $0 for days 1-60. • $408 copay per day for days 61-90. • $0 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • 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]
Outpatient Hospital[1]	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 $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.
DOCTOR VISITS		
Doctor Visits		In-Network and Out-of-Network:
• **Primary Care Provider**	You may pay $0 or up to 20%[2] coinsurance per visit.	You may pay $0 or up to 20%[2] coinsurance per visit.
• **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.

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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.
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 Procedures**[1] • **Lab Services**[1] • **MRI, CAT Scan**[1] • **X-Rays** • **Therapeutic Radiology**[1] (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-ray services. You may pay $0 or up to 20%[2] coinsurance for all other services listed.
HEARING SERVICES		
Hearing Services		In-Network:
• **Medicare-Covered Hearing Exams**	You may pay $0 or up to 20%[2] coinsurance for Medicare-covered hearing exams.	You may pay $0 or up to 20%[2] coinsurance 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.
• **Fitting and Evaluation for Hearing Aid**	You pay $0 for 1 fitting and evaluation every 3 years.	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 routine hearing exam or fitting and evaluation for hearing aids.
• **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 benefit allowance towards hearing aids per ear every 3 years.

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DENTAL SERVICES		
Dental Services	You receive a $2,500 benefit allowance every year for diagnostic, preventive, and comprehensive dental benefits combined.	In-Network and Out-of-Network: You receive a $2,000 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.
• **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
• **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 Out-of-Network: You pay $0 for Medicare dental services. You pay 50% coinsurance for diagnostic, preventive, and comprehensive dental services.

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VISION SERVICES		
Vision Services		In-Network and Out-of-Network:
• **Medicare-Covered Eye Exams**	You may pay $0 or up to 20%[2] coinsurance for Medicare-covered eye exams.	You may pay $0 or up to 20%[2] coinsurance for 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.
• **Medicare-Covered Eyewear**	You pay $0 for Medicare-covered eyewear.	You pay $0 for Medicare-covered eyewear.
• **Routine Eyewear**	You pay $0 for routine eyewear; You receive a $350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year.	You pay $0 for routine eyewear; You receive a $250 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year. Out-of-Network: You may pay $0 or up to 20%2 superscript coinsurance for Medicare-covered eye exams. You pay $0 for 1 routine eye exam per year. You pay 50% coinsurance for Medicare and routine eyewear.

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MENTAL HEALTH SERVICES		
Inpatient Mental Health Services[1]	You pay a $1,632 deductible per benefit period. You pay: • $0 for days 1-60. • $408 copay per day for days 61-90. • $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • 20% 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 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 $1,632 deductible per benefit period. You pay: • $0 for days 1-60. • $408 copay per day for days 61-90. • $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • 20% 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 update these rates on its website (www.myzinghealth.com) once available. If you have Medicaid benefits, your costs could be less.[2]
Outpatient Mental Health Services[1] • **Outpatient Group Therapy/Individual Therapy Visit[1]**	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 Facility[1]	You pay: • $0 for days 1-20. • $204 for days 21-100. • All costs for each day after day 100 of the benefit period. 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: • $0 for days 1-20 • $204 for days 21-100 • All costs for each day after day 100 of the benefit period. 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]
REHABILITATION SERVICES		
Physical Therapy/Speech Therapy[1]	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 Therapy[1]	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 Rehabilitation[1] • **Intensive Cardiac Rehabilitation[1]**	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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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.
TRANSPORTATION		
Transportation (Non-Emergency)	You pay $0 for 36 one-way trips per year to plan approved health-related locations.	Non-Covered.
MEDICARE PART B DRUGS		
Medicare Part B Drugs[1]		In-Network and Out-of-Network:
• **Insulin[1]**	You pay 0% to 20%[2] coinsurance for insulin not to exceed $35.	You pay 0% to 20%[2] coinsurance for insulin not to exceed $35.
• **Chemotherapy and Other drugs[1]**	You pay 20% coinsurance for chemotherapy and other Part B drugs.	You pay 20% coinsurance for chemotherapy and other Part B drugs.
Step Therapy may be required.		
FOOT CARE		
Podiatry 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.
Podiatry Visit (Routine Foot Care)	You pay $0; up to 12 visits/year.	In-Network and Out-of-Network: You pay $0; up to 12 visits/year.

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MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment[1] • **Prosthetics**[1] Prior authorization required for items/supplies over $1,500.	You 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.
Diabetes Supplies and Services	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.
• **Diabetic Therapeutic Shoes or Inserts**	You may pay $0 or up to 20%[2] coinsurance.	You may pay $0 or up to 20%[2] coinsurance.
• **Diabetes Self-Management Training**	You pay $0.	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 may pay $0 or up to 20%[2] per visit.	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] 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.

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OUTPATIENT SUBSTANCE ABUSE		
Individual and Group Therapy Visit[1]	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 Visit[1]	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.
IN-HOME SUPPORT SERVICES		
In-Home Support Services	You pay $0 for 60 hours per year of Papa Pals services.	In Network: You pay $0 for 60 hours per year of Papa Pals services. Out-of-Network: You pay 50% coinsurance for 60 hours per year from services.
FITNESS		
Fitness - Health Club Membership or At-Home Fitness Kit	You pay $0.	In Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
Weight Management Program	You pay $0.	In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.

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24/7 NURSING HOTLINE		
24/7 Nurse Hotline	You pay $0.	You pay $0.
PERSONAL EMERGENCY RESPONSE SYSTEM		
Personal Emergency Response System	You pay $0.	In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
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 or surgery..
Chronic Condition Meals	You pay $0 for 28 meals (limited to one 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 one 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 chronic condition and participate in a lifestyle transition program.

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OVER-THE-COUNTER ITEMS/HEALTHY FOODS/UTILITY		
Over-the-Counter Items Allowance	You pay $0 for $170/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 $135/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). 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.

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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.
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.	$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
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.

[2]If 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.