Zing HEALTH™

Summary of Benefits

January 1, 2025 - December 31, 2025

Ohio
HMO C-SNP (Duals Focused)

H4624-035 Zing Select Diabetes & Heart Complete OH (HMO C-SNP)
Service Area: Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, and Summit 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.	**H4624-035** **Zing Select Diabetes & Heart Complete OH (HMO C-SNP)** *Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, and Summit Counties*
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. If you receive "Extra Help," you may pay $0[2].
Deductible (medical)	Medicare-defined Part B Deductible amount applies to all In-Network Medicare-covered Services[2]. 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.

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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]
Outpatient Hospital[1]	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.
DOCTOR VISITS	
Doctor Visits	
• **Primary Care Provider**	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.
PREVENTIVE CARE	
Preventive Care (e.g., flu vaccine, diabetic screenings)	$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.
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.
Urgently Needed Services	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.
HEARING SERVICES	
Hearing Services	
• **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.
• **Fitting and Evaluation for Hearing Aid**	You pay $0 for 1 fitting and evaluation every 3 years.
• **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 $2,500 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.
• **Diagnotic 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
VISION SERVICES	
Vision Services	
• **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 vision exam per year.
• **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.

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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]**
Outpatient Mental Health Services[1] • **Outpatient Group Therapy/Individual Therapy Visit[1]**	You may pay $0 or up to 20%[2] coinsurance per visit.
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]**

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REHABILITATION SERVICES	
Physical Therapy/Speech Therapy[1]	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.
Cardiac Rehabilitation[1]	
• **Intensive Cardiac Rehabilitation[1]**	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.
Ambulance (Air)[1]	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.
MEDICARE PART B DRUGS	
Medicare Part B Drugs[1]	
• **Insulin[1]**	You pay 0% to 20%[2] coinsurance for insulin not to exceed $35.
• **Chemotherapy and Other drugs[1]** Step Therapy may be required.	You pay 20% 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.
Podiatry Visit (Routine Foot Care)	You pay $0; up to 12 visits/year.
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.
Diabetes Supplies and Services	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.
• **Diabetes Self-Management Training**	You pay $0.

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CHIROPRACTIC CARE AND ACUPUNCTURE	
Chiropractic Visit (Medicare-Covered)	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] coinsurance per visit.
HOME HEALTH CARE	
Home Health Care (Medicare-Covered)[1]	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.
OUTPATIENT SUBSTANCE ABUSE	
Individual and Group Therapy Visit[1]	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.
RENAL DIALYSIS	
Renal Dialysis	You may pay $0 or up to 20%[2] coinsurance.
Kidney Disease Education Services	You pay $0.
IN-HOME SUPPORT SERVICES	
In-Home Support Services	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.
Weight Management Program	You pay $0.
24/7 NURSING HOTLINE	
24/7 Nurse Hotline	You pay $0.
PERSONAL EMERGENCY RESPONSE SYSTEM	
Personal Emergency Response System	You pay $0.
MEAL BENEFITS	
Post Discharge Meals	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.

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OVER-THE-COUNTER ITEMS/HEALTHY FOODS/UTILITY	
Over-the-Counter Items Allowance	You pay $0 for $153/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.
PART D PRESCRIPTION DRUGS	
Phase 1: Deductible Stage	You pay $590. (T1 and T6 Excluded)
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
Tier 2 - Generic (includes excluded drugs)	25%/25%/25%
Tier 3 - Preferred Brand	25%/25%/25%
Tier 4 - Non-Preferred Drug	25%/25%/25%
Tier 5 - Specialty Tier (30-day supply only)	25%
Tier 6 - Select Care Drugs	$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
Tier 2 - Generic (includes excluded drugs)	$0/$0/$0
Tier 3 - Preferred Brand	25%/25%/25%
Tier 4 - Non-Preferred Drug	25%/25%/25%
Tier 5 - Specialty Tier (30-day supply only)	25%
Tier 6 - Select Care Drugs	$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.