Zing HEALTH™

2026

Summary of Benefits

HMO C-SNP

ILLINOIS

H4624-027 Zing Select Diabetes & Heart Complete IL (HMO C-SNP)
Service Area: Boone, Cook, DeKalb, DuPage, Kane, Kankakee, Kendall, Lake, McHenry, Ogle, Will, and Winnebago Counties

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Zing Health contracts with Medicare to offer Medicare Advantage HMO, HMO SNP, PPO, and PPO SNP plans in select states. Enrollment in Zing Health depends on contract renewal. All Zing Health products and services are provided exclusively by or through operating subsidiaries of Zing Health Consolidator, Inc., including Zing Health, Inc., and Zing Health of Michigan, Inc. The Zing Health name, logo, and other Zing Health marks are owned by Zing Health Holdings, Inc.

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. This plan is specifically for someone who has been diagnosed with Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and valvular heart disease), Chronic heart failure and/or Diabetes mellitus.

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: 711). Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 – March 31 (except Thanksgiving and Christmas Day) and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30, 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. Services with a [2] may have $0 copay if you have full Medicaid.

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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. [2]
Deductible (medical)	$257 [2], these are 2025 cost-sharing amounts and can change for 2026. See Part D Prescription Drug section for Part D deductible.
Maximum Out-of-Pocket Responsibility (medical)	You pay no more than $7,000 annually for in-network Medicare-covered services.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE	
Inpatient Hospital [1]	For 2025 this amount was: For each Medicare-covered stay: • $1,676 deductible per benefit period • $0 for days 1-60 • $419 per day for days 61-90 • $0 for days 91 and beyond **These amounts may change for 2026. If you have Medicaid benefits, your costs could be less.** [2]
Outpatient Hospital [1]	You pay $0.
Ambulatory Surgical Center (ASC) [1]	You may pay 20% [2] coinsurance per visit.
DOCTOR VISITS	
Doctor Visits	
• **Primary Care Provider**	You may pay 20% [2] coinsurance per visit.
• **Specialists**	You may pay 20% [2] coinsurance per visit.
PREVENTIVE CARE	
Preventive Care (e.g., colorectal cancer screening, flu vaccine, mammogram)	You pay $0 per service.
EMERGENCY CARE	
Emergency Care	You may pay 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 included)	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 20% [2] coinsurance with a maximum limit of $40 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 for services. • **Diagnostic tests and procedures** [1] • **Lab services** [1] • **MRI, CAT Scan** [1] • **X-Rays** • **Therapeutic Radiology** [1] (chemotherapy, nuclear medicine, radiation)	You may pay 20% [2] coinsurance for all services listed.
HEARING SERVICES	
Hearing Services	
• **Medicare-Covered Hearing Exams**	You may pay 20% [2] coinsurance for Medicare-covered hearing exams.
• **Routine Hearing Exam**	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.
• **Hearing Aids**	You pay $0 for 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.
• **Medicare Dental Services** [1]	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
• **Comprehensive Dental Services** [1]	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 20% [2] coinsurance for Medicare-covered eye exams.
• **Routine Eye Exams**	You pay $0 for 1 routine eye exam per year.
• **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, or a pair of Contacts every year.

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MENTAL HEALTH SERVICES	
Inpatient Mental Health Services [1]	For 2025 this amount was: For each Medicare-covered stay: • $1,676 deductible per benefit period • $0 for days 1-60 • $419 per day for days 61-90 **These amounts may change for 2026. 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% - 20% [2] coinsurance per Medicare-covered session.
SKILLED NURSING	
Skilled Nursing Facility [1]	For each Medicare-covered stay: • $0 copay for days 1 through 20 • $209.50 per day for days 21 through 100 • All costs for each day after 100 of the benefit period **If you have Medicaid benefits, your costs could be less. These are 2025 cost-sharing amounts and may change for 2026.** [2]
REHABILITATION SERVICES	
Physical Therapy/Speech Therapy [1]	You may pay 20% [2] coinsurance per visit.
Occupational Therapy [1]	You may pay 20% [2] coinsurance per visit.
Cardiac Rehabilitation [1]	
• **Intensive Cardiac Rehabilitation** [1]	You may pay 20% [2] coinsurance per visit.
AMBULANCE	
Ambulance (Ground) [1]	You may pay 20% [2] coinsurance for Medicare-covered services.
Ambulance (Air) [1]	You may pay 20% [2] coinsurance for Medicare-covered services.

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TRANSPORTATION	
Transportation (Non-Emergency)	You pay $0 for 24 one-way trips per year to plan approved health-related locations. Trips are limited to 30 miles.
MEDICARE PART B DRUGS	
Medicare Part B Drugs [1]	
• **Insulin [1]**	You may pay 0% - 20% [2] coinsurance for insulin not to exceed $35 for a 1-month supply.
• **Chemotherapy and Other Drugs [1]**	You may pay 0% - 20% [2] coinsurance for chemotherapy and other Part B drugs.
Step Therapy may be required.	
FOOT CARE	
Podiatry Visit (Medicare-Covered)	You may pay 20% [2] coinsurance per visit.
Podiatry Visit (Routine Foot Care)	You pay $0; up to 6 visits/year.
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment [1]	
• **Prosthetics [1]**	You may pay 20% [2] coinsurance for Medicare-covered benefits.
Diabetes Supplies and Services [1]	You may pay 20% [2] coinsurance for Medicare-covered benefits.
• **Diabetic Therapeutic Shoes or Inserts [1]**	You may pay 20% [2] coinsurance for Medicare-covered benefits.
• **Diabetes Self-Management Training**	You pay $0.
CHIROPRACTIC CARE AND ACUPUNCTURE	
Chiropractic Visit (Medicare-Covered)	You may pay 20% [2] coinsurance per visit.
Acupuncture Visit (Medicare-Covered)	You may pay 20% [2] coinsurance per visit.

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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 20% [2] coinsurance per visit.
Opioid Treatment Visit [1]	You may pay 20% [2] coinsurance per visit.
RENAL DIALYSIS	
Renal Dialysis	You may pay 20% [2] coinsurance for Medicare-covered benefits.
Kidney Disease Education Services	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.
FITNESS	
Fitness - Health Club Membership	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 14 meals after each inpatient facility discharge or surgery.
Chronic Condition Meals	You pay $0 for 14 meals if you have a qualifying chronic condition and participate in a lifestyle transition program.

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ZING SMART CARD **The following benefits are administered through Zing's Debit Card.**	
Special Supplemental Benefits for the Chronically Ill (SSBCI) The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify. Any unused balances cannot be converted to cash or rolled over to the next benefit period.	You may receive $180/month for use towards plan-approved over-the-counter items, food items and/or utilities (electric, gas, heating oil, sanitation or water). See the plan's Evidence of Coverage booklet for more information. Members with Cardiovascular Disorders, Chronic Heart Failure, and/or 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 may receive this benefit for the first 90 days of their effective date. To continue to receive this benefit, you must complete a Health Risk Assessment (HRA) within 90 days of your effective date. Renewing members must complete their HRA within 11 months of their annual HRA due date.

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PART D PRESCRIPTION DRUGS	
Stage #1: Yearly Deductible Stage	Your deductible amount is $615. (T1, T6 and all insulins are excluded) If you get Extra Help paying for your prescription drugs, your deductible may be paid by Extra Help.
Stage #2: Initial Coverage Stage (after you pay your deductible, if applicable)	You are in the Initial Coverage Stage until your total yearly drug cost reaches $2,100. 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 / up to 100 days) Insulins (30 days): Tiers 1, 3, 5, & 6: $0; Tier 4: up to $35 If you get Extra Help paying for your prescription drugs, you pay: $0, $1.60, or $5.10 copay for Generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs	
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 / up to 100 days) Insulins (100 days): Tiers 1, 3, & 6: $0; Tier 4: up to $70 If you get Extra Help paying for your prescription drugs, you pay: $0, $1.60, or $5.10 copay for Generic drugs (including brand drugs treated as generic) $0, $4.90, or $12.65 copay for all other drugs	
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
Stage #3: 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.