Zing HEALTH™

2026

Summary of Benefits

HMO/PPO

INDIANA

H4624-003 Zing Select Care IN (HMO)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

H6876-004 Zing Open Choice IN (PPO)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby 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 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: 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 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.	**H4624-003** **Zing Select Care IN (HMO)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties*	**H6876-004** **Zing Open Choice IN (PPO)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby 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.	$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.
Maximum Out-of-Pocket Responsibility (medical)	You pay no more than $4,500 annually for in-network Medicare-covered services.	You pay no more than $6,350 annually for in-network and out-of-network Medicare-covered services combined.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE		
Inpatient Hospital [1]	You pay $350 per day for days 1-6; You pay $0 per day for days 7 and beyond per admission or stay.	In-Network: You pay $339 per day for days 1-6; You pay $0 per day for days 7 and beyond per admission or stay. Out-of-Network: You pay $400 per day for days 1-6; You pay $0 per day for days 7 and beyond per admission or stay.
Outpatient Hospital [1]	You pay $225 per visit.	In-Network and Out-of-Network: You pay $275 per visit.
Ambulatory Surgical Center (ASC) [1]	You pay $125 per visit.	In-Network and Out-of-Network: You pay $175 per visit.
DOCTOR VISITS		
Doctor Visits • **Primary Care Provider** • **Specialists**	You pay $0 per visit. You pay $15 per visit.	In-Network and Out-of-Network: You pay $0 per visit. In-Network: You pay $30 per visit. Out-of-Network: You pay $40 per visit for specialists.
PREVENTIVE CARE		
Preventive Care (e.g., colorectal cancer screening, flu vaccine, mammogram)	You pay $0 per service.	In-Network and Out-of-Network: You pay $0 per service.

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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.	You pay $110; If you are admitted to the hospital within 24 hours, then you do not have to pay $110.
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 $50,000 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 $50,000 maximum benefit amount per year.
Urgently Needed Services	You pay $0 per visit at a PCP office; You pay $10 per visit at other locations.	You pay $0 per visit at a PCP office; You pay $40 per visit at other locations.
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.		In-Network and Out-of-Network:
• **Diagnostic Tests and Procedures** [1]	You pay $0 for outpatient COVID Tests; You pay $25 for all other Medicare-covered diagnostic tests and procedures.	You pay $0 for outpatient COVID Tests; You pay $30 for all other Medicare-covered diagnostic tests and procedures.
• **Lab Services** [1]	You pay $0 for Lab services.	You pay $0 for Lab services.
• **MRI, CAT Scan** [1]	You pay $50 for CT, MRI, PET Scan at a doctor's office; You pay $150 at a facility.	You pay $50 for CT, MRI, PET Scan at a doctor's office; You pay $150 at a facility.
• **X-Rays**	You pay $0 for X-rays.	You pay $25 for X-rays.
• **Therapeutic Radiology** [1] (chemotherapy, nuclear medicine, radiation)	You pay 20% of the cost for Medicare-covered services.	You pay 20% of the cost for Medicare-covered services.

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HEARING SERVICES		
Hearing Services		In-Network and Out-of-Network:
• **Medicare-Covered Hearing Exams**	You pay $35 for Medicare-covered hearing exams.	You pay $40 for Medicare-covered hearing exams.
• **Routine Hearing Exam**	You pay $0 for 1 routine hearing exam per year.	Our plan covers up to 1 routine hearing exam per year. In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
• **Hearing Aid Fitting and Evaluation**	You pay $0 for 1 hearing aid fitting and evaluation every 3 years.	Our plan covers up to 1 hearing aid fitting and evaluation every 3 years. In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
• **Hearing Aids**	You pay $0 for hearing aids; You receive a $750 benefit allowance towards hearing aids per ear every 3 years.	Our plan covers up to a $750 benefit allowance towards hearing aids per ear every 3 years. In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.

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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.	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 or out-of-network.
• **Medicare Dental Services** [1]	You pay $0 for certain emergent or complicated dental services received when in the hospital.	In-Network and Out-of-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	Our plan covers the following 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 $0. Out-of-Network: You pay 50% coinsurance.

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• **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	Our plan covers the following 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: You pay $0. Out-of-Network: You pay 50% coinsurance.

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VISION SERVICES		
Vision Services		In-Network and Out-of-Network:
• **Medicare-Covered Eye Exams**	You pay $35 for Medicare-covered eye exams.	You pay $40 for Medicare-covered eye exams.
• **Routine Eye Exams**	You pay $0 for 1 routine eye exam per year.	Our plan covers up to 1 routine eye exam per year. In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
• **Medicare-Covered Eyewear**	You pay $0 for Medicare-covered eyewear.	In-Network and Out-of-Network: 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.	Our plan covers up to a $200 maximum benefit amount for routine eyewear towards 1 pair of covered contact lenses, eyeglasses (lenses and frames), eyeglass lenses, or eyeglass frames. In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.

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MENTAL HEALTH SERVICES		
Inpatient Mental Health Services [1]	You pay $350 per day for days 1-6; You pay $0 per day for days 7 to 90 per admission or stay.	In-Network: You pay $339 per day for days 1-6; You pay $0 per day for days 7 to 90 per admission or stay. Out-of-Network: You pay $400 per day for days 1-6; You pay $0 per day for days 7 to 90 per admission or stay.
Outpatient Mental Health Services [1] • **Outpatient Group Therapy/ Individual Therapy Visit** [1]	You pay $0 per Medicare-covered session.	In-Network: You pay $0 per Medicare-covered session. Out-of-Network: You pay $10 per Medicare-covered session.
SKILLED NURSING		
Skilled Nursing Facility [1]	You pay $0 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 $0 for days 1-20. You pay $214 per day for days 21-100 of each Medicare-covered stay.

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REHABILITATION SERVICES		
Physical Therapy/Speech Therapy [1]	You pay $20 per visit.	In-Network: You pay $35 per visit. Out-of-Network: You pay $40 per visit.
Occupational Therapy [1]	You pay $20 per visit.	In-Network: You pay $35 per visit. Out-of-Network: You pay $40 per visit.
Cardiac Rehabilitation [1] • **Intensive Cardiac Rehabilitation** [1]	You pay $0 per visit.	In-Network and Out-of-Network: You pay $0 per visit.
AMBULANCE		
Ambulance (Ground) [1]	You pay $200 for Medicare-covered services.	In-Network and Out-of-Network: You pay $250 for Medicare-covered services.
Ambulance (Air) [1]	You pay 20% of the cost for Medicare-covered services.	In-Network and Out-of-Network: You pay 20% of the cost for Medicare-covered services.
TRANSPORTATION		
Transportation (Non-Emergency)	You pay $0 for 12 one-way trips per year to plan approved health-related locations. Trips are limited to 30 miles.	Not Covered.

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MEDICARE PART B DRUGS		
Medicare Part B Drugs [1]		In-Network and Out-of-Network:
• **Insulin** [1]	You pay 0% to 20% coinsurance for insulin not to exceed $35 for a 1-month supply.	You pay 0% to 20% coinsurance for insulin not to exceed $35 for a 1-month supply.
• **Chemotherapy and Other Drugs** [1] Step Therapy may be required.	You pay 0% to 20% coinsurance for chemotherapy and other Part B drugs.	You pay 0% to 20% coinsurance for chemotherapy and other Part B drugs.
FOOT CARE		
Podiatry Visit (Medicare-Covered)	You pay $35 per visit.	In-Network: You pay $35 per visit. Out-of-Network: You pay $40 per visit.
Podiatry Visit (Routine Foot Care)	You pay $20 per visit; up to 4 visits/year.	In-Network and Out-of-Network: You pay $0 per visit; up to 4 visits/year.

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MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment [1]		In-Network and Out-of-Network:
• **Prosthetics** [1]	You pay 20% for Medicare-covered benefits.	You pay 20% for Medicare-covered benefits.
Diabetes Supplies and Services [1]	You pay 0% - 20%. You pay $0 for preferred brand diabetic test strips, meters and supplies prescribed by a physician and obtained at a pharmacy. For 2026, Zing's preferred brands are Accu-Chek and True Metrix. You pay $0 for preferred brand Continuous Glucose Monitors (CGMs) prescribed by a physician and obtained at a pharmacy. For 2026, Zing's preferred CGMs are Dexcom G6 and G7. You pay 20% for non-preferred diabetic test strips, meters and supplies, non-preferred CGMs and CGMs billed by DME.	In-Network and Out-of-Network: You pay 0% - 20%. You pay $0 for preferred brand diabetic test strips, meters and supplies prescribed by a physician and obtained at a pharmacy. For 2026, Zing's preferred brands are Accu-Chek and True Metrix. You pay $0 for preferred brand Continuous Glucose Monitors (CGMs) prescribed by a physician and obtained at a pharmacy. For 2026, Zing's preferred CGMs are Dexcom G6 and G7. You pay 20% for non-preferred diabetic test strips, meters and supplies, non-preferred CGMs and CGMs billed by DME.
• **Diabetic Therapeutic Shoes or Inserts** [1]	You pay 20%.	You pay 20%.
• **Diabetes Self-Management Training**	You pay $0.	You pay $0.

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CHIROPRACTIC CARE AND ACUPUNCTURE		
Chiropractic Visit (Medicare-Covered)	You pay $15 per visit.	In-Network: You pay $15 per visit. Out-of-Network: 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.
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 Visit [1]	You pay $0 per visit.	In-Network and Out-of-Network: You pay $0 per visit.
Opioid Treatment Visit [1]	You pay $35 per visit.	In-Network and Out-of-Network: You pay $40 per visit.
RENAL DIALYSIS		
Renal Dialysis	You pay 20% for Medicare-covered benefits.	In-Network and Out-of-Network: You pay 20% for Medicare-covered benefits.
Kidney Disease Education Services	You pay $0 for Medicare-covered benefits.	In-Network and Out-of-Network: You pay $0 for Medicare-covered benefits.

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IN-HOME SUPPORT SERVICES		
In-Home Support Services	You pay $0 for 30 hours per year of Papa Pals services.	Not Covered.
FITNESS		
Fitness - Health Club Membership	You pay $0.	In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
24/7 NURSING HOTLINE		
24/7 Nurse Hotline	You pay $0.	In-Network: You pay $0. Out-of-Network: You pay 50% coinsurance.
MEAL BENEFITS		
Post Discharge Meals	You pay $0 for 14 meals after each inpatient facility discharge or surgery.	In-Network: You pay $0 for 14 meals after each inpatient facility discharge or surgery. Out-of-Network: You pay 50% coinsurance for 14 meals after each inpatient facility discharge or surgery.

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ZING SMART CARD **The following benefits are administered through Zing's Debit Card.**		
Over-the-Counter (OTC) Allowance Any unused balances cannot be converted to cash or rolled over to the next benefit period.	You may receive $90/quarter for over-the-counter items.	In-Network and Out-of-Network: You may receive $120/quarter for over-the-counter items.
Help With Certain Chronic Conditions **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 $75/month for use towards plan-approved 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 2 or more clinically confirmed diagnosis of: Cancer, Cardiovascular Disorders, Chronic Heart Failure, Chronic Kidney Disease, Chronic Lung Disorders, Dementia or Diabetes who have a high risk of hospitalization or other adverse health outcome and require intensive care coordination are eligible for this benefit.	In-Network: You may receive $55/month for use towards plan-approved 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 2 or more clinically confirmed diagnosis of: Cancer, Cardiovascular Disorders, Chronic Heart Failure, Chronic Kidney Disease, Chronic Lung Disorders, Dementia or Diabetes who have a high risk of hospitalization or other adverse health outcome and require intensive care coordination are eligible for this benefit.

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PART D PRESCRIPTION DRUGS		
Stage #1: Deductible Stage	Your deductible amount is $0.	Your deductible amount is $0.
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.	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: $0; Tier 4: up to $35		
Tier 1 - Preferred Generic	$0 / $0 / $0	$0 / $0 / $0
Tier 2 - Generic (includes excluded drugs)	$8 / $16 / $24	$15 / $30 / $45
Tier 3 - Preferred Brand	$47 / $94 / $141	$47 / $94 / $141
Tier 4 - Non-Preferred Drug	25% / 25% / 25%	25% / 25% / 25%
Tier 5 - Specialty Tier (30-day supply only)	33%	33%
Mail Order Copay (30 days / 60 days / up to 100 days) Insulins (100 days): Tiers 1 & 3: $0; Tier 4: up to $70		
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	$47 / $94 / $94	$47 / $94 / $94
Tier 4 - Non-Preferred Drug	25% / 25% / 25%	25% / 25% / 25%
Tier 5 - Specialty Tier (30-day supply only)	33%	33%
Stage #3: Catastrophic Coverage Stage	The plan pays the full cost for your covered Part D drugs. You pay $0.	

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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.