

2026

# Summary of Benefits

## HMO/PPO C-SNP

### INDIANA

**H4624-011 Zing Select Diabetes & Heart IN (HMO C-SNP)**

**Service Area:** Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

**H6876-005 Zing Open Choice Diabetes & Heart IN (PPO C-SNP)**

**Service Area:** Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties

**H4624-031 Zing Elite Diabetes & Heart IN (HMO C-SNP)**

**Service Area:** Lake and Marion Counties

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](http://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. These plans are 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](http://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](http://myzinghealth.com).

## Monthly Premium, Deductible, and Limits on How Much you Pay for Covered Services

### Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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*Uses a Provider-Specific Network<sup>+</sup>*

### 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.

\$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.

#### 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 \$4,950 annually for in-network and out-of-network Medicare-covered services combined.

You pay no more than \$4,500 annually for in-network Medicare-covered services.

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## INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

### Inpatient Hospital <sup>1</sup>

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 and Out-of-Network:

You pay \$339 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

You pay \$350 per day for days 1-6; You pay \$0 per day for days 7 and beyond per admission or stay.

### Outpatient Hospital <sup>1</sup>

You pay \$125 per visit.

In-Network and Out-of-Network:

You pay \$125 per visit.

You pay \$125 per visit.

### Ambulatory Surgical Center (ASC) <sup>1</sup>

You pay \$50 per visit.

In-Network and Out-of-Network:

You pay \$50 per visit.

You pay \$50 per visit.

## DOCTOR VISITS

### Doctor Visits

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

You pay \$0 per visit.

You pay \$0 per visit for Cardiologist, Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Pulmonologist. You pay \$15 for all other Specialists

In-Network and Out-of-Network:

You pay \$0 per visit.

You pay \$0 per visit for Cardiologist, Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Pulmonologist. You pay \$30 for all other Specialists.

You pay \$0 per visit.

You pay \$0 per visit for Cardiologist, Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Pulmonologist. You pay \$10 for all other 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.

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.

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 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.

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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 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 \$10 per visit at other locations.

You pay \$0 per visit at a PCP office; You pay \$10 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 for services.

- **Diagnostic Tests and Procedures** <sup>1</sup>

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

In-Network and Out-of-Network:

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 \$25 for all other Medicare-covered diagnostic tests and procedures.

- **Lab Services** <sup>1</sup>

You pay \$0 for Lab services.

You pay \$0 for Lab services.

You pay \$0 for Lab services.

- **MRI, CAT Scan** <sup>1</sup>

You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$100 at a facility.

You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$100 at a facility.

You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$100 at a facility.

- **X-Rays**

You pay \$0 for X-rays.

You pay \$0 for X-rays.

You pay \$0 for X-rays.

- **Therapeutic Radiology** <sup>1</sup>  
 (chemotherapy, nuclear medicine, radiation)

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

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

- **Medicare-Covered Hearing Exams**

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

In-Network and Out-of-Network:

You pay \$45 for Medicare covered hearing exams.

You pay \$30 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.

You pay \$0 for 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.

You pay \$0 for 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.

You pay \$0 for hearing aids; You receive 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

#### • Medicare Dental Services <sup>1</sup>

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.

#### • 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

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.

In-Network and Out-of-Network:

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

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.

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.

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
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#### • Comprehensive Dental Services <sup>1</sup>

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.

You pay \$0 for comprehensive dental services.

- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/ root planing)
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## VISION SERVICES

### Vision Services

- **Medicare-Covered Eye Exams**

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other 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.

In-Network and Out-of-Network:

You pay \$0 for diabetic retinopathy exams; you pay \$45 for all other Medicare-covered eye exams.

Our plan covers up to 1 routine eye exam per year.

In-Network:  
You pay \$0.

Out-of-Network:  
You pay 50% coinsurance.

In-Network and Out-of-Network:

You pay \$0 for Medicare covered eyewear.

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.

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

You pay \$0 for 1 routine eye 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, or a pair of Contacts every year.

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## MENTAL HEALTH SERVICES

### Inpatient Mental Health Services <sup>1</sup>

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 and Out-of-Network:

You pay \$339 per day for days 1-6; You pay \$0 per day for days 7 to 90 per admission or stay.

You pay \$350 per day for days 1-6; You pay \$0 per day for days 7 to 90 per admission or stay.

### Outpatient Mental Health Services <sup>1</sup>

- **Outpatient Group Therapy/Individual Therapy Visit <sup>1</sup>**

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 Facility <sup>1</sup>

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.

You pay \$0 for days 1-20.  
You pay \$214 per day for days 21-100 of each Medicare-covered stay.

## REHABILITATION SERVICES

### Physical Therapy/ Speech Therapy <sup>1</sup>

You pay \$20 per visit.

In-Network and Out-of-Network:

You pay \$20 per visit.

You pay \$20 per visit.

### Occupational Therapy <sup>1</sup>

You pay \$20 per visit.

In-Network and Out-of-Network:

You pay \$20 per visit.

You pay \$20 per visit.

### Cardiac Rehabilitation <sup>1</sup>

- **Intensive Cardiac Rehabilitation <sup>1</sup>**

You pay \$0 per visit.

In-Network and Out-of-Network:

You pay \$0 per visit.

You pay \$0 per visit.

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### AMBULANCE

#### Ambulance (Ground) <sup>1</sup>

You pay \$200 for Medicare-covered services.

In-Network and Out-of-Network:

You pay \$150 for Medicare-covered services.

You pay \$200 for Medicare-covered services.

#### Ambulance (Air) <sup>1</sup>

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.

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

### 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.

Not Covered.

You pay \$0 for 30 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 <sup>1</sup>

- **Insulin <sup>1</sup>**

You pay 0% to 20% coinsurance for insulin not to exceed \$35 for a 1-month supply.

In-Network and Out-of-Network:

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 <sup>1</sup>**

Step Therapy may be required.

You pay 0% to 20% coinsurance for chemotherapy and other Part B drugs.

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FOOT CARE

Podiatry Visit (Medicare-Covered)

	In-Network and Out-of-Network:	
You pay \$15 per visit.	You pay \$20 per visit.	You pay \$15 per visit.

Podiatry Visit (Routine Foot Care)

	In-Network and Out-of-Network:	
You pay \$0 per visit; up to 12 visits/year.	You pay \$0 per visit; up to 12 visits/year.	You pay \$0 per visit; up to 12 visits/year.

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## MEDICAL EQUIPMENT/SUPPLIES

### Durable Medical Equipment <sup>1</sup>

#### • Prosthetics <sup>1</sup>

You pay 20% for Medicare-covered benefits.

In-Network and Out-of-Network:

You pay 20% for Medicare-covered benefits.

You pay 20% for Medicare-covered benefits.

### Diabetes Supplies and Services <sup>1</sup>

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.

You pay \$0.

You pay \$0.

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.

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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.

You pay \$0.

You pay \$0.

#### • Diabetic Therapeutic Shoes or Inserts <sup>1</sup>

#### • Diabetes Self-Management Training

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### CHIROPRACTIC CARE AND ACUPUNCTURE

#### Chiropractic Visit (Medicare-Covered)

You pay \$15 per visit.

In-Network and Out-of-Network:

You pay \$15 per visit.

You pay \$15 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) <sup>1</sup>

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.

### OUTPATIENT SUBSTANCE ABUSE

#### Individual and Group Therapy Visit <sup>1</sup>

You pay \$0 per visit.

In-Network and Out-of-Network:

You pay \$0 per visit.

You pay \$0 per visit.

#### Opioid Treatment Visit <sup>1</sup>

You pay \$30 per visit.

In-Network and Out-of-Network:

You pay \$30 per visit.

You pay \$30 per visit.

## HMO/PPO C-SNP

### Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

**H4624-011**

**Zing Select Diabetes & Heart IN (HMO C-SNP)**

*Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Madison, Marion, Morgan, Porter, and Shelby Counties*

**H6876-005**

**Zing Open Choice Diabetes & Heart IN (PPO C-SNP)**

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**H4624-031**

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*Uses a Provider-Specific Network<sup>+</sup>*

### RENAL DIALYSIS

#### Renal Dialysis

You pay 20% for Medicare-covered benefits.

In-Network and Out-of-Network:

You pay 20% for Medicare-covered benefits.

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.

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.

In-Network:

You pay \$0 for 30 hours per year of Papa Pals services.

You pay \$0 for 60 hours per year of Papa Pals services.

Out-of-Network:

You pay 50% coinsurance for 30 hours per year for services.

### FITNESS

#### Fitness - Health Club Membership

You pay \$0.

In-Network:

You pay \$0.

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.

You pay \$0.

Out-of-Network:

You pay 50% coinsurance.



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### PERSONAL EMERGENCY RESPONSE SYSTEM

#### Personal Emergency Response System

You pay \$0.

Not Covered.

You pay \$0.

### 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.

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.

Not Covered.

You pay \$0 for 14 meals if you have a qualifying chronic condition and participate in a lifestyle transition program.

### 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 \$75/quarter for over-the-counter items.

#### In-Network and Out-of-Network:

You may receive \$60/quarter for over-the-counter items.

Over-the-Counter allowance is not covered separately from the Special Supplemental Benefits for the Chronically Ill. Please see the SSBCI benefit for OTC coverage information.

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### 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 \$120/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 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.

In-Network:

You may receive \$110/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 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.

You may receive \$158/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 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

<b>Stage #1: Deductible Stage</b>	Your deductible amount is \$0.	Your deductible amount is \$0.	Your deductible amount is \$0.
<b>Stage #2: Initial Coverage Stage (after you pay your deductible, if applicable)</b>	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.	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

Tier 1 - Preferred Generic	\$0 / \$0 / \$0	\$0 / \$0 / \$0	\$0 / \$0 / \$0
Tier 2 - Generic (includes excluded drugs)	\$8 / \$16 / \$24	\$8 / \$16 / \$24	\$8 / \$16 / \$24
Tier 3 - Preferred Brand	\$47 / \$94 / \$141	\$47 / \$94 / \$141	\$47 / \$94 / \$141
Tier 4 - Non-Preferred Drug	25% / 25% / 25%	25% / 25% / 25%	25% / 25% / 25%
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 / up to 100 days)

Insulins (100 days): Tiers 1, 3, & 6: \$0; Tier 4: up to \$70

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	25% / 25% / 25%	25% / 25% / 25%	25% / 25% / 25%
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

### 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.

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