

2027

Summary of Benefits

**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



ILLINOIS HMO C-SNP

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 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. 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.

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance for Medicare covered Part A and B services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [medicare.gov](https://www.medicare.gov) or get a copy by calling 800-MEDICARE (800-633-4227), 7 days a week, 24 hours a day. TTY users should call 877-486-2048.

This document is available in other formats such as braille, large print, or audio.

For more information, please call us at 866-946-4458 (TTY: 711). Hours are 8 a.m. to 8 p.m., 7 days a week from October 1 - March 31 (except Thanksgiving and Christmas Day) and 8 a.m. to 8 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.

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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)	\$283. These are 2026 cost-sharing amounts and can change for 2027. See Part D Prescription Drug section for Part D deductible.
Maximum Out-of-Pocket Responsibility (medical)	You pay no more than \$9,850 annually for in-network Medicare-covered services.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital ¹

For 2026 this amount was:

For each Medicare-covered stay:

- \$1,736 deductible per benefit period
- \$0 for days 1-60
- \$434 per day for days 61-90
- \$0 for days 91 and beyond

These amounts may change for 2027.

Outpatient Hospital ¹

You may pay 20% ² coinsurance per visit.

Ambulatory Surgical Center (ASC) ¹

You pay 20% coinsurance.

DOCTOR VISITS

Doctor Visits

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

You pay 20% coinsurance per visit.

You pay 20% 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 pay 20% coinsurance with a maximum limit of \$115 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 pay 20% 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 pay 20% coinsurance for all services listed.

HEARING SERVICES

Hearing Services

- Medicare-Covered Hearing Exams
- Routine Hearing Exam
- Hearing Aid Fitting and Evaluation
- Hearing Aids

You pay 20% coinsurance for Medicare-covered hearing exams.

You pay \$0 for 1 routine hearing exam per year.

You pay \$0 for 1 hearing aid fitting and evaluation every 3 years.

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

- **Medicare Dental Services ¹**
- **Diagnostic and Preventive Dental Services**
- **Comprehensive Dental Services ¹**

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.

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 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**
- **Routine Eye Exams**
- **Medicare-Covered Eyewear**
- **Routine Eyewear**

You pay 20% coinsurance for 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 \$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 2026 this amount was:

For each Medicare-covered stay:

- \$1,736 deductible per benefit period
- \$0 for days 1-60
- \$434 per day for days 61-90

These amounts may change for 2027.

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
- \$217 per day for days 21 through 100
- All costs for each day after 100 of the benefit period

These are 2026 cost-sharing amounts and may change for 2027.

REHABILITATION SERVICES

Physical Therapy/Speech Therapy ¹

You pay 20% coinsurance per visit.

Occupational Therapy ¹

You pay 20% coinsurance per visit.

Cardiac Rehabilitation ¹

- Intensive Cardiac Rehabilitation ¹

You pay 20% coinsurance per visit.

AMBULANCE

Ambulance (Ground) ¹

You pay 20% coinsurance for Medicare-covered services.

Ambulance (Air) ¹

You pay 20% coinsurance for Medicare-covered services.

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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.

Members diagnosed with End Stage Renal Disease / Chronic Kidney Disease Level 5: You pay \$0 for Unlimited one-way trips to dialysis centers.

MEDICARE PART B DRUGS

Medicare Part B Drugs ¹

- Insulin ¹
- Chemotherapy and Other Drugs ¹

Step Therapy may be required.

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

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

FOOT CARE

Podiatry Visit (Medicare-Covered)

You pay 20% 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 pay 20% coinsurance for Medicare-covered benefits.

Diabetes Supplies and Services ¹

- Diabetic Monitors ¹
- Diabetic Therapeutic Shoes or Inserts ¹
- Diabetes Self-Management Training

You pay 20% coinsurance for Medicare-covered benefits.

You pay 20% coinsurance for diabetic test strips, meters, and supplies.

You pay 20% coinsurance for Medicare-covered benefits.

You pay \$0.

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CHIROPRACTIC CARE AND ACUPUNCTURE

Chiropractic Visit
(Medicare-Covered) ¹

You pay 20% coinsurance per visit.

Acupuncture Visit
(Medicare-Covered)

You pay 20% 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 pay 20% coinsurance per visit.

Opioid Treatment Visit ¹

You pay 20% coinsurance per visit.

RENAL DIALYSIS

Renal Dialysis

You pay 20% 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 to assist with Instrumental Activities of Daily Living such as light house work, cleaning, or companionship services. Your Pal can also transport you to local grocery stores or pharmacies.

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.

You have access to medical alert system. These devices give you 24/7 emergency support helping you stay safe and independent, no landline required.

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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.

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.

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 \$135/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.

To be considered for SSBCI benefits, members must have a qualifying condition such as cardiovascular disorders, chronic heart failure, diabetes, or chronic kidney disease stage 5. Members must also have a high risk of hospitalization or other adverse health outcome and require intensive care coordination. Please see the Evidence of Coverage (EOC) for the full list of eligible conditions and complete eligibility requirements.

Members must be continuously enrolled with Zing for 2 months prior to receiving this benefit.

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PART D PRESCRIPTION DRUGS

Stage #1: Yearly Deductible Stage

Your deductible amount is \$700.

Tier 1, Tier 6, and all insulins are excluded from the deductible.

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 \$2,400. 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, and 6: \$0; Tier 4 and 5: up to \$35

If you get Extra Help paying for your prescription drugs, you pay:

\$0, \$1.65, or \$5.80 copay for Generic drugs (including brand drugs treated as generic)

\$0, \$5, or \$14.40 copay for all other drugs

Tier 1 - Preferred Generic

\$0 / \$0 / \$0

Tier 2 - Generic

(includes excluded drugs)

18% / 18% / 18%

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, and 6: \$0; Tier 4: up to \$70

If you get Extra Help paying for your prescription drugs, you pay:

\$0, \$1.65, or \$5.80 copay for Generic drugs (including brand drugs treated as generic)

\$0, \$5, or \$14.40 copay for all other drugs

Tier 1 - Preferred Generic	\$0 / \$0 / \$0
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Tier 2 - Generic (includes excluded drugs)	\$0 / \$0 / \$0
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Tier 3 - Preferred Brand	25% / 25% / 25%
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Tier 4 - Non-Preferred Drug	25% / 25% / 25%
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Tier 5 - Specialty Tier (30-day supply only)	25%
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Tier 6 - Select Care Drugs	\$0 / \$0 / \$0
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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.
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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 800-772-1213, Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 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.

Extra Help

If you receive Extra Help for your drugs, you will have a \$0 deductible.

Prior to reaching your annual \$2,400 out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- \$5.80 for generic/preferred multi-source drug or biosimilar; \$14.40 for any other drug; OR
- \$1.65 for generic/preferred multi-source drug or biosimilar; \$5.00 for any other drug; OR
- \$0 for all drugs

After reaching your annual \$2,400 out-of-pocket limit, you will pay \$0 for the remainder of the calendar year, regardless of the level of Extra Help you receive. Additional information will be available on your LIS rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for Extra Help. To find out if you qualify for Extra Help, please contact the Social Security Office at 800-772-1213 (TTY: 800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.