

2027

Summary of Benefits

H6876-004 Zing Open Choice IN (PPO)

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

INDIANA PPO

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 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.

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.

Deductible (medical)

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 \$7,900 annually for in-network Medicare covered services.
You pay no more than \$9,900 annually for in-network and out-of-network Medicare-covered services combined.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital ¹

In-Network:

You pay \$376 per day for days 1-7; You pay \$0 per day for days 8 and beyond per admission or stay.

Out-of-Network:

You pay \$450 per day for days 1-7; You pay \$0 per day for days 8 and beyond per admission or stay.

Outpatient Hospital ¹

In-Network and Out-of-Network:

You pay \$425 per visit.

Ambulatory Surgical Center (ASC) ¹

In-Network and Out-of-Network:

You pay \$300 per visit.

DOCTOR VISITS

Doctor Visits

- Primary Care Provider
- Specialists

In-Network and Out-of-Network:

You pay \$0 per visit.

In-Network:

You pay \$35 per visit.

Out-of-Network:

You pay \$45 per visit for specialists.

PREVENTIVE CARE

Preventive Care

(e.g., colorectal cancer screening, flu vaccine, mammogram)

In-Network and Out-of-Network:

You pay \$0 per service.

EMERGENCY CARE

Emergency Care

You pay \$115; If you are admitted to the hospital within 24 hours, then you do not have to pay \$115.

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.

Urgently Needed Services

You pay \$0 per visit at a PCP office; You pay \$40 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** ¹
- **Lab Services** ¹
- **MRI, CAT Scan** ¹
- **X-Rays**
- **Therapeutic Radiology** ¹
(chemotherapy, nuclear medicine, radiation)

In-Network and Out-of-Network:

You pay \$0 for outpatient COVID Tests; You pay \$45 for all other Medicare-covered diagnostic tests and procedures.

In-Network and Out-of-Network:

You pay \$0 for Lab services.

In-Network and Out-of-Network:

You pay \$200 for CT, MRI, PET Scan at a doctor's office; You pay \$300 at a facility.

In-Network:

You pay \$25 for X-rays at a doctor's office; You pay \$30 at a facility.

Out-of-Network:

You pay \$40 for X-rays at a doctor's office; You pay \$40 at a facility.

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

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HEARING SERVICES

Hearing Services

- **Medicare-Covered Hearing Exams**

In-Network and Out-of-Network:

You pay \$40 for Medicare-covered hearing exams.

- **Routine Hearing Exam**

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**

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**

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

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

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

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.

• Comprehensive Dental Services ¹

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

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

In-Network and Out-of-Network:

You pay \$40 for 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.

- **Medicare-Covered Eyewear**
- **Routine Eyewear**

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.

MENTAL HEALTH SERVICES

Inpatient Mental Health Services ¹

In-Network:

You pay \$290 per day for days 1-7; You pay \$0 per day for days 8 to 90 per admission or stay.

Out-of-Network:

You pay \$400 per day for days 1-7; You pay \$0 per day for days 8 to 90 per admission or stay.

Outpatient Mental Health Services ¹

- **Outpatient Group Therapy/ Individual Therapy Visit ¹**

In-Network:

You pay \$25 per Medicare-covered session.

Out-of-Network:

You pay \$30 per Medicare-covered session.

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SKILLED NURSING

Skilled Nursing Facility ¹

In-Network and Out-of-Network:

You pay \$0 for days 1-20.

You pay \$221 per day for days 21-100 of each Medicare-covered stay.

REHABILITATION SERVICES

Physical Therapy/Speech Therapy ¹

In-Network:

You pay \$35 per visit.

Out-of-Network:

You pay \$50 per visit.

Occupational Therapy ¹

In-Network:

You pay \$35 per visit.

Out-of-Network:

You pay \$50 per visit.

Cardiac Rehabilitation ¹

- Intensive Cardiac Rehabilitation ¹

In-Network and Out-of-Network:

You pay \$40 per visit.

AMBULANCE

Ambulance (Ground) ¹

In-Network and Out-of-Network:

You pay \$330 for Medicare-covered services.

Ambulance (Air) ¹

In-Network and Out-of-Network:

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

TRANSPORTATION

Transportation (Non-Emergency)

Not Covered.

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.

- Chemotherapy and Other Drugs ¹

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

Step Therapy may be required.

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FOOT CARE

Podiatry Visit (Medicare-Covered)

In-Network:
You pay \$35 per visit.

Out-of-Network:
You pay \$40 per visit.

Podiatry Visit (Routine Foot Care)

Our plan covers up to 4 visits/year.

In-Network:
You pay \$35 per visit.

Out-of-Network:
You pay \$40 per visit.

MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment ¹

- Prosthetics ¹

In-Network and Out-of-Network:
You pay 20% for Medicare-covered benefits.

Diabetes Supplies and Services ¹

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 2027, Zing's preferred brands are Accu-Chek and True Metrix. You pay 20% for non-preferred diabetic test strips, meters and supplies.

- Diabetic Monitors ¹

You pay \$0 for preferred brand Continuous Glucose Monitors (CGMs) prescribed by a physician and obtained at a pharmacy.

For 2027, Zing's preferred CGMs are Dexcom G6 and G7.

You pay 20% for non-preferred CGMs, and CGMs billed by DME.

- Diabetic Therapeutic Shoes or Inserts ¹

You pay 20%.

- Diabetes Self-Management Training

You pay \$0.

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CHIROPRACTIC CARE AND ACUPUNCTURE

Chiropractic Visit ¹
(Medicare-Covered)

In-Network:
You pay \$15 per visit.

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

Acupuncture Visit
(Medicare-Covered)

In-Network and Out-of-Network:
You pay \$0 per visit.

HOME HEALTH CARE

Home Health Care ¹
(Medicare-Covered)

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.

OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit ¹

In-Network and Out-of-Network:
You pay \$0 per visit.

Opioid Treatment Visit ¹

In-Network and Out-of-Network:
You pay \$0 per visit.

RENAL DIALYSIS

Renal Dialysis

In-Network and Out-of-Network:
You pay 20% for Medicare-covered benefits.

Kidney Disease Education Services

In-Network and Out-of-Network:
You pay \$0 for Medicare-covered benefits.

FITNESS

Fitness - Health Club Membership

In-Network:
You pay \$0.

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

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24/7 NURSING HOTLINE

24/7 Nurse Hotline

In-Network:

You pay \$0.

Out-of-Network:

You pay 50% coinsurance.

MEAL BENEFITS

Post Discharge Meals

Our plan covers 14 meals after each inpatient facility discharge or surgery.

In-Network:

You pay \$0.

Out-of-Network:

You pay 50% coinsurance.

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.

In-Network and Out-of-Network:

You may receive \$50/quarter for over-the-counter items.

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PART D PRESCRIPTION DRUGS

Stage #1: Deductible Stage

Your deductible amount is \$450.

Tier 1, Tier 2, 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): Tier 1: \$0; Tiers 3, 4, and 5: up to \$35

Tier 1 - Preferred Generic

\$0 / \$0 / \$0

Tier 2 - Generic (includes excluded drugs)

\$9 / \$18 / \$27

Tier 3 - Preferred Brand

22% / 22% / 22%

Tier 4 - Non-Preferred Drug

25% / 25% / 25%

Tier 5 - Specialty Tier (30-day supply only)

28%

Mail Order Copay (30 days / 60 days / up to 100 days)

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

Tier 1 - Preferred Generic

\$0 / \$0 / \$0

Tier 2 - Generic (includes excluded drugs)

\$0 / \$0 / \$0

Tier 3 - Preferred Brand

22% / 22% / 22%

Tier 4 - Non-Preferred Drug

25% / 25% / 25%

Tier 5 - Specialty Tier (30-day supply only)

28%

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 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

Low Income Subsidy (LIS) - 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.