

2027

Summary of Benefits

H4624-043 Zing Elite Select TN-MS (HMO)

TN Service Area: Shelby County

MS Service Area: DeSoto County

H4624-044 Zing Select Care TN-MS (HMO)

TN Service Area: Davidson, Fayette, Robertson, Shelby, Sumner, Williamson, and Wilson Counties

MS Service Area: DeSoto, Hinds, Madison, Marshall, Rankin, Tate, and Tunica Counties

TENNESSEE-MISSISSIPPI HMO

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.

H4624-043

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*Uses a Provider-Specific Network**

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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.

\$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.

\$0. See Part D prescription drug section for Part D deductible.

Maximum Out-of-Pocket Responsibility (medical)

You pay no more than \$6,400 annually for in-network Medicare-covered services.

You pay no more than \$6,400 annually for in-network Medicare-covered services.

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INPATIENT AND OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital ¹

You pay \$429 per day for days 1-7; You pay \$0 per day for days 8 and beyond per admission or stay.

You pay \$425 per day for days 1-7; You pay \$0 per day for days 8 and beyond per admission or stay.

Outpatient Hospital ¹

You pay \$325 per visit.

You pay \$400 per visit.

Ambulatory Surgical Center (ASC) ¹

You pay \$150 per visit.

You pay \$225 per visit.

DOCTOR VISITS

Doctor Visits

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

You pay \$0 per visit.

You pay \$0 per visit.

You pay \$20 per visit.

You pay \$25 per visit.

PREVENTIVE CARE

Preventive Care

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

You pay \$0 per service.

You pay \$0 per service.

EMERGENCY CARE

Emergency Care

You pay \$130; If you are admitted to the hospital within 24 hours, then you do not have to pay \$130.

You pay \$130; If you are admitted to the hospital within 24 hours, then you do not have to pay \$130.

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.

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 \$5 per visit at other locations.

You pay \$0 per visit at a PCP office; You pay \$25 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

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 \$35 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 \$150 for CT, MRI, PET Scan at a doctor's office; You pay \$200 at a facility.

You pay \$175 for CT, MRI, PET Scan at a doctor's office; You pay \$250 at a facility.

- **X-Rays**

You pay \$0 for X-rays.

You pay \$0 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.

HEARING SERVICES

Hearing Services

- **Medicare-Covered Hearing Exams**

You pay \$25 for Medicare-covered hearing exams.

You pay \$35 for Medicare-covered hearing exams.

- **Routine Hearing Exam**

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

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.

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.

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- **Medicare Dental Services ¹**

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

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

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

You pay \$0 for comprehensive dental services.

- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/ root planing)
- Prosthodontics, fixed and removable (dentures, partials)
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VISION SERVICES

Vision Services

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

You pay \$25 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 \$250 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, or a pair of Contacts every year.

You pay \$35 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 \$350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, or a pair of Contacts every year.

MENTAL HEALTH SERVICES

Inpatient Mental Health Services ¹

You pay \$290 per day for days 1-8; You pay \$0 per day for days 9 to 90 per admission or stay.

You pay \$290 per day for days 1-8; You pay \$0 per day for days 9 to 90 per admission or stay.

Outpatient Mental Health Services ¹

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

You pay \$10 per Medicare-covered session.

You pay \$25 per Medicare-covered session.

SKILLED NURSING

Skilled Nursing Facility ¹

You pay \$10 for days 1-20.
You pay \$221 per day for days 21-100 of each Medicare-covered stay.

You pay \$10 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

You pay \$30 per visit.

You pay \$30 per visit.

Occupational Therapy ¹

You pay \$30 per visit.

You pay \$50 per visit.

Cardiac Rehabilitation ¹

- **Intensive Cardiac Rehabilitation ¹**

You pay \$55 per visit.

You pay \$55 per visit.

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AMBULANCE

Ambulance
(Ground) ¹

You pay \$350 for Medicare-covered services.

You pay \$350 for Medicare-covered services.

Ambulance
(Air) ¹

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 18 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.

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**

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 \$25 per visit.

You pay \$35 per visit.

Podiatry Visit
(Routine Foot Care)

You pay \$0 per visit; up to 6 visits/year.

You pay \$20 per visit; up to 4 visits/year.

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MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment ¹

- 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% - 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.

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.

You pay 20%.

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.

You pay 20%.

- Diabetic Therapeutic Shoes or Inserts ¹

You pay \$0.

You pay \$0.

- Diabetes Self-Management Training

CHIROPRACTIC CARE AND ACUPUNCTURE

Chiropractic Visit (Medicare-Covered) ¹

You pay \$15 per visit.

You pay \$15 per visit.

Acupuncture Visit (Medicare-Covered)

You pay \$0 per visit.

You pay \$0 per visit.

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HOME HEALTH CARE

Home Health Care
(Medicare-Covered) ¹

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.

OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit ¹

You pay \$0 per visit.

You pay \$0 per visit.

Opioid Treatment Visit ¹

You pay \$0 per visit.

You pay \$0 per visit.

RENAL DIALYSIS

Renal Dialysis

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.

You pay \$0 for Medicare-covered benefits.

IN-HOME SUPPORT SERVICES

In-Home Support Services

You pay \$0 for 30 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.

You pay \$0 for 30 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.

You pay \$0.

24/7 NURSING HOTLINE

24/7 Nurse Hotline

You pay \$0.

You pay \$0.

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MEAL BENEFITS

Post Discharge Meals

You pay \$0 for 14 meals after each inpatient facility discharge or surgery.

You pay \$0 for 14 meals after each inpatient facility discharge or surgery.

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 \$145/quarter for over-the-counter items.

You may receive \$85/quarter for over-the-counter items.

Flex Card

You receive a \$400 debit card allowance every year to apply towards the following non-Medicare covered benefits at your discretion:

- Dental (preventive and comprehensive)
- Vision (routine and eyewear)

Not Covered.

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PART D PRESCRIPTION DRUGS

Stage #1: Yearly Deductible Stage

Your deductible amount is \$350. Tier 1, Tier 2, and all insulins are excluded from the deductible.

Once you have paid \$350 for your Tiers 3, 4, and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

Your deductible amount is \$500. Tier 1, Tier 2, and all insulins are excluded from the deductible.

Once you have paid \$500 for your Tiers 3, 4, and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

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.

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

\$0 / \$0 / \$0

Tier 2 - Generic (includes excluded drugs)

\$8 / \$16 / \$24

\$6 / \$12 / \$18

Tier 3 - Preferred Brand

22% / 22% / 22%

22% / 22% / 22%

Tier 4 - Non-Preferred Drug

25% / 25% / 25%

25% / 25% / 25%

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

29%

28%

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

Insulins (100 days): Tier 1: \$0; Tiers 3, 4, and 5: 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

22% / 22% / 22%

22% / 22% / 22%

Tier 4 - Non-Preferred Drug

25% / 25% / 25%

25% / 25% / 25%

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

29%

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.

+Zing Elite Select TN-MS (HMO) 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 Select TN-MS (HMO)'s PSP specific network, the plan may not pay for these services.