Zing HEALTH™
MEDICARE REIMAGINED

Summary of Benefits

JANUARY 1, 2024 – DECEMBER 31, 2024

INDIANA (C-SNP)

H4624-024 Zing Select Diabetes & Heart Complete IN (HMO C-SNP)
Service Area: Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties

H6876-006 Zing Choice Diabetes & Heart Complete IN (PPO C-SNP)
Service Area: Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, 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, and with select State Medicaid programs. Enrollment in Zing Health depends on contract renewal.

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 www.myzinghealth.com.

To join Zing Health, you must be entitled to Medicare Part A, be enrolled in Part B, and live in the plans 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 users should call 711) 7 days a week, 8 a.m. to 8 p.m. or visit us at www.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.**	**H4624-024** **Zing Select Diabetes & Heart Complete IN (HMO C-SNP)** ***Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties***	**H6876-006** **Zing Choice Diabetes & Heart Complete IN (PPO C-SNP)** ***Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties***
PREMIUMS, DEDUCTIBLES & MOOP		
Monthly Plan Premium *(includes both medical and drugs)*	You pay $42.30 If you receive "Extra Help", you may pay $0[2]	You pay $42.30 If you receive "Extra Help", you may pay $0[2]
Deductible	Medicare-defined Part B Deductible Amount Applies to All In-Network Medicare-Covered Services. See Part D Prescription Drug section for Part D deductible.	Medicare-defined Part B Deductible Amount Applies to All In-Network and Out-Of-Network Medicare-Covered Services. See Part D Prescription Drug section for Part D deductible.
Maximum Out-of-Pocket Responsibility (In-Network) *(does not include Part D prescription drugs)*	You pay no more than $8,850 annually for in-network services	You pay no more than $8,850 annually for in-network services. You pay no more than $13,300 annually for in-network and out-of-network services combined.

[2]If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay $0 for your Medicare-covered services as noted by the cost sharing in this chart

Benefit Coverage **Services with a [1] may require prior authorization.**	**H4624-024** **Zing Select Diabetes & Heart Complete IN (HMO C-SNP)** *Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*	**H6876-006** **Zing Choice Diabetes & Heart Complete IN (PPO C-SNP)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*
INPATIENT & OUTPATIENT HOSPITAL COVERAGE		
Inpatient Hospital[1]	You pay a $1,632^ deductible per benefit period. You pay: • $0 for days 1-60^ • $408 copay per day for days 61-90^ • $0 per day after day 90 while using your 60 lifetime reserve days • 100% of all costs beyond the lifetime reserve days ^These are the final 2024 cost-sharing amounts. **If you have Medicaid benefits, your costs could be less.[2]**	In-Network and Out-of-Network: You pay a $1,632^ deductible per benefit period. You pay: • $0 for days 1-60^ • $408 copay per day for days 61-90^ • $0 per day after day 90 while using your 60 lifetime reserve days • 100% of all costs beyond the lifetime reserve days ^These are the final 2024 cost-sharing amounts. **If you have Medicaid benefits, your costs could be less.[2]**
Outpatient Hospital[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
Ambulatory Surgical Center (ASC)[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
DOCTOR VISITS		
Doctor Visits • Primary Care Provider • Specialists	You may pay $0 or up to 20%[2] coinsurance per visit You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit You may pay $0 or up to 20%[2] coinsurance per visit
PREVENTIVE CARE		
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing Other preventive services are available. There are some covered services that have a cost.	In-Network and Out-of-Network: You pay nothing Other preventive services are available. There are some covered services that have a cost.

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Benefit Coverage **Services with a [1] may require prior authorization.**	**H4624-024** **Zing Select Diabetes & Heart Complete IN (HMO C-SNP)** *Allen, Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*	**H6876-006** **Zing Choice Diabetes & Heart Complete IN (PPO C-SNP)** *Boone, Hamilton, Hancock, Hendricks, Johnson, Lake, Marion, Porter, and Shelby Counties*
EMERGENCY CARE		
Emergency Care	You may pay $0 or up to 20% coinsurance with a maximum limit of $100 per visit If admitted to the hospital within 24 hours of ER visit, the emergency cost share is waived.	You may pay $0 or up to 20% coinsurance with a maximum limit of $100 per visit If admitted to the hospital within 24 hours of ER visit, the emergency cost share is waived.
Worldwide Emergency and Urgent Care	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. Emergency transportation is 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. Emergency transportation is not included.
Urgently Needed Services	You may pay $0 or up to 20%[2] coinsurance with a maximum limit of $55 per visit	You may pay $0 or up to 20%[2] coinsurance with a maximum limit of $55 per visit
DIAGNOSTIC SERVICES / LABS / IMAGING		
Diagnostic Services/ Labs/Imaging If a member receives multiple services on the same day, only the maximum copay applies. • Diagnostic Tests and Procedures[1] • Lab Services[1] • MRI, CAT Scan[1] • X-Rays • Therapeutic Radiology[1] (radiation, chemotherapy)	You may pay $0 or up to 20%[2] coinsurance for all services listed.	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance for all services listed.

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HEARING SERVICES		
Hearing Services		In-Network:
• Medicare-Covered Hearing Exams	You may pay $0 or up to 20%[2] coinsurance for Medicare-covered hearing exams	You may pay $0 or up to 20% [2] coinsurance for Medicare-covered hearing exams
• Routine Hearing Exam	You pay $0 for one (1) routine hearing exam per year.	You pay $0 for one (1) routine hearing exam per year.
• Fitting and Evaluation for Hearing Aid	You pay $0 for one (1) fitting and evaluation every three (3) years	You pay $0 for one (1) fitting and evaluation every three (3) years
• Hearing Aids	You receive a $750 benefit allowance towards hearing aids per ear every three (3) years.	You receive a $750 benefit allowance towards hearing aids per ear every three (3) years. Out-of-Network: You may pay $0 or up to 20%[2] coinsurance for Medicare-covered hearing exams. You pay 50% coinsurance for hearing aids. You receive a $750 benefit allowance towards hearing aids per ear every three (3) years. You pay 50% coinsurance for routine hearing services, up to one (1) routine hearing exam per year and one (1) hearing aid fitting and evaluation every three (3) years.

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DENTAL SERVICES		
Dental Services	You receive a $3,500 benefit allowance every year for preventive and comprehensive dental benefits combined.	In-Network: You receive a $2,500 benefit allowance every year for preventive and comprehensive dental benefits combined.
• Routine (Preventive) Dental Services	You pay a $0 copay for routine dental services. • Oral exams up to one (1) every six (6) months • $0 copay for prophylaxis (cleaning) up to one (1) every six (6) months • $0 copay for a fluoride treatment for up to one (1) every year • $0 copay for x-rays up to one (1) set per year	You pay a $0 copay for routine dental services. • Oral exams up to one (1) every six (6) months • $0 copay for prophylaxis (cleaning) up to one (1) every six (6) months • $0 copay for a fluoride treatment for up to one (1) every year • $0 copay for x-rays up to one (1) set per year
• Comprehensive Dental Services[1]	You pay $0 for comprehensive dental services. Unlimited benefit for: • Non-routine Services (other services) • Diagnostic Services (exams, x-rays) • Restorative Services (crowns) • Endodontics (root canals) • Periodontics (scaling/ root planning) • Prosthodontics, Other Oral/Maxillofacial Surgery (dentures or fixed prosthetics and partials) • Extractions (1 per tooth per year)	You pay $0 for comprehensive dental services. Unlimited benefit for: • Non-routine Services (other services) • Diagnostic Services (exams, x-rays) • Restorative Services (crowns) • Endodontics (root canals) • Periodontics (scaling/ root planning) • Prosthodontics, Other Oral/Maxillofacial Surgery (dentures or fixed prosthetics and partials) • Extractions (1 per tooth per year) Out-of-Network: You pay $0 for Medicare-covered comprehensive dental services. You pay 50% coinsurance for non-Medicare-covered dental services (preventive and comprehensive) up to $2,500 benefit allowance every year.

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VISION SERVICES		
Vision Services		In-Network:
• Medicare-Covered Eye Exams	You may pay $0 or up to 20%[2] coinsurance for Medicare-covered eye exams	You may pay $0 or up to 20%[2] coinsurance for Medicare-covered eye exams
• Routine Eye Exams	You pay $0 for one (1) routine vision exam per year.	You pay $0 for one (1) routine vision exam per year.
• Medicare-Covered Eyewear	You pay $0 for Medicare-covered eyewear	You pay $0 for Medicare-covered eyewear
• Routine Eyewear	You pay $0 for routine eyewear; You receive a $350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year	You pay $0 for routine eyewear; You receive a $350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year Out-of-Network: You may pay $0 or up to 20%[2] coinsurance for Medicare-covered eye exams You pay 50% coinsurance, non-Medicare-covered vision services and eyewear up to $350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of contacts every year.

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MENTAL HEALTH SERVICES		
Inpatient Mental Health Services[1]	You pay a $1,632 deductible per benefit period. You pay: • $0 for days 1-60 • $408 copay per day for days 61-90 • $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • 20% of the cost for mental health services from providers during the stay • Part A only pays for up to 190 days of inpatient psychiatric care for a lifetime. These are the final 2024 cost-sharing amounts. **If you have Medicaid benefits, your costs could be less.[2]**	In-Network and Out-of-Network: You pay a $1,632 deductible per benefit period. You pay: • $0 for days 1-60 • $408 copay per day for days 61-90 • $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • 20% of the cost for mental health services from providers during the stay • Part A only pays for up to 190 days of inpatient psychiatric care for a lifetime. These are the final 2024 cost-sharing amounts. **If you have Medicaid benefits, your costs could be less.[2]**
Outpatient Mental Health Services[1] • Outpatient Group Therapy/Individual Therapy Visit[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit

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SKILLED NURSING		
Skilled Nursing Facility[1]	You pay: • $0 for days 1 through 20 • $204 for days 21 through 100 • All costs for each day after day 100 of the benefit period. These are the final 2024 cost-sharing amounts. If you have Medicaid benefits, your costs could be less.[2]	In-Network and Out-of-Network: You pay: • $0 for days 1 through 20 • $204 for days 21 through 100 • All costs for each day after day 100 of the benefit period. These are the final 2024 cost-sharing amounts. If you have Medicaid benefits, your costs could be less.[2]
REHABILITATION SERVICES		
Physical Therapy / Speech Therapy[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
Occupational Therapy[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
Cardiac Rehabilitation[1] • Intensive Cardiac Rehabilitation[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
AMBULANCE		
Ambulance (Ground)[1]	You may pay $0 or up to 20%[2] coinsurance	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance
Ambulance (Air)[1]	You may pay $0 or up to 20%[2] coinsurance	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance

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TRANSPORTATION		
Transportation (Non-Emergency)[1]	You pay $0 for 48 one-way trips per year to plan approved health-related locations. Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease	You pay $0 for 36 one-way trips per year to plan approved health-related locations. Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease
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	You pay 0% to 20% coinsurance for insulin not to exceed $35
• Chemotherapy and Other drugs[1] Step Therapy may be required	You pay $0 copay or 20% coinsurance for chemotherapy and other Part B drugs	You pay $0 copay or 20% coinsurance for chemotherapy and other Part B drugs
FOOT CARE		
Podiatry Visit (Medicare-Covered)	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
Podiatry Visit (Routine Foot Care)	You pay $0; up to 12 visits / year	In-Network and Out-of-Network: You pay $0; up to 12 visits / year

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MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment[1] • Prosthetics[1] Prior authorization required for items/ supplies over $1,500	You may pay $0 or up to 20%[2] coinsurance	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance
Diabetes Supplies and Services	You may pay $0 or up to 20%[2] coinsurance	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance
• Diabetic Therapeutic Shoes or Inserts	You may pay $0 or up to 20%[2] coinsurance	You may pay $0 or up to 20%[2] coinsurance
• Diabetes Self-Management Training	You pay $0	You pay $0
CHIROPRACTIC CARE & ACUPUNCTURE		
Chiropractic Visit (Medicare-Covered)	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance 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)	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.

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OUTPATIENT SUBSTANCE ABUSE		
Individual and Group Therapy Visit[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
Opioid Treatment Visit[1]	You may pay $0 or up to 20%[2] coinsurance per visit	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance per visit
RENAL DIALYSIS		
Renal Dialysis	You may pay $0 or up to 20%[2] coinsurance	In-Network and Out-of-Network: You may pay $0 or up to 20%[2] coinsurance
Kidney Disease Education Services	You pay $0	In-Network and Out-of-Network: You pay $0
IN-HOME SUPPORT SERVICES		
In-Home Support Services	You pay $0 for 60 hours per year of Papa Pals services.	You pay $0 for 60 hours per year of Papa Pals services.
FITNESS		
Fitness - Health Club Membership and At-Home Fitness Kit	You pay $0	You pay $0
Weight Management Program	You pay $0	You pay $0
24 / 7 NURSING HOTLINE		
24 / 7 Nurse Hotline	You pay $0	You pay $0
PERSONAL EMERGENCY RESPONSE SYSTEM		
Personal Emergency Response System	You pay $0	You pay $0
MEAL BENEFITS		
Post Discharge Meals	You pay $0 for 10 meals after each inpatient facility discharge or surgery	You pay $0 for 10 meals after each inpatient facility discharge or surgery
Chronic Condition Meals	You pay $0 for 28 meals (limited to one (1) event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program	You pay $0 for 28 meals (limited to one (1) event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program

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OVER-THE-COUNTER ITEMS / HEALTHY FOODS / UTILITY		
Over-the-Counter Items Allowance	You pay $0 for $254 / month to use for over-the-counter items, unused funds do not roll-over to next month. Combined with Healthy Food & Utilities Allowance.	You pay $0 for $213 / month to use for over-the-counter items, unused funds do not roll-over to next month. Combined with Healthy Food & Utilities Allowance.
Healthy Food and Utilities Allowance	Members with Chronic Heart Failure, Cardiovascular Disorders, and Diabetes can also use their over-the-counter allowance for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.	Members with Chronic Heart Failure, Cardiovascular Disorders, and Diabetes can also use their over-the-counter allowance for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.
FLEX CARD BENEFIT		
Flex Card	You receive a $650 debit card every year to apply towards the following non-Medicare covered benefits at your discretion: • Hearing • Dental (preventive and comprehensive) • Vision (routine and eyewear)	You receive a $500 debit card every year to apply towards the following non-Medicare covered benefits at your discretion: • Hearing • Dental (preventive and comprehensive) • Vision (routine and eyewear)

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PART D PRESCRIPTION DRUGS		
Phase 1: Deductible Stage	You pay $545 (T1 & T6 Excluded) If you get Extra Help paying for your prescription drugs, your deductible may be paid by Extra Help.	You pay $545 (T1 & T6 Excluded) If you get Extra Help paying for your prescription drugs, your deductible may be paid by Extra Help.
Phase 2: Initial Coverage Stage	You are in the Initial Coverage Stage until your total yearly drug cost reach $5,030. Total yearly drug costs are the total drug costs paid both by you and the plan. Once you've reached this amount, you enter the coverage gap.	
Standard Retail Benefits (30 days /60 days /100 days)		
Tier 1 - Preferred Generic (includes insulins)	$0 / $0 / $0	$0 / $0 / $0
Tier 2 - Generic (includes excluded drugs)	25% / 25% / 25%	25% / 25% / 25%
Tier 3 - Preferred Brand	25% / 25% / 25%	25% / 25% / 25%
Tier 4 - Non-Preferred Drug	25% / 25% / 25%	25% / 25% / 25%
Tier 5 - Specialty Tier (30-day supply only)	25%	25%
Tier 6 - Select Care Drugs	$0 / $0 / $0	$0 / $0 / $0
Mail Order Copay (30 days / 60 days / 100 days)		
Tier 1 - Preferred Generic (includes insulins)	$0 / $0 / $0	$0 / $0 / $0
Tier 2 - Generic (includes excluded drugs)	$0 / $0 / $0	$0 / $0 / $0
Tier 3 - Preferred Brand	25% / 25% / 25%	25% / 25% / 25%
Tier 4 - Non-Preferred Drug	25% / 25% / 25%	25% / 25% / 25%
Tier 5 - Specialty Tier (30-day supply only)	25%	25%
Tier 6 - Select Care Drugs	$0 / $0 / $0	$0 / $0 / $0
Phase 3: Gap Coverage	During this phase, you will pay 25% for generic or brand-name drugs.	
Phase 4: Catastrophic Coverage Stage	The plan pays the full cost for your covered Part D drugs. You pay nothing.	

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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 our Customer Service department or access our "Evidence of Coverage" online or request one by mail.