Zing HEALTH™

Summary of Benefits

Illinois

H7330-001 Zing Choice IL (HMO)
H7330-002 Zing Open Access IL (HMO-POS)
Service Area(s): Cook County

January 1, 2021 – December 31, 2021

Y0149_SB-HMO-POS-001.002-Cook_M

About Zing Health Plan

Zing Health Plan is a Medicare Advantage plan designed to cover all the benefits you receive under Original Medicare. In addition, the plan covers Part D prescription drugs, dental, vision, hearing and much more at no additional monthly plan premium.

Whether new to Medicare or an existing Medicare beneficiary, Zing Health has you covered. We understand navigating the Medicare maze isn't always easy. That's why you can count on us to assist you with answering questions you may have when making important health care decisions.

We've been asked, "Why Zing"? The word "Zing" denotes energy, vigor, excitement, or stimulating quality which is what Zing seeks to infuse into our healthcare delivery model. Our goal is to provide our members with health care benefits that will assist them in obtaining optimal health. Zing Health takes a holistic approach to delivering comprehensive health care which includes robust Health and Wellness Programs.

Important Plan Information

Zing Choice IL (HMO) and Zing Open Access IL (HMO-POS) is a Medicare Advantage plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

This easy to use guide helps you to understand what benefits are covered by the plans. The benefit information provided is a summary of what we cover and what you can expect to pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, call us or request the "Evidence of Coverage" booklet.

For more information, please call us at **1-866-946-4458** (TTY users should call 711), or visit us at **www.myzinghealth.com**.

Who can join?

To join Zing Choice IL (HMO) and Zing Open Access IL (HMO-POS), you have Medicare Part A and be enrolled in Part B, and live in the plans service area. The service area includes the following county: **Cook County**.

What providers can I use?

Zing Choice IL (HMO) and Zing Open Access IL (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use providers that are not in our network, we may not pay for out-of-network services.

Once enrolled in the plan, you will select a primary care physician (PCP). Most of your health care services will be referred by the doctor you select. That means you may need a referral before you can see other health care professionals. In some instances, a prior authorization may be required for some services you receive.

Zing Open Access IL (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. With the POS option, members have access to doctors, specialists and/or hospitals in-network or out-of-network. However, the Primary Care Provider (PCP) must be in network. You may also experience a higher cost share for services received out-of-network.

What are our hours of operation?

Hours of operation are between 8:00 a.m. and 8:00 p.m. Monday through Friday (from April 1 through September 30). And 8:00 a.m. to 8:00 p.m. 7 days a week (from October 1 through March 31).

- If you are a member of this plan, call toll free **1-866-946-4458 (TTY users should call 711) or visit us at www.myzinghealth.com.**
- If you are not a member of this plan, call toll-free **1-866-946-4458.**

What does Original Medicare cover?

If you want to know more about the 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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Monthly Premium	**$0** Monthly plan premium In addition, you must keep paying your Medicare Part B premium.	
Plan Deductible	This plan does not have a deductible.	
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. This does not include prescription drug out-of-pocket cost.	
Yearly Maximum Out-of-pocket responsibility? (Does not include prescription drugs)	**$2,950** is the most you'll pay for covered services you receive from in-network providers. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year for covered medical and hospital services.	**$3,500** is the most you'll pay for covered services you receive from in-network providers. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year for covered medical and hospital services.

Covered Medical and Hospital Benefits

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
Inpatient Hospital Coverage*		
Acute Inpatient Hospital Care*	**In-Network:** ▪ You pay $200 copay per day for days 1 through 5. ▪ You pay nothing per day for days 6 and beyond. **Out-of-Network:** Not covered.	**In-Network:** ▪ You pay $175 copay per day for days 1 through 5. ▪ You pay nothing per day for days 6 and beyond. **Out-of-Network:** You pay 30% of the cost.
Outpatient Hospital Coverage*		
Outpatient Services*	**In-Network:** You pay $25 copay to $150 copay for Outpatient hospital services. Copay may vary depending on the place of service. Outpatient hospital services may include approved procedures like diagnostic procedures, casts, stitches, or outpatient surgery. For a complete list of services, please refer to the Evidence of Coverage. **Out-of-Network:** Not covered.	**In-Network:** You pay $25 copay to $150 copay for Outpatient hospital services. Copay may vary depending on the place of service. Outpatient hospital services may include approved procedures like diagnostic procedures, casts, stitches, or outpatient surgery. For a complete list of services, please refer to the Evidence of Coverage. **Out-of-Network:** You pay 30% of the cost.
Doctor Visits*		
Primary Care Physician (PCP)	**In-Network:** You pay $0 copay for a Primary Care Physician visit. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for a Primary Care Physician visit. **Out-of-Network:** Not covered.

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
Specialists*	**In-Network:** You pay $25 copay for Specialist visits. **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for Specialist visits. **Out-of-Network:** You pay 30% of the cost.
Preventive Care*		
Our plan covers many Medicare-covered preventive services, including: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Bone mass measurement ▪ Breast cancer screening (mammogram) ▪ Cardiovascular disease (behavioral therapy) ▪ Cardiovascular screenings ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▪ Depression screening ▪ Diabetes screenings ▪ Diabetes self-management training ▪ Glaucoma tests (continued on next page)	**In-Network:** You pay $0 copay. Other preventive services are available. There are some covered services that have a cost. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay. Other preventive services are available. There are some covered services that have a cost. **Out-of-Network:** You pay 30% of the cost.

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
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Preventive Care continued: ▪ Hepatitis B shots and screening ▪ Hepatitis C screening test ▪ HIV screening ▪ Lung cancer screening ▪ Medical nutrition therapy services ▪ Obesity screening and counseling ▪ Pneumococcal shot ▪ Prostate cancer screenings ▪ Sexually transmitted infections screening and counseling ▪ Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▪ "Welcome to Medicare" preventive visit (one-time) ▪ Yearly "Wellness" visit	**In-Network:** You pay $0 copay. Other preventive services are available. There are some covered services that have a cost. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay. Other preventive services are available. There are some covered services that have a cost. **Out-of-Network:** You pay 30% of the cost.
Emergency Care		
Emergency Care Services	**In-Network:** You pay $90 copay per visit. If you are admitted to the hospital within 24 hours, the copay is waived. **Out-of-Network:** You pay $90 copay per visit. If you are admitted to the hospital within 24 hours, the copay is waived.	**In-Network:** You pay $90 copay per visit. If you are admitted to the hospital within 24 hours, the copay is waived. **Out-of-Network:** You pay $90 copay per visit. If you are admitted to the hospital within 24 hours, the copay is waived.
Worldwide Emergency Care	Covered	Covered

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
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Urgently Needed Services		
Urgent Care Services	**In-Network:** You pay $10 copay per visit. **Out-of-Network:** You pay $10 copay per visit.	**In-Network:** You pay $10 copay per visit. **Out-of-Network:** You pay $10 copay per visit.
Diagnostic Services, Labs and Imaging* **(Costs for these services may vary based on place of service)**		
Diagnostic Tests and Procedures	**In-Network:** You pay $25 copay for Diagnostic tests and procedures. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** Not covered.	**In-Network:** You pay $25 copay for Diagnostic tests and procedures. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** You pay 30% of the cost.
Lab Services	**In-Network:** You pay $0 copay for Lab services. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for Lab services. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** You pay 30% of the cost.
Diagnostic Radiological Services (such as MRIs, CT Scans)*	**In-Network:** You pay $50 to $150 copay for Diagnostic radiology services. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** Not covered.	**In-Network:** You pay $50 to $150 copay for Diagnostic radiology services. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** You pay 30% of the cost.

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Therapeutic Radiological Services (such as radiation treatment for cancer)*	**In-Network:** You pay 20% of the cost for Therapeutic radiology services. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** Not covered.	**In-Network:** You pay 20% of the cost for Therapeutic radiology services. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** You pay 30% of the cost.
Outpatient X-rays*	**In-Network:** You pay $0 copay for Medicare-covered outpatient x-rays. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for Medicare-covered outpatient x-rays. If a member receives multiple services on the same day, only the maximum copay applies. **Out-of-Network:** You pay 30% of the cost.
Hearing Services		
Hearing Exams (Medicare-covered)	**In-Network:** You pay $25 copay for Medicare-covered hearing exam. **Out-of-Network:** Not covered.	**In-Network:** You pay $25 copay for Medicare-covered hearing exam. **Out-of-Network:** You pay 30% of the cost for Medicare-covered hearing exam.
Routine Hearing Exams	**In-Network:** You pay $0 copay for a routine hearing exam up to (1) per year. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for a routine hearing exam up to (1) per year. **Out-of-Network:** Not covered.

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Hearing Aid Evaluation/Fitting	**In-Network:** You pay $0 copay for a Hearing Aid fitting and evaluation up to (1) every (3) years. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for a Hearing Aid fitting and evaluation up to (1) every (3) years. **Out-of-Network:** Not covered.
Hearing Aids	**In-Network:** Zing Health Plan covers a **$750** maximum benefit amount allowance towards hearing aids every (3) years per ear. You are responsible for all cost beyond the maximum allowed amount. **Out-of-Network:** Not covered.	**In-Network:** Zing Health Plan covers a **$750** maximum benefit amount allowance towards hearing aids every (3) years per year. You are responsible for all cost beyond the maximum allowed amount. **Out-of-Network:** Not covered.

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Dental Services		
Preventive Dental Benefits	**In-Network:** You pay: ▪ $0 copay for Oral exams for up to (1) every 6 months ▪ $0 copay for (1) Prophylaxis (Cleaning) every 6 months ▪ $0 copay for a Fluoride treatment for up to (1) every year ▪ $0 copay for Bitewing X-rays up to (1) set per year ▪ $0 copay for Dental X-ray(s) for up to (1) every year ▪ $0 copay for Panoramic X-rays for up to (1) every (5) years Our plan covers a **$2,500** maximum benefit amount every year for preventive and comprehensive dental benefits combined. **Out-of-Network:** Not covered.	**In-Network:** You pay: ▪ $0 copay for Oral exams for up to (1) every 6 months ▪ $0 copay for (1) Prophylaxis (Cleaning) every 6 months ▪ $0 copay for a Fluoride treatment for up to (1) every year ▪ $0 copay for Bitewing X-rays up to (1) set per year ▪ $0 copay for Dental X-ray(s) for up to (1) every year ▪ $0 copay for Panoramic X-rays for up to (1) every (5) years Our plan covers a **$2,500** maximum benefit amount every year for preventive and comprehensive dental benefits combined. **Out-of-Network:** Not covered.

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Comprehensive Dental Benefits	**In-Network:** You pay: ▪ $0 copay for Amalgam and/or composite filling every (3) years per tooth ▪ $0 copay for Extractions ((1) extraction per tooth per year) ▪ $0 copay Root canals ((1) per lifetime, per tooth) ▪ $0 copay for Scaling/Root Planning (Deep cleaning) (every (24) months per quadrant) ▪ $0 copay for Complete crown (every (5) years, per tooth) ▪ $0 copay for Dentures or fixed prosthetics/partials once every (5) years Our plan covers up to a **$2,500** maximum benefit amount every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. **Out-of-Network:** Not covered.	**In-Network:** You pay: ▪ $0 copay for Amalgam and/or composite filling every (3) years per tooth ▪ $0 copay for Extractions ((1) extraction per tooth per year) ▪ $0 copay Root canals ((1) per lifetime, per tooth) ▪ $0 copay for Scaling/Root Planning (Deep cleaning) (every (24) months per quadrant) ▪ $0 copay for Complete crown (every (5) years, per tooth) ▪ $0 copay for Dentures or fixed prosthetics/partials once every (5) years Our plan covers up to a **$2,500** maximum benefit amount every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. **Out-of-Network:** Not covered.

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Vision Services		
Eye Exams (Medicare-covered)	**In-Network:** You pay $25 copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). **Out-of-Network:** You pay 30% of the cost.
Routine Eye Exam	**In-Network:** You pay $0 copay for (1) routine eye exam, refraction up to (1) per year. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for (1) routine eye exam, refraction up to (1) per year. **Out-of-Network:** Not covered.
Eyewear (Medicare-covered)	**In-Network:** You pay $0 for (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 for (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery. **Out-of-Network:** You pay 30% of the cost.
Routine Eyewear	**In-Network:** **$250** Maximum benefit coverage amount towards Eyeglasses (frames and lenses) or Contact lenses (1) per year. You are responsible for all cost exceeding the maximum benefit amount for routine eyewear. **Out-of-Network:** Not covered.	**In-Network:** **$300** Maximum benefit coverage amount towards Eyeglasses (frames and lenses) or Contact lenses (1) per year. You are responsible for all cost exceeding the maximum benefit amount for routine eyewear. **Out-of-Network:** Not covered.

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Mental Health Services*		
Inpatient Mental Health Care* Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**In-Network:** You pay: ▪ $200 copay per day for days 1 through 5. ▪ $0 copay per day for days 6 through 90. **Out-of-Network:** Not covered.	**In-Network:** You pay: ▪ $175 copay per day for days 1 through 5. ▪ $0 copay per day for days 6 through 90. **Out-of-Network:** You pay 30% of the cost.
Outpatient Mental Health Care Individual and Group Therapy Visit	**In-Network:** You pay $25 copay. **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay. **Out-of-Network:** You pay 30% of the cost.
Skilled Nursing Facility (SNF)*		
Our plan covers up to 100 days in the SNF.	**In-Network:** ▪ You pay $0 copay for days 1 through 20. ▪ You pay $160 copay per day for days 21 through 100. **Out-of-Network:** Not covered.	**In-Network:** ▪ You pay $0 copay for days 1 through 20. ▪ You pay $160 copay per day for days 21 through 100. **Out-of-Network:** You pay 30% of the cost.
Rehabilitation Services*		
Occupational Therapy Services*	**In-Network:** You pay $20 copay for Occupational therapy per visit. **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for Occupational therapy per visit. **Out-of-Network:** You pay 30% of the cost.

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Physical Therapy and Speech and Language Therapy Services*	**In-Network:** You pay $20 copay for Physical therapy and Speech and Language therapy per visit. **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for Physical therapy and Speech and Language therapy per visit. **Out-of-Network:** You pay 30% of the cost.
Cardiac and Pulmonary Rehabilitation services	**In-Network:** You pay $0 for Cardiac and Pulmonary Rehabilitation services per visit. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 for Cardiac and Pulmonary Rehabilitation services per visit. **Out-of-Network:** You pay 30% of the cost.
Ambulance*		
Ground Service (one-way trip)	**In-Network:** You pay $175 copay for a covered one-way ambulance trip. **Out-of-Network:** Same as In-Network.	**In-Network:** You pay $175 copay for a covered one-way ambulance trip. **Out-of-Network:** Same as In-Network.
Air Service (one-way trip)	**In-Network:** You pay 20% Coinsurance for covered air ambulance service. **Out-of-Network:** Not covered.	**In-Network:** You pay 20% Coinsurance for covered air ambulance service. **Out-of-Network:** You pay 30% Coinsurance for covered air ambulance service.
Transportation		
Non-Emergency Transportation Services The member must contact the plan for more details and participating transportation vendors.	**In-Network:** You pay $0 for up to 24 one-way trips per year to plan approved health-related locations. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 for up to 24 one-way trips per year to plan approved health-related locations. **Out-of-Network:** Not covered.

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Medicare Part B Drugs*		
Medicare Part B Drugs* Medicare-covered Part B Drugs may be subject to step therapy requirements.	**In-Network:** ▪ You pay 20% of the cost for chemotherapy drugs. ▪ You pay 20% of the cost for other Part B drugs. **Out-of-Network:** Not covered.	**In-Network:** ▪ You pay 20% of the cost for chemotherapy drugs. ▪ You pay 20% of the cost for other Part B drugs. **Out-of-Network:** You pay 30% of the cost.
Ambulatory Surgery Center*		
Ambulatory Surgery Center (ASC)*	**In-Network:** You pay $75 copay for Surgery at an ambulatory surgical center. **Out-of-Network:** Not covered.	**In-Network:** You pay $50 copay for Surgery at an ambulatory surgical center. **Out-of-Network:** You pay 30% of the cost.

Outpatient Prescription Drugs

Part D Deductible

No Deductible. Because your plan does not have a deductible, this stage does not apply to you. You start the Initial Coverage Stage when you fill your first prescription.

Initial Coverage

You are in the initial coverage stage until you reach $4,130 in drug costs (year to date).

	Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply	Mail Order 90-day supply
H7330-001 Zing Choice IL (HMO)			
Tier 1 (Preferred Generic)	**$2** copay	**$7** copay	**$14** copay
Tier 2 (Generic)	**$10** copay	**$15** copay	**$30** copay
Tier 3 (Preferred Brand)	**$35** copay	**$45** copay	**$90** copay
Tier 4 (Non-Preferred Drug)	**$95** copay	**$100** copay	**$200** copay
Tier 5 (Specialty Tier)	**33%** of the cost	**33%** of the cost	N/A
Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay
H7330-002 Zing Open Access IL (HMO-POS)			
Tier 1 (Preferred Generic)	**$2** copay	**$7** copay	**$14** copay
Tier 2 (Generic)	**$10** copay	**$15** copay	**$30** copay
Tier 3 (Preferred Brand)	**$35** copay	**$45** copay	**$90** copay
Tier 4 (Non-Preferred Drug)	**$95** copay	**$100** copay	**$200** copay
Tier 5 (Specialty Tier)	**33%** of the cost	**33%** of the cost	N/A
Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay

Initial Coverage Stage: Long Term Care and Out-of-Network Pharmacies (one-month supply)		
	H7330-001 Zing Choice IL (HMO)	**H7330-002 Zing Open Access IL (HMO-POS)**
Long-term Care Tiers 1-6	If you reside in a long-term care facility, you pay the same as a retail pharmacy.	
Out-of-Network Tiers 1-6	You may get drugs from an out-of-network pharmacy at a higher cost than a preferred network pharmacy.	

Coverage Gap

You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,550.

	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Mail Order 90-day supply**
H7330-001 Zing Choice IL (HMO)			
Tier 1 (Preferred Generic)	**$2** copay	**$7** copay	**$14** copay
Tier 2 (Generic)	**$10** copay	**$15** copay	**$30** copay
Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay
H7330-002 Zing Open Access IL (HMO-POS)			
Tier 1 (Preferred Generic)	**$2** copay	**$7** copay	**$14** copay
Tier 2 (Generic)	**$10** copay	**$15** copay	**$30** copay
Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay

During this stage, you pay the above copays for Tier 1 - Preferred Generic, Tier 2 - Generic and Tier 6 - Select Care Drugs.

During this stage, you pay 25% of the cost for generic drugs and brand name drugs (plus a portion of the dispensing fee) for drugs in Tier 3 – Preferred Brand, Tier 4 – Non-Preferred Brand Drug and Tier 5 – Specialty Tier.

Catastrophic Coverage	
H7330-001 Zing Choice IL (HMO)	**H7330-002 Zing Open Access IL (HMO-POS)**
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: ▪ 5% of the cost, or $3.70 copay for generic (including brand drugs treated as generic) and ▪ 5% of the cost, or $9.20 copay for all other drugs Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.	

Important Part D plan information:

- Your cost share may differ depending on 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 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 Part D drug coverage stages, please call our Customer Service or access our "Evidence of Coverage" online or request one by mail.

Additional Benefits, Care and Services

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
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Additional Benefits Premium		
	You pay $0 premium for additional benefits.	You pay $0 premium for additional benefits.
Acupuncture		
Acupuncture (Medicare-covered)	**In-Network:** $0 copay per visit for up to (12) visits in 90 days for chronic low back pain. No more than 20 acupuncture treatments may be administered annually. **Out-of-Network:** Not covered.	**In-Network:** $0 copay per visit for up to (12) visits in 90 days for chronic low back pain. No more than 20 acupuncture treatments may be administered annually. **Out-of-Network:** You pay 30% of the cost.

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Foot Care (Podiatry Services)		
Podiatry Services (Medicare-covered)	**In-Network:** You pay a $25 copay for Medicare-covered Podiatry services. **Out-of-Network:** Not covered.	**In-Network:** You pay a $20 copay for Medicare-covered Podiatry services. **Out-of-Network:** You pay 30% of the cost.
Routine Podiatry Services	**In-Network:** You pay $20 copay for (4) visits for Routine Podiatry covered services per year. **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for (6) visits for Routine Podiatry covered services per year. **Out-of-Network:** You pay 30% of the cost.
Medical Equipment and Supplies*		
Durable Medical Equipment (wheelchairs, oxygen, etc.)*	**In-Network:** You pay 20% of the cost for DME. **Out-of-Network:** Not covered.	**In-Network:** You pay 20% of the cost for DME. **Out-of-Network:** You pay 30% of the cost.
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies*	**In-Network:** You pay 20% of the cost for Prosthetic devices. **Out-of-Network:** Not covered.	**In-Network:** You pay 20% of the cost for Prosthetic devices. **Out-of-Network:** You pay 30% of the cost.

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
Diabetes Supplies and Services	**In-Network:** You pay: ▪ $0 copay for Preferred Diabetic test strips. ▪ 20% of the cost for Non-preferred Diabetic test strips and diabetic monitoring supplies. ▪ $0 copay for Diabetes Self Management Training. ▪ 20% of the cost for Therapeutic shoes or inserts. **Out-of-Network:** Not covered.	**In-Network:** You pay: ▪ $0 copay for Preferred Diabetic test strips. ▪ 20% of the cost for Non-preferred Diabetic test strips and diabetic monitoring supplies. ▪ $0 copay for Diabetes Self Management Training. ▪ 20% of the cost for Therapeutic shoes or inserts. **Out-of-Network:** You pay 30% of the cost.
Chiropractic Care		
Chiropractic Services (Medicare-covered)	**In-Network:** You pay $20 copay for manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). **Out-of-Network:** You pay 30% of the cost.
Home Health Care*		
Home Health Care*	**In-Network:** You pay $0 copay for Medicare-covered home health care services. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copay for Medicare-covered home health care services. **Out-of-Network:** You pay 30% of the cost.

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
Hospice		
Hospice Care	You must get your care from a Medicare-certified hospice provider. You must consult with the plan before you select hospice. You pay part of the cost for outpatient drugs. Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage plan.	You must get your care from a Medicare-certified hospice provider. You must consult with the plan before you select hospice. You pay part of the cost for outpatient drugs. Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage plan.
Outpatient Substance Abuse*		
Individual and Group Therapy Visit*	**In-Network:** You pay $25 copay for Individual therapy sessions per visit. You pay $25 copay for Group therapy sessions per visit. **Out-of-Network:** Not covered.	**In-Network:** You pay $20 copay for Individual therapy sessions per visit. You pay $20 copay for Group therapy sessions per visit. **Out-of-Network:** You pay 30% of the cost.
Renal Dialysis*		
Renal Dialysis*	**In-Network:** You pay 20% of the cost for Medicare-covered dialysis treatments. You pay $0 copay for Kidney disease education services. **Out-of-Network:** Not covered.	**In-Network:** You pay 20% of the cost for Medicare-covered dialysis treatments. You pay $0 copay for Kidney disease education services. **Out-of-Network:** You pay 30% of the cost.

Wellness Programs

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
Over-the-Counter (OTC) Items		
Over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog.	**In-Network:** You get up to $75 every three (3) months for OTC Items. Please visit our website at www.myzinghealth.com to see our list of covered over-the-counter items. **Out-of-Network:** Not covered.	**In-Network:** You get up to $75 every three (3) months for OTC Items. Please visit our website at www.myzinghealth.com to see our list of covered over-the-counter items. **Out-of-Network:** Not covered.
Health Club Memberships		
Silver & Fit® Fitness	**In-Network:** Silver & Fit® Fitness membership is available at no cost while you are a member of our plan. You can find a list of participating clubs on our website at www.myzinghealth.com or call Customer Service. **Out-of-Network:** Not covered.	**In-Network:** Silver & Fit® Fitness membership is available at no cost while you are a member of our plan. You can find a list of participating clubs on our website at www.myzinghealth.com or call Customer Service. **Out-of-Network:** Not covered.
Weight Watchers® Membership	**In-Network:** Our plan provides complimentary vouchers for membership in the Weight Watchers® program. Meals are not covered. **Out-of-Network:** Not covered.	**In-Network:** Our plan provides complimentary vouchers for membership in the Weight Watchers® program. Meals are not covered. **Out-of-Network:** Not covered.

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
TeleHealth		
MD Live TeleHealth Services	**In-Network:** You pay $0 copay for access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical services. Doctors can diagnose and prescribe medications if medically necessary. Please call us for more details. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 for access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical services. Doctors can diagnose and prescribe medications if medically necessary. Please call us for more details. **Out-of-Network:** Not covered.
Nursing Hotline		
24/7 Nurse Advice Line	**In-Network:** A Zing Health Plan Registered Nurse is available at no cost to you 24 hours a day, 7 days a week by phone at: 1-855-4-ZHNURSE (1-855-494-6877). Nurses can evaluate health conditions based on signs & symptoms and may refer you to an urgent care and/or emergency room. **Out-of-Network:** Not covered.	**In-Network:** A Zing Health Plan Registered Nurse is available at no cost to you 24 hours a day, 7 days a week by phone at: 1-855-4-ZHNURSE (1-855-494-6877) . Nurses can evaluate health conditions based on signs & symptoms and may refer you to an urgent care and/or emergency room. **Out-of-Network:** Not covered.

Benefit Coverage	H7330-001 Zing Choice IL (HMO)	H7330-002 Zing Open Access IL (HMO-POS)
Note: Services with an * may require prior authorization or a referral.		
Safety Devices		
In-Home Safety Devices	**In-Network:** You pay $0 for In-Home safety devices. Plan approved items include: grab bar, handheld shower wand, toilet safety rail, bathtub assist bar, bath transfer bench (assembly, install and repair not included). **Out-of-Network:** Not covered.	**In-Network:** You pay $0 for In-Home safety devices. Plan approved items include: grab bar, hand held shower wand, toilet safety rail, bath tub assist bar, bath transfer bench (assembly, install and repair not included). **Out-of-Network:** Not covered.
Meal Benefit		
Re-admission Prevention Meals	**In-Network:** Readmission prevention meals benefit is covered. You get a maximum of 10 meals, for a total of 10 days after a hospitalization (limitations and exclusions apply). **Out-of-Network:** Not covered.	**In-Network:** Re-admission prevention meals benefit is covered. You get a maximum of 10 meals, for a total of 10 days after a hospitalization (limitations and exclusions apply). **Out-of-Network:** Not covered.

For a complete listing of your plan benefits and coverage, please refer to your Evidence of Coverage document or contact the plan for more detail.