Zing HEALTH™
Medicare Advantage Plan

Summary of Benefits

JANUARY 1, 2022 – DECEMBER 31, 2022

ILLINOIS (HMO)

H7330-001 Zing Choice IL (HMO)

Service Area: Cook, DeKalb, DuPage, Kankakee, and Lake Counties

H4624-001 Zing Choice IL (HMO)

Service Area: Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties

Y0149_2022-SB-001-HMO-IL_M

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Important Plan Information

Zing Health 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 does not 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)**, 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 following counties:

Zing Choice IL (HMO) H7330-001: Cook, DeKalb, DuPage, Kankakee, and Lake counties.

Zing Choice IL (HMO) H4624-001: Boone, Kane, McHenry, Ogle, Will and Winnebago counties.

What providers can I use?

Zing Choice IL (HMO) has a network of doctors, hospitals, pharmacies, and other providers. As a member, you must select an in-network primary care physician (PCP). Your plan does not require a referral to see a specialist. In some instances, a prior authorization may be required for some services you receive. Except in emergency situations or out-of-area urgently needed services, if you use providers that are not in our network, the plan may not pay for these services.

What are our hours of operation?

Hours of operation are between 8 a.m. and 8 p.m. Monday through Friday (from April 1 through September 30) and 8 a.m. to 8 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, review 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.

This document is available in other formats such as braille, large print or audio. This document is also available in Spanish. For additional information, call us at **1-866-946-4458**, (TTY users should call 711).

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

	H7330-001 Zing Choice IL (HMO) *Cook, DeKalb, DuPage, Kankakee, and Lake Counties*	H4624-001 Zing Choice IL (HMO) *Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties*
Monthly Premium	**$0** Monthly plan premium In addition, you must keep paying your Medicare Part B 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.	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 plans protect 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.	Yes. Like all Medicare health plans, our plans protect 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).	**$3,450** 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 Medicare covered medical and hospital services.	**$3,450** 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 Medicare covered medical and hospital services.

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Covered Medical and Hospital Benefits

Benefit Coverage Services with a [1] may require prior authorization.	**H7330-001** **Zing Choice IL (HMO)** ***Cook, DeKalb, DuPage, Kankakee, and Lake Counties***	**H4624-001** **Zing Choice IL (HMO)** ***Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties***
HOSPITAL COVERAGE		
Inpatient Hospital Coverage [1]	$250 copay per day for days 1 through 6 $0 per day for days 7 through 90 After day 90, your plan covers an unlimited number of days for an inpatient hospital stay.	$250 copay per day for days 1 through 6 $0 per day for days 7 through 90 After day 90, your plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage [1]	$300 copay for Outpatient Surgery at an Outpatient Hospital Facility. 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.	$300 copay for Outpatient Surgery at an Outpatient Hospital Facility. 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.
Ambulatory Surgical Center [1]	$200 copay for Outpatient Surgery at an Ambulatory Surgical Center.	$200 copay for Outpatient Surgery at an Ambulatory Surgical Center.
Primary Care Physician (PCP)	$0 copay per visit	$0 copay per visit
Telehealth	$0 copay per telehealth visit You can access board certified doctors and behavioral health specialist via phone and/or video technology for diagnosis and treatment of certain non-emergency medical conditions. Doctors can diagnose and prescribe medications if medically necessary. Please call us for more details.	$0 copay per telehealth visit You can access board certified doctors and behavioral health specialist via phone and/or video technology for diagnosis and treatment of certain non-emergency medical conditions. Doctors can diagnose and prescribe medications if medically necessary. Please call us for more details.
Specialists	$25 copay per visit	$25 copay per visit

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PREVENTIVE CARE		
• **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 screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)** • **Depression screening** • **Diabetes screenings** • **Glaucoma tests** • **Hepatitis B shots and screening** • **Hepatitis C screening test** • **HIV screening** • **Lung cancer screening** • **Medical nutrition therapy Services** • **Obesity screening and counseling** • **Prostate cancer screenings (PSA)** • **Sexually transmitted infections screening and counseling** • **Smoking and tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)** • **Vaccines, including Flu shots** • **"Welcome to Medicare" preventive visit (one time)** • **Annual Wellness visit**	Our plan covers many preventive services at no cost when you see an in-network provider.	Our plan covers many preventive services at no cost when you see an in-network provider.

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EMERGENCY CARE		
Emergency Care Services	$120 copay per visit If you are admitted to the hospital within 24 hours, the copay is waived.	$120 copay per visit If you are admitted to the hospital within 24 hours, the copay is waived.
Worldwide Emergency Care	$0 copay	$0 copay
URGENTLY NEEDED SERVICES		
Urgent Care Services	$10 copay per visit	$10 copay per visit
DIAGNOSTIC SERVICES/LABS/ IMAGING		
Diagnostic Tests and Procedures	$25 copay If a member receives multiple services on the same day, only the maximum copay applies.	$25 copay If a member receives multiple services on the same day, only the maximum copay applies.
Lab Services and X-Rays	$0 copay If a member receives multiple services on the same day at the same location, only the maximum copay applies.	$0 copay If a member receives multiple services on the same day at the same location, only the maximum copay applies.
Diagnostic Radiological Services (e.g., MRIs and CTR Scans) [1]	$50 to $150 copay Copayment may vary depending on the place of service. If a member receives multiple services on the same day at the same location, only the maximum copay applies.	$50 to $150 copay Copayment may vary depending on the place of service. If a member receives multiple services on the same day at the same location, only the maximum copay applies.
Therapeutic Radiological Services [1] **(e.g., radiation treatment for cancer)**	20% of the cost. If a member receives multiple services on the same day at the same location, only the maximum copay applies.	20% of the cost. If a member receives multiple services on the same day at the same location, only the maximum copay applies.

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HEARING SERVICES		
Hearing Exam (Medicare Covered)	$25 copay for a Medicare covered diagnostic hearing exam.	$25 copay for a Medicare covered diagnostic hearing exam.
Routine Hearing Exam	$0 copay for one (1) routine hearing exam per year. Not covered out-of-network.	$0 copay for one (1) routine hearing exam per year. Not covered out-of-network.
Hearing Aid Evaluation/ Fitting	$0 copay for one (1) hearing aid evaluation/fitting every three (3) years. Not covered out-of-network.	$0 copay for one (1) hearing aid evaluation/fitting every three (3) years. Not covered out-of-network.
Hearing Aids	**$750** benefit allowance towards hearing aids per ear every three (3) years. You are responsible for all cost beyond the maximum allowed amount. Not covered out-of-network.	**$750** benefit allowance towards hearing aids per ear every three (3) years. You are responsible for all cost beyond the maximum allowed amount. Not covered out-of-network.

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DENTAL SERVICES		
Preventive Dental Benefits	**In-Network:** $0 copay for 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 bitewing x-rays up to one (1) set per year $0 copay for panoramic x-rays for up to one (1) every five (5) years **$2,500** benefit allowance every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. Not covered out-of-network.	**In-Network:** $0 copay for 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 bitewing x-rays up to one (1) set per year $0 copay for panoramic x-rays for up to one (1) every five (5) years **$2,500** benefit allowance every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. Not covered out-of-network.

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DENTAL SERVICES *(continued)*		
Comprehensive Dental Benefits	**In-Network:** $0 copay for amalgam and/or composite filling every three (3) years per tooth $0 copay for extractions one (1) extraction per tooth, per year $0 copay for root canals one (1) per lifetime, per tooth $0 copay for scaling/root planning (deep cleaning) every (24) months per quadrant $0 copay for complete crown every five (5) years, per tooth $0 copay for dentures or fixed prosthetics/partials once every five (5) years **$2,500** benefit allowance every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. Not covered out-of-network.	**In-Network:** $0 copay for amalgam and/or composite filling every three (3) years per tooth $0 copay for extractions one (1) extraction per tooth, per year $0 copay for root canals one (1) per lifetime, per tooth $0 copay for scaling/root planning (deep cleaning) every (24) months per quadrant $0 copay for complete crown every five (5) years, per tooth $0 copay for dentures or fixed prosthetics/partials once every five (5) years **$2,500** benefit allowance every year for preventive and comprehensive dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. Not covered out-of-network.

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VISION SERVICES		
Eye Exams (Medicare-covered)	$25 copay for a Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).	$25 copay for a Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).
Routine Eye Exam	$0 copay for (1) routine eye exam/refraction up to (1) per year Not covered out-of-network.	$0 copay for (1) routine eye exam/refraction up to (1) per year Not covered out-of-network.
Eyewear (Medicare Covered)	$0 copay for one (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery.	$0 copay for one (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery.
Routine Eyewear	**$290** benefit allowance towards eyewear (frames and lenses or contact lenses) one (1) per year. You are responsible for all cost exceeding the maximum benefit amount for routine eyewear. Not covered out-of-network.	**$290** benefit allowance towards eyewear (frames and lenses or contact lenses) one (1) per year. You are responsible for all cost exceeding the maximum benefit amount for routine eyewear. Not covered out-of-network.

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MENTAL HEALTH SERVICES		
Inpatient Mental Health Services [1]	$250 copay per day for days 1 through 6 $0 per day for days 7 through 90 Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	$250 copay per day for days 1 through 6 $0 per day for days 7 through 90 Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.
Outpatient Mental Health Services	$25 copay for Medicare-covered individual therapy visits. $25 copay for Medicare-covered group therapy visits.	$25 copay for Medicare-covered individual therapy visits. $25 copay for Medicare-covered group therapy visits.
SKILLED NURSING		
Skilled Nursing Facility (SNF)[1]	$0 copay per day for days 1 through 20 $188 copay per day for days 21 through 100 Our plan covers up to 100 days per benefit period in a SNF.	$0 copay per day for days 1 through 20 $188 copay per day for days 21 through 100 Our plan covers up to 100 days per benefit period in a SNF.
THERAPY AND REHABILITATION SERVICES		
Occupational Therapy Services [1]	$20 copay per visit	$20 copay per visit
Physical Therapy and Speech-Language Therapy [1]	$20 copay per visit	$20 copay per visit
Cardiac and Pulmonary Rehabilitation Services	$0 copay per visit	$0 copay per visit

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AMBULANCE		
Ground Service (one-way trip)	$175 copay per date of service	$175 copay per date of service
Air Service (one-way trip)	20% coinsurance	20% coinsurance
TRANSPORTATION		
Non-Emergency Transportation Services	$0 copay for **24** one-way trips per year to plan approved locations. The member must contact the plan to arrange transportation. Not covered out-of-network.	$0 copay for **24** one-way trips per year to plan approved locations. The member must contact the plan to arrange transportation. Not covered out-of-network.
ADDITIONAL DRUG COVERAGE		
Medicare Part B Drugs [1]	20% coinsurance for chemotherapy drugs. 20% coinsurance for Part B drugs.	20% coinsurance for chemotherapy drugs. 20% coinsurance for Part B drugs.

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Part D Prescription Drugs

Benefit Coverage	H7330-001 Zing Choice IL (HMO) *Cook, DeKalb, DuPage, Kankakee, and Lake Counties*	H4624-001 Zing Choice IL (HMO) *Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties*
OUTPATIENT PRESCRIPTION DRUGS		
<u>If you don't have Extra Help for your drugs, you'll pay the following:</u> **Deductible Stage**	**$0** 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.	**$0** 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 Stage	You are in the Initial Coverage Stage until you reach **$4,430** in drug costs (year to date). You pay the following until your total yearly drug cost reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and your plan. Once you've reached this amount, you enter the coverage gap. As part of the Insulin Savings Program, you will pay no more than **$35** for a one-month supply for select insulins during the Initial Coverage Stage. Specialty drugs are limited to a 30-day supply. **This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil (Viagra) is available on Tier 2.**	You are in the Initial Coverage Stage until you reach **$4,430** in drug costs (year to date). You pay the following until your total yearly drug cost reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and your plan. Once you've reached this amount, you enter the coverage gap. As part of the Insulin Savings Program, you will pay no more than **$35** for a one-month supply for select insulins during the Initial Coverage Stage. Specialty drugs are limited to a 30-day supply. **This plan includes enhanced drug coverage of certain excluded drugs. Generic only Sildenafil (Viagra) is available on Tier 2.**

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OUTPATIENT PRESCRIPTION DRUGS *(continued)*

Standard Retail Cost-Sharing	30-day Supply	60-day Supply	90-day Supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$5 copay	$10 copay	$15 copay
Tier 3: Preferred Brand	$47 copay	$94 copay	$141 copay
Tier 4: Non-Preferred Brand	$100 copay	$200 copay	$300 copay
Tier 5: Specialty Tier	33% coinsurance	n/a	n/a
Standard Mail Order Cost-Sharing	**30-day Supply**	**60-day Supply**	**90-day Supply**
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$5 copay	$5 copay	$5 copay
Tier 3: Preferred Brand	$47 copay	$94 copay	$94 copay
Tier 4: Non-Preferred Brand	$100 copay	$200 copay	$200 copay
Tier 5: Specialty Tier	33% coinsurance	n/a	n/a
Out-of-Network and Long-Term Pharmacy	**31-day Supply**		
Tier 1: Preferred Generic	$0 copay		
Tier 2: Generic	$5 copay		
Tier 3: Preferred Brand	$47 copay		
Tier 4: Non-Preferred Brand	$100 copay		
Tier 5: Specialty Tier	33% coinsurance		

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OUTPATIENT PRESCRIPTION DRUGS *(continued)*		
Coverage Gap Stage	Most Medicare drug plans have a Coverage Gap (also called the "donut hole"). The coverage gap begins after you and your drug plan together have spent **$4,430** for covered drugs. After you enter the coverage gap, you pay **25%** of the plan's costs for covered brand name drugs and **25%** of the plan's cost for generic drugs until your cost total **$7,050**. During this stage, you will continue to pay the same retail, mail-order, and long-term care copay as in the Initial Coverage Stage for drugs on Tier 1. Also, during this stage, your out-of-pocket costs for select insulins will be up to **$35**. For generic drugs, the amount paid by the plan (**75%**) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. You will remain in the coverage gap stage until your drug costs total **$7,050**, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a Coverage Gap (also called the "donut hole"). The coverage gap begins after you and your drug plan together have spent **$4,430** for covered drugs. After you enter the coverage gap, you pay **25%** of the plan's costs for covered brand name drugs and **25%** of the plan's cost for generic drugs until your cost total **$7,050**. During this stage, you will continue to pay the same retail, mail-order, and long-term care copay as in the Initial Coverage Stage for drugs on Tier 1. Also, during this stage, your out-of-pocket costs for select insulins will be up to **$35**. For generic drugs, the amount paid by the plan (**75%**) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. You will remain in the coverage gap stage until your drug costs total **$7,050**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

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OUTPATIENT PRESCRIPTION DRUGS *(continued)*

Standard Retail Cost-Sharing	30-day Supply	60-day Supply	90-day Supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Standard Mail Order Cost-Sharing	**30-day Supply**	**60-day Supply**	**90-day Supply**
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Long-Term Pharmacy	**31-day Supply**		
Tier 1: Preferred Generic	$0 copay		

Catastrophic Coverage Stage	The Catastrophic Coverage Stage begins after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of:	The Catastrophic Coverage Stage begins after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of:
Drug Type	**Cost-Share Information**	**Cost-Share Information**
Generic/Preferred Multi-Source Drugs	• **5%** of the cost, or • **$3.95** copay (including brand drugs treated as generic)	• **5%** of the cost, or • **$3.95** copay (including brand drugs treated as generic)
Brand Name and Other Drugs	• **$9.85** copay for all other drugs	• **$9.85** copay for all other drugs

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the drug stages.

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.

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INSULIN SAVINGS PROGRAM

Insulin Savings Program	This plan participates in the Insulin Savings Program which provides reduced cost on select insulins through the first three drug stages (Deductible, Initial Coverage and Coverage Gap Stages). The Insulin Savings Program does not apply to the Catastrophic Coverage Stage. You are not eligible for this program if you receive Extra Help.

Standard Retail Cost-Sharing	30-day Supply	60-day Supply	90-day Supply
Tier 3: Preferred Brand	$35 copay	$70 copay	$105 copay
Standard Mail Order Cost-Sharing	**30-day Supply**	**60-day Supply**	**90-day Supply**
Tier 3: Preferred Brand	$35 copay	$70 copay	$70 copay

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Additional Benefits, Care and Services

Benefit Coverage Services with a [1] may require prior authorization.	**H7330-001** **Zing Choice IL (HMO)** ***Cook, DeKalb, DuPage, Kankakee, and Lake Counties***	**H4624-001** **Zing Choice IL (HMO)** ***Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties***
FOOT CARE (PODIATRY SERVICES)		
Podiatry Services (Medicare-covered)	$25 copay per visit	$25 copay per visit
Routine Podiatry Services	$20 copay for (4) visits per year Not covered out-of-network.	$20 copay for (4) visits per year Not covered out-of-network.
MEDICAL EQUIPMENT AND SUPPLIES		
Durable Medical Equipment (wheelchairs, oxygen, etc.) [1]	20% coinsurance per item Prior authorization is required for DME in the amount of $500 or more.	20% coinsurance per item Prior authorization is required for DME in the amount of $500 or more.
Prosthetic Devices (braces, artificial limbs, etc.) and Related Medical Supplies [1]	20% coinsurance per item Prior authorization is required for prosthetic devices in the amount of $500 or more.	20% coinsurance per item Prior authorization is required for prosthetic devices in the amount of $500 or more.
Diabetes Supplies and Services	$0 copay for preferred diabetic test strips and monitoring supplies 20% coinsurance for non-preferred diabetic test strips and monitoring supplies $0 copay for diabetes self-management training 20% coinsurance for therapeutic shoes or shoe inserts	$0 copay for preferred diabetic test strips and monitoring supplies 20% coinsurance for non-preferred diabetic test strips and monitoring supplies $0 copay for diabetes self-management training 20% coinsurance for therapeutic shoes or shoe inserts

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Benefit Coverage Services with a [1] may require prior authorization.	**H7330-001** **Zing Choice IL (HMO)** ***Cook, DeKalb, DuPage, Kankakee, and Lake Counties***	**H4624-001** **Zing Choice IL (HMO)** ***Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties***
CHIROPRACTIC CARE		
Chiropractic Services (Medical Covered)	$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).	$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).
HOME HEALTH CARE		
Home Health Care [1] (Medicare-covered)	$0 copay	$0 copay
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 [1]	$25 copay per visit	$25 copay per visit
Opioid Treatment Services [1]	$25 copay per visit	$25 copay per visit
RENAL DIALYSIS		
Renal Dialysis [1]	20% of the cost for Medicare-covered dialysis treatments. $0 copay for kidney disease education services.	20% of the cost for Medicare-covered dialysis treatments. $0 copay for kidney disease education services.

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Wellness Programs

Additional Covered Benefits	H7330-001 Zing Choice IL (HMO) *Cook, DeKalb, DuPage, Kankakee, and Lake Counties*	H4624-001 Zing Choice IL (HMO) *Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties*
OVER-THE-COUNTER (OTC) ITEMS		
Over-the-Counter (OTC) **Your coverage includes OTC items, medications and products.**	**$75** every (3) months for OTC items. The OTC debit card allows members to purchase health related items from retail pharmacies as well as mail order purchases. Any remaining balance will not roll over to the next OTC quarter. You can order: • Online – visit NationsOTC.com/ZingHealth • By Phone – call a NationsOTC Member Experience Advisor at 1-877-273-3381 (TTY: 711), 24 hours a day, seven days a week, 365 days a year. • By Mail – Fill out and return the order form in the NationsOTC/Zing Health product catalog. • Retail – through an approved, in network retailer Please visit our website at **www.myzinghealth.com** to see our list of covered over-the-counter items. Not covered out-of-network.	**$75** every (3) months for OTC items. The OTC debit card allows members to purchase health related items from retail pharmacies as well as mail order purchases. Any remaining balance will not roll over to the next OTC quarter. You can order: • Online – visit NationsOTC.com/ZingHealth • By Phone – call a NationsOTC Member Experience Advisor at 1-877-273-3381 (TTY: 711), 24 hours a day, seven days a week, 365 days a year. • By Mail – Fill out and return the order form in the NationsOTC/Zing Health product catalog. • Retail – through an approved, in network retailer Please visit our website at **www.myzinghealth.com** to see our list of covered over-the-counter items. Not covered out-of-network.

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MEAL BENEFIT		
Healthy Foods Card (Grocery Debit Card) **Members must have one or more of the following chronic condition categories:** **1. Chronic alcohol and other drug dependence** **2. Autoimmune disorders** **3. Cancer, excluding pre-cancer conditions or in-situ status** **4. Cardiovascular disorders** **5. Chronic heart failure** **6. Dementia** **7. Diabetes mellitus** **8. End-stage liver disease** **9. End-stage renal disease (ESRD) requiring dialysis** **10. Severe hematologic disorders** **11. HIV/AIDS** **12. Chronic lung disorders** **13. Chronic and disabling mental health conditions** **14. Neurologic disorders** **15. Stroke**	Members with a qualifying chronic condition can purchase plan-approved food products through a **mail** order solution or at participating **retail** locations using their physical card. Members receive a **$25** monthly allowance to buy healthy foods and produce. For a complete list of qualifying chronic conditions, please call Customer Service or reference your Evidence of Coverage booklet. Not covered out-of-network.	Members with a qualifying chronic condition can purchase plan-approved food products through a **mail** order solution or at participating **retail** locations using their physical card. Members receive a **$25** monthly allowance to buy healthy foods and produce. For a complete list of qualifying chronic conditions, please call Customer Service or reference your Evidence of Coverage booklet. Not covered out-of-network.
Re-admission Prevention Meals	You pay nothing for post-acute meals immediately following an Inpatient Hospital stay to aid in nutritional recovery. Plan covers a maximum of 3 meals per day for up to 10 days for a maximum of 10 meals (limitations and exclusions apply). Not covered out-of-network.	You pay nothing for post-acute meals immediately following an Inpatient Hospital stay to aid in nutritional recovery. Plan covers a maximum of 3 meals per day for up to 10 days for a maximum of 10 meals (limitations and exclusions apply). Not covered out-of-network.

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IN-HOME SUPPORT SERVICES		
In-Home Senior Assistance	PAPA, Inc. combats loneliness and social isolation by connecting PAPA Pals with our members for companionship and help with Instrumental Activities of Daily Living (IADL). PAPA Pals assist members with services including but not limited to grocery shopping, medication pick up, doctor's appointments, technical guidance, reminders, light house help, light exercise and activity. PAPA Pals can support our members either in their homes or virtually. Members are eligible for **30 hours per year** of PAPA services. Contact Customer Service for more information. Not covered out-of-network.	PAPA, Inc. combats loneliness and social isolation by connecting PAPA Pals with our members for companionship and help with Instrumental Activities of Daily Living (IADL). PAPA Pals assist members with services including but not limited to grocery shopping, medication pick up, doctor's appointments, technical guidance, reminders, light house help, light exercise and activity. PAPA Pals can support our members either in their homes or virtually. Members are eligible for **30 hours per year** of PAPA services. Contact Customer Service for more information. Not covered out-of-network.
HEALTH CLUB MEMBERSHIPS		
Silver & Fit Fitness®	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. Not covered out-of-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. Not covered out-of-network.

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HEALTH CLUB MEMBERSHIPS *(continued)*		
Weight Management Program	Your plan also provides complimentary vouchers for membership in the Weight Watchers program. Weight Watchers meals are not covered. Not covered out-of-network.	Your plan also provides complimentary vouchers for membership in the Weight Watchers program. Weight Watchers meals are not covered. Not covered out-of-network.
NURSING HOTLINE		
24/7 Nurse Advice Line	Members may call the Nurse Advice Line with questions about health-related issues, symptoms you may be experiencing, and to get advice about seeing a doctor or going to the hospital. A 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) Not covered out-of-network.	Members may call the Nurse Advice Line with questions about health-related issues, symptoms you may be experiencing, and to get advice about seeing a doctor or going to the hospital. A 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) Not covered out-of-network.

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SAFETY DEVICES		
In-Home Safety Devices	$0 copay Your plan covers approved in-home safety devices of the following items: grab bar, hand-held shower wand, toilet safety rail, bathtub assist bar, raised toilet seat, bedside commode, bath bench, bath transfer bench (assembly, install and repair not included). Not covered out-of-network.	$0 copay Your plan covers approved in-home safety devices of the following items: grab bar, hand-held shower wand, toilet safety rail, bathtub assist bar, raised toilet seat, bedside commode, bath bench, bath transfer bench (assembly, install and repair not included). Not covered out-of-network.

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.