



# Summary of Benefits

JANUARY 1, 2023 - DECEMBER 31, 2023

## ILLINOIS (HMO-POS)

H7330-002 Zing Open Access IL (HMO-POS)

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

H4624-002 Zing Open Access IL (HMO-POS)

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

## Important Plan Information

Zing Health is a HMO-POS with a Medicare contract. Enrollment in Zing Health 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 to 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](http://www.myzinghealth.com)**.

## Who can join?

To join **Zing Open Access IL (HMO-POS)**, you must be entitled to Medicare Part A and be enrolled in Part B and live in the plans service area. The service area includes the following counties:

Zing Open Access IL (HMO-POS) H7330-002: Cook, DeKalb, DuPage, Kankakee and Lake counties.

Zing Open Access IL (HMO-POS) H4624-002: Boone, Kane, McHenry, Ogle, Will and Winnebago counties.

## What providers can I use?

**Zing Open Access (HMO-POS)** 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.

The point of service (POS) option allows you to go out-of-network for certain services. The out-of-network provider must agree to accept the plan's terms and conditions for service. This is called an HMO with a point-of-service (POS) option.

## 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](http://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](http://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).

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

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**H4624-002**  
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<b>Monthly Premium</b>  If you get Extra Help paying for your prescription drugs, your premium or a portion of your premium may be paid by Extra Help.	<b>\$25</b> Monthly plan premium  In addition, you must keep paying your Medicare Part B premium.	<b>\$25</b> Monthly plan premium  In addition, you must keep paying your Medicare Part B premium.
<b>Plan Deductible</b>	This plan does not have a deductible.	This plan does not have a deductible.
<b>Is there any limit on how much I will pay for my covered services?</b>	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.
<b>Yearly Maximum Out-of-Pocket responsibility? (Does not include prescription drugs).</b>	<b>Combined In and Out-of-Network Out-of-Pocket Maximum</b>  <b>\$3,650</b> is the most you'll pay for covered services you receive from in-network and out-of-network providers combined.  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.	<b>Combined In and Out-of-Network Out-of-Pocket Maximum</b>  <b>\$3,650</b> is the most you'll pay for covered services you receive from in-network and out-of-network providers combined.  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.

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## HOSPITAL COVERAGE

### Inpatient Hospital Coverage <sup>1</sup>

#### **In-Network:**

\$275 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.

#### **Out-of-Network:**

Same as In-Network

#### **In-Network:**

\$275 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.

#### **Out-of-Network:**

Same as In-Network

### Outpatient Hospital Coverage <sup>1</sup>

#### **In-Network:**

\$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.

#### **Out-of-Network:**

Same as In-Network

#### **In-Network:**

\$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.

#### **Out-of-Network:**

Same as In-Network

### Ambulatory Surgical Center <sup>1</sup>

#### **In-Network:**

\$200 copay for Outpatient Surgery at an Ambulatory Surgical Center.

#### **Out-of-Network:**

Same as In-Network

#### **In-Network:**

\$200 copay for Outpatient Surgery at an Ambulatory Surgical Center.

#### **Out-of-Network:**

Same as In-Network

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## HOSPITAL COVERAGE *(continued)*

<b>Primary Care Physician (PCP)</b>	<p><b>In-Network:</b></p> <p>\$0 copay per visit</p> <p>Not covered out-of-network.</p>	<p><b>In-Network:</b></p> <p>\$0 copay per visit</p> <p>Not covered out-of-network.</p>
<b>TeleHealth</b>	<p><b>In-Network:</b></p> <p>\$0 copay per telehealth visit.</p> <p>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 services.</p> <p>Doctors can diagnose and prescribe medications if medically necessary.</p> <p>Please call us for more details.</p> <p>Not covered out-of-network.</p>	<p><b>In-Network:</b></p> <p>\$0 copay per telehealth visit.</p> <p>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 services.</p> <p>Doctors can diagnose and prescribe medications if medically necessary.</p> <p>Please call us for more details.</p> <p>Not covered out-of-network.</p>
<b>Specialists</b>	<p><b>In-Network:</b></p> <p>\$25 copay per visit</p> <p><b>Out-of-Network:</b></p> <p>Same as In-Network</p>	<p><b>In-Network:</b></p> <p>\$25 copay per visit</p> <p><b>Out-of-Network:</b></p> <p>Same as In-Network</p>

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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

### In-Network:

Our plan covers many preventive services at no cost.

### Out-of-Network:

Same as In-Network

### In-Network:

Our plan covers many preventive services at no cost.

### Out-of-Network:

Same as In-Network

## Benefit Coverage

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## EMERGENCY CARE

### Emergency Care Services

\$125 copay per visit  
  
 If you are admitted to the hospital within 24 hours, the copay is waived.

\$125 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 <sup>1</sup>

**In-Network:**  
 \$25 copay  
  
**Out-of-Network:**  
 Same as In-Network  
  
 If a member receives multiple services on the same day, only the maximum copay applies.

**In-Network:**  
 \$25 copay  
  
**Out-of-Network:**  
 Same as In-Network  
  
 If a member receives multiple services on the same day, only the maximum copay applies.

### Lab Services <sup>1</sup>

**In-Network:**  
 \$0 copay  
  
**Out-of-Network:**  
 Same as In-Network  
  
 If a member receives multiple services on the same day, only the maximum copay applies.

**In-Network:**  
 \$0 copay  
  
**Out-of-Network:**  
 Same as In-Network  
  
 If a member receives multiple services on the same day, only the maximum copay applies.

## Benefit Coverage

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## DIAGNOSTIC SERVICES/LABS/ IMAGING (continued)

### X-Ray Services

**In-Network:**

\$0 copay

If a member receives multiple services on the same day at the same location, only the maximum copay applies.

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$0 copay

If a member receives multiple services on the same day at the same location, only the maximum copay applies.

**Out-of-Network:**

Same as In-Network

### Diagnostic Radiological Services <sup>1</sup> (e.g., MRIs and CTR Scans)

**In-Network:**

\$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.

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$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.

**Out-of-Network:**

Same as In-Network

### Therapeutic Radiological Services <sup>1</sup> (e.g., radiation treatment for cancer)

**In-Network:**

20% of the cost.

If a member receives multiple services on the same day at the same location, only the maximum copay applies.

**Out-of-Network:**

Same as In-Network

**In-Network:**

20% of the cost.

If a member receives multiple services on the same day at the same location, only the maximum copay applies.

**Out-of-Network:**

Same as In-Network



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## HEARING SERVICES

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

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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 x-rays up to one (1) set per year

**\$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 x-rays up to one (1) set per year

**\$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.

## Benefit Coverage

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## DENTAL SERVICES *(continued)*

### Comprehensive Dental Benefits

#### In-Network:

You pay \$0 for Medicare-covered services

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)

**\$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:

You pay \$0 for Medicare-covered services

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)

**\$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.

## Benefit Coverage

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## VISION SERVICES

**Eye Exams  
(Medicare-covered)**

**In-Network:**

\$25 copay for a Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$25 copay for a Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).

**Out-of-Network:**

Same as In-Network

**Routine Eye Exam**

**In-Network:**

\$0 copay for (1) routine eye exam/refraction up to (1) per year  
  
Not covered out-of-network.

**In-Network:**

\$0 copay for (1) routine eye exam/refraction up to (1) per year  
  
Not covered out-of-network.

**Eyewear (Medicare Covered)**

**In-Network:**

\$0 copay for one (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery.

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$0 copay for one (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery.

**Out-of-Network:**

Same as In-Network

**Routine Eyewear**

**In-Network:**

**\$400** benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts.

You are responsible for all cost exceeding the maximum benefit amount for routine eyewear.

Not covered out-of-network.

**In-Network:**

**\$400** benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts.

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 <sup>1</sup>

**In-Network:**

\$275 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.

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$275 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.

**Out-of-Network:**

Same as In-Network

### Outpatient Mental Health Services

**In-Network:**

\$25 copay for Medicare-covered individual therapy visits.

\$25 copay for Medicare-covered group therapy visits.

**Out-of-Network:**

Same as In-Network

Prior authorization may be required.

**In-Network:**

\$25 copay for Medicare-covered individual therapy visits.

\$25 copay for Medicare-covered group therapy visits.

**Out-of-Network:**

Same as In-Network

Prior authorization may be required.

## SKILLED NURSING

### Skilled Nursing Facility (SNF)<sup>1</sup>

**In-Network:**

\$0 copay per day for days 1 through 20

\$196 copay per day for days 21 through 100

Our plan covers up to 100 days per benefit period in a SNF.

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$0 copay per day for days 1 through 20

\$196 copay per day for days 21 through 100

Our plan covers up to 100 days per benefit period in a SNF.

**Out-of-Network:**

Same as In-Network

## Benefit Coverage

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## THERAPY AND REHABILITATION SERVICES

### Occupational Therapy Services <sup>1</sup>

**In-Network:**  
 \$20 copay per visit  
**Out-of-Network:**  
 Same as In-Network

**In-Network:**  
 \$20 copay per visit  
**Out-of-Network:**  
 Same as In-Network

### Physical Therapy and Speech-Language Therapy <sup>1</sup>

**In-Network:**  
 \$20 copay per visit  
**Out-of-Network:**  
 Same as In-Network

**In-Network:**  
 \$20 copay per visit  
**Out-of-Network:**  
 Same as In-Network

### Cardiac and Pulmonary Rehabilitation Services <sup>1</sup>

**In-Network:**  
 \$0 copay per visit  
**Out-of-Network:**  
 Same as In-Network

**In-Network:**  
 \$0 copay per visit  
**Out-of-Network:**  
 Same as In-Network

## AMBULANCE

### Ground Service (one-way trip)

\$175 copay

\$175 copay

### Air Service (one-way trip)

20% coinsurance

20% coinsurance

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<p><b>TRANSPORTATION</b></p>		
<p><b>Non-Emergency Transportation Services</b></p>	<p><b>In-Network:</b></p> <p>\$0 copay for <b>24</b> one-way trips per year to plan approved health-related locations. The member must contact the plan to arrange transportation.</p> <p>Not covered out-of-network.</p>	<p><b>In-Network:</b></p> <p>\$0 copay for <b>24</b> one-way trips per year to plan approved health-related locations. The member must contact the plan to arrange transportation.</p> <p>Not covered out-of-network.</p>
<p><b>ADDITIONAL DRUG COVERAGE</b></p>		
<p><b>Medicare Part B Drugs <sup>1</sup></b></p>	<p><b>In-Network:</b></p> <p>20% coinsurance for chemotherapy drugs.</p> <p>20% coinsurance for Part B drugs.</p> <p><b>Out-of-Network:</b></p> <p>Same as In-Network</p>	<p><b>In-Network:</b></p> <p>20% coinsurance for chemotherapy drugs.</p> <p>20% coinsurance for Part B drugs.</p> <p><b>Out-of-Network:</b></p> <p>Same as In-Network</p>

## Part D Prescription Drugs

### Benefit Coverage

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### PART D PRESCRIPTION DRUGS

#### Stage 1: 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.

#### Stage 2: Initial Coverage Stage

You are in the Initial Coverage Stage until your total yearly drug cost reach **\$4,660**. Total yearly drug cost are the total drug costs paid both you and the plan.

Once you've reached this amount, you enter the coverage gap.

Standard Retail Cost-Sharing	30-day Supply	100-day Supply	30-day Supply	100-day Supply
<b>Tier 1: Preferred Generic Select Insulins</b>	\$0 copay \$0 copay	\$0 copay \$0 copay	\$0 copay \$0 copay	\$0 copay \$0 copay
<b>Tier 2: Generic</b>	\$5 copay	\$15 copay	\$5 copay	\$15 copay
<b>Tier 3: Preferred Brand</b>	\$47 copay	\$141 copay	\$47 copay	\$141 copay
<b>Tier 4: Non-Preferred Drug</b>	\$100 copay	\$300 copay	\$100 copay	\$300 copay
<b>Tier 5: Specialty Tier</b>	33% coinsurance	Not Covered	33% coinsurance	Not Covered
Standard Mail Order Cost-Sharing	30-day Supply	100-day Supply	30-day Supply	100-day Supply
<b>Tier 1: Preferred Generic Select Insulins</b>	\$0 copay \$0 copay	\$0 copay \$0 copay	\$0 copay \$0 copay	\$0 copay \$0 copay
<b>Tier 2: Generic</b>	\$0 copay	\$0 copay	\$0 copay	\$0 copay
<b>Tier 3: Preferred Brand</b>	\$47 copay	\$94 copay	\$47 copay	\$94 copay
<b>Tier 4: Non-Preferred Drug</b>	\$100 copay	\$200 copay	\$100 copay	\$200 copay
<b>Tier 5: Specialty Tier</b>	33% coinsurance	Not Covered	33% coinsurance	Not Covered
Out-of-Network and Long-Term Pharmacy	OON 30-day Supply LTC 31-day Supply		OON 30-day Supply LTC 31-day Supply	
<b>Tier 1: Preferred Generic</b>	\$0 copay		\$0 copay	
<b>Tier 2: Generic</b>	\$5 copay		\$5 copay	
<b>Tier 3: Preferred Brand</b>	\$47 copay		\$47 copay	
<b>Tier 4: Non-Preferred Drug</b>	\$100 copay		\$100 copay	
<b>Tier 5: Specialty Tier</b>	33% coinsurance		33% coinsurance	



## Benefit Coverage

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**Zing Open Access IL**  
**(HMO-POS)**  
*Cook, DeKalb, DuPage, Kankakee, and Lake Counties*

**H4624-002**  
**Zing Open Access IL**  
**(HMO-POS)**  
*Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties*

## PART D PRESCRIPTION DRUGS *(continued)*

### Coverage Gap Stage

Most Medicare drug plans have a Coverage Gap Stage (also called the “donut hole”). The Coverage Gap Stage begins after you and your drug plan together have spent **\$4,660** 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 **\$7,400**.

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 **\$7,400**, which is the end of the coverage gap.

During this stage, you will continue to pay **\$0** cost-share for select insulins and tier 1 drugs.

Not everyone will enter the coverage gap.

### 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 **\$7,400**, you pay the greater of:

### Drug Type

### Cost-Share Information

#### Generic/Preferred Multi-Source Drugs

- **5%** of the cost, or
- **\$4.15** copay (including brand drugs treated as generic)

#### Brand Name and Other Drugs

- **\$10.35** copay for all other drugs

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.

## Additional Benefits, Care and Services

<b>Benefit Coverage</b> <b>Services with a <sup>1</sup> may require prior authorization.</b>	<b>H7330-002</b> <b>Zing Open Access IL (HMO-POS)</b> <i>Cook, DeKalb, DuPage, Kankakee, and Lake Counties</i>	<b>H4624-002</b> <b>Zing Open Access IL (HMO-POS)</b> <i>Boone, Kane, McHenry, Ogle, Will, and Winnebago Counties</i>
<b>FOOT CARE (PODIATRY SERVICES)</b>		
<b>Podiatry Services (Medicare-covered)</b>	<b>In-Network:</b> \$25 copay per visit  <b>Out-of-Network:</b> Same as In-Network  Prior authorization may be required.	<b>In-Network:</b> \$25 copay per visit  <b>Out-of-Network:</b> Same as In-Network  Prior authorization may be required.
<b>Routine Podiatry Services</b>	<b>In-Network:</b> \$20 copay for (4) visits per year  Not covered out-of-network.	<b>In-Network:</b> \$20 copay for (4) visits per year  Not covered out-of-network.
<b>MEDICAL EQUIPMENT AND SUPPLIES</b>		
<b>Durable Medical Equipment (wheelchairs, oxygen, etc.) <sup>1</sup></b>	<b>In-Network:</b> 20% coinsurance per item  Prior authorization is required for DME in the amount of \$1,500 or more.  <b>Out-of-Network:</b> Same as In-Network	<b>In-Network:</b> 20% coinsurance per item  Prior authorization is required for DME in the amount of \$1,500 or more.  <b>Out-of-Network:</b> Same as In-Network
<b>Prosthetic Devices (braces, artificial limbs, etc.) <sup>1</sup></b>	<b>In-Network:</b> 20% coinsurance per item  Prior authorization is required for prosthetic devices in the amount of \$1,500 or more.  <b>Out-of-Network:</b> Same as In-Network	<b>In-Network:</b> 20% coinsurance per item  Prior authorization is required for prosthetic devices in the amount of \$1,500 or more.  <b>Out-of-Network:</b> Same as In-Network

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## MEDICAL EQUIPMENT AND SUPPLIES *(continued)*

### Diabetes Supplies and Services

**In-Network:**

\$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

**Out-of-Network:**

Same as In-Network

Prior authorization may be required.

**In-Network:**

\$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

**Out-of-Network:**

Same as In-Network

Prior authorization may be required.

## CHIROPRACTIC CARE

### Chiropractic Services (Medical Covered)

**In-Network:**

\$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:**

Same as In-Network

Prior authorization may be required.

**In-Network:**

\$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:**

Same as In-Network

Prior authorization may be required.

### 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.

Not covered out-of-network.

**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.

Not covered out-of-network.

## HOME HEALTH CARE

### Home Health Care (Medicare-covered)

**In-Network:**

\$0 copay

**Out-of-Network:**

Same as In-Network

Prior authorization may be required.

**In-Network:**

\$0 copay

**Out-of-Network:**

Same as In-Network

Prior authorization may be required.

## Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

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## HOSPICE

### Hospice Care

You must get your care from a Medicare-certified hospice provider.

You pay part of the cost for outpatient drugs.

You must get your care from a Medicare-certified hospice provider.

You pay part of the cost for outpatient drugs.

## OUTPATIENT SUBSTANCE ABUSE

### Individual and Group Therapy Visit <sup>1</sup>

**In-Network:**

\$25 copay per visit

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$25 copay per visit

**Out-of-Network:**

Same as In-Network

### Opioid Treatment Services <sup>1</sup>

**In-Network:**

\$25 copay per visit

**Out-of-Network:**

Same as In-Network

**In-Network:**

\$25 copay per visit

**Out-of-Network:**

Same as In-Network

## RENAL DIALYSIS

### Renal Dialysis

**In-Network:**

20% of the cost for Medicare-covered dialysis treatments.

\$0 copay for kidney disease education services.

Not covered out-of-network.

**In-Network:**

20% of the cost for Medicare-covered dialysis treatments.

\$0 copay for kidney disease education services.

Not covered out-of-network.

## Wellness Programs

### Additional Covered Benefits

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### OVER-THE-COUNTER (OTC) ITEMS

#### Over-the-Counter (OTC)

Your coverage includes OTC items, medications and products.

#### In-Network:

**\$100** 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.

#### In-Network:

**\$100** 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.

## Additional Covered Benefits

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### MEAL BENEFIT

#### Special Supplemental Benefits for the Chronically Ill 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

#### In-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 **\$35** monthly allowance to buy healthy foods and produce.

For a complete list of qualifying chronic conditions, please see the Benefit Features section of this booklet or call Customer Service or reference your Evidence of Coverage booklet.

Not covered out-of-network.

#### In-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 **\$35** monthly allowance to buy healthy foods and produce.

For a complete list of qualifying chronic conditions, please see the Benefit Features section of this booklet or call Customer Service or reference your Evidence of Coverage booklet.

Not covered out-of-network.

#### Re-admission Prevention Meals

#### In-Network:

\$0 copay

Zing's re-admission prevention benefit is for 10 meals after each discharge.

Not covered out-of-network.

#### In-Network:

\$0 copay

Zing's re-admission prevention benefit is for 10 meals after each discharge.

Not covered out-of-network.

## Additional Covered Benefits

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## IN-HOME SUPPORT SERVICES

### PAPA In-Home Senior Assistance

#### **In-Network:**

\$0 copay

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.

Not covered out-of-network.

#### **In-Network:**

\$0 copay

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.

Not covered out-of-network.

## HEALTH CLUB MEMBERSHIPS

### Silver & Fit Fitness®

#### **In-Network:**

\$0 copay

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.

#### **In-Network:**

\$0 copay

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.

## Additional Covered Benefits

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*Boone, Kane, McHenry, Ogle, Will,  
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## HEALTH CLUB MEMBERSHIPS *(continued)*

### Weight Management Program

**In-Network:**

\$0 copay

Your plan also provides complimentary vouchers for membership in the Weight Watchers program.

Weight Watchers meals are not covered.

Not covered out-of-network.

**In-Network:**

\$0 copay

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

**In-Network:**

\$0 copay

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.

**In-Network:**

\$0 copay

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.



## Additional Covered Benefits

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**H4624-002**  
**Zing Open Access IL**  
**(HMO-POS)**  
*Boone, Kane, McHenry, Ogle, Will,*  
*and Winnebago Counties*

## SAFETY DEVICES

### In-Home Safety Devices

#### **In-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.

#### **In-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.

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-946-4458 (TTY users should call 711).

## Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [www.myzinghealth.com](http://www.myzinghealth.com) or call 1-866-946-4458 (TTY users should call 711) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- For our Health Maintenance Organization (HMO) plans only, these plans except in emergency or urgent situations, do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- For our Health Maintenance Organization Point of Service (HMO-POS) plans only, these plans allow you to see providers outside of our network (non-contracted providers). However, while we pay for certain covered services provided by a non-contractee provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- For our Chronic Condition Special Needs plans (CSNP) only, your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- For our Dual Eligible Special Needs plans (DSNP) only, your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Zing Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

# Notice of Non-Discrimination

## **Discrimination is against the law.**

Zing Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Zing Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Zing Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Customer Service at 1-866-946-4458 (TTY 711).

If you believe that Zing Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Zing Health  
Civil Rights Coordinator  
225 W. Washington Street, Suite 450  
Chicago, Illinois 60606  
Phone: 1-866-946-4458, TTY number 711  
Fax: 1-866-946-4458  
Email: [civilrightscoordinator@myzinghealth.com](mailto:civilrightscoordinator@myzinghealth.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Zing Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

# Aviso de no discriminación

## La discriminación es ilegal.

Zing Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Zing Health no excluye a las personas ni las trata de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

Zing Health:

- Brinda asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen efectivamente con nosotros, tales como:
  - o Intérpretes calificados en el lenguaje de signos
  - o Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Brinda servicios gratuitos de idiomas a personas cuyo idioma principal no es el inglés, como:
  - o Intérpretes calificados
  - o Información escrita en otros idiomas.

Si necesita estos servicios, comuníquese con Servicio al Cliente al 1-866-946-4458 (TTY 711).

Si cree que Zing Health no ha brindado estos servicios o ha discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante:

Zing Health  
Civil Rights Coordinator  
225 W. Washington Street, Suite 450  
Chicago, Illinois 60606  
Teléfono: 1-866-946-4458, número TTY 711  
Fax: 1-866-946-4458

Correo electrónico: [civilrightscordinator@myzinghealth.com](mailto:civilrightscordinator@myzinghealth.com)

Puede presentar una queja por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja, un Coordinador de Derechos Civiles de Zing Health está disponible para ayudarlo.

También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los EE. UU., Oficina de Derechos Civiles, electrónicamente a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o teléfono a:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

# Multi-language Interpreter Services / Servicios de interpretación multilingüe

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-946-4458 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-946-4458 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-946-4458 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-946-4458 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-946-4458 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-946-4458 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-946-4458 (TTY: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-946-4458 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-946-4458 (TTY: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-946-4458 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة. 1-866-946-4458 (TTY: 711) فوري، ليس عليك سوى الاتصال بنا على مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-946-4458 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-946-4458 (TTY: 711). Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-946-4458 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-946-4458 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-866-946-4458 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。