Zing HEALTH™
MEDICARE REIMAGINED

OAK STREET HEALTH

Summary of Benefits

JANUARY 1, 2023 – DECEMBER 31, 2023

ILLINOIS (HMO-POS)

H7330-004 Zing Signature Care IL (HMO-POS)

Service Area: Cook County

Y0149_2023-SB-004-SignatureCare-HMO-POS-IL_M

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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**.

Who can join?

To join **Zing Signature Care 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: Cook.

What providers can I use?

Zing Signature Care IL (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. As a member, you must select an Oak Street Health (OSH) primary care provider (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**.
- 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

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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 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).	**Combined In and Out-of-Network Out-of-Pocket Maximum** **$3,450** 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.

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Benefit Coverage

Services with a [1] may require prior authorization.

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HOSPITAL COVERAGE

Inpatient Hospital Coverage [1]	**In-Network:** $250 copay per day for days 1 through 5 $0 per day for days 6 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 [1]	**In-Network:** $250 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 [1]	**In-Network:** $150 copay for Outpatient Surgery at an Ambulatory Surgical Center. **Out-of-Network:** Same as In-Network
Primary Care Physician (PCP)	**In-Network:** $0 copay per visit Not covered out-of-network.

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Benefit Coverage **Services with a [1] may require prior authorization.**	H7330-004 Zing Signature Care IL (HMO-POS) *Cook County*

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HOSPITAL COVERAGE *(continued)*

TeleHealth	**In-Network:** $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 services. Doctors can diagnose and prescribe medications if medically necessary. Please call us for more details. Not covered out-of-network.
Specialists	**In-Network:** $20 copay per visit Not covered out-of-network.

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Benefit Coverage

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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.

Not covered out-of-network.

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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.
Worldwide Emergency Care	$0 copay

URGENTLY NEEDED SERVICES

Urgent Care Services	$10 copay per visit

DIAGNOSTIC SERVICES/LABS/ IMAGING

Diagnostic Tests and Procedures [1]	**In-Network:** $25 copay If a member receives multiple services on the same day, only the maximum copay applies. Not covered out-of-network.

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DIAGNOSTIC SERVICES/LABS/ IMAGING *(continued)*

Lab Services [1]	**In-Network:** $0 copay If a member receives multiple services on the same day, only the maximum copay applies. Not covered out-of-network.
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. Not covered out-of-network.
Diagnostic Radiological Services [1] (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. Not covered out-of-network.
Therapeutic Radiological Services [1] (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. Not covered out-of-network

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HEARING SERVICES

Hearing Exam (Medicare Covered)	**In-Network:** $20 copay for a Medicare covered diagnostic hearing exam. Not covered out-of-network.
Routine Hearing Exam	**In-Network:** $0 copay for one (1) routine hearing exam per year. Not covered out-of-network.
Hearing Aid Evaluation/ Fitting	**In-Network:** $0 copay for one (1) hearing aid evaluation/fitting every three (3) years Not covered out-of-network.
Hearing Aids	**In-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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Benefit Coverage

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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

$0 copay for panoramic x-rays for up to one (1) every five (5) years

$3,000 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.

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)

$3,000 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)	**In-Network:** $20 copay for a Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). Not covered out-of-network.
Routine Eye Exam	**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. Not covered out-of-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.

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MENTAL HEALTH SERVICES

Inpatient Mental Health Services [1]	**In-Network:** $250 copay per day for days 1 through 5 $0 per day for days 6 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:** $20 copay for Medicare-covered individual therapy visits. $20 copay for Medicare-covered group therapy visits. Not covered out-of-network.

SKILLED NURSING

Skilled Nursing Facility (SNF)[1]	**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. Not covered out-of-network.

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THERAPY AND REHABILITATION SERVICES

Occupational Therapy Services [1]	**In-Network:** $20 copay per visit Not covered out-of-network.
Physical Therapy and Speech-Language Therapy [1]	**In-Network:** $20 copay per visit Not covered out-of-network.
Cardiac and Pulmonary Rehabilitation Services [1]	**In-Network:** $0 copay per visit Not covered out-of-network.

AMBULANCE

Ground Service (one-way trip)	$175 copay per date of service
Air Service (one-way trip)	20% coinsurance

TRANSPORTATION

Non-Emergency Transportation Services	**In-Network:** $0 copay for **unlimited** one-way trips per year to plan approved health-related locations. The member must contact the plan to arrange transportation. Not covered out-of-network.

ADDITIONAL DRUG COVERAGE

Medicare Part B Drugs [1]	**In-Network:** 20% coinsurance for chemotherapy drugs. 20% coinsurance for Part B drugs. Not covered out-of-network.

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Part D Prescription Drugs

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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
Tier 1: Preferred Generic **Select Insulins**	$0 copay $0 copay	$0 copay $0 copay
Tier 2: Generic	$5 copay	$15 copay
Tier 3: Preferred Brand	$47 copay	$141 copay
Tier 4: Non-Preferred Drug	$100 copay	$300 copay
Tier 5: Specialty Tier	33% coinsurance	Not Covered

Standard Mail Order Cost-Sharing	30-day Supply	100-day Supply
Tier 1: Preferred Generic **Select Insulins**	$0 copay $0 copay	$0 copay $0 copay
Tier 2: Generic	$0 copay	$0 copay
Tier 3: Preferred Brand	$47 copay	$94 copay
Tier 4: Non-Preferred Drug	$100 copay	$200 copay
Tier 5: Specialty Tier	33% coinsurance	Not Covered

Out-of-Network and Long-Term Pharmacy	OON 30-day Supply LTC 31-day Supply
Tier 1: Preferred Generic	$0 copay
Tier 2: Generic	$5 copay
Tier 3: Preferred Brand	$47 copay
Tier 4: Non-Preferred Drug	$100 copay
Tier 5: Specialty Tier	33% coinsurance

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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.

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Additional Benefits, Care and Services

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FOOT CARE (PODIATRY SERVICES)

Podiatry Services (Medicare-covered)	**In-Network:** $20 copay per visit Not covered out-of-network.
Routine Podiatry Services	**In-Network:** $20 copay for (6) visits per year Not covered out-of-network.

MEDICAL EQUIPMENT AND SUPPLIES

Durable Medical Equipment (wheelchairs, oxygen, etc.) [1]	**In-Network:** 20% coinsurance per item Prior authorization is required for DME in the amount of $1,500 or more. Not covered out-of-network.
Prosthetic Devices (braces, artificial limbs, etc.) [1]	**In-Network:** 20% coinsurance per item Prior authorization is required for prosthetic devices in the amount of $1,500 or more. Not covered out-of-network.

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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 Not covered out-of-network.

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). Not covered out-of-network.
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.

HOME HEALTH CARE

Home Health Care (Medicare-covered)	**In-Network:** $0 copay Not covered out-of-network.

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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.

OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit [1]	**In-Network:** $20 copay per visit **Out-of-Network:** Same as In-Network
Opioid Treatment Services [1]	**In-Network:** $20 copay per visit Not covered out-of-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.

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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:

$125 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

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.

Flex Card

The Flex Card benefit is a debit card that may be used to cover up to a specified dollar amount of your out-of-pocket expenses at any dental, vision, or hearing provider that accepts VISA. The debit card is prepaid by the plan; it is not a credit card. You cannot convert the card to cash or loan it to other people. Cosmetic procedures are not covered under this benefit.

Any unused allocated money will revert to the plan at the end of the year or when you leave the plan.

You are eligible for **$250** on the debit Flex Card. Any unused amount does not carry over to the next year.

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IN-HOME SUPPORT SERVICES

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 at no cost to the member.

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.

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.

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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.

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.

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.

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Pre-Enrollment Checklist

Zing HEALTH™

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 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-contracteed 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.

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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

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

Zing HEALTH™
MEDICARE REIMAGINED

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:
  - Intérpretes calificados en el lenguaje de signos
  - 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:
  - Intérpretes calificados
  - 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: civilrightscoordinator@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.

Zing HEALTH
MEDICARE REIMAGINED

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 quí vị cần thông dịch viên xin gọi 1-866-946-4458 (TTY: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 فوري، ليس عليك سوى الاتصال بنا على 1-866-946-4458 (TTY: 711). هذه خدمة. سيقوم شخص ما يتحدث العربية بمساعدتك. 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 Italianovi 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ございます。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。