



# Summary of Benefits

JANUARY 1, 2024 - DECEMBER 31, 2024

## MICHIGAN (C-SNP)

H4624-012 Zing Select Diabetes & Heart MI (HMO C-SNP)

**Service Area:** Genesee, Oakland, and Wayne Counties

H4624-023 Zing ESRD Select MI (HMO C-SNP)

**Service Area:** Oakland and Wayne Counties

H6876-003 Zing Open Choice Diabetes & Heart MI (PPO C-SNP)

**Service Area:** Wayne County

Zing Health contracts with Medicare to offer Medicare Advantage HMO, HMO SNP, PPO, and PPO SNP plans in select states, and with select State Medicaid programs. Enrollment in Zing Health depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-866-946-4458 (TTY 711) and request the “Evidence of Coverage” or access it online at [www.myzinghealth.com](http://www.myzinghealth.com).

To join Zing Health, you must be entitled to Medicare Part A, be enrolled in Part B, and live in the plans service area. The service area includes the counties listed in the first row of the chart below for each plan.

For HMO plans, except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print, or audio.

For more information, please call us at 1-866-946-4458 (TTY users should call 711) 7 days a week, 8 a.m. to 8 p.m. or visit us at [www.myzinghealth.com](http://www.myzinghealth.com).

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

<b>Benefit Coverage</b> Services with a <sup>1</sup> may require prior authorization.	<b>H4624-012</b> <b>Zing Select Diabetes &amp; Heart MI (HMO C-SNP)</b> <i>Genesee, Oakland, and Wayne Counties</i>	<b>H4624-023</b> <b>Zing ESRD Select MI (HMO C-SNP)</b> <i>Oakland and Wayne Counties</i> <i>Uses a Provider-Specific Network*</i>	<b>H6876-003</b> <b>Zing Open Choice Diabetes &amp; Heart MI (PPO C-SNP)</b> <i>Wayne County</i>
<b>PREMIUMS, DEDUCTIBLES &amp; MOOP</b>			
<b>Monthly Plan Premium</b> <i>(includes both medical and drugs)</i>	You pay \$0	You pay \$0	You pay \$0
<b>Deductible</b>	No deductible for medical. See Part D prescription drugs section for Part D deductible.	No deductible for medical. See Part D prescription drugs section for Part D deductible.	No deductible for medical. See Part D prescription drugs section for Part D deductible.
<b>Maximum Out-of-Pocket Responsibility (In-Network)</b> <i>(does not include Part D prescription drugs)</i>	You pay no more than \$4,500 annually	You pay no more than \$4,950 annually	You pay no more than \$4,950 annually for in-network services You pay no more than \$8,950 annually for in-network and out-of-network services combined.

\*Zing ESRD Select MI (HMO C-SNP) is a Provider Specific Plan (PSP) and has a network of doctors, hospitals, pharmacies, and other providers. As a member, you must select an in-network primary care physician (PCP). As a member of this PSP, you must select a Nephrologist from a subset of Nephrologists within this allowable network. Except in emergency situations or out-of-area urgently needed services, if you use providers that are not associated with Zing ESRD Select MI (HMO C-SNP)'s specific network, the plan may not pay for these services.

## Benefit Coverage

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### INPATIENT & OUTPATIENT HOSPITAL COVERAGE

<b>Inpatient Hospital<sup>1</sup></b>	You pay \$300 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay	You pay \$250 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay	In-Network and Out-of-Network: You pay \$310 per day for days 1-6; You pay nothing per day for days 7 and beyond per admission or stay
<b>Outpatient Hospital<sup>1</sup></b>	You pay \$250 per visit	You pay \$250 per visit	In-Network and Out-of-Network: You pay \$250
<b>Ambulatory Surgical Center (ASC)<sup>1</sup></b>	You pay \$175 per visit	You pay \$110 per visit	In-Network and Out-of-Network: You pay \$225

### DOCTOR VISITS

<b>Doctor Visits</b>			In-Network and Out-of-Network:
<ul style="list-style-type: none"> <li>• <b>Primary Care Provider</b></li> <li>• <b>Specialists</b></li> </ul>	<p>You Pay \$0 per visit</p> <p>You Pay \$15 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, and Pulmonologists;</p> <p>You pay \$25 per visit for all other Specialists</p>	<p>You Pay \$0 per visit</p> <p>You Pay \$0 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, and Pulmonologists;</p> <p>You pay \$25 per visit for all other Specialists</p>	<p>You Pay \$0 per visit</p> <p>You Pay \$15 per visit for Endocrinologist, Gerontologist, Nephrologist, Ophthalmologist, Cardiologist, and Pulmonologists;</p> <p>You pay \$25 per visit for all other Specialists</p>

### PREVENTIVE CARE

<b>Preventive Care</b> (e.g., flu vaccine, diabetic screenings)	You pay nothing Other preventive services are available. There are some covered services that have a cost.	You pay nothing Other preventive services are available. There are some covered services that have a cost.	In-Network and Out-of-Network: You pay nothing Other preventive services are available. There are some covered services that have a cost.
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## EMERGENCY CARE

<b>Emergency Care</b>	You pay \$120; If you are admitted to the hospital within 24 hours, then you do not have to pay \$120	You pay \$120; If you are admitted to the hospital within 24 hours, then you do not have to pay \$120	You pay \$120; If you are admitted to the hospital within 24 hours, then you do not have to pay \$120
<b>Worldwide Emergency and Urgent Care</b>	You pay \$0 for emergency and urgent care services received outside of the United States and its territories. Our plan will reimburse up to a \$100,000 maximum benefit amount per year.  Emergency transportation is not included.	You pay \$0 for emergency and urgent care services received outside of the United States and its territories. Our plan will reimburse up to a \$100,000 maximum benefit amount per year.  Emergency transportation is not included.	You pay \$0 for emergency and urgent care services received outside of the United States and its territories. Our plan will reimburse up to a \$100,000 maximum benefit amount per year.  Emergency transportation is not included.
<b>Urgently Needed Services</b>	You pay \$0 at a PCP office; You pay \$25 at other locations	You pay \$0 at a PCP office; You pay \$10 at other locations	You pay \$0 at a PCP office; You pay \$20 at other locations

## DIAGNOSTIC SERVICES / LABS / IMAGING

<b>Diagnostic Services/ Labs/Imaging</b> If a member receives multiple services on the same day, only the maximum copay applies.			In-Network and Out-of-Network:
<ul style="list-style-type: none"> <li>• <b>Diagnostic Tests and Procedures<sup>1</sup></b></li> </ul>	You pay \$0 for outpatient COVID Tests; You pay \$25 for all other Medicare-covered diagnostic tests and procedures	You pay \$0 for outpatient COVID Tests; You pay \$25 for all other Medicare-covered diagnostic tests and procedures	You pay \$0 for outpatient COVID Tests; You pay \$30 for all other Medicare-covered diagnostic tests and procedures
<ul style="list-style-type: none"> <li>• <b>Lab Services<sup>1</sup></b></li> </ul>	You pay \$0 for Lab services	You pay \$0 for Lab services	You pay \$0 for Lab services
<ul style="list-style-type: none"> <li>• <b>MRI, CAT Scan<sup>1</sup></b></li> </ul>	You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$150 at a facility	You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$150 at a facility	You pay \$50 for CT, MRI, PET Scan at a doctor's office; You pay \$150 at a facility
<ul style="list-style-type: none"> <li>• <b>X-Rays</b></li> </ul>	You pay \$0 for X-rays	You pay \$0 for X-rays	You pay \$0 for X-rays
<ul style="list-style-type: none"> <li>• <b>Therapeutic Radiology<sup>1</sup></b> (radiation, chemotherapy)</li> </ul>	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services

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## HEARING SERVICES

### Hearing Services

- Medicare-Covered Hearing Exams
- Routine Hearing Exam
- Hearing Aid Fitting and Evaluation
- Hearing Aids

You pay \$30 for Medicare-covered hearing exams

You pay \$0 for one (1) routine hearing exam per year.

You pay \$0 for one (1) hearing aid fitting and evaluation every three (3) years

You receive a \$750 benefit allowance towards hearing aids per ear every three (3) years.

You pay \$30 for Medicare-covered hearing exams

You pay \$0 for one (1) routine hearing exam per year.

You pay \$0 for one (1) hearing aid fitting and evaluation every three (3) years

You receive a \$750 benefit allowance towards hearing aids per ear every three (3) years.

### In-Network:

You pay \$30 for Medicare-covered hearing exams

You pay \$0 for one (1) routine hearing exam per year.

You pay \$0 for one (1) hearing aid fitting and evaluation every three (3) years

You receive a \$750 benefit allowance towards hearing aids per ear every three (3) years.

### Out-of-Network:

You pay \$30 for Medicare-covered hearing exams

You pay 50% coinsurance for hearing aids. You receive a \$750 benefit allowance towards hearing aids per ear every three (3) years.

You pay 50% coinsurance for routine hearing services, up to one (1) routine hearing exam per year and one (1) hearing aid fitting and evaluation every three (3) years.

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## DENTAL SERVICES

### Dental Services

- Routine (Preventive) Dental Services

You receive a \$2,500 benefit allowance every year for preventive and comprehensive dental benefits combined.

You pay a \$0 copay for routine dental services.

- Oral exams up to one (1) every six (6) months
- \$0 copay for prophylaxis (cleaning) up to one (1) every six (6) months
- \$0 copay for a fluoride treatment for up to one (1) every year
- \$0 copay for x-rays up to one (1) set per year

You receive a \$3,000 benefit allowance every year for preventive and comprehensive dental benefits combined.

You pay a \$0 copay for routine dental services.

- Oral exams up to one (1) every six (6) months
- \$0 copay for prophylaxis (cleaning) up to one (1) every six (6) months
- \$0 copay for a fluoride treatment for up to one (1) every year
- \$0 copay for x-rays up to one (1) set per year

In-Network:

You receive a \$2,000 benefit allowance every year for preventive and comprehensive dental benefits combined.

You pay a \$0 copay for routine dental services.

- Oral exams up to one (1) every six (6) months
- \$0 copay for prophylaxis (cleaning) up to one (1) every six (6) months
- \$0 copay for a fluoride treatment for up to one (1) every year
- \$0 copay for x-rays up to one (1) set per year

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#### • Comprehensive Dental Services<sup>1</sup>

You pay \$0 for comprehensive dental services.

Unlimited benefit for:

- Non-routine Services (other services)
- Diagnostic Services (exams, x-rays)
- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/ root planning)
- Prosthodontics, Other Oral/Maxillofacial Surgery (dentures or fixed prosthetics and partials)
- Extractions (1 per tooth per year)

You pay \$0 for comprehensive dental services.

• Unlimited benefit for:

- Non-routine Services (other services)
- Diagnostic Services (exams, x-rays)
- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/ root planning)
- Prosthodontics, Other Oral/Maxillofacial Surgery (dentures or fixed prosthetics and partials)
- Extractions (1 per tooth per year)

In-Network:

You pay \$0 for comprehensive dental services.

Unlimited benefit for:

- Non-routine Services (other services)
- Diagnostic Services (exams, x-rays)
- Restorative Services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/ root planning)
- Prosthodontics, Other Oral/Maxillofacial Surgery (dentures or fixed prosthetics and partials)
- Extractions (1 per tooth per year)

Out-of-Network:

You pay \$0 for Medicare-covered comprehensive dental services.

You pay 50% coinsurance for non-Medicare-covered dental services (routine and comprehensive) up to the maximum benefit limit of \$2,000 every year.

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## VISION SERVICES

### Vision Services

- Medicare-Covered Eye Exams
- Routine Eye Exams
- Medicare-Covered Eyewear
- Routine Eyewear

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams

You pay \$0 for one (1) routine vision exam per year.

You pay \$0 for Medicare-covered eyewear

You pay \$0 for routine eyewear; You receive a \$350 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams

You pay \$0 for one (1) routine vision exam per year.

You pay \$0 for Medicare-covered eyewear

You pay \$0 for routine eyewear; You receive a \$300 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year

### In-Network:

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams

You pay \$0 for one (1) routine vision exam per year.

You pay \$0 for Medicare-covered eyewear

You pay \$0 for routine eyewear; You receive a \$300 benefit allowance towards Eyeglass (lenses and frames), Eyeglass lenses, Eyeglass frames, and a pair of Contacts every year

### Out-of-Network:

You pay \$0 for diabetic retinopathy exams; you pay \$30 for all other Medicare-covered eye exams

You pay 50% coinsurance for non-Medicare-covered vision services and eyewear

You pay \$0 for Medicare-covered and non-Medicare-covered eyewear, with a \$300 benefit allowance towards non-Medicare-covered eyeglass (lenses and frames), eyeglass lenses, eyeglass frames, contact lenses)



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## MENTAL HEALTH SERVICES

### Inpatient Mental Health Services<sup>1</sup>

You pay \$300 for days 1-6; \$0 copay for days 7 through 90 for each Medicare-covered stay  
Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.

You pay \$250 for days 1-6; \$0 copay for days 7 through 90 for each Medicare-covered stay  
Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.

In-Network and Out-of-Network:  
You pay \$310 for days 1-6; \$0 copay for days 7 through 90 for each Medicare-covered stay  
Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.

### Outpatient Mental Health Services<sup>1</sup>

- Outpatient Group Therapy/Individual Therapy Visit<sup>1</sup>

You pay \$30 per Medicare-covered session

You pay \$25 per Medicare-covered session

In-Network and Out-of-Network:  
You pay \$30 per Medicare-covered session

## SKILLED NURSING

### Skilled Nursing Facility<sup>1</sup>

You pay nothing for days 1 through 20  
You pay \$203 per day for days 21 through 100 of each Medicare-covered stay

You pay nothing for days 1 through 20  
You pay \$203 per day for days 21 through 100 of each Medicare-covered stay

In-Network and Out-of-Network:  
You pay nothing for days 1 through 20  
You pay \$203 per day for days 21 through 100 of each Medicare-covered stay

## REHABILITATION SERVICES

### Physical Therapy / Speech Therapy<sup>1</sup>

You pay \$20 per visit

You pay \$20 per visit

In-Network and Out-of-Network:  
You pay \$25 per visit

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

You pay \$20 per visit

You pay \$20 per visit

In-Network and Out-of-Network:  
You pay \$25

### Cardiac Rehabilitation<sup>1</sup>

- Intensive Cardiac Rehabilitation<sup>1</sup>

You pay \$0 per service

You pay \$0 per service

In-Network and Out-of-Network:  
You pay \$0 per service

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## AMBULANCE

<b>Ambulance (Ground)<sup>1</sup></b>	You pay \$200 for Medicare-covered services	You pay \$200 for Medicare-covered services	In-Network and Out-of-Network: You pay \$225
<b>Ambulance (Air)<sup>1</sup></b>	You pay 20% for Medicare-covered services	You pay 20% for Medicare-covered services	In-Network and Out-of-Network: You pay 20%

## TRANSPORTATION

<b>Transportation (Non-Emergency)</b>	You pay \$0 for 48 one way trips per year to plan approved health-related locations.  Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease	You pay \$0 for unlimited trips per year to plan approved health-related locations.	You pay \$0 for 48 one way trips per year to plan approved health-related locations.  Unlimited Transportation to Dialysis Centers for members with End-Stage Renal Disease
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## MEDICARE PART B DRUGS

<b>Medicare Part B Drugs<sup>1</sup></b>			In-Network and Out-of-Network:
<ul style="list-style-type: none"> <li>• <b>Insulin<sup>1</sup></b></li> </ul>	You pay 0% to 20% coinsurance for insulin not to exceed \$35	You pay 0% to 20% coinsurance for insulin not to exceed \$35	You pay 0% to 20% coinsurance for insulin not to exceed \$35
<ul style="list-style-type: none"> <li>• <b>Chemotherapy and Other drugs<sup>1</sup></b> Step Therapy may be required</li> </ul>	You pay 20% coinsurance for chemotherapy and other Part B drugs	You pay 20% coinsurance for chemotherapy and other Part B drugs	You pay 20% coinsurance for chemotherapy and other Part B drugs

## FOOT CARE

<b>Podiatry Visit (Medicare-Covered)</b>	You pay \$15 per visit	You pay \$0 per visit	In-Network and Out-of-Network: You pay \$15 per visit
<b>Podiatry Visit (Routine Foot Care)</b>	You pay \$0 per visit; up to 6 visits / year	You pay \$0 per visit; up to 12 visits / year	In-Network and Out-of-Network: You pay \$15 per visit; up to 12 visits / year

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## MEDICAL EQUIPMENT/SUPPLIES

### Durable Medical Equipment<sup>1</sup>

- **Prosthetics<sup>1</sup>**  
Prior authorization required for items/supplies over \$1,500

You pay 20%

You pay 20%

In-Network and Out-of-Network:

You pay 20%

### Diabetes Supplies and Services

- **Diabetic Therapeutic Shoes or Inserts**
- **Diabetes Self-Management Training**

You pay 0% - 20%

You pay 0% - 20%

In-Network and Out-of-Network:

You pay 0% - 20%

You pay \$0

You pay \$0

You pay \$0

You pay \$0

You pay \$0

You pay \$0

## CHIROPRACTIC CARE & ACUPUNCTURE

### Chiropractic Visit (Medicare-Covered)

You pay \$20 per visit

You pay \$20 per visit

In-Network and Out-of-Network:

You pay \$20 per visit

### Acupuncture Visit (Medicare-Covered)

You pay \$0 per visit

You pay \$0 per visit

In-Network and Out-of-Network:

You pay \$0 per visit

## HOME HEALTH CARE

### Home Health Care (Medicare-covered)

You pay \$0 per visit

You pay \$0 per visit

In-Network and Out-of-Network:

You pay \$0 per visit

## HOSPICE

### Hospice Care

You must get your care from a Medicare-certified hospice provider. You pay part of the cost for outpatient drugs.

You must get your care from a Medicare-certified hospice provider. You pay part of the cost for outpatient drugs.

You must get your care from a Medicare-certified hospice provider. You pay part of the cost for outpatient drugs.

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## OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Visit <sup>1</sup>	You pay \$30 per visit	You pay \$30 per visit	In-Network and Out-of-Network: You pay \$30 per visit
Opioid Treatment Visit <sup>1</sup>	You pay \$30 per visit	You pay \$25 per visit	In-Network and Out-of-Network: You pay \$30 per visit

## RENAL DIALYSIS

Renal Dialysis	You pay 20%	You pay \$0	In-Network and Out-of-Network: You pay 20%
Kidney Disease Education Services	You pay \$0	You pay \$0	In-Network and Out-of-Network: You pay \$0

## IN-HOME SUPPORT SERVICES

In-Home Support Services	You pay \$0 for 60 hours per year of Papa Pals services	You pay \$0 for 60 hours per year of Papa Pals services	You pay \$0 for 60 hours per year of Papa Pals services
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## FITNESS

Fitness - Health Club Membership and At-Home Fitness Kit	You pay \$0	You pay \$0	You pay \$0
Weight Management Program	You pay \$0	You pay \$0	You pay \$0

## 24 / 7 NURSING HOTLINE

24 / 7 Nurse Hotline	You pay \$0	You pay \$0	You pay \$0
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## PERSONAL EMERGENCY RESPONSE SYSTEM

Personal Emergency Response System	You pay \$0	You pay \$0	You pay \$0
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### MEAL BENEFITS

<b>Post Discharge Meals</b>	You pay \$0 for 10 meals after each inpatient facility discharge	You pay \$0 for 10 meals after each inpatient facility discharge	You pay \$0 for 10 meals after each inpatient facility discharge
<b>Chronic Condition Meals</b>	You pay \$0 for 28 meals (limited to one (1) event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program	You pay \$0 for 28 meals (limited to one (1) event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program	You pay \$0 for 28 meals (limited to one (1) event per year) if you have a qualifying chronic condition and participate in a lifestyle transition program

### OVER-THE-COUNTER ITEMS / HEALTHY FOODS / UTILITY

<b>Over-the-Counter Items Allowance</b>	You pay \$0 for \$116 / month to use for over-the-counter items, unused funds do not roll-over to next month.  Combined with Healthy Food & Utilities	You pay \$0 for \$157 / month to use for over-the-counter items, unused funds do not roll-over to next month.  Combined with Healthy Food & Utilities	You pay \$0 for \$73 / month to use for over-the-counter items, unused funds do not roll-over to next month.  Combined with Healthy Food & Utilities
<b>Healthy Food and Utilities Allowance</b>	Members with Chronic Heart Failure, Cardiovascular Disorders, and Diabetes can also use their over-the-counter allowance for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.	Members with End Stage Renal Disease requiring dialysis can also use their over-the-counter allowance for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.	Members with Chronic Heart Failure, Cardiovascular Disorders, and Diabetes can also use their over-the-counter allowance for plan-approved food items, and/or utilities (electric, gas, heating oil, sanitation or water). Any unused balances cannot be converted to cash or rolled over to the next benefit period.

### FLEX CARD BENEFIT

<b>Flex Card</b>	You receive a \$750 debit card every year to apply towards the following non-Medicare-covered benefits at your discretion: <ul style="list-style-type: none"> <li>• Hearing</li> <li>• Dental (preventive and comprehensive)</li> <li>• Vision (routine and eyewear)</li> </ul>	You receive a \$500 debit card every year to apply towards the following non-Medicare-covered benefits at your discretion: <ul style="list-style-type: none"> <li>• Hearing</li> <li>• Dental (preventive and comprehensive)</li> <li>• Vision (routine and eyewear)</li> </ul>	You receive a \$750 debit card every year to apply towards the following non-Medicare-covered benefits at your discretion: <ul style="list-style-type: none"> <li>• Hearing</li> <li>• Dental (preventive and comprehensive)</li> <li>• Vision (routine and eyewear)</li> </ul>
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## Benefit Coverage

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

### H4624-012

#### Zing Select Diabetes & Heart MI (HMO C-SNP)

Genesee, Oakland, and Wayne Counties

### H4624-023

#### Zing ESRD Select MI (HMO C-SNP)

Oakland and Wayne Counties

Uses a Provider-Specific Network\*

### H6876-003

#### Zing Open Choice Diabetes & Heart MI (PPO C-SNP)

Wayne County

## PART D PRESCRIPTION DRUGS

<b>Phase 1: Deductible Stage</b>	You pay \$0	You pay \$0	You pay \$0
<b>Phase 2: Initial Coverage Stage</b>	You are in the Initial Coverage Stage until your total yearly drug cost reach \$5,030. Total yearly drug costs are the total drug costs paid both by you and the plan. Once you've reached this amount, you enter the coverage gap.		
<b>Standard Retail Benefits (30 days /60 days /100 days)</b>			
<b>Tier 1 - Preferred Generic (includes insulins)</b>	\$0 / \$0 / \$0	\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Tier 2 - Generic (includes excluded drugs)</b>	\$5 / \$10 / \$15	\$5 / \$10 / \$15	\$5 / \$10 / \$15
<b>Tier 3 - Preferred Brand</b>	\$47 / \$94 / \$141	\$47 / \$94 / \$141	\$47 / \$94 / \$141
<b>Tier 4 - Non-Preferred Drug</b>	\$100 / \$200 / \$300	\$100 / \$200 / \$300	\$100 / \$200 / \$300
<b>Tier 5 - Specialty Tier (30-day supply only)</b>	33%	33%	33%
<b>Tier 6 - Select Care Drugs</b>	\$0 / \$0 / \$0	\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Mail Order Copay (30 days / 60 days / 100 days)</b>			
<b>Tier 1 - Preferred Generic (includes insulins)</b>	\$0 / \$0 / \$0	\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Tier 2 - Generic (includes excluded drugs)</b>	\$0 / \$0 / \$0	\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Tier 3 - Preferred Brand</b>	\$47 / \$94 / \$94	\$47 / \$94 / \$94	\$47 / \$94 / \$94
<b>Tier 4 - Non-Preferred Drug</b>	\$100 / \$200 / \$200	\$100 / \$200 / \$200	\$100 / \$200 / \$200
<b>Tier 5 - Specialty Tier (30-day supply only)</b>	33%	33%	33%
<b>Tier 6 - Select Care Drugs</b>	\$0 / \$0 / \$0	\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Phase 3: Gap Coverage</b>	During this phase you will pay 25% for generic or brand-name drugs. During this stage, you will continue to pay \$0 cost-share for select insulins and tier 1 drugs.		
<b>Phase 4: Catastrophic Coverage Stage</b>	The plan pays the full cost for your covered Part D drugs. You pay nothing.		

## Benefit Coverage

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

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#### Zing ESRD Select MI (HMO C-SNP)

*Oakland and Wayne Counties*

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*Wayne County*

## Additional Drug Coverage

### Erectile Dysfunction (ED Drugs) - sildenafil

Covered at Tier 2 cost-share amount

Cost-Sharing may change depending on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, the pharmacy you choose, and when you enter a new phase of the drug stages.

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1-800-325-0778.

For more information on additional pharmacy specific cost-share and the drug coverage stages, please call our Customer Service department or access our "Evidence of Coverage" online or request one by mail.

\*Zing ESRD Select MI (HMO C-SNP) is a Provider Specific Plan (PSP) and has a network of doctors, hospitals, pharmacies, and other providers. As a member, you must select an in-network primary care physician (PCP). As a member of this PSP, you must select a Nephrologist from a subset of Nephrologists within this allowable network. Except in emergency situations or out-of-area urgently needed services, if you use providers that are not associated with Zing ESRD Select MI (HMO C-SNP)'s specific network, the plan may not pay for these services.

