Zing HEALTH™

January 1, 2020 – December 31, 2020

2020 Summary of Benefits

Zing Choice IL (HMO)
H7330-001

Cook County

Medicare Advantage Plan

H7330_MK002_092019_M CMS Accepted 09/28/2019

About Zing Health Plan

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

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

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

Important Plan Information

Zing Choice IL H7330-001 (HMO) is a Medicare Advantage plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

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

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

Who can join?

To join Zing Choice IL (HMO), you must be entitled to Medicare Part A, be enrolled in Part B, not have End Stage Renal Disease (ESRD), and live in the plan's service area. Our service area includes the following county: Cook County.

What providers can I use?

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

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

What are our hours of operation?

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

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

What does Original Medicare cover?

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Monthly Premium, Deductible and Maximum Out-of-Pocket	
How much is the monthly plan premium?	**$0** Monthly plan premium In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.
What is my yearly maximum out-of-pocket responsibility?	**$3,900** is the most you'll pay for covered services you receive from in-network providers. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year for covered medical and hospital services.

Covered Medical and Hospital Benefits

Original Medicare	Zing Choice IL (HMO)
Acute Inpatient Hospital Care (1)	
In 2019, the amounts for each benefit period are: ▪ You pay a **$1,364** deductible and no coinsurance for days 1 – 60 of each benefit period ▪ You pay **$341** per day for days 61 – 90 of each benefit period ▪ You pay **$682** per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime) ▪ You pay all costs for each day after you use all the lifetime reserve days These amounts may change for 2020.	You pay: ▪ **$200 Copay** per day for days 1 through 7 ▪ **You pay nothing** for days 8 through 90 ▪ Your plan covers an unlimited number of days for an inpatient hospital stay
Outpatient Hospital Care (1,3)	
You pay a **20%** coinsurance for the doctor's services. You pay a **20%** specified coinsurance for outpatient hospital facility services. The coinsurance cannot exceed the Part A inpatient hospital deductible.	You pay: ▪ **$75 Copay** for Surgery at an ambulatory surgical center ▪ **$150 Copay** for Outpatient hospital services 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.
Doctor's Office Visits (2,3)	
If the Part B deductible (**$185** in 2019) applies, you must pay all costs (up to the Medicare-approved amount) until you meet the yearly Part B deductible. You pay **20%** of the Medicare-approved amount (except for certain preventive services for which you may pay nothing). This amount may change for 2020.	You pay: ▪ **$0 Copay** for a Primary care physician visit ▪ **$25 Copay** for Specialist visits

Original Medicare	Zing Choice IL (HMO)
Preventive Care	
Medicare covers many common preventive services at no cost sharing and includes: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse screening and counseling ▪ Bone mass measurement (bone density) ▪ Breast cancer screening (mammograms) ▪ 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 ▪ Diabetes self-management training ▪ Flu shots ▪ Glaucoma tests ▪ Hepatitis B shots and screening ▪ Hepatitis C screening test ▪ HIV screening ▪ Lung cancer screening ▪ Medical nutrition therapy services ▪ Obesity screening and counseling ▪ Pneumococcal shot ▪ Prostate cancer screenings ▪ Sexually transmitted infection (STI) screening and counseling ▪ Smoking and tobacco use cessation counseling ▪ "Welcome to Medicare" preventive visit (one-time) ▪ Yearly "Wellness" visit	You pay: ▪ **$0 Cost share** for Preventive Care services covered by Original Medicare Your plan covers many preventive services at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered. Authorization rules may apply.

Original Medicare	Zing Choice IL (HMO)
Emergency Care (3)	
You pay a specified copayment for the hospital emergency department visit, and you pay **20%** of the Medicare-approved amount for the doctor's or other health care provider's services. Not covered outside the U.S. except under limited circumstances.	You pay: ▪ **$90 Copay** for Emergency care If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Not covered outside the U.S.
Urgently Needed Services (3)	
You pay **20%** of the Medicare-approved amount for the doctor's or other health care services. Urgent care services are provided to treat a sudden illness or injury that is non-emergent and requires immediate attention.	You pay: ▪ **$35 Copay** for Urgent care services at an urgent center If you are admitted to the hospital within 24 hours, your urgent care copay is waived.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (1,2,3) **Cost share may vary depending on the where the service is provided.**	
You pay **20%** of the Medicare-approved amount for Medicare-covered X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. If you get the test at a hospital or a hospital-owned clinic as an outpatient service, you also pay the hospital copayment. Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.	You pay: ▪ **$25 Copay** for Diagnostic tests and procedures ▪ **You pay nothing** for Outpatient X-rays ▪ **You pay nothing** for Lab services ▪ **$50 to $150 Copay** for Diagnostic radiology services (such as MRIs, CT scans) ▪ **20% Coinsurance** for Therapeutic radiology services (such as radiation treatment for cancer) If a member receives multiple services on the same day, only the maximum copay applies. Copay may vary depending on the place of service.

Original Medicare	Zing Choice IL (HMO)
Hearing and Balance Exams (2,3)	
You pay **20%** coinsurance for a Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. Routine hearing exams and hearing aids are not covered by Original Medicare.	You pay: ▪ **$25 Copay** for a Medicare-covered hearing exam to diagnose and treat hearing and balance issues ▪ **$0 Copay** for a routine hearing exam up to (1) per year ▪ **$0 Copay** for a Hearing Aid fitting and evaluation up to (1) every (3) years ▪ Our plan covers a **$750** maximum benefit amount allowance towards **hearing aids** every (3) years per ear You are responsible for all cost beyond the maximum allowed amount. There is no out-of-network option for supplemental hearing services.
Dental Services	
Medicare does not cover most dental services (this includes services in connection with preventive care, dentures, fillings, removal, or replacement of teeth).	**Preventive Dental Benefits:** ▪ **$0 Copay** for Oral exams for up to (1) every (6) months ▪ **$0 Copay** for (1) Prophylaxis (Cleaning) every (6) months ▪ **$0 Copay** for a Fluoride treatment for up to (1) every year ▪ **$0 Copay** for Bitewing X-rays up to (1) set per year ▪ **$0 Copay** for Dental X-ray(s) for up to (1) every year ▪ **$0 Copay** for Panoramic X-rays for up to (1) every (5) years Our plan covers a **$2000 maximum benefit amount** every year for **preventive** and **comprehensive** dental benefits combined.

Original Medicare	Zing Choice IL (HMO)
Dental Services (continued)	
	Comprehensive Dental Benefits: ▪ **$0 Copay** for Amalgam and/or composite filling every (3) years per tooth ▪ **$0 Copay** for Extractions ((1) extraction per tooth per year) ▪ **$0 Copay** Root canals ((1) per lifetime, per tooth) ▪ **$0 Copay** for Scaling/Root Planning (Deep cleaning) (every (24) months per quadrant) ▪ **$0 Copay** for Complete crown (every (5) years, per tooth) ▪ **$0 Copay** for Dentures or fixed prosthetics/ partials once every (5) years Our plan covers up to a **$2000 maximum benefit amount** every year for **preventive** and **comprehensive** dental benefits combined. You are responsible for all cost beyond the maximum allowed amount. There is no out-of-network option for supplemental dental services.
Vision Services (2,3)	
You pay **20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay **20%** of the Medicare-approved amount. Medicare does not cover eye examinations related to prescribing glasses.	▪ **$25 Copay** for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) ▪ **$0 Copay** for (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery ▪ **$0 Copay** for (1) routine eye exam, refraction up to (1) per year ▪ **$250 Maximum benefit coverage** amount towards **Eyeglasses** (frames and lenses) or **Contact lenses** (1) per year You are responsible for all cost exceeding the maximum benefit amount for routine eyewear. There is no out-of-network option for supplemental vision services.

Original Medicare	Zing Choice IL (HMO)
Inpatient Mental Health Care (1)	
In 2019, the amounts for each benefit period are: ▪ You pay a **$1,364** deductible and no coinsurance for days 1 – 60 of each benefit period ▪ You pay **$341** per day for days 61 – 90 of each benefit period ▪ You pay **$682** per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime) ▪ You pay all costs for each day after you use all the lifetime reserve days Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime. These amounts may change for 2020.	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. ▪ **$200 Copay** per day for days 1 through 7 ▪ **$0 Copay** per day for days 8 through 90
Outpatient Mental Health Care (1,3)	
Generally, you pay **20%** of the Medicare-approved amount: ▪ Visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions ▪ Outpatient treatment of your condition (like counseling or psychotherapy) ▪ Partial hospitalization program: is a structured program of active outpatient psychiatric treatment that is more intense than the care received in our doctor's or therapist's office and is an alternative to inpatient hospitalization	You pay: ▪ **$25 Copay** for an Outpatient individual therapy visit ▪ **$25 Copay** for an Outpatient group therapy visit ▪ **$55 Copay** for Outpatient partial hospitalization

Original Medicare	Zing Choice IL (HMO)
Skilled Nursing Facility (SNF) (1)	
In 2019, you pay: Medicare requires a (3) day inpatient hospital stay prior to a SNF admission. ▪ **$0** copay for the first 20 days of each benefit period ▪ **$170.50** per day for days 21 – 100 of each benefit period ▪ All costs for each day after day 100 in a benefit period These amounts may change for 2020.	Our plan covers up to 100 days per benefit period in a SNF. A (3) day inpatient hospital stay is not required prior to a SNF admission. ▪ **$0 Copay** for per day for days 1 through 20 ▪ **$160 Copay** per day for days 21 through 100 You will not be charged additional cost sharing for professional services. There is no limit to the number of benefit periods you may have.
Outpatient Rehabilitation (1,3)	
Cardiac (heart) rehab services: You pay **20%** of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. Occupational therapy: You pay **20%** of the Medicare-approved amount. Physical therapy and speech therapy: You pay **20%** of the Medicare-approved amount.	You pay: ▪ **$0 Copay** for Cardiac rehab services ▪ **$0 Copay** for Pulmonary rehab services ▪ **$20 Copay** for Occupational therapy visit ▪ **$20 Copay** for Physical therapy and Speech and Language therapy visit
Ambulance (3)	
You pay **20%** of the Medicare-approved amount.	You pay: ▪ **$100 Copay** for a covered one-way ambulance trip ▪ **20% Coinsurance** for covered air ambulance service

Original Medicare	Zing Choice IL (HMO)
Transportation (Non-emergency)	
Not covered by Original Medicare.	You pay: ▪ **$0 Copay** for up to 24 one-way trips per year to plan approved health-related locations The member must contact the plan for more details and participating transportation vendors.
Part B Drugs (1,3)	
Medicare covers a limited number of drugs including but not limited to injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer). You pay **20%** of the Medicare-approved amount for these covered drugs, and the Part B deductible applies.	You pay: ▪ **20% Coinsurance** of the cost for Chemotherapy drugs ▪ **20% Coinsurance** of the cost for other Part B drugs
Foot Care (Podiatry Services) (2,3)	
Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay **20%** of the Medicare-approved amount. Routine podiatry care is not covered by Medicare.	You pay: ▪ **$25 Copay** for Medicare-covered Podiatry (foot) care ▪ **$20 Copay** for (6) visits for Routine Podiatry covered services per year

Original Medicare	Zing Choice IL (HMO)
Diabetes Supplies and Services (1,3)	
You pay **20%** coinsurance of the Medicare approved amount for diabetes supplies (like glucose monitors, test strips, lancets). You pay **20%** coinsurance for diabetes self-management training. You pay **20%** coinsurance for diabetic therapeutic shoes or inserts.	You pay: ▪ **$0 Copay** for **preferred** Diabetes monitoring supplies ▪ **20% Coinsurance** for **non-preferred** Diabetes monitoring supplies ▪ **$0 Copay** for Diabetes self-management training ▪ **20%** of the cost for Therapeutic shoes or inserts The cost share may vary depending on specified manufactures for diabetes monitoring supplies. Contact the plan for details.
Durable Medical Equipment (e.g., wheelchairs, oxygen) Prosthetics (e.g., braces, artificial limbs) (1,3)	
You pay **20%** of the Medicare-approved amount for durable medical equipment. For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay **20%** of the Medicare-approved amount.	You pay: ▪ **20%** of the cost for Durable Medical Equipment (DME) ▪ **20%** of the cost for Prosthetics

Wellness Programs

Original Medicare	Zing Choice IL (HMO)
Health Club Membership Silver & Fit® Fitness	
Not covered by Original Medicare.	**You pay nothing** to belong to a participating fitness clubs 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.

Original Medicare	Zing Choice IL (HMO)
Over-the-Counter (OTC) Health Items	
Not covered by Original Medicare.	Our plan will pay up to **$75** every three months for the purchase of covered over-the-counter items. Please visit our website to see our list of covered over-the-counter items.
Weight Watchers® Membership	
Not covered.	Our plan provides complimentary vouchers for membership in the Weight Watchers® program. Meals are not covered.
TeleHealth	
Original Medicare covers certain TeleHealth services under limited circumstances.	You pay: ▪ **$10 Copay** for access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical services. Please call us for more details.
In-Home Safety Devices	
Not covered by Original Medicare as a supplemental benefit.	You pay: ▪ **$0 Copay** for In-Home safety devices Plan approved items include: grab bar, hand held shower wand, toilet safety rail, bath tub assist bar, bath transfer bench (assembly, install and repair not included).

Prescription Drug Benefits

Original Medicare	Zing Choice IL (HMO)
Deductible	
Centers for Medicare and Medicaid Services (CMS) defined Standard Benefit Plan deductible for 2020 is **$435**.	**You pay $0** Deductible.
Initial Coverage	
In Original Medicare, if you don't already have creditable prescription drug coverage (for example, from a current or former employer or union) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan, or you can get all your Medicare coverage by joining a Medicare Advantage Plan.	You pay the following until your total yearly drug costs reach **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you enter the coverage gap. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long term care facility (LTC), you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. For retail cost-sharing see table 1. For mail order cost-sharing see table 2.

Part D Rx Benefits: Table 1

Standard Retail Cost-Sharing	One-Month supply	Two-Month supply	Three-Month supply
Tier 1 (Preferred Generic)	**$5** copay	**$10** copay	**$15** copay
Tier 2 (Generic)	**$15** copay	**$30** copay	**$45** copay
Tier 3 (Preferred Brand)	**$45** copay	**$90** copay	**$135** copay
Tier 4 (Non-Preferred Drug)	**$95** copay	**$190** copay	**$285** copay
Tier 5 (Specialty Tier)	**33%** of the cost	N/A	N/A
Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay

Part D Rx Benefits: Table 2

Part D Rx Benefits Standard Mail Order	One-Month supply	Two-Month supply	Three-Month supply
Tier 1 (Preferred Generic)	**$5** copay	**$10** copay	**$12.50** copay
Tier 2 (Generic)	**$15** copay	**$30** copay	**$37.50** copay
Tier 3 (Preferred Brand)	**$45** copay	**$90** copay	**$112.50** copay
Tier 4 (Non-Preferred Drug)	**$95** copay	**$190** copay	**$237.50** copay
Tier 5 (Specialty Tier)	**33%** of the cost	N/A	N/A
Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after you and your drug plan together have spent **$4,020** for covered drugs.

After you enter the coverage gap, you pay **25%** of the plan's cost for covered brand name drugs and **25%** of the plan's cost for covered generic drugs until your cost total **$6,350**.

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 costs total **$6,350**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350**, you pay the greater of:

- **5%** of the cost, or **$3.60** copay for generic (including brand drugs treated as generic) and
- **$8.95** for all other drugs

Important Part D plan information:

- Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check the Zing Choice IL (HMO) formulary to confirm the specific tier on which your drugs may be covered.
- If you reside in a long-term care facility, you pay the same as at a retail pharmacy. A one-month supply = 31 days.
- You may get drugs from an out-of-network retail pharmacy at the same cost as an in-network retail pharmacy.
- Medications covered on Tier 6 are subject to higher cost during the coverage gap.
- Specialty drugs are limited to a 30-day supply.
- Your cost share may differ depending on when you enter another phase of the Part D benefit and if you qualify for "Extra Help". To find out if you qualify for "Extra Help", please contact the Social Security Office at 1-800-772-1213 Monday through Friday, 7 a.m.–7 p.m. TTY users should call 1-800-325-0778.
- For more information on additional pharmacy specific cost share and the Part D drug coverage stages, please call our Customer Service or access our "Evidence of Coverage" online or request one by mail.

Other Care and Services

Original Medicare	Zing Choice IL (HMO)
Chiropractic Care (1,3)	
Medicare covers manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider. You pay **20%** of the Medicare-approved amount.	You pay: ▪ **$20 Copay** for manipulation of the spine to correct a subluxation (when (1) or more of the bones of your spine move out of position)
Home Health Care (1)	
You pay **$0** copay for covered home health care services. Covered services include part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, occupational therapy, medical and social services, medical equipment and supplies. A doctor must order your care, and a Medicare-certified home health agency must provide it.	You pay: ▪ **$0 Copay** for home health care services
Hospice	
You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare-certified hospice. Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage Plan.	You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.

Original Medicare	Zing Choice IL (HMO)
Outpatient Substance Abuse (1,3)	
You pay **20%** coinsurance of the Medicare-approved amount.	You pay: ▪ **$25 Copay** for an Outpatient Individual therapy visit ▪ **$25 Copay** for an Outpatient Group therapy visit
Renal Dialysis (1,3)	
You pay **20%** of the Medicare-approved amount for dialysis treatments. You pay **20%** of the Medicare amount for up to (6) sessions of kidney disease education services.	You pay: ▪ **20%** of the total cost for Dialysis treatments ▪ **$0 Copay** for Kidney disease education services

(1) This service may require prior authorization.
(2) This service may require a referral from your doctor.
(3) Under Original Medicare, the Part B deductible applies for this service.

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:
  - Qualified sign language interpreters
  - 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:
  - Qualified interpreters
  - Information written in other languages

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

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
303 W. Madison, Suite 800
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 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.

Multi-Language Interpreter Services

Zing HEALTH™

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-946-4458 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-946-4458 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-946-4458 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-946-4458（TTY：711）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-946-4458 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-946-4458 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-946-4458 (رقم هاتف الصم والبكم: 711.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-946-4458 (телетайп: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-946-4458 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-946-4458 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-946-4458 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-946-4458 (TTY: 711).

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-946-4458 (TTY: 711).

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