

Mount Carmel MediGold No Premium (HMO) offered by Mount Carmel Health Plan, Inc. (Mount Carmel MediGold)

Annual Notice of Change for 2027

You're enrolled as a member of Mount Carmel MediGold No Premium (HMO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in Mount Carmel MediGold No Premium (HMO).
- To change to a **different plan**, visit [Medicare.gov](https://www.Medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. www.thpmedicare.org/mount-carmel/for-members/plan-documents Get a copy at or call Member Services at 1-800-240-3851 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-800-240-3851 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.
- This information is available in large print or audio.

About Mount Carmel MediGold No Premium (HMO)

- Mount Carmel MediGold (HMO) is a Medicare Advantage organization with a Medicare contract. Enrollment in Mount Carmel MediGold depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Mount Carmel Health Plan, Inc. (Mount Carmel MediGold). When it says “plan” or “our plan,” it means Mount Carmel MediGold No Premium (HMO).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in** Mount Carmel MediGold No Premium (HMO). Starting January 1, 2027, you'll get your medical and drug coverage through Mount Carmel MediGold No Premium (HMO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	\$4,900	\$5,500
Primary care office visits	\$0 copay per visit	\$0 copay per visit
Specialist office visits	\$35 copay per visit	\$35 copay per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	\$325 copay per day for days 1-5; \$0 copay per day for days 6-90	\$385 copay per day for days 1-5; \$0 copay per day for days 6-90

	2026 (this year)	2027 (next year)
Part D drug coverage (Go to Sections 1.6 and 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible (applies to Tiers 3-5) \$150 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 You pay no more than \$0 per month supply of each covered insulin product on this tier. • Drug Tier 2: \$5 You pay no more than \$5 per month supply of each covered insulin product on this tier. • Drug Tier 3: 25% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier.	Part D drug coverage deductible (applies to Tiers 3-5) \$275 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 You pay no more than \$0 per month supply of each covered insulin product on this tier. • Drug Tier 2: \$5 You pay no more than \$5 per month supply of each covered insulin product on this tier. • Drug Tier 3: 25% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
	• Drug Tier 4: 45% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 31% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have cost sharing for drugs that are covered under our enhanced benefit.	• Drug Tier 4: 40% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 30% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0 There is no change for the upcoming benefit year.
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	\$19.20	\$6.20
If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)		
Monthly premium for optional supplemental benefits: Dental Silver	Dental Silver-\$16	Dental Silver-\$17
Monthly premium for optional supplemental benefits: Dental Gold	Dental Gold-\$37	Dental Gold-\$39

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2026 (this year)	2027 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Our costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$4,900	\$5,500 Once you've paid \$5,500 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory* www.thpmedicare.org/mount-carmel/find-a-provider to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.thpmedicare.org/mount-carmel/find-a-provider.
- Call Member Services at 1-800-240-3851 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-240-3851 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.2 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* www.thpmedicare.org/mount-carmel/find-a-provider to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.thpmedicare.org/mount-carmel/find-a-provider.
- Call Member Services at 1-800-240-3851 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-240-3851 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Emergency Care	<u>In- and Out-of-Network</u> \$110 copay for each visit for Medicare-covered emergency care services.	<u>In- and Out-of-Network</u> \$130 copay for each visit for Medicare-covered emergency care services.
Fitness Benefit (One Pass[®])	<u>In-Network</u> At Home Kits are offered for Physical and Mental fitness.	<u>In-Network</u> At Home Kits are offered for Physical fitness.

	2026 (this year)	2027 (next year)
Inpatient Hospital Care	<u>In-Network</u> For Medicare-covered inpatient hospital stays, \$325 copay per day for days 1-5; \$0 copay per day for days 6-90.	<u>In-Network</u> For Medicare-covered inpatient hospital stays, \$385 copay per day for days 1-5; \$0 copay per day for days 6-90.
Inpatient Services in a Psychiatric Hospital	<u>In-Network</u> For Medicare-covered inpatient mental health stays, \$325 copay per day for days 1-5; \$0 copay per day for days 6-90.	<u>In-Network</u> For Medicare-covered inpatient mental health stays, \$385 copay per day for days 1-5; \$0 copay per day for days 6-90.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	<u>In-Network</u> For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), \$175 copay.	<u>In-Network</u> For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), \$200 copay.
Outpatient Hospital Observation	<u>In-Network</u> \$315 copay per stay for Medicare-covered outpatient hospital observation services.	<u>In-Network</u> \$375 copay per stay for Medicare-covered outpatient hospital observation services.

	2026 (this year)	2027 (next year)
Outpatient Surgery	Includes services provided at hospital outpatient facilities and ambulatory surgical centers. <u>In-Network</u> For Medicare-covered services at an outpatient hospital facility, \$265 copay. For Medicare-covered services at an ambulatory surgical center, \$265 copay.	<u>In-Network</u> For Medicare-covered services at an outpatient hospital facility, \$295 copay. For Medicare-covered services at an ambulatory surgical center, \$295 copay.
Over-the-Counter Items	\$125 maximum plan coverage amount every 3 months for OTC items.	\$50 maximum plan coverage amount every 3 months for OTC items.
Skilled Nursing Facility (SNF) Care	<u>In-Network</u> For Medicare-covered SNF stays, \$0 copay per day for days 1-20; \$218 copay per day for days 21-60; \$0 copay per day for days 61-100.	<u>In-Network</u> For Medicare-covered SNF stays, \$0 copay per day for days 1-20; \$221 copay per day for days 21-65; \$0 copay per day for days 66-100.

Supplemental Vision/Hearing Allowance (Flexible Benefit Card)**In-Network:**

You received \$500 /year on your Flexible Benefit Card to apply towards out-of-pocket costs for covered Vision/Hearing services.

In-Network:

The Flexible Benefit allowance for Vision and Hearing out-of-pocket costs will no longer be available in 2027.

Please keep your card.

Beginning in 2027, your card will be used only for Member Rewards. After you complete your Annual Wellness Visit and submit the required attestation, \$50 will be added to your card.

**Transportation Services
(routine)****In-Network**

\$0 copay for routine transportation services (Unlimited round trips to plan-approved health-related locations) using taxi, rideshare services, van, and medical transport. Excluding Stretcher rides, other modes include any special transport requirements for medically fragile or physically/mentally challenged members, based on the members medical needs documentation.

In-Network

\$0 copay for routine transportation services (Unlimited round trips to plan-approved health-related locations) using taxi, rideshare services, van, and medical transport. Excluding Stretcher rides, other modes include any special transport requirements for medically fragile or physically/mentally challenged members, based on the members medical needs documentation. Other modes of transportation include ambulance, wheelchair, and extra-large wheelchair vehicles.

Vision Services

\$200 maximum plan coverage amount every year for all non-Medicare-covered eyewear.

\$250 maximum plan coverage amount every year for all non-Medicare-covered eyewear.

**Worldwide Emergency /
Urgently Needed Care
Services**

\$110 copay for each
emergency care visit outside
of the United States and its
territories.

\$110 copay for each urgently
needed care visit outside of
the United States and its
territories.

**\$130 copay for each
emergency care visit
outside of the United
States and its territories.**

**\$130 copay for each
urgently needed care visit
outside of the United
States and its territories.**

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically and posted online at: www.thpmedicare.org/mount-carmel/my-medications/formulary.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-240-3851 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30th, call Member Services at 1-800-240-3851 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are 3 **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier drugs until you've reached the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,400.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. *You may have cost sharing for excluded drugs that are covered under our enhanced benefit.* You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	\$150 During this stage, you pay \$0-\$5 cost sharing for drugs on Tier 1 Preferred Generic, Tier 2 Generic and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier until you've reached the yearly deductible.	\$275 During this stage, you pay \$0-\$5 cost sharing for drugs on Tier 1 Preferred Generic, Tier 2 Generic and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (next year)
Tier 1 (Preferred Generic): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay \$0	You pay \$0
Tier 2 (Generic): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay \$5 You pay no more than \$5 per month supply of each covered insulin product on this tier.	You pay \$5 You pay no more than \$5 per month supply of each covered insulin product on this tier.
Tier 3 (Preferred Brand): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay 25% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier.	You pay 25% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier.
Tier 4 (Non-Preferred Drug): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay 45% of the total cost Your cost for a one-month mail-order prescription is 45% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier.	You pay 40% of the total cost Your cost for a one-month mail-order prescription is 40% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Tier 5 (Specialty Tier): We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay 31% of the total cost Your cost for a one-month mail-order prescription is 31% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier.	You pay 30% of the total cost Your cost for a one-month mail-order prescription is 30% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier.

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Member Reward	Complete an Annual Wellness Visit and submit the required attestation to receive a \$50 reward loaded onto your Flexible Benefit Card.	Complete an Annual Wellness Visit and submit the required attestation to receive a \$50 reward loaded onto your Member Rewards Card. The Flexible Benefit Card is being renamed the Member Rewards Card, so please keep your current card. In 2027, it will be used exclusively for Member Rewards.
Over-the-Counter allowance benefit vendor name change	OTC Health Solutions	CVS Flex Benefits

SECTION 3 How to Change Plans

To stay in Mount Carmel MediGold No Premium (HMO), you don't need to do anything.

Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Mount Carmel MediGold No Premium (HMO).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Mount Carmel MediGold No Premium (HMO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with Medicare separate drug coverage**, you can enroll in a Part D plan, and you'll automatically be disenrolled from Mount Carmel MediGold No Premium (HMO).

- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-800-240-3851 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [Medicare.gov](https://www.medicare.gov), check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Mount Carmel Health Plan, Inc. offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
 - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Ohio HIV Drug Assistance Program (OHDAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call Ohio HIV Drug Assistance Program (OHDAP) at 1-800-777-4775. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-866-785-5714 option 2 (TTY users call 711) or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 5 Questions?

Get Help from Mount Carmel MediGold No Premium (HMO)

- **Call Member Services at 1-800-240-3851. (TTY users call 711.)**

We're available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

- **Read your 2027 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for Mount Carmel MediGold No Premium (HMO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.thpmedicare.org/mount-carmel/for-members/plan-documents or call Member Services at 1-800-240-3851 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.thpmedicare.org/mount-carmel/for-members/plan-documents**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Ohio, the SHIP is called Ohio Senior Health Insurance Information Program.

Call Ohio Senior Health Insurance Information Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Ohio Senior Health Insurance Information Program at 1-800-686-1578. Learn more about Ohio Senior Health Insurance Information Program by visiting (<https://insurance.ohio.gov/consumers/medicare/01-oshiip>).

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with Medicare.gov**

You can chat live at [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- **Visit Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION, AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS, AND ACCESSIBILITY SERVICES

Trinity Health understands that we all have different lived experiences, needs, identities, customs, and abilities. We are committed to providing quality, accessible, equitable care and services that are responsive to the needs of the diverse communities served.

Mount Carmel MediGold welcomes all individuals who come to us for care, treatment, and services. We comply with all Federal civil right laws and do not exclude anyone or treat them differently because of their age, race, color, ethnicity (including limited English proficiency and primary language), national origin, religion, culture, language, physical or mental disability, socioeconomic status (including ability to pay or participation in Medicaid, Medicare or Children's Health Insurance Program), sex (including sex at birth or legal sex), sex characteristics (including intersex traits), pregnancy or related conditions, sex stereotypes, sexual orientation, gender identity or expression, veteran status, or any other category protected by law.

As a sponsored ministry of the Catholic Church, we provide healthcare services guided by the moral principles described in the Ethical and Religious Directives for Catholic Healthcare Services published by the U.S. Conference of Catholic Bishops.

Mount Carmel MediGold provides free auxiliary aids and communication services, so that people can communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, contact

Language Assistance Services at 1-800-240-3851
Telecommunications Relay Service (TRS): 7-1-1

Mount Carmel MediGold allows service animals that are trained to do work or perform tasks for the benefit of individuals with a disability.

If you need another type of reasonable modification or accessibility services, please discuss it with your provider or the Section 1557/Americans with Disabilities Act Coordinator:

ATTN: Member Services Manager

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Phone: 1-800-240-3851 (TTY 711)

Fax: 1-833-256-2871

Email: medigoldappeals@mchs.com

If you believe that Mount Carmel MediGold has failed to provide these services or discriminated in another way, you can file a grievance with:

Member Services

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

1-800-240-3851

medigoldappeals@mchs.com

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, DC 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html> This notice is available at the Mount Carmel MediGold website:
www.thpmedicare.org/mount-carmel/

This policy pertains to the privacy practices of Mount Carmel Health Plan, Inc., DBA Mount Carmel MediGold (“Company”). When this policy says “we,” “us,” “our,” it means Mount Carmel Health Plan, Inc., / Mount Carmel MediGold.

Mount Carmel MediGold NOTICE OF PRIVACY PRACTICES

Policy last revised February 16, 2026

Protection of Information

Company understands that your information is highly personal and is committed to safeguarding your protected health information (“PHI”). Please read this Notice of Privacy Practices thoroughly. Company is required by law to maintain the privacy of PHI. We are required to provide you with notice of our legal duties and privacy practices with respect to PHI. We will only use or disclose your PHI as permitted or required by applicable state or federal law. We can help you understand our privacy practices and your rights.

Permitted Uses and Disclosures

Treatment

We may use and disclose PHI to doctors, hospitals, pharmacies and/or other health care providers who are involved in your care and treatment.

For example, doctors may request PHI from us for coordination of care purposes or doctors may send Company information about your diagnosis and treatment plan so we can arrange additional services. Company may also disclose your PHI to health care providers in connection with preventive health, early detection and disease and case management programs.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Payment

To help pay for your covered services, we may use and disclose PHI in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility and coverage; determining prescription drug compliance; collecting premiums; calculating cost-sharing amounts and coordination of benefits; and responding to complaints, appeals and requests for external review.

For example, we may use your medical history and other health information about you to decide whether a treatment is a covered benefit and what the payment should be – and during

the process we may disclose information to your provider. We also use PHI to obtain payment for any mail-order pharmacy services provided to you or to obtain payment for premiums.

Health Care Operations

Company may use and disclose PHI about you to develop better services for you. Other routine operations requiring use and disclosure of PHI include population health and wellness; underwriting and premium rating; administration of pharmacy benefit programs; coordination of benefits; and other general administrative activities including information resources and data management. Company is specifically prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes as required by the Genetic Information and Nondiscrimination Act ("GINA").

Other Uses and Disclosures

Information and Health Promotion Activities

Company may use and disclose some of your PHI for certain health promotion activities. For example, your name and address may be used to send you newsletters or general communications. Company may also send you information based on your own health concerns. We may send you this information if it has determined that a product or service may help you. These communications will explain how the products or services relate to your well-being and can improve your health.

Research

Under certain circumstances, Company may use and disclose your PHI for research purposes. Research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Researchers are required to safeguard all PHI they receive. We may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects; however, with very limited exceptions such disclosures must first be cleared through this special approval process.

More Stringent State and Federal Laws

There may be times where certain areas of state law is more stringent than the Health Insurance Portability and Accountability Act and associated regulations ("HIPAA"). Certain federal laws also are more stringent than HIPAA. Company will continue to abide by these more stringent state and federal laws.

The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.

State law is more stringent when the individual is entitled to greater access to records than under HIPAA. State law also is more restrictive when the records are more protected from disclosure by state law than under HIPAA. For example, Ohio law may require that we obtain your authorization before releasing records containing HIV/AIDS diagnosis or before disclosing information regarding treatment you received at an Ohio licensed behavioral health facility. And in Idaho, electronic medical records must be provided by hospitals within three (3) days of the request being received.

Permitted Uses or Disclosures With an Opportunity for You to Agree or Object

Family/Friends

Company may disclose PHI about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps you pay for your care. You have a right to request that your PHI not be shared with some or all of your family or friends.

Other Permitted Uses and Disclosures

Company may also disclose your PHI as follows.

Administer Your Plan

We may disclose PHI to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Business Associates

To organizations that provide services to us and assure us in writing that they will protect the information. We will give out as little information as possible to allow our business associates to complete these tasks and Company requires these business associates to appropriately safeguard the privacy of your information.

Membership in Trinity Health

Members of Trinity Health (including Company) participate together in an organized health care arrangement for utilization review and quality assessment activities with respect to this information. Members of Trinity Health may also use your PHI for treatment, payment and/or health care operations permitted by HIPAA with respect to operations of the organized health care arrangement.

Uses and Disclosures Permitted by Public Policy or Law Without Your Authorization

Law Enforcement

Company will use and disclose PHI to federal, state, and local law enforcement officials as required by applicable law, such as identifying a criminal suspect or a missing person, or providing information about a crime victim or criminal conduct.

Legal Proceedings

Company will use and disclose PHI in response to a court order or other lawful purpose.

Required by Law

Company will disclose PHI about you when required by federal, state or local law to make reports or other disclosures. We may also make disclosures for judicial and administrative proceedings such as lawsuits or other disputes in response to a court order. Company will disclose your medical information to government agencies concerning victims of abuse, neglect or domestic violence. We will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies. Specialized government functions will include military and veteran's activities, national security and intelligence activities, and protective services for the President and others. Company will make certain disclosures that are required in order to comply with workers' compensation or similar programs.

Public Health Oversight or Safety

Company will use and disclose PHI to avert a serious threat to health and safety of a person or the public. We will use and disclose PHI to Public Health Agencies for immunizations, communicable diseases, etc. Company will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA-regulated products or activities, including collecting and reporting adverse events, tracking and facilitating product recalls, etc. and post-marketing surveillance.

Health Information Exchange (HIE)

Your PHI may be disclosed to an approved health information exchange ("HIE") to facilitate the provision of health care to you. The HIE has a duty under the law to maintain appropriate administrative, physical and technical safeguards to protect the privacy and security of PHI. Only authorized individuals may access and use PHI from the HIE. You or your personal representative have the right to request in writing that Company do either or both of the following: (i) not disclose any of your PHI to the HIE; and (ii) not disclose specific categories of your PHI to the HIE.

Any restrictions on the disclosure of PHI you request as described in the prior sentence may result in a health care provider not having access to information that is necessary for the provider to render appropriate care to you. Company will honor all requests for restrictions on disclosure of PHI to health information exchange(s) as required by law.

For more information or to request restrictions, please contact Company, either by mail or by calling Member Services.

Mail

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Phone

1-800-240-3851 (TTY/TDD 711)
8 a.m. to 8 p.m., seven days a week

Use or Disclosure Requiring Your Authorization**Marketing**

Company is not permitted to provide your PHI to any other person or company for marketing to you of any products or services other than certain Plan products or services unless you have signed an authorization. If Company receives direct or indirect payment from or on behalf of a third party to make a communication that encourages you to purchase or use that third party's product or service, we will obtain your authorization.

Psychotherapy Notes, Sale of PHI, and Other Uses

In addition to marketing and research, the following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes (if recorded by a mental health professional); and (ii) disclosures that constitute a sale of PHI. Company does not share or sell your PHI to companies that market health care products or services directly to consumers for use by those companies to contact you, such as drug companies, unless you have signed an authorization.

Other uses and disclosures of your medical information not described in this Notice will be made only with your written authorization. Written authorizations will let you know why we are using your PHI. You have the right to revoke an authorization at any time. If you have questions regarding authorizations, please call Member Services.

Individual Rights

Under federal privacy regulations, you have the following rights regarding your personal health information. You can exercise these rights as described below by contacting Company, either by mail or by calling Member Services.

Mail

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Member Services

1-800-240-3851 (TTY/TDD 711)
8 a.m. to 8 p.m., seven days a week

Right to Confidential Communications. You have the right to request in writing to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that Company only contact you at work or by mail.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. Company will consider your request, but is not required to agree to your requested restrictions.

Right to Inspect and Copy. With some exceptions, you have the right to inspect and copy information about your PHI as long as we maintain the information. In certain limited circumstances, Company may be required to deny your request.

Right to Amend. With some exceptions, you have the right to request in writing an amendment of your PHI for as long as Company maintains the information.

Right to an Accounting. With some exceptions, you have a right to receive an accounting of certain disclosures of your PHI that Company has made.

Right to Receive a Copy of this Notice. You have the right to receive a paper copy of this Notice of Privacy Practices upon request.

Right to Notification of Breach. You will receive notification of any breach of your unsecured PHI.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Company. You may submit complaints directly to Company by mail or by calling Member Services.

Mail

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Member Services

1-800-240-3851 (TTY/TDD 711)

8 a.m. to 8 p.m., seven days a week

Company assures you that filing a complaint will in no way affect your covered services or membership in our plan – we will not retaliate against you for filing a complaint.

Complaints may also be filed with the Department of Health and Human Services, Office for Civil Rights, by:

- Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201,
- Calling 1-877-696-6775
- Visiting www.hhs.gov/ocr/privacy/hipaa/complaints

Further Information

To obtain additional information, please contact Member Services at 1-800- 240-3851 (TTY: 711). Member Services is available 8 a.m. to 8 p.m., seven days a week.

Changes to This Notice

Company will abide by the terms of the notice currently in effect. We reserve the right to change the terms of its notice and to make the new notice provisions effective for all PHI that it maintains. We will notify you in writing of any substantial changes to the notice. Our current Notice of Privacy Practices is always available on our website.

Mount Carmel MediGold No Premium (HMO) is a local HMO plan with a Medicare contract. Enrollment depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services. Health coverage is offered by Mount Carmel Health Plan, Inc.

Mount Carmel MediGold is a Medicare Advantage organization with a Medicare contract. Enrollment in Mount Carmel MediGold depends on contract renewal. Benefits vary by county. Other pharmacies, physicians or providers are available in the plan’s network. Speak with a licensed sales agent during call center hours: April 1 to September 7, 8 a.m. to 8 p.m., Monday through Friday; September 8 to March 31, 8 a.m. to 8 p.m., seven days a week. To file a grievance, call 1-800-MEDICARE (TTY: 711) to file a complaint with Medicare. One Pass® is a

registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. Mount Carmel MediGold is an affiliate of Trinity Health. In select counties, Mount Carmel MediGold offers Medicare Advantage plans in partnership with Trinity Health's regional health ministry. Most operational and administrative functions for the plan are performed through the plan's headquarters in Columbus, Ohio. Mount Carmel MediGold has the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer.

According to CMS regulations at 42 CFR sections 422.108 and 423.462, Mount Carmel MediGold, as a Medicare Advantage organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws. Out-of-network care is only considered when services are not accessible in-network (does not apply for PPO). Out-of-network or non-contracted providers are under no obligation to treat Mount Carmel MediGold members, except in emergency situations. Mount Carmel MediGold encourages members or their provider to contact Member Services for a pre-service organization determination before you receive a service. Please call Member Services at 800-240-3851 (TTY: 711) or see your Evidence of Coverage for more information, including cost-sharing that applies to out-of-network services. To file a grievance, call 800-240-3851 (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or call 1-800-MEDICARE (TTY: 711) to file a complaint with Medicare. You can also fax 833-802-2495 or write to: Mount Carmel MediGold, (HMO), Attn: Appeals and Grievances Department, 5955 E Broad Street, Health Plan - Second Floor, Columbus OH 43213. One Pass® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. The One Pass program varies by plan/area. Equipment, classes, personalized fitness plans and events may vary by location. One Pass is not responsible for the services or information provided by third parties. Employers should consult an appropriate tax professional to determine if individuals have any tax obligations. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-240-3851 (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 800-240-3851 (TTY: 711).