

# 2026 Summary of Benefits Mount Carmel MediGold Glory No RX (HMO)



MOUNT CARMEL MediGold  
Health Plan

A Member of Trinity Health

# 2026 Summary of Benefits

## Mount Carmel MediGold Glory No RX (HMO)

This is a summary of Medicare health care coverage for Mount Carmel MediGold Glory No RX (HMO).

January 1 – December 31, 2026

### **Mount Carmel MediGold Glory No RX (HMO)**

is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan 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 1-800-240-3851 (TTY 711) and request the “Evidence of Coverage” or access it online at [www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/).

To join **Mount Carmel MediGold Glory No RX (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Ohio: Adams, Allen, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Coshocton, Crawford, Darke, Defiance, Delaware, Fairfield, Fayette, Franklin, Fulton, Gallia, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Jackson, Knox, Licking, Logan, Lucas, Madison, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Preble, Putnam, Richland, Ross, Seneca, Shelby, Union, Van Wert, Vinton, Warren, Washington, Wood and Wyandot.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

Find a provider at this link

[www.thpmedicare.org/mount-carmel/find-a-provider](http://www.thpmedicare.org/mount-carmel/find-a-provider).

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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

For more information, please call us at 1-800-240-3851 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week, or visit us at [www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/).

# Premiums and Benefits

This is a short list of benefits and cost sharing for our plan. For a complete list, see the *Evidence of Coverage* on our website at [www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/).

| Premiums and Benefits                                                   |                                                                                                                         | Mount Carmel MediGold Glory No RX (HMO) |
|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>Monthly Plan Premium</b>                                             | You pay \$0 each month.<br>You must continue to pay your Medicare Part B premium.                                       |                                         |
| <b>Part B Premium Buy-down</b>                                          | Our plan will reduce your monthly Medicare Part B premium by \$122.50.                                                  |                                         |
| <b>Deductible</b>                                                       | You pay \$0 for in-network medical benefits.                                                                            |                                         |
| <b>Maximum Out-of-Pocket Responsibility</b>                             | You pay no more than \$4,900 annually.<br>Includes copays and other costs for in-network medical services for the year. |                                         |
| <b>Inpatient Hospital</b>                                               | For in-network inpatient hospital stays, you pay:<br>\$95 copay per day for days 1-7; \$0 copay per day for days 8-90.  |                                         |
| <b>Outpatient Hospital</b>                                              | For services at an in-network outpatient hospital, you pay \$175 copay.                                                 |                                         |
| <b>Ambulatory Surgical Center (ASC)</b>                                 | You pay \$175 copay in-network.                                                                                         |                                         |
| <b>Doctor Visits</b>                                                    |                                                                                                                         |                                         |
| <ul style="list-style-type: none"> <li>Primary care provider</li> </ul> | You pay \$0 copay in-network.                                                                                           |                                         |
| <ul style="list-style-type: none"> <li>Specialists</li> </ul>           | You pay \$30 copay in-network.                                                                                          |                                         |
| <b>Preventive Care</b><br>(e.g., flu vaccine, diabetic screenings)      | You pay nothing in-network.                                                                                             |                                         |

| <b>Premiums and Benefits</b>                                                              |                                                                                                                                                                                                                                                                                                                                                                         | <b>Mount Carmel MediGold Glory No RX (HMO)</b> |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>Emergency Care</b>                                                                     | <p>You pay \$110 copay per visit. ER cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition.</p> <p>\$110 copay for each emergency care visit outside of the United States and its territories. Worldwide ER services cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition.</p> |                                                |
| <b>Urgently Needed Services</b>                                                           | <p>You pay \$35 copay per visit.</p> <p>\$110 copay for each urgently needed care visit outside of the United States and its territories.</p> <p>\$200 to \$250 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.</p>                                                                              |                                                |
| <b>Diagnostic Services /Labs /Imaging /Radiology</b>                                      |                                                                                                                                                                                                                                                                                                                                                                         |                                                |
| <ul style="list-style-type: none"> <li>Diagnostic tests and procedures</li> </ul>         | You pay \$25 copay in-network.                                                                                                                                                                                                                                                                                                                                          |                                                |
| <ul style="list-style-type: none"> <li>Lab services</li> </ul>                            | You pay \$0 copay in-network.                                                                                                                                                                                                                                                                                                                                           |                                                |
| <ul style="list-style-type: none"> <li>MRIs, CAT scans</li> </ul>                         | You pay \$95 copay in-network.                                                                                                                                                                                                                                                                                                                                          |                                                |
| <ul style="list-style-type: none"> <li>X-rays</li> </ul>                                  | You pay \$25 copay in-network.                                                                                                                                                                                                                                                                                                                                          |                                                |
| <ul style="list-style-type: none"> <li>Therapeutic radiology services</li> </ul>          | <p>You pay 20% of the total cost in-network.</p> <p>May require prior authorization.</p>                                                                                                                                                                                                                                                                                |                                                |
| <b>Hearing Services</b>                                                                   |                                                                                                                                                                                                                                                                                                                                                                         |                                                |
| <ul style="list-style-type: none"> <li>Medicare-covered hearing exam</li> </ul>           | You pay \$30 copay in-network.                                                                                                                                                                                                                                                                                                                                          |                                                |
| <ul style="list-style-type: none"> <li>Routine hearing exam</li> </ul>                    | You pay \$0 copay in-network (1 exam every year).                                                                                                                                                                                                                                                                                                                       |                                                |
| <ul style="list-style-type: none"> <li>Fitting and evaluation for hearing aids</li> </ul> | You pay \$0 copay in-network (unlimited visits every year).                                                                                                                                                                                                                                                                                                             |                                                |

| Premiums and Benefits                                                              | Mount Carmel MediGold Glory No RX (HMO)                                                                                                                                            |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Hearing aids</li> </ul>                     | <p>You pay \$599 to \$899 copay in-network for prescription hearing aids – all types (2 hearing aids every year).</p> <p>Must use TruHearing® provider to access this benefit.</p> |
| <b>Dental Services</b>                                                             |                                                                                                                                                                                    |
| <ul style="list-style-type: none"> <li>Medicare-covered dental services</li> </ul> | <p>You pay \$30 copay in-network.</p>                                                                                                                                              |

| Premiums and Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Mount Carmel MediGold Glory No RX (HMO)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <ul style="list-style-type: none"> <li>• Preventive dental services               <ul style="list-style-type: none"> <li>○ 2 oral exams every year</li> <li>○ 2 cleanings every year</li> <li>○ 2 fluoride treatments every year</li> <li>○ 1 X-ray; x-ray benefit is for bitewing x-rays two to eight per calendar year, vertical bitewing x-rays one per consecutive 36 months, or one full mouth x-ray every 36 consecutive months.</li> <li>○ 1 visit for other diagnostic dental services; intraoral tomosynthesis benefit is for two to eight x-rays per calendar year for bitewing and periapical, or 1 per consecutive 36 months for comprehensive series.</li> <li>○ 1 visit for other preventive dental services; space maintainer benefit is for 1 per consecutive 60 months, re-cement or re-bond of space maintainer is for 1 per consecutive 6 months, or removal of fixed space maintainer is unlimited.</li> </ul> </li> </ul> | <p>\$1,000 maximum plan coverage amount every year for diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit.</p> <p>You pay \$0 copay in-network for an office visit. Services include exams, X-rays, other diagnostic dental services, cleanings, fluoride treatments, other preventive dental services.</p> <p>You must use the Dental Benefit Providers, Inc. provider network to access this benefit.</p> |

| Premiums and Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Mount Carmel MediGold Glory No RX (HMO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| <ul style="list-style-type: none"> <li>Comprehensive dental services:</li> <li>Restorative Services: 1 visit; frequencies include unlimited, one per consecutive 6 months, one per consecutive 12 months, or one per consecutive 60 months depending on service code.</li> <li>Endodontics: 1 visit; frequencies include one per tooth per lifetime, two per tooth per lifetime, or unlimited depending on service code.</li> <li>Periodontics: 1 visit; frequencies include unlimited, two per calendar year, two per consecutive 12 months, one per consecutive 36 months, or one per quadrant per consecutive 24 or 36 months depending on service code.</li> <li>Oral and Maxillofacial Surgery: 1 visit; frequency includes unlimited, 1 per site per visit, consecutive 36 months, or lifetime, 1 per tooth per lifetime, 1 per consecutive 36 months, or 1 biopsy per site per visit depending on service code.</li> <li>Adjunctive General Services: 1 visit; frequency is unlimited, 1 per consecutive 6 months, or 2</li> </ul> | <p>\$1,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. This amount is combined with the diagnostic and preventive dental services benefit.</p> <p>You pay 50% of the total cost in-network for restorative services.</p> <p>You pay 70% of the total cost in-network for endodontics services.</p> <p>You pay 70% of the total cost in-network for periodontics services.</p> <p>You pay 50% of the total cost in-network for oral and maxillofacial surgery services.</p> <p>You pay \$0 copay in-network for adjunctive general services.</p> <p>You must use the Dental Benefit Providers, Inc. provider network to access this benefit.</p> |

| Premiums and Benefits                                                                                                          | Mount Carmel MediGold Glory No RX (HMO)                                                                                                                                                                                 |
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| per calendar year depending on the service code.                                                                               |                                                                                                                                                                                                                         |
| <b>Vision Services</b>                                                                                                         |                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>Medicare-covered benefits</li> </ul>                                                    | <p>You pay \$30 copay in-network for an eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay \$0 copay in-network for one pair of eyeglasses or contact lenses after cataract surgery.</p> |
| <ul style="list-style-type: none"> <li>Routine eye exams</li> </ul>                                                            | <p>You pay \$0 copay in-network (1 exam every year).</p>                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>Routine eyewear</li> </ul>                                                              | <p>\$200 maximum plan coverage amount every year for all non-Medicare-covered eyewear. Must use a Spectera, Inc. provider to access this benefit.</p>                                                                   |
| <b>Mental Health Services</b>                                                                                                  |                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>Outpatient therapy with a psychiatrist</li> </ul>                                       | <p>You pay \$25 copay in-network for individual sessions.</p> <p>You pay \$25 copay in-network for group sessions.</p>                                                                                                  |
| <ul style="list-style-type: none"> <li>Outpatient therapy with a mental health care professional (non-psychiatrist)</li> </ul> | <p>You pay \$25 copay in-network for individual sessions.</p> <p>You pay \$25 copay in-network for group sessions.</p>                                                                                                  |
| <b>Skilled Nursing Facility (SNF)</b>                                                                                          | <p>For in-network SNF stays, you pay:</p> <p>\$0 copay per day for days 1-20; \$218 copay per day for days 21-60; \$0 copay per day for days 61-100.</p>                                                                |
| <b>Physical Therapy</b>                                                                                                        | <p>You pay \$20 copay in-network.</p>                                                                                                                                                                                   |
| <b>Ambulance</b>                                                                                                               | <p>You pay \$200 copay in-network for ground ambulance services.</p> <p>You pay \$250 copay in-network for air ambulance services.</p> <p>May require prior authorization.</p>                                          |



| Premiums and Benefits                                      | Mount Carmel MediGold Glory No RX (HMO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| <b>Transportation</b>                                      | <p>You pay \$0 copay in-network (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.)</p> <p>You must call 1-833-944-0516 to access this benefit.</p>                                                                                                                               |
| <b>Medicare Part B Drugs</b>                               | <p>You pay \$35 copay in-network for Medicare Part B insulin drugs.</p> <p>You pay 20% of the total cost in-network for Medicare Part B chemotherapy and radiation drugs.*</p> <p>You pay 20% of the total cost in-network for other Medicare Part B drugs.*</p> <p>May require prior authorization or step therapy.</p> <p>*You may pay less than a 20% coinsurance for certain Part B rebatable drugs. If the drug price has increased at a rate faster than the rate of inflation, the amount you pay will be based on a lower, inflation-adjusted price.</p> |
| <b>Podiatry Services</b>                                   | <p>You pay \$30 copay in-network for Medicare podiatry services.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Durable Medical Equipment</b>                           | <p>You pay 20% of the total cost in-network durable medical equipment.</p> <p>May require prior authorization.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prosthetic Devices (braces, artificial limbs, etc.)</b> | <p>Prosthetic devices: You pay 20% of the total cost for in-network devices.</p> <p>Related medical supplies: You pay 20% of the total cost for in-network supplies.</p> <p>May require prior authorization.</p>                                                                                                                                                                                                                                                                                                                                                 |

| Premiums and Benefits                 |                                                                                                                                                                                                                                                                                            | Mount Carmel MediGold Glory No RX (HMO) |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <b>Diabetic Supplies and Services</b> | <p>Diabetic supplies: You pay \$0 copay for in-network supplies.</p> <p>Diabetes self-management training: You pay \$0 copay for in-network training.</p> <p>Therapeutic shoes or inserts: You pay 20% of the total cost for in-network shoes.</p> <p>May require prior authorization.</p> |                                         |
| <b>Fitness Benefit</b>                | <p>You pay \$0 copay for the fitness benefit. One Pass® network must be used for this benefit.</p>                                                                                                                                                                                         |                                         |
| <b>Meal Benefit</b>                   | <p>You pay \$0 copay for the meal benefit.</p> <p>The benefit consists of 2 meals per day for 7 days, immediately following a qualifying discharge. There is no annual limit on occurrences.</p> <p>You must use GA Foods to access this benefit.</p>                                      |                                         |

## Additional Benefits

This plan provides additional benefits. For more information, see the *Evidence of Coverage* on our website at [www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/).

| Additional Benefits                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Flexible Benefit Card- Including Member Rewards/Incentive and Supplemental Vision/Hearing Allowance</b> | <p>Included! You receive \$150 annual allowance on your card you can use towards plan-covered vision and hearing services. This benefit does not carry over to the next plan year.</p> <p>You can receive \$50 annually added to your Flexible Benefit Card in your Member Rewards wallet when you complete an Annual Wellness Visit and fill out/return the necessary attestation.</p> |
| <b>Over the Counter (OTC) Allowance</b>                                                                    | <p>\$0 copay.</p> <p>\$75 maximum plan coverage amount every 3 months for OTC items.</p> <p>Unused portion does not carry over to the next period.</p> <p>You must use OTCHS to access this benefit.</p>                                                                                                                                                                                |

| Additional Benefits                                    |                                                                                                                  |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| <b>24 Hour Nurse Advice Line + Virtual Care Visits</b> | \$0 copay.<br>You must call 1-855-638-5842 to access this benefit.                                               |
| <b>Visitor Travel Allowance</b>                        | \$3,500<br>This benefit allowance does not carry over to the next plan year.<br>May require prior authorization. |
| <b>Acupuncture</b>                                     | \$20 copay, 6 visits every year, for in-network services.<br>May require prior authorization.                    |

## Optional Supplemental Benefits

This plan offers some extra benefits that are not covered by Original Medicare and not included in its benefits package. These extra benefits are called **Optional Supplemental Benefits**. If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. For more information, see the *Evidence of Coverage* on our website at [www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/).

| Optional Supplemental Benefits |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Optional Dental Silver</b>  | <p>The premium for the Dental Silver benefit is \$16 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable).</p> <ul style="list-style-type: none"> <li>• There is an annual maximum benefit limit of \$1,500.</li> <li>• \$0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays.</li> <li>• 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery.</li> <li>• 0% - 50% coinsurance for restorative services.</li> </ul> |

## Optional Supplemental Benefits

### Optional Dental Gold

The premium for the Dental Gold benefit is \$37 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable).

- There is an annual maximum benefit limit of \$2,000.
- \$0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays.
- 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery.
- 0% - 50% coinsurance for restorative services.
- 50% coinsurance for crowns, bridges and dentures.

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 800-964-4525 (TTY: 711).

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit [www.thpmedicare.org/mount-carmel/for-members/plan-documents](http://www.thpmedicare.org/mount-carmel/for-members/plan-documents) or call 800-964-4525 (TTY:711) to view a copy of the EOC.
- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select new doctors.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.
- ☐ Except in an emergency or urgent situation, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- ☐ **Effect on Current Coverage:** Your current health care coverage will end once your new Medicare coverage starts. For example, if you have a different Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

## **We're Here for You**

If you have any questions about your Mount Carmel MediGold benefits, we are a phone call or click away. You can reach us at 800-240-3851 (TTY: 711), 8 a.m. – 8 p.m., 7 days a week. On certain holidays, your call will be handled by our automated phone system. You may also visit our website, [www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/) Medicare is also available at 1-800-MEDICARE, 24 hours a day, 7 days a week. We look forward to serving you!

Mount Carmel MediGold (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in Mount Carmel MediGold depends on contract renewal. Benefits vary by county.

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-240-3851 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-964- 4525 (TTY: 711).

Mount Carmel MediGold Glory No RX (HMO) is a HMO plan with a Medicare contract. Enrollment in plan(s) 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. Out-of-network/non-contracted providers are under no obligation to treat Mount Carmel MediGold members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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..

### **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 Glory No RX (HMO) 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 Glory No RX (HMO) 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 Glory No RX (HMO) 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**

3100 Easton Square Place, Suite 300  
Columbus, OH 43219

**Phone:**

[1-800-240-3851](tel:1-800-240-3851) (TTY 711)

**Fax:**

1-833-802-2495

**Email:**

[medigoldappeals@mchs.com](mailto:medigoldappeals@mchs.com)

If you believe that Mount Carmel MediGold Glory No RX (HMO) has failed to provide these services or discriminated in another way, you can file a grievance with:

**Member Services**

3100 Easton Square Place Suite 300  
Columbus, OH 43219

**1-800-240-3851**

[medigoldappeals@mchs.com](mailto: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 Glory No RX (HMO) website:  
[www.thpmedicare.org/mount-carmel/](http://www.thpmedicare.org/mount-carmel/)

## **Notice of Accessibility**

**English:** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-240-3851 (TTY: 711) or speak to your provider.

**Spanish:** Español

ATENCIÓN: Si habla español, dispone de servicios gratuitos de asistencia lingüística. También dispone de recursos y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al 1-800-240-3851 (TTY: 711) o hable con su proveedor.

**Simplified Chinese:** 中文

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-240-3851（文本电话：711）或咨询您的服务提供商。”

**Vietnamese:** Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-240-3851 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.”

**Albanian:** SHQIP

VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-240-3851 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.”

**Korean:** 한국어

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-240-3851 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.”

**Bengali:** বাংলা

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-240-3851 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।”

**Polish:** POLSKI

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-240-3851 (TTY: 711) lub porozmawiaj ze swoim dostawcą”.

**German: Deutsch**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-240-3851 (TTY: 711) an oder wenden Sie sich an Ihren Anbieter.

**Italian: Italiano**

ATTENZIONE: Se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-240-3851 (TTY: 711) o parla con il tuo fornitore.

**Japanese: 日本語**

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-240-3851 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

**Russian: РУССКИЙ**

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-240-3851 (TTY: 711) или обратитесь к своему поставщику услуг.

**Croatian: hrvatski**

PAŽNJA: Ako govorite hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima također su dostupne besplatno. Nazovite 1-800-240-3851 (TTY: 711) ili razgovarajte sa svojim davateljem usluga.

**Serbian: Српски**

ПАЖЊА: Ако говорите Српски, доступне су вам бесплатне услуге језичке помоћи. Одговарајућа помоћна средства и услуге за пружање информација у приступачним форматима такође су доступни бесплатно. Позовите 1-800-240-3851 (TTY: 711) или разговарајте са својим оператером.

**Tagalog: Tagalog**

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-240-3851 (TTY: 711) o makipag-usap sa iyong provider.

**Haitian: Kreyòl Ayisyen**

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-240-3851 (TTY: 711) oswa pale avèk founisè w la.

#### **Yiddish: יידיש**

אכטונג: אויב איר רעדט אריינשטעלן שפראך, זענען פרייע שפראך הילף סערוויסעס פאראן פאר אייך. פאסיגע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך פאראן פריי פון אפצאל. רופט אדער רעדט מיט אייער פראוויידער (TTY: 711) 1-800-240-3851

#### **Arabic: العربية**

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-240-3851 (TTY: 711) أو تحدث إلى مقدم الخدمة.

#### **French: Français**

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-240-3851 (ATS : 711) ou contactez votre fournisseur.

#### **Urdu: اردو**

دھیان دیں: اگر آپ بولتے ہیں انسرٹ لینگویج، آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں پر کال (TTY: 711) معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-240-3851 کریں یا اپنے فراہم کنندہ سے بات کریں۔

#### **Greek: Ελληνικά**

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-240-3851 (TTY: 711) ή απευθυνθείτε στον πάροχό σας».

#### **Swahili/Bantu: Kiswahili**

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-240-3851 (TTY: 711) au zungumza na mtoa huduma wako.”

#### **Farsi/Persian:**

فارسی

توجه: اگر وارد کردن زبان صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-240-3851 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

#### **Dutch: Nederlands**

LET OP: Als u Nederlands, spreekt, kunt u gratis gebruikmaken van taalondersteuning. Ook zijn er gratis hulpmiddelen en diensten beschikbaar om informatie in toegankelijke formaten te verstrekken. Bel 1-800-240-3851 (TTY: 711) of neem contact op met uw provider.



**Ukrainian:** українська мова

УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-240-3851 (TTY: 711) або зверніться до свого постачальника».

**Romanian:** România

ATENȚIE: Dacă vorbiți România, aveți la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit materiale auxiliare și servicii adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-240-3851 (TTY: 711) sau discutați cu furnizorul dumneavoastră.

**Laotian:** ລາວ

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-240-3851 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ."

**Hindi:** हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-240-3851 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"

**Thai:** ไทย

หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-240-3851 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ"

**Karen:** ထာနုန်လီဖဲအံၤ

ဆူ- နမ့ၢ်ကတိၤ ထာနုန်လီဖဲအံၤ အဃိ, တၢ်အိၣ်ဒီး ကျိၣ်တၢ်ဆိၣ်ထွဲမၤစၢၤ လၢတလၢ် ဘျီလၢ်စ့ၤလၢနီၢ်လီၤ. တၢ်အိၣ်ဒီး တၢ်မၤစၢၤတၢ်န့ၢ်ဟ့ၣ်ပီးလီၤဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြးအဘျီ လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အိၣ်သ့တဖၣ် လၢတလၢ်ဘျီလၢ်စ့ၤ လၢနီၢ်လီၤ. ကိး 1-800-240-3851 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး န့ၢ်လၢဟ့ၣ် န့ၢ်တၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်."

**Somali:** Soomaali

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luqadda bilaashka ah ayaa diyaar kuu ah. Kaalmooyinka iyo adeegyada ku habboon ee lagu bixiyo macluumaadka qaabab la heli karo ayaa sidoo kale lagu heli karaa lacag la'aan. Wac 1-800-240-3851 (TTY: 711) ama la hadal adeeg bixiyahaaga.