2027 Summary of Benefits

Mount Carmel MediGold Premier (HMO)



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Mount Carmel MediGold Premier (HMO)

This is a summary of Medicare health care and prescription drug coverage for Mount Carmel MediGold Premier (HMO).

January 1 – December 31, 2027

Mount Carmel MediGold Premier (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/.

To join **Mount Carmel MediGold Premier (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, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Darke, Greene, Hamilton, Miami, Montgomery, Preble, Shelby and Warren.

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.

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

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/.

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/.

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)
Monthly Plan Premium (includes both medical and drugs)	You pay $109 each month. You must continue to pay your Medicare Part B premium.
Deductible	You pay $0 for in-network medical benefits. You pay $0 for Part D prescription drugs on Tiers 3, 4, and 5.
Maximum Out of Pocket Responsibility (does not include Part D prescription drugs)	You pay no more than $3,900 annually. Includes copays and other costs for in-network medical services for the year.
Inpatient Hospital	$190 copay per day for days 1-4; $0 copay per day for days 5-90. May require prior authorization.
Outpatient Hospital	For services at an in-network outpatient hospital, you pay $175 copay.
Ambulatory Surgical Center (ASC)	You pay $175 copay in-network.
Doctor Visits	
• Primary care provider	You pay $0 copay in-network.
• Specialists	You pay $30 copay in-network.
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing in-network.

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)
mergency Care	You pay $130 copay per visit. ER cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition. $130 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.
rently eeded Services	You pay $40 copay per visit. $130 copay for each urgently needed care visit outside of the United States and its territories. $200 to $250 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.
iagnostic Services as mainadob y	
• Diagnostic tests and procedures	You pay $20 copay in-network.
• Lab services	You pay $0 copay in-network.
• MRIs, CAT scans	You pay $85 copay in-network.
• X-rays	You pay $20 copay in-network.
• Therapeutic radiology services	You pay 20% of the total cost in-network.
Hearin Services	
• Medicare-covered hearing exam	You pay $30 copay in-network.
• Routine hearing exam	You pay $0 copay in-network (1 exam every year).
• Fitting and evaluation for hearing aids	You pay $0 copay in-network (unlimited visits every year).

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)
• Hearing aids	You pay $199 to $499 copay in-network for prescription hearing aids – all types (2 hearing aids every year). Must use TruHearing® provider to access this benefit.
ental Services	
• Medicare-covered dental services	You pay $30 copay in-network.

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)

• Preventive dental services
  ○ 2 oral exams every year
  ○ 2 cleanings every year
  ○ 2 fluoride treatments every year
  ○ 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
  ○ 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.
  ○ 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.
	$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.
	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
	You must use the Dental Benefit Providers, Inc. provider network to access this benefit.

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)
• Comprehensive dental services: • 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. • Endodontics: 1 visit; frequencies include one per tooth per lifetime, two per tooth per lifetime, or unlimited depending on service code. • 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. • 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. • Adjunctive General Services: 1 visit; frequency is unlimited, 1 per consecutive 6 months, or 2 per calendar year depending on the service code.	$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. You pay 50% of the total cost in-network for restorative services. You pay 70% of the total cost in-network for endodontics services. You pay 70% of the total cost in-network for periodontics services. You pay 50% of the total cost in-network for oral and maxillofacial surgery services. You pay $0 copay in-network for adjunctive general services. You must use the Dental Benefit Providers, Inc. provider network to access this benefit.

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)
ision Services	
• Medicare-covered benefits	You pay $30 copay in-network for an eye exam to diagnose and treat diseases and conditions of the eye. You pay $0 copay in-network for one pair of eyeglasses or contact lenses after cataract surgery.
• Routine eye exams	You pay $0 copay in-network (1 exam every year).
• Routine eyewear	$300 maximum plan coverage amount every year for all non-Medicare-covered eyewear. Must use a Spectera, Inc. provider to access this benefit.
Mental Healt Services	
• Outpatient therapy with a psychiatrist	You pay $25 copay in-network for individual sessions. You pay $25 copay in-network for group sessions.
• Outpatient therapy with a mental health care professional (non-psychiatrist)	You pay $25 copay in-network for individual sessions. You pay $25 copay in-network for group sessions.
Silled ur in acility (S)	For in-network SNF stays, you pay: $0 copay per day for days 1-20; $221 copay per day for days 21-65; $0 copay per day for days 66-100.
P ysical era y	You pay $35 copay in-network.
Am ulan ce	You pay $200 copay in-network for ground ambulance services. You pay $250 copay in-network for air ambulance services. May require prior authorization.

Premiums and Benefits	Mount Carmel Med Gold Premier (HMO)
ransportation	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. Other modes of transportation include ambulance, wheelchair, and extra-large wheelchair vehicles.) You must call 833-944-0516 to access this benefit.
Medicare Part B rus	You pay 20% of the total cost in-network for Medicare Part B chemotherapy and radiation drugs.* You pay 20% of the total cost in-network for other Medicare Part B drugs.* You pay a $35 copay in-network for Medicare Part B insulin drugs. May require prior authorization or step therapy. *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.
Podatry Services	You pay $30 copay in-network for Medicare podiatry services.
ura le Medcal ument	You pay 20% of the total cost in-network durable medical equipment. May require prior authorization.
Prost etic eices(races, artificallim s, etc)	Prosthetic devices: You pay 20% of the total cost for in-network devices. Related medical supplies: You pay 20% of the total cost for in-network supplies. May require prior authorization.

Premiums and Ben	Mount Carmel Med Gold Premier (HMO)
iabetic Supplies and Ser	Diabetic supplies: You pay $0 copay for in-network supplies. Diabetes self-management training: $0 copay for in-network training. Therapeutic shoes or inserts: You pay 20% of the total cost for in-network shoes. May require prior authorization.
itness Benefit	You pay $0 copay for the fitness benefit. One Pass® network must be used for this benefit.
Meal Benefit	You pay $0 copay for the meal benefit. The benefit consists of 2 meals per day for 7 days, immediately following a qualifying discharge. There is no annual limit on occurrences. You must use GA Foods to access this benefit.

Part Prescription rugs

This is a summary of Part D prescription drug coverage and cost sharing for our plan. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/mount-carmel/.

Part Prescription rugs	
Part nsulin Coverage	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.
ruCoverage	Included! Call for details.
eductible	You do not pay a deductible.

nitialCo era e	You pay the following until your total yearly drug costs reach $2,400. Total yearly drug costs are the drug costs paid by both you and our Part D plan.	
0 ayS u ly	**Stan dard etail** 30-day supply	**MailO rder** 30-day supply
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$5	$0
Tier 3: Preferred Brand	25% of the total cost	25% of the total cost
Tier 4: Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5: Specialty Tier	33% of the total cost	33% of the total cost
0 ayS u ly	**Stan dard etail** 90-day supply	**MailO rder** 90-day supply
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$15	$0
Tier 3: Preferred Brand	25% of the total cost	25% of the total cost
Tier 4: Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5: Specialty Tier	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Cata stro i cCo era e	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,400 limit for the calendar year. During this payment stage, you pay nothing for your covered Part D drugs. ED drugs will have the Tier 2 copay in the catastrophic coverage for 2027.	

Your cost-sharing may be different if you use a Long -Term Care pharmacy, or an out-of-network pharmacy or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan's Evidence of Coverage on our website www.thpmedicare.org/mount-carmel/ for complete information about your costs or covered drugs.

Additional Benefits

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

Additional Benefits	
Over the Counter (OTC) Allowance	$0 copay. $100 maximum plan coverage amount every 3 months for OTC items. Unused portion does not carry over to the next period. You must use CVS Flex Benefits (formerly known as Over-the-Counter Health Solutions) to access this benefit.
24 Hour Nurse Advice Line Virtual Care Visits	$0 copay. You must call 1-855-638-5842 to access this benefit.
Historical Allowance	$3,500 This benefit is per plan year and does not carry over to the next plan year. May require prior authorization.
Acupuncture	$20 copay, 12 visits every year, for in-network services. 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/.

Optional Supplemental Benefits	
Optional Dental Silver	The premium for the Dental Silver benefit is $17 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 $1,500. • $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.
Optional Dental Gold	The premium for the Dental Gold benefit is $39 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.

Mount Carmel MediGold Premier (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.

MI t is a Medicare Advantage organization with a Medicare contract. Enrollment MI in t 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. MI is a voluntary program. t is an affiliate of Trinity Health u MI in select counties, t 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. t has a 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, t , 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 t members, except in emergency situations. t encourages members to call 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: t , (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). 800-240-3851 (TTY: 711).

O C O M G A SAB O O SC M A O ,A A AB O A G A G A SS S A C ,A A A S,A ACC SS B S C S

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.

Ml t 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.

Ml t 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

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Ml t 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:

A Mem er Ser i ces Man a er
5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213
P on e
1-800-240-3851 (TTY 711)

a
1-833-802-2495

mai l
medigoldappeals@mchs.com

u nM rm If you beMe t has failed to provide these services or discriminated in another way, you can file a grievance with:

Mem er Ser i ce s
5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213
00 2 0
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 website: www.themedicalcare.org/mount-carmel/

NOTICE OF PRIVACY PRACTICES

Policy last revised February 16, 2026

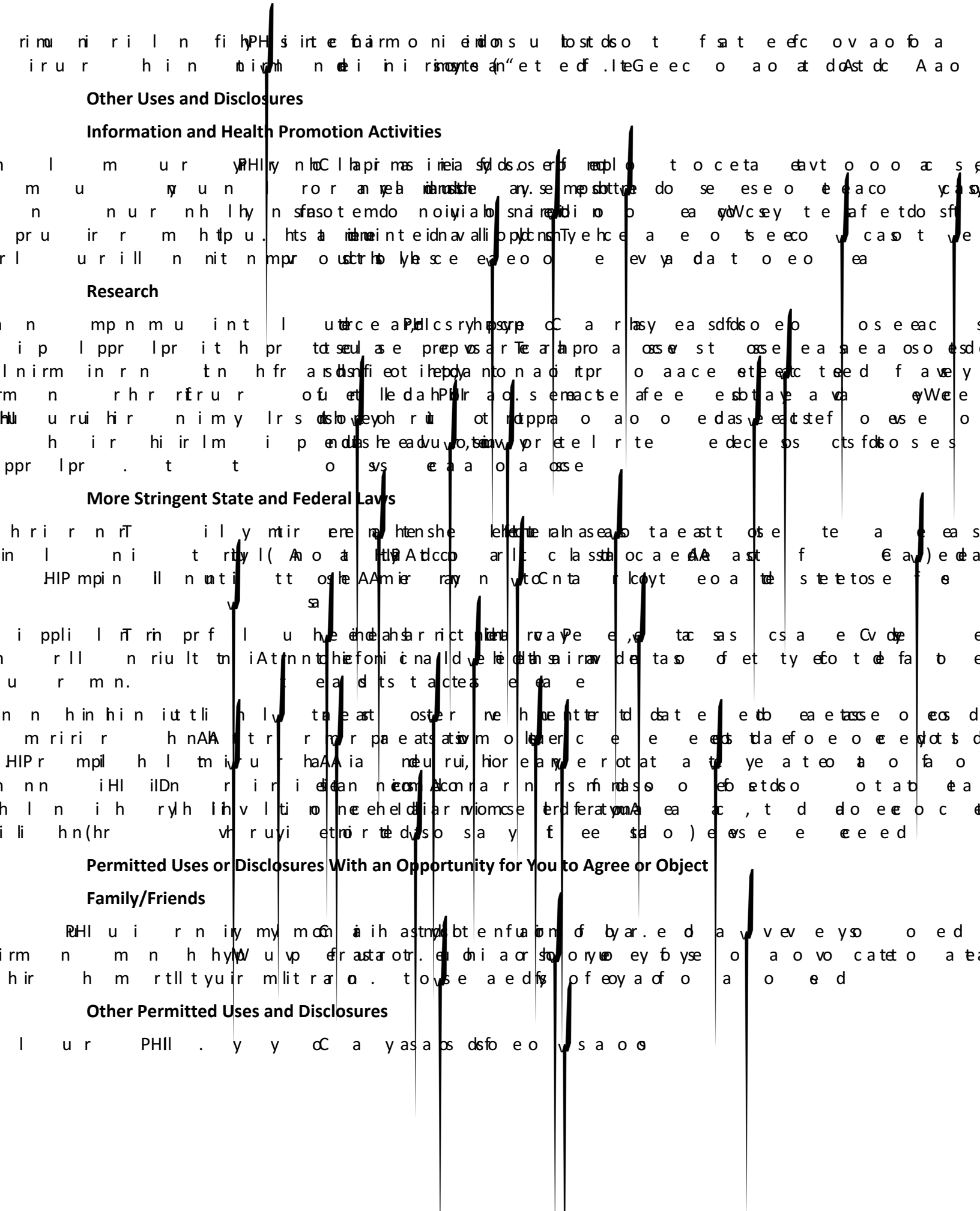
Protection of Information

Permitted Uses and Disclosures

Treatment

Payment

Health Care Operations



Administer Your Plan

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Membership in Trinity Health

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Law Enforcement

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Legal Proceedings

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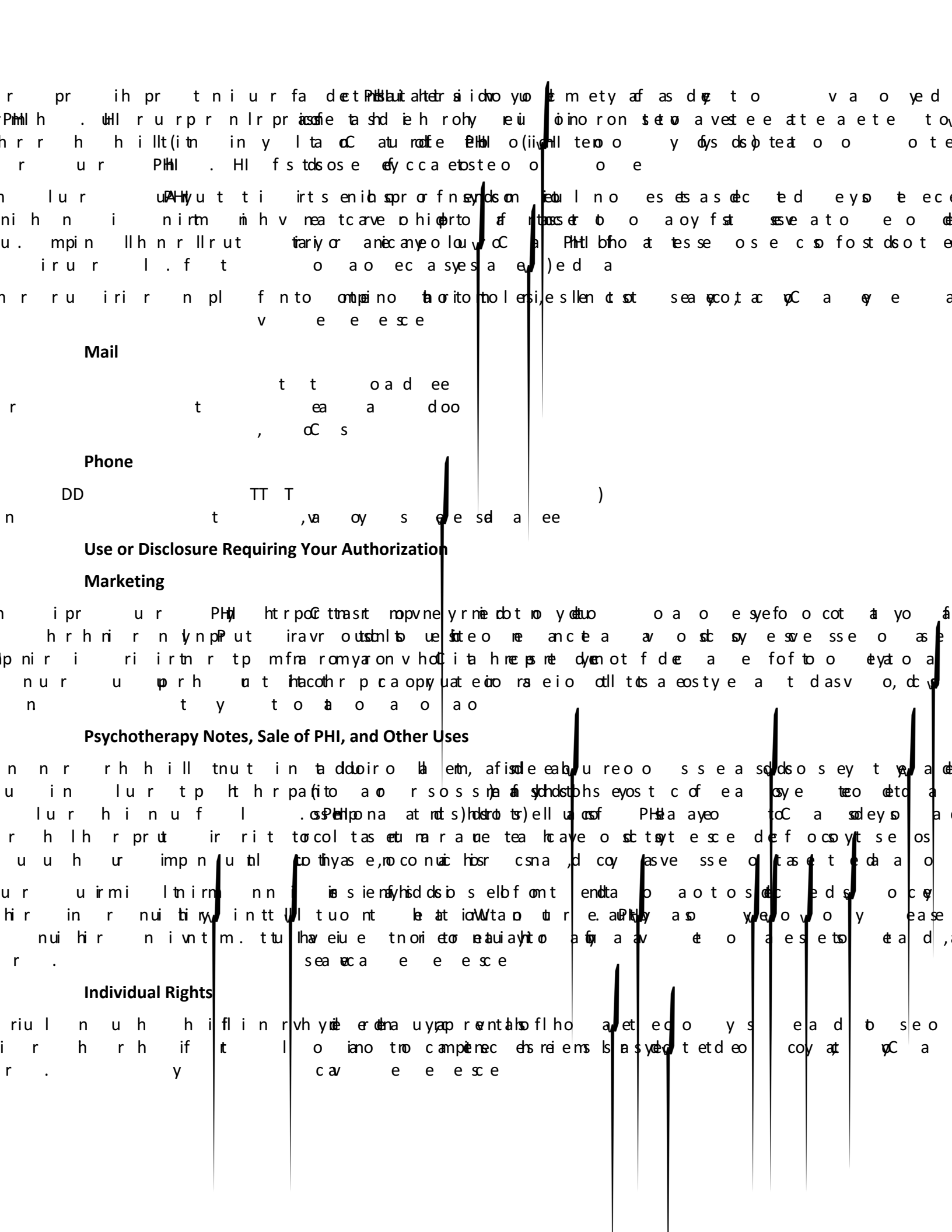
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Public Health Oversight or Safety

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Health Information Exchange (HIE)

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h h H I u u n f r h t l i t m p n e a n p r p r o p o i t y m e i r s t a i a p l d v l d e e a o t a a t o t v a e , y d s



Mail

Phone

Use or Disclosure Requiring Your Authorization

Marketing

Psychotherapy Notes, Sale of PHI, and Other Uses

Individual Rights

Mail

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Member Services

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Right to Confidential Communications. i n r n i r i v t n i n t o d a e t e t o v t e s e v f o t e e
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Right to Request Restrictions. i r n n i r v n t i n t o l a u e r t e t t o e s e s t e c s o c e a s s e
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i h **Right to Inspect and Copy.** i h r i h t n o W n i p s n i y , m e e v c t e s o t o a e t e o s f e c t a d o
n i m n i n h n i r m y n n i a r k i n l o n i s , a t m o t s a f e a t p a n m e t o a t o c e a t e , d c s y a s y e
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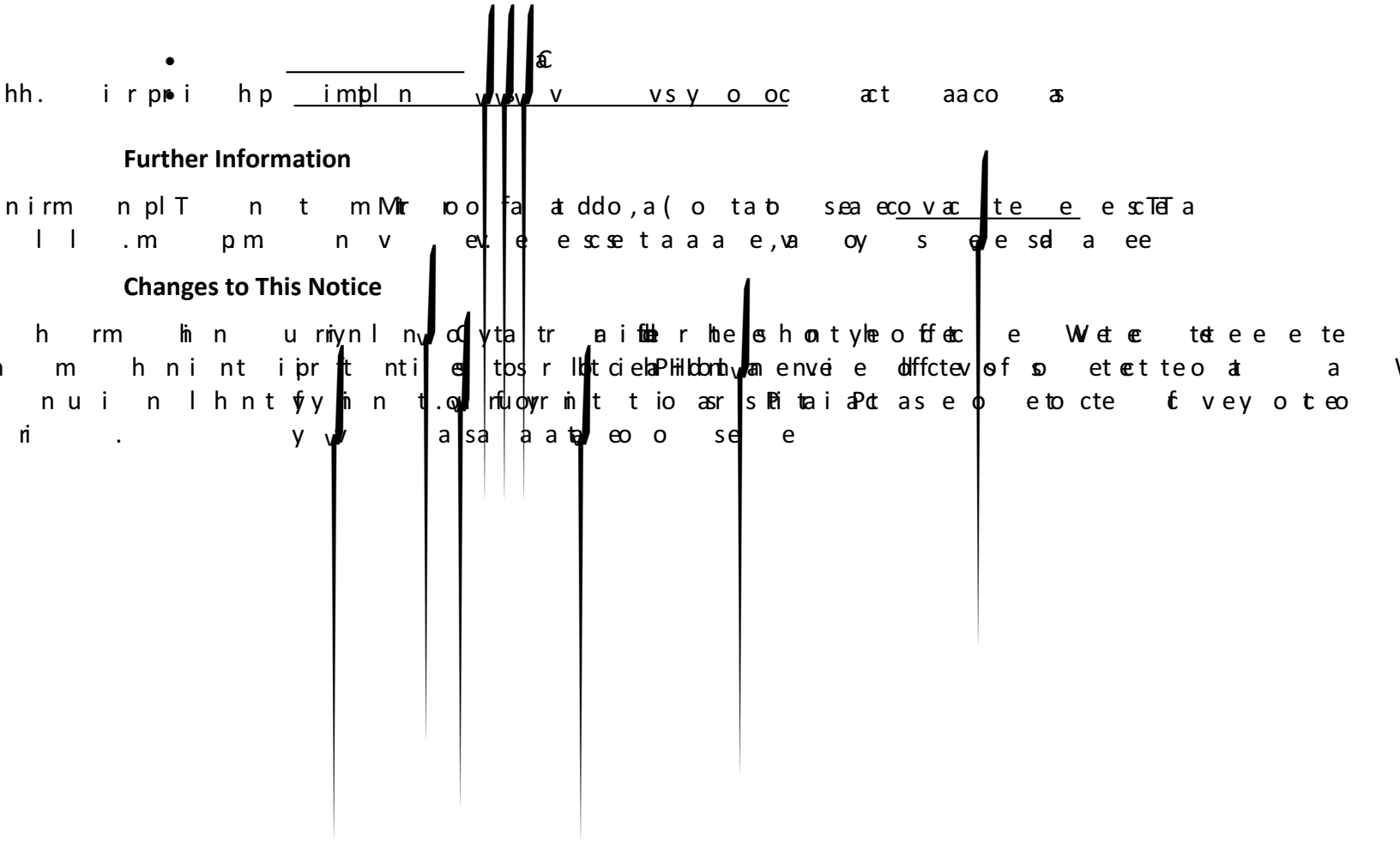
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