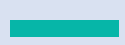
Scan with phone camera to access online easy-reader version.

2023

Welcome to the Mountain Health CO-OP

Created for, and governed by, our members like you.



mountainhealth.coop

855-447-2900 / memberservice@mhc.coop

We're an insurance company where members are also the owners. Imagine that!

As a CO-OP member, you are now part owner of this insurance company.

Visit us online

What is a CO-OP?

Health CO-OPs were formed to provide affordable health insurance to their members and increase competition and choice in the marketplace.

CO-OP's have a member governed board, you as a member have a say in this company.

We were created by people like you to ensure our neighbors, friends and family have access to healthcare.

We've added some great benefits for you to make the most of your coverage without breaking the bank.

We're proud to be part of your wellness journey along with our plan administrator, University of Utah Health Plans (UUHP).

Special Notice

Mountain Health CO-OP is proud to partner with the **University of Utah Health Plans (UUHP)** to bring you a more transparent and hands on insurance experience.

UUHP serves as the Third Party Administrator (TPA) for your insurance policy, which means that they help process claims, issue ID cards, and can answer benefit questions for your plan.

You will see their logo frequently throughout your experience as a CO-OP member.

Please refer to your ID card for contact information or call us.

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4 Your Health Coverage

6 Plan & Network Info

8 Using Your Plan's Signature Benefits

10 Member Portal & ID Cards

12 Insurance Terms

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Questions?

Our Member Services Team is here to help!

If you have questions about your current plan, claims and coverage, enrollment, billing, payments, and general member services:

855-447-2900
M-F 8am-5pm
Mountain Standard Time

WHAT TO DO NEXT

Set up your free account to access your health plan.

Scan with your phone camera to register

Your Health Coverage

Did you know that routinely visiting a Primary Care Provider (PCP) can lower your medical costs and help you maintain a healthy lifestyle?

We support a relationship with your PCP and can help you identify one to meet your needs. It's easy! You can call our Member Service team or search online at **www.mountainhealth.coop/find-a-doctor** and then navigate to your state.

TIP: Your participating Network name can be found on your ID card or on the next page of this booklet.

Understand your deductible and co-pays on the **Summary of Benefits and Coverage (SBC).**

Prior authorization requirements, excluded benefits, and out-of-network options are found on the **Policy Document.**

Is my prescription covered?

Search drug directory

Find all your plan documents on our website or via the **Member Portal**

Reporting required life changes to your policy

Why is this required?
Any life changes must be reported to your policy to ensure you're getting the right amount of benefits and claims are processed properly.

Employee Plans: please contact your HR department.

Individual Plans: Any changes to your plan must be managed through the platform you purchased it on. Please see the options below to find where you can update your individually purchased plan.

Life changes that require an update:

- Home address
- Birth
- Marriage
- Income +/ -
- Employment status

Your Health Idaho
Call: 855-944-3246
Online: via your account
YourHealthIdaho.org

Marketplace / Exchange
Call: 800-318-2596
Online: via your account
healthcare.gov

Mountain Health CO-OP
Call: 855-447-2900
Online: Navigate to the **Members page** on our website or visit **mountainhealth.coop/members/**
Email completed form to
memberservice@mhc.coop

Emergency Care & Unexpected Treatment

If you experience an emergency, call 911 or go to the nearest hospital.

It is not uncommon to hear stories of people having an emergency situation only to be stuck with high dollar bills once everything is over.

This practice is known as surprise/**balance billing** and can occur when you are treated at an out-of-network facility or provider or have ancillary services performed by an out-of-network provider at an in-network facility.

Balance billing is no longer allowed with our plans for emergency or surprise situations.

If you are ever balance billed in an unexpected situation, please call us immediately.

You have coverage after normal business hours for non-emergency care.

Ask your provider about how they accommodate after-hours visits. Most providers have an on-call process. Otherwise, you can visit the closest urgent care center.

Telehealth is available for CO-OP members 24/7

You're enrolled in the

LINK Network

Our LINK plans are designed to emphasize preventive healthcare in partnership with St. Luke's delivery care system.

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
This is the insurance contract. It's a legally binding contract between us, the insurance company, and you, the policy holder. It contains key features, terms and conditions.

Outline of Coverage (OOC)
This provides a very brief description of the important features of your policy. This is ***not*** the insurance contract and only the actual policy provisions will control.

Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

You're enrolled in the Plus Network

Our Plus plans are designed to support the relationship with your primary care provider. This means the plan keeps your co-pay lower by providing the option to visit Tier 1 providers, who are available through participating Community Health Centers.

You are not limited to Tier 1 providers in a Plus plan. You may also visit Tier 2 providers, though the co-pay or co- insurance will vary by plan.

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
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Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

You're enrolled in the

Access Care Network

Our Access Care plans are a Point of Service plan.

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
This is the insurance contract. It's a legally binding contract between us, the insurance company, and you, the policy holder. It contains key features, terms and conditions.

Outline of Coverage (OOC)
This provides a very brief description of the important features of your policy. This is ***not*** the insurance contract and only the actual policy provisions will control.

Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

You're enrolled in the Connected Care Network

Our Connected Care plans are designed to allow freedom of choice while working to reduce your out-of-pocket costs.

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
This is the insurance contract. It's a legally binding contract between us, the insurance company, and you, the policy holder. It contains key features, terms and conditions.

Outline of Coverage (OOC)
This provides a very brief description of the important features of your policy. This is ***not*** the insurance contract and only the actual policy provisions will control.

Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

You're enrolled in the

Engage Network

Our Engage plans are a standard Point of Service plan featuing a wide range of in-network providers.

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
This is the insurance contract. It's a legally binding contract between us, the insurance company, and you, the policy holder. It contains key features, terms and conditions.

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This provides a very brief description of the important features of your policy. This is *not* the insurance contract and only the actual policy provisions will control.

Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

You're enrolled in the

High Plains Network

Our High Plains plans are designed to emphasize preventive healthcare with a cost-efficient network of providers.

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
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Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

You're enrolled in the

Rocky Mountain Network

Stay In-Network & Save Money

In-Network

You will receive the highest level of benefits when you see an in-network provider.

You won't be billed for balances on covered services beyond any copayment, deductible, and/or coinsurance.

Our in-network providers automatically submit claims to us on your behalf so you don't have to do anything.

Out-of-Network

Benefits are payable at a lower level when an out-of-network provider is *voluntarily* chosen.

Out-of-network providers and facilities may choose to bill the difference between the CO-OP's allowable fee and their billed charge. This practice is known as balance billing.

CO-OP members will be responsible for the balance billed amount.

Scan to Find a Doctor

Surprise Billing Protection

You are protected from surprise/balance billing when you receive emergency care or treatment from an out-of-network provider at an in-network emergency center. Read more about "Surprise Billing" in your policy document.

Documents to Understand and Read Carefully

Policy
This is the insurance contract. It's a legally binding contract between us, the insurance company, and you, the policy holder. It contains key features, terms and conditions.

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This provides a very brief description of the important features of your policy. This is ***not*** the insurance contract and only the actual policy provisions will control.

Summary of Benefits and Coverage (SBC)
This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Individual Members who receive invoices may experience a one-time billing change at the end of the calendar year to accommodate changes to the Applied Premium Tax Credit (APTC). The CO-OP will provide advanced notice of this change.

Our care management teams help members get the right care at the right time for the best outcome using evidence-based guidelines.

Health Risk Assessment Program

Our care management team offers you the opportunity to complete a free, confidential and voluntary health risk assessment (HRA) to see how healthy you are.

The HRA identifies personal risk factors and provides an action plan to help prevent future conditions or manage current conditions.

This program entitles you to work one-on-one with a nurse care manager. It is our goal to assist you in getting the best possible health care.

Call Member Services at 855-447-2900 or learn more at mountainhealth.coop.

Coverage Decisions

All utilization review decisions and care management actions are based on a determination of appropriateness of care and service according to the benefit coverage for the member.

The CO-OP provides no incentive or reward for issuing denials of coverage.

There is no use of incentives to encourage barriers to care and services. Utilization Review decisions are based on nationally recognized criteria, plan benefits and adherence of utilization management policies and procedures.

Interpreter Services
We have interpreters available for most languages.

Call Member Services Team **(801) 587-6480, option 6** to ask for help finding a interpreter who speaks your language.

You can also find this information on our website in the Provider Directory.

Telephone relay services, or TTY/TDD, are also available by calling 711 or **(800) 346-4128**.

Nondiscrimination
Mountain Health CO-OP does not discriminate based on race, color, national origin, disability, age, sex, gender, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Privacy Policy
Mountain Health CO-OP and University of Utah Health Plans are legally required to protect the privacy of each member's health information, and doing so is of extreme importance.

Protected Health Information (PHI) is information that includes your personal and demographic information that identifies you and that relates to your past, present or future physical or mental health condition and related health care services.

To read our full Notice of Privacy Practices, please visit ***mountain-health.coop/privacy-policy/***

If you would like a free copy of these materials printed and mailed to you, please contact our Member Services Team.

Using Your Plan

Signature Benefits[1]

We support your health and wellness. We created our signature benefits for members like you.

These benefits offer access to care you need annually and help identify underlying health issues you may not know about.

24/7 Telehealth

Talk with an in-network doctor or mental health specialist within minutes for as little as $20 per visit.[2]

Travel Benefit

We help cover the cost of traveling to a specialist for unique care.

Pre-Approval Required

Hundreds of Medications at No Extra Cost

Our pharmacy is as transparent as it gets. We offer hundreds of prescriptions for members with no out-of-pocket cost.

Scan to search if your prescription is covered.

100% Covered Preventive Care Services In-Network

We cover these services 100%[3] to help catch health changes before they become major problems.

Get access to numerous **health screenings**, such as diabetes and many cancers, along with a collection of **immunizations**.

Preventive services also include **counseling for lifestyle changes**.

Vision Exams

Protect your peepers by using your **$60 reimbursment**[4] for vision exams at **any** optometrist. Your eyes can be a key indicator of your overall health.

Dental Exams

Use your **$100 reimbursment**[4] for teeth cleaning or dental exams at **any** dentist.

How To Redeem Your $60 and $100 Exam Reimbursements

1 Choose & schedule.

Book your eye and dentals exams at any provider you'd like.

TIP

Check cost of service ***before*** *your visit to maximize your reimbursement.*

Ex: Choosing a dentist that charges $80 for a cleaning vs $120 means you'll pay zero after we reimburse you.

Choosing a $120 cleaning means you'll pay $20 total.

2 Get proof of services after your visit.

We need documentation of the service in order to reimburse you.

Proof of payment isn't required, only proof of **services received**.

Ideally, a printout/itemized statement from the licensed provider is best.

MUST INCLUDE

1. **Proof that the covered service was received**
2. **Date of service**
3. **Name and address of provider (if available, provider NPI)**
4. **Patient's name**
5. **Address**
6. **Member ID**

3 Send & submit.

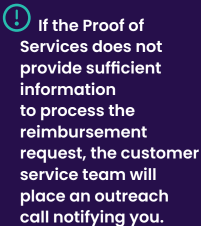
The easiest way to submit your proof of services is **through the member portal** by taking a photo with your phone.

BY TEXT
Send image or scan of document to us via the member portal

E-MAIL
Scan proof of service to memberservice@mhc.coop

FAX
Attn: Member Reimbursement
Fax to (801) 281-6121

MAIL
University of Utah Health Plans
PO Box 45180
Salt Lake City, UT
84145-0180



If the Proof of Services does not provide sufficient information to process the reimbursement request, the customer service team will place an outreach call notifying you.

Coordination of benefits does not apply.

4 Reimbursement arrives.

Reimbursement will be mailed to you by check **within 15 business days of receipt.**

The CO-OP will reimburse you and your dependents listed on the policy up to $100.

Questions?

Message member services directly.

or call (855) 447-2900

Fine Print

1 CO-OP Signature Benefits are available for members with individual and employer plans only.

2 Copays vary based on your plan. Your telehealth coverage details can be found on your Summary of Benefits and Coverage (SBC) document.

3 Review your Outline of Coverage for more information.

4 This is a reimbursement program, which allows you to go to any provider you prefer. No insurance ID card required since the provider does not bill us directly. Instead, you submit a request for reimbursement directly to the CO-OP using an image of the service receipt.

We recommend that to confirm cost of service ahead of time to make the most of your reimbursement. Even if you have standalone insurance for vision or dental, you can still claim this added benefit.

Track your expenses and view plan details.

Member Portal & ID Cards

Access your health plan information via your phone 24/7 through our member portal.

Set up your free portal account from our website.

PORTAL TOOLS

- › View your coverage details
- › Check your benefit balances
- › View claims history
- › Manage contact information
- › View medications and details
- › Find a provider
- › Estimate the cost of a treatment
- › Interact with your care manager
- › View targeted health education content

See your Explanation of Benefits

Monitor out-of-pocket expenses & deductible

Send messages & documents to the Member Service team

See eligibility for your services, and more.

Upload receipts for vision and eye exams reimbursements

All your medical details in one place.

Find Your Card

A paper copy is included in this packet.

Replacement paper cards can be requested from our website.

Mobile ID Card

Scan the QR code with your phone to register or login to the member portal to find your ID card and more.

Reading Your Insurance Card

Your network for finding doctors and service providers.

Level of coverage

Your member ID

For ordering and picking up prescriptions

For employer plans

How much you pay per visit or service (copay) after you reach your annual deductible.

Annual amount you're required to pay before CO-OP begins reimbursing costs of treatments.

MOUNTAIN HEALTH CO-OP

Access Care

Test Plan Name

Group #:

John Q. Sample
ID: 123456789

Dependent One
Dependent Two
Dependent Three
Dependent Four
Dependent Five
Dependent Six

Pharmacy
RXBIN: 610830
RXPCN: REALRXMHC

Copay: In-Network
PCP / Specialist: $30/$50
ER/Urgent Care: 40%*/$75
RX: $5/$20/$50/$100
*After Deductible
Deductible: In/Out-of-Network
Ind: $1,000/$2,250 MED Only
Fam: $2,000/$5,100 MED Only
MOOP**: In/Out-of-Network
Individual: $6,500/$18,000
Family: $13,000/$36,000
**Maximum Out-of-Pocket

Search health insurance terms on Healthcare.gov/glossary

Terms to Know

Health insurance terminology is confusing. These key terms are useful when reading your insurance documents.

Documents to Understand and Read Carefully

Policy

This is the insurance contract. It's a legally binding contract between us, the insurance company, and you, the policy holder. It contains key features, terms and conditions.

Summary of Benefits and Coverage (SBC)

This shows how you and the plan share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

Outline of Coverage (OOC)

This provides a very brief description of the important features of your policy. This is ***not*** the insurance contract and only the actual policy provisions will control.

Premium

The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance. If you have a Marketplace health plan, you may be able to lower your costs with a premium tax credit.

Coinsurance

Your share of the costs of a covered health care service, calculated **as a percentage** (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe.

COPAY VS. COINSURANCE A copayment is a fixed amount. Coinsurance is a percentage of total cost for the service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance.

Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Out-of-pocket Limit

The most you **could** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs.

This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Allowable Amount

The maximum amount your plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Copayment (Copay)

A fixed amount ($20, for example) you pay for a covered health care service ***after*** you've paid your deductible.

EXAMPLE Your plan's **allowable cost** for a doctor's office visit is $100. Your **copayment** for the visit = $20.

If deductible is fully paid: You pay $20, usually at the time of the visit. If deductible not paid: You pay $100, the full allowable amount for the visit.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. Read more about "Surprise Billing" in your policy document.

Cost Sharing

The most you have to pay for covered services in a plan year.
After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of Covered Benefits. The Out-of-Pocket limit doesn't include your monthly premiums.

The Annual Out-of-Pocket Maximum includes the following: 1. Plan Year Deductible 2. Copayments; and 3. Coinsurance.

Deductible

The most you have to pay for covered services in a plan year.
After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of Covered Benefits. The Out-of-Pocket limit doesn't include your monthly premiums.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.
Important Note: Preauthorization isn't a promise your health insurance or plan will cover the cost.

F.A.Q.

How do I know if my procedure is covered or requires preauthorization?

Step 1 Request the **CPT code** (Current Procedural Terminology) from your provider. These unique 5-digit codes identify the procedure anywhere in the United States.

Step 2 Visit the pre-auth section of our Providers page on our website. Choose relevant category for more details.

Or follow the QR to search CPT codes requiring prior authorization:

How does the CO-OP ensure the quality of its coverage and service? Your health is the bottom line for the CO-OP. We design insurance plans with benefits we know our members will value and use.

We are accredited by the National Committee for Quality Assurance (NCQA), which works to improve the quality of healthcare across the country. The CO-OP has a dedicated team that completes a rigorous procedure to earn this accreditation, always using the feedback received from the process to find opportunities to improve our operations and service for members – all so we serve you better.

How do I replace my Member ID card? You can order a replacement on our website on our Members page. Or contact our Member Services team. Access your ID Card on the go, anywhere and anytime, through the member portal. Visit our website for more details.

I have questions about my coverage but can't find the answers on the website or my documents. Where do I go? Our Member Service team is here to ensure you always have the information you need about your plan via email memberservice@mhc.coop or by phone 855-447-2900.

How thorough is the CO-OP's network of providers? Every hospital in Montana, Idaho, and Wyoming is covered under the CO-OP's networks*. We also work with a number of facilities and providers to give our members access to specialists of all kinds.

Employer groups also receive access to a network of national providers, so if you have locations outside of the CO-OP's primary states (Montana, Idaho and Wyoming), your employees will have coverage through our national network.

**Networks may vary by plan. Please use the Provider Finder to find the providers for your network.*

Can I change my insurance plan outside Open Enrollment?

Outside Open Enrollment, you can only get health insurance — or change plans — if you qualify for a Special Enrollment period due to qualifying life events:

- Getting married, divorced or legally separated
- Giving birth or adopting
- Starting, ending or losing a job
- Losing other health insurance coverage
- A death in the family
- Changes in residence

View complete list on healthcare.gov

How do I cancel my plan?

Don't end your plan until you know for sure when your new coverage starts. Once you end health insurance coverage, you can't re-enroll until the next annual Open Enrollment Period (unless you qualify for a Special Enrollment Period).

Frequent Contacts

PHARMACY
855-885-7695

Customer Service
855-447-2900

TTY Users
1-800-346-4128, or dial 711

Translation Services
801-587-6480, Opt 6

Member Inquiries
memberservice@mhc.coop

Request for Reinstatement
memberservice@mhc.coop

Idaho
5995 W State St
Boise, ID 83703

Montana
810 Hialeah St
Helena, MT 59601

Wyoming
1439 Stillwater Avenue
Unit 11
Cheyenne, WY 82009

Report life changes to your policy through the place plan was purchased.

Your Health Idaho

Call: 855-944-3246
Online Account: YourHealthIdaho.org

Marketplace / Exchange

Call: 800-318-2596
Online Account: healthcare.gov

Mountain Health CO-OP

Call: 855-447-2900
Online Form: mountainhealth.coop/members/

Employee Plan

Contact: Your Human Resource member

Pharmacy
855-885-7695

Customer Service
855-447-2900

TTY Users
1-800-346-4128, or dial 711

Translation Services
801-587-6480, Opt 6

Member Inquiries
memberservice@mhc.coop

Request for Reinstatement
memberservice@mhc.coop

Scan to Find a Doctor

Idaho
5995 W State St
Boise, ID 83703

Montana
810 Hialeah St
Helena, MT 59601

Wyoming
1439 Stillwater Avenue
Unit 11
Cheyenne, WY 82009