Steps to get started
using your plan

Idaho | Montana | Wyoming

Welcome to the Mountain Health CO-OP

Fall 2024

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

MOUNTAIN HEALTH CO-OP

800-299-6080
www.mountainhealth.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-OPs have a member-governed board, which means you as a member have a say in this organization.

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.

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.

IN THIS BOOKLET

Questions?

Our Member Service Team is here to help!

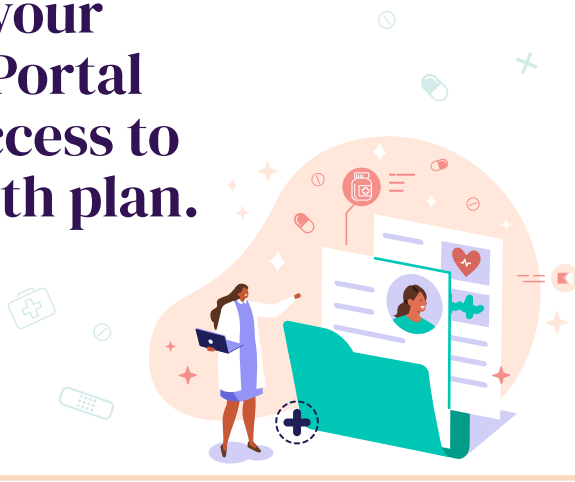
If you have questions about your current plan, claims and coverage, enrollment, billing, payments, or general member services:

800-299-6080
M-F 8am-5pm
Mountain Standard Time

We're proud to be part of your wellness journey.

WHAT TO DO NEXT

Activate your Member Portal for full access to your health plan.



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?

Scan to search details

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 that claims are processed properly.

Employer 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.

Some changes that require an update:

- Home address
- Birth or Death
- 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: 800-299-6080
Online: Navigate to the ***Members page*** on our website:
mountainhealth.coop/members/

Emergency Care & Unexpected Treatment

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

Scan to learn more about Surprise/Balance billing

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. Ground ambulance is not included in Surprise Billing.

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

Now what?

Get started using your plan

(Yes, we *want* you to use your plan!)

First, know where to find your stuff.

Activate your Member Portal to see all medical details in one place. To register, you'll need your member ID card found in this Welcome Packet.

Next, know what's included in your plan.

Avoid unexpected costs by checking ahead of time to make sure every provider involved with your treatment is considered in-network.

How do I know if this is covered?

FIND THE TOOLS TO CHECK

- Estimate cost of a treatment in the Member Portal
- Confirm Coverage with CPT Codes
- Emergency Coverage
- Services Requiring Prior Authorization

Understanding
Preventive Care

Much more than your annual doctor visit.

Preventive health care refers to proactive measures taken to maintain and improve an individual's overall well-being and prevent the onset of illness or disease.

It involves a range of practices and strategies aimed at identifying potential health risks early on, promoting healthy lifestyles, and minimizing the likelihood of developing certain conditions.

Preventive health care includes regular check-ups, vaccinations, screenings, and diagnostic tests that help detect any signs of disease at an early stage when treatment is most effective.

Additionally, adopting healthy habits such as exercising regularly, maintaining a balanced diet, managing stress levels, and avoiding harmful substances like tobacco and excessive alcohol consumption are key components of preventive health care.

By prioritizing prevention, individuals can actively protect and enhance their health, leading to a higher quality of life and reduced healthcare costs in the long run.

What counts as preventive?

Screening tests, women's health, and immunizations are some categories falling under preventive care services.

CHECK FULL LIST PREVENTIVE CARE

$0 Out-of-Pocket Drugs & Supplies

Find all details on our website:
mountainhealth.coop/preventive-health-care/

New Benefit!

$0 Mental Health Visit

Mental wellness is just as important as physical wellness.

That's why we're offering your first mental health visit of your plan year at no cost to you!

STEP 1

Choose an in-network mental health provider and make an appointment.

Make sure to select one with experience that may match your lifestyle best. You can even choose a provider through Doctor on Demand.

STEP 2

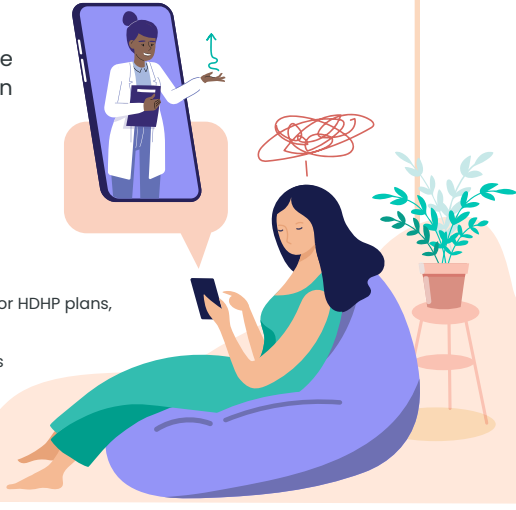
Go to your appointment.

After your visit, your doctor will submit your claim to the CO-OP, and our team will make sure your first mental health visit of the year is covered when we process it.

24/7 Access to Behavioral Healthcare via Doctor on Demand

All mental health services are available online at anytime, including depression screening for adults and adolescents beginning routinely at age 12.

Many medications for depression and mood regulation are available for $0 out-of-pocket.



Note Exclusions apply for members with Standard or HDHP plans, which is indicated on member ID cards.

Members covered by our LINK network may use this benefit by seeing providers at St. Luke's Health System or by using Doctor on Demand.

Check your outline of coverage or contact Member Services for more information

Your Signature Benefits[1]

We created our signature benefits to support the health and wellness of members like you.

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

MAX YOUR PLAN

Get paid up to *$210 per year* to take care of yourself.

Your Signature Benefits, like dental and vision exam reimbursements, are all available before meeting your deductible.

Start using them anytime.

Learn more

24/7 Telehealth

Talk with an in-network doctor or mental health specialist within minutes.[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.

Health Assessment Program

Complete a ***free*** health assessment with our new partner Porter from home and earn $50.

Vision Exams

Get up to **$60 reimbursed**[4] to protect your peepers for vision exams at **any** optometrist.

Dental Exams

Get up to **$100 reimbursed**[4] for teeth cleaning or dental exams at **any** dentist.

How To Redeem Your $60 and $100 Exam Reimbursements

STEP

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.

STEP

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**

STEP

3 Send & submit.

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

UPLOAD

Via your member portal:

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.

STEP

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 for dental exams and up to $60 for vision exams.

Questions?

Call Member Service directly.

800-299-6080

Signature Benefit Fine Print

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

2 See your Outline of Coverage for more details.

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 you 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 24/7 through our member portal.

Set up your free, member portal account from our website.

All your medical details in one place.

MEMBER PORTAL TOOLS

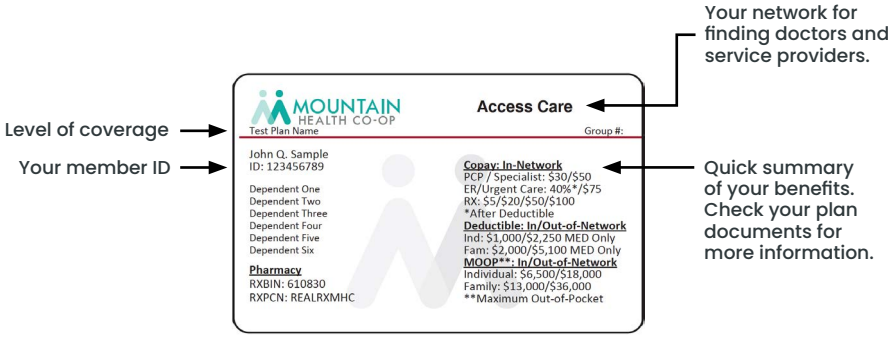
- Review Your Claims
- Check the Status of an Authorization
- Get Replacement ID Cards
- Check your Deductible and Maximum Out-of-Pocket
- Find a Doctor
- View Medications and Details
- View Targeted Health Information
- And more

Find Your Card

You can order a replacement paper card or download a digital copy through your Member Portal

More Details

Reading Your Insurance Card



Search health insurance terms on Healthcare.gov/glossary

Terms to Know

Health insurance terminology is confusing. These key terms are useful to know 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 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 brief description of the important features of your policy.

Premium

The amount you pay for your health insurance every month. If you have a Marketplace health plan, you may be able to lower your costs with a premium tax credit.

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.

Coinsurance & Copay

Your share of the costs for a covered medical expense, expressed as a percentage. For example, a 25% coinsurance means you must pay 25% of the medical bill and the policy covers the remaining 75% cost. This amount applies towards your out-of-pocket maximum.

Coinsurance vs Copay: copay is a fixed amount, coinsurance is a percentage of total bill cost, split with the insurance company.

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 or the visit.

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."

Cost Sharing (sometimes called "out-of-pocket" costs)

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"). Family cost sharing is the share of costs you and your spouse and/or child(ren) must pay out of your own pocket.

Out-of-Pocket Limit or Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include:

- Your monthly premiums
- Anything you spend for services your plan doesn't cover
- Out-of-network care and services
- Costs above the allowed amount for a service that a provider may charge

Plan Year

A 12-month period of benefits coverage which may not be the same as the calendar year. If you signed up during open enrollment, your plan year will begin on January 1 of the following year. However, if you signed up outside of open enrollment (known as Special Enrollment) or through an employer, your plan will go into effect the first day of the following month.

e.g. January 15 enrollees are able to use their new plan on February 1.

To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

In-Network Provider & Rates

A Provider is 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.

Provider Networks are doctors, hospitals, and other healthcare facilities who have contracts with Mountain Health Co-Op to provide services at lower negotiated rates. These rates are known as In-Network rates. You will always save money using an in-network provider.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Search more health insurance terms on Healthcare.gov/glossary

F.A.Q.

I have questions about my coverage but can't find answers on the website or my documents. What should I do?

Contact Us

Our Member Service team is here to help. You will speak to a real person without a long wait time.

Call 800-299-6080 or message the team securely through your member portal account.

How to file a claim?

Not all providers bill insurance for you, but that doesn't mean the service isn't covered. File a claim to recover a provider fee if the service is covered under your plan. The best way to manage claims is in the Member Portal.

To Expedite your Claim Request

• Make sure the bills identify the patient.

• All bills should show the date of treatment, description of service, and amount of charges.

•Procedure Codes and Diagnosis codes must be included or claim form will be returned.

•All statements should have Member identification number listed.

How do I maximize my coverage?

Use In-Network providers as much as possible.

Inquire about services before they're performed to confirm that every provider involved in your treatment is In-Network.

Be aware that even if you see a provider in your network, they may use an out-of-network provider for some services such as routine lab work.

Ask prior to receiving these services or you may receive a bill for the difference (balance billing) if the situation was not an emergency.

Learn all tips:

Frequent Contacts

Pharmacy
855-885-7695

Customer Service
800-299-6080

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

Translation Services
800-299-6080

Member Inquiries
Login to your member portal

Request for Reinstatement
memberservice@mhc.coop

Montana
810 Hialeah St
Helena, MT 59601

Wyoming
1439 Stillwater Avenue
Unit 11
Cheyenne, WY 82009

Our Website

Your Benefits

Member Details

Find Plans

Help with Health Conditions

Find Forms

Privacy Policy
Mountain Health CO-OP 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 *mountainhealth.coop/privacy-policy/*

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

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.

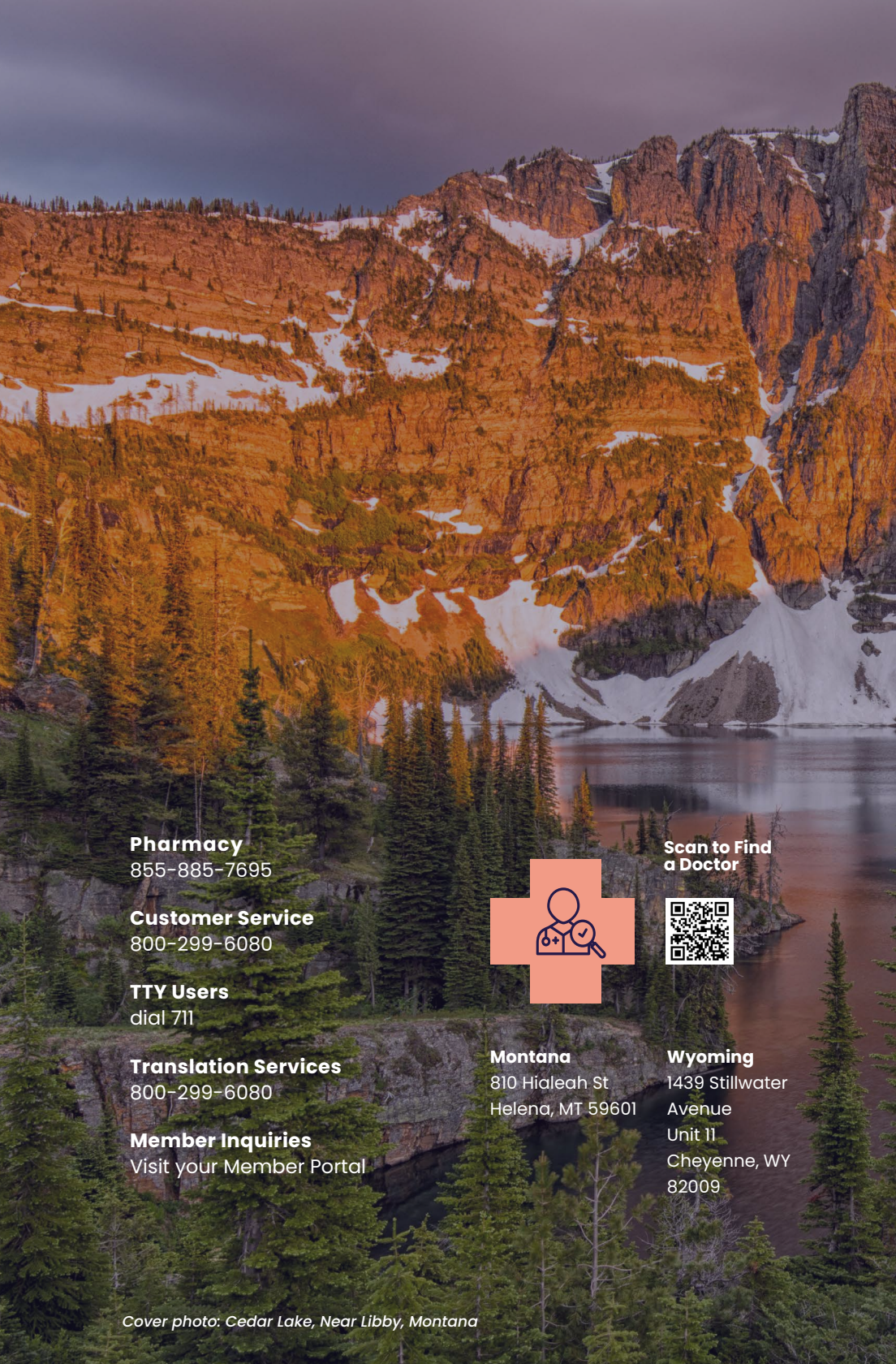
Interpreter Services
Call 800-299-6080 and connect with Member Service for assistance with translation.

Si usted, o alguien a quien usted está ayudando, tiene preguntas

acerca de MHC, tiene derecho a obtener ayuda e información en su

idioma sin costo alguno. Para hablar con un intérprete, llame al 800-299-6080

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.



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Montana
810 Hialeah St
Helena, MT 59601

Wyoming
1439 Stillwater Avenue
Unit 11
Cheyenne, WY 82009

Cover photo: Cedar Lake, Near Libby, Montana