myPromiseHealth.com

Member User Guide

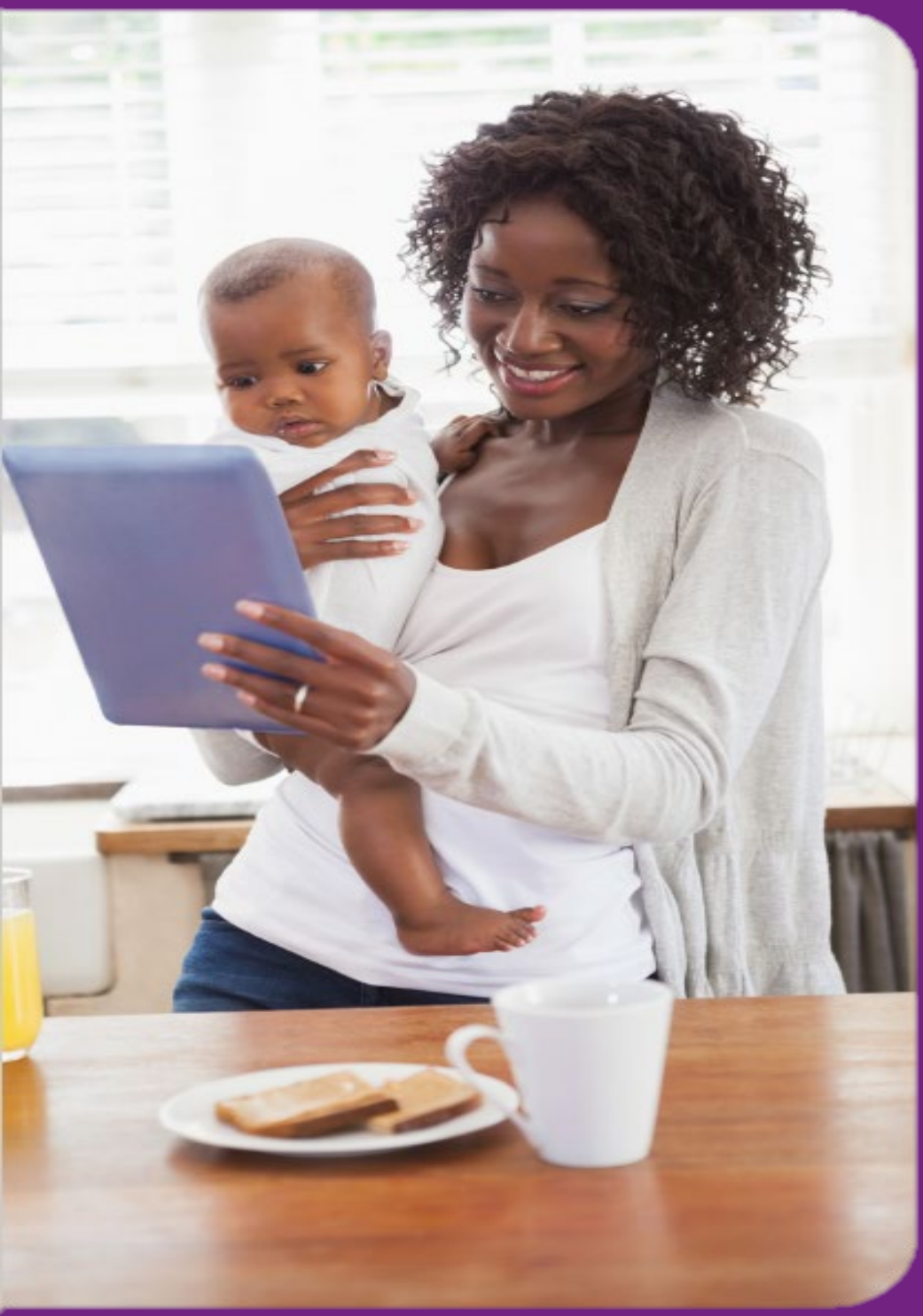


Table of Contents

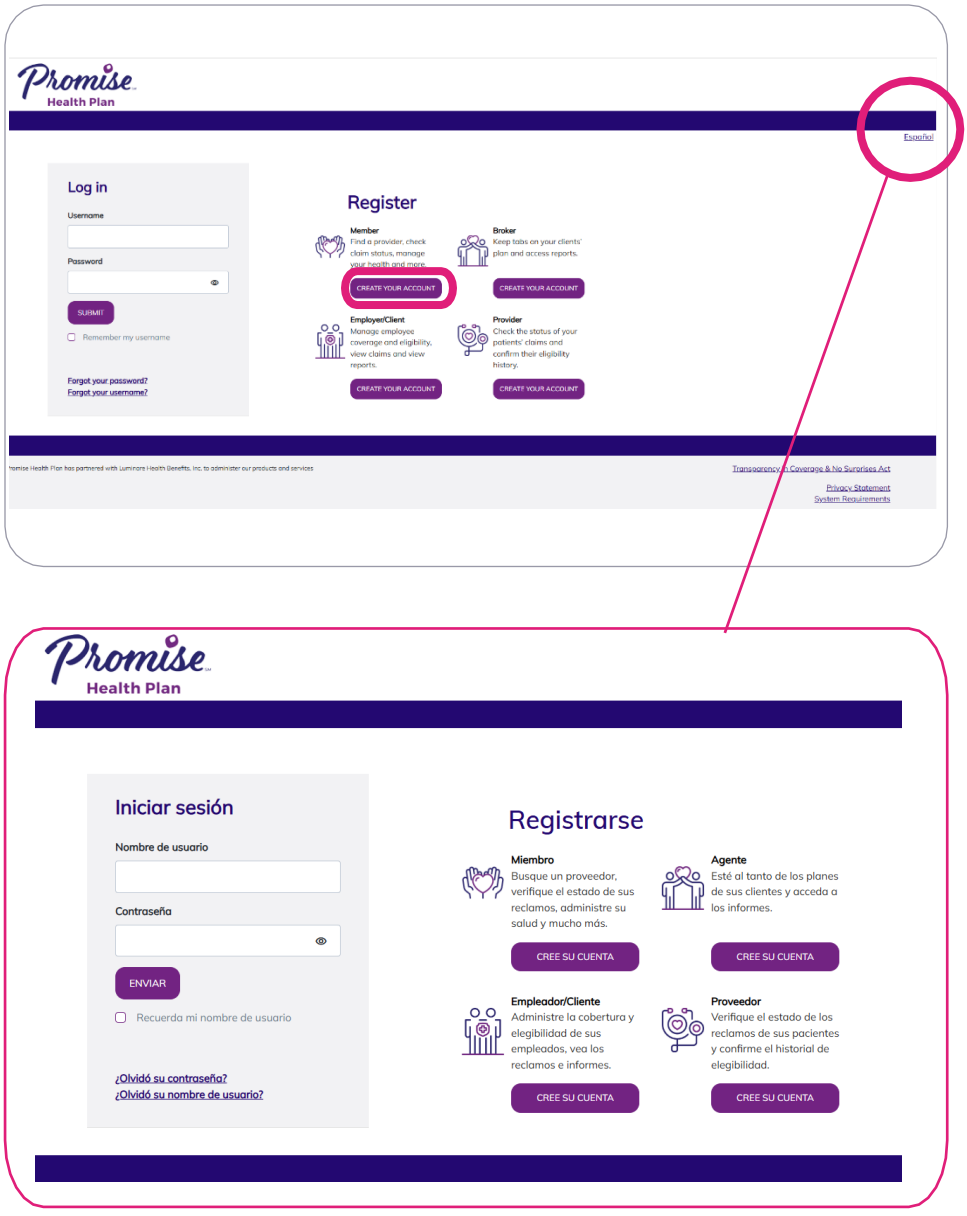
Registration

To register as a member on myPromiseHealthPlan.com for the first time, you will need to follow these steps:

Step One: Create Account

Go to myPromiseHealthPlan.com and select the **Create Your Account** button under the Plan Participant section.

Each plan member will need to create their own account.



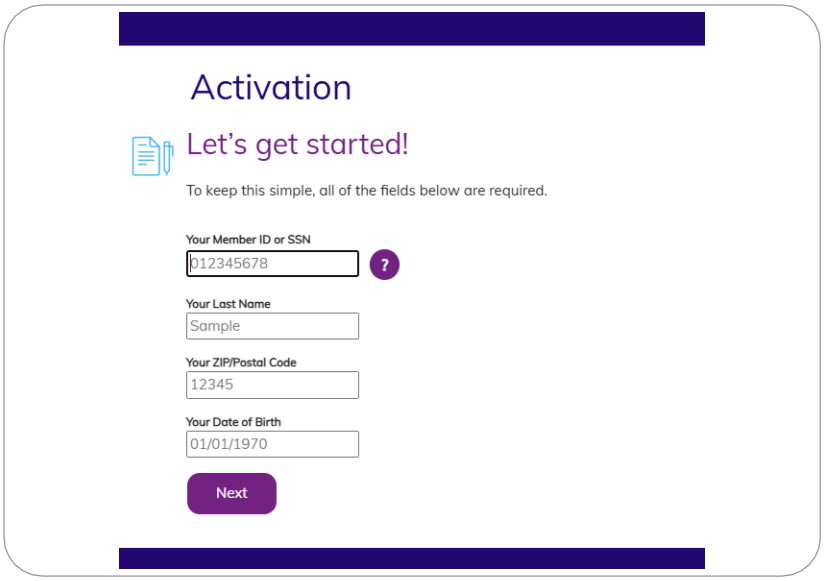
Also available in Spanish.

Note: If at any time, you forget your username or password, you can select the appropriate link under the login button on the home page and then follow the prompts.

Step Two: Activation

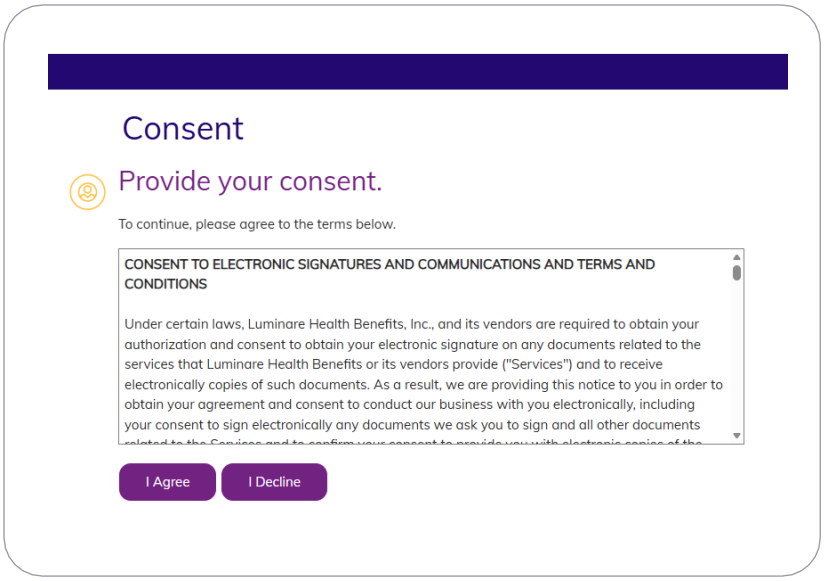
a. Enter the required fields with the information from your ID card.

b. Click **Next**.



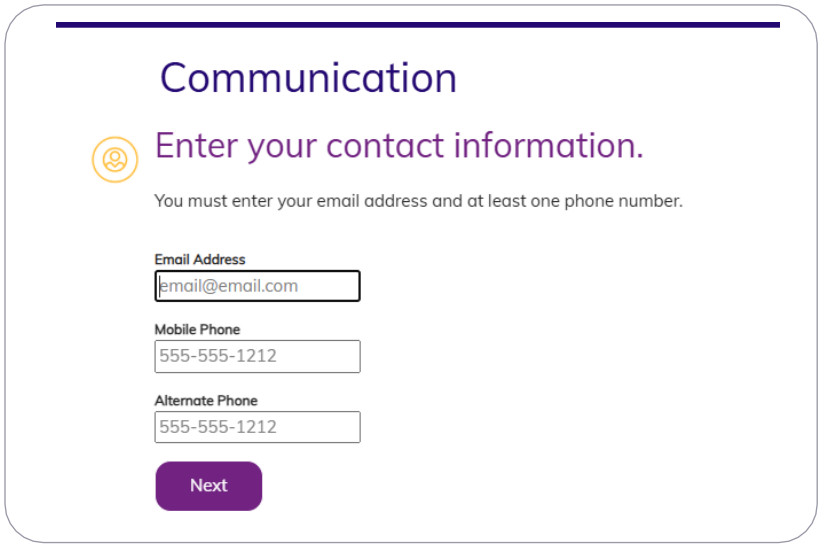
Step Three: Provide Consent

Click “I agree” to accept the consent to electronic signatures and communications and terms and conditions.



Step Four: Contact Information

Enter your contact information in the fields below. You must enter your email address and at least one phone number.

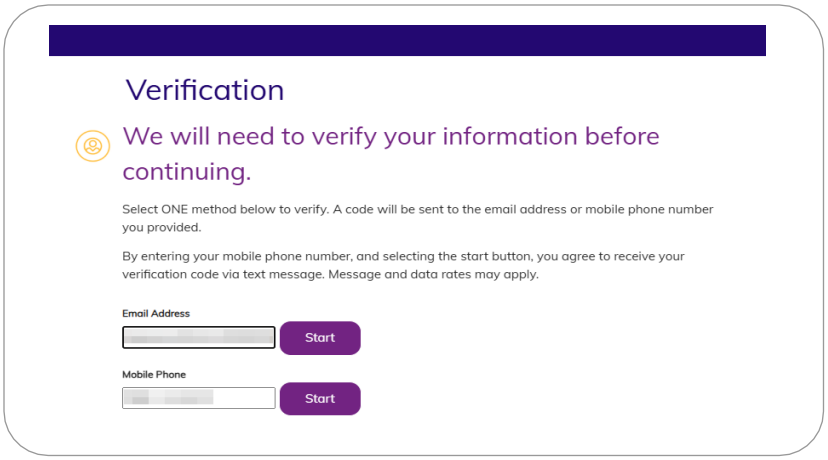


Step Five: Verification

Click **Start** next to the communication method you would like to verify, and a code will be sent to the email address or mobile phone number you provided.

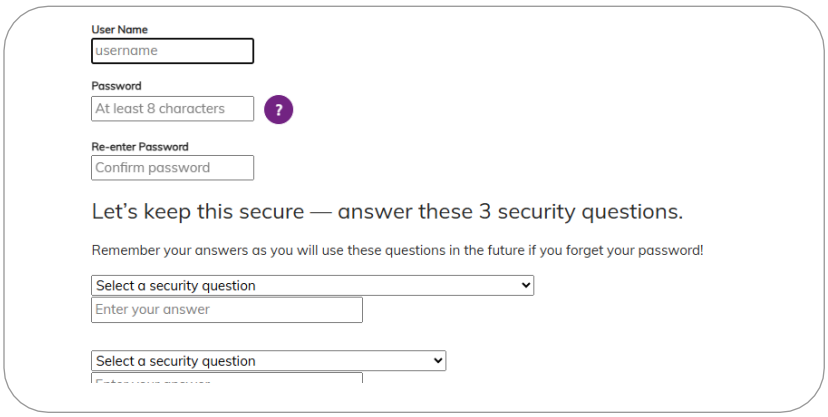
Enter the verification code in the indicated field.

Click **Next** to continue



Step Six: Personalization

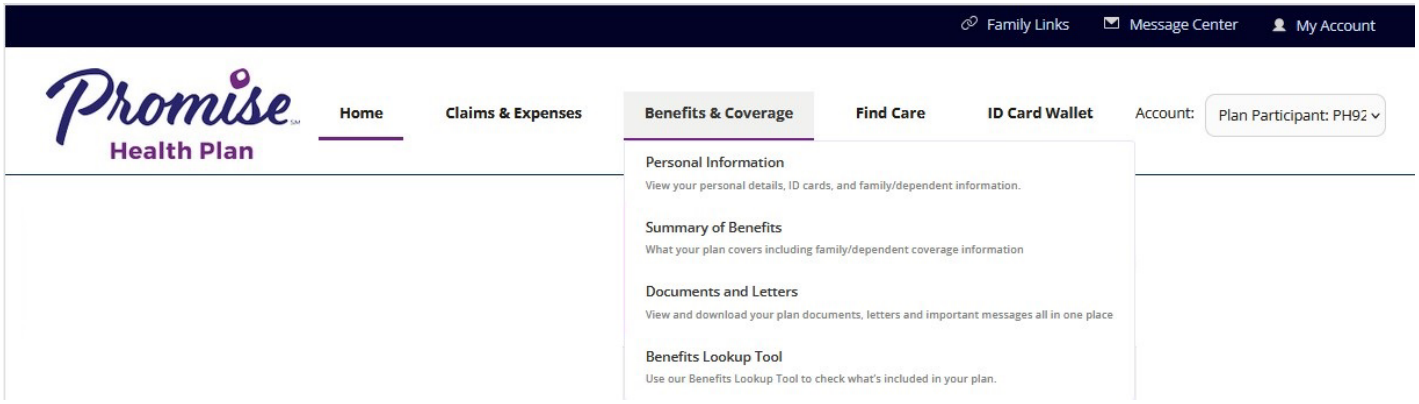
Create your profile by entering a username and password. Answer three security questions and click **Next**.



Note: Once you're registered on this site, please be sure to bookmark it as a favorite, and return directly to myPromiseHealthPlan.com for all future visits.

Navigation Menu

The Navigation Menu appears at the top of each page and provides access to primary portal functions.



Navigation options include:

- **Home** – Access the Dashboard
- **Claims & Expenses** – View and manage claims
- **Submit a Claim*** – Submit a manual claim
- **Benefits & Coverage** – View plan and coverage information
- **Find Care** – Search for in-network providers
- **ID Card Wallet** – Access digital ID cards
- **Message Center** – Send and receive secure messages
- **My Account** – Manage account settings
- **Family Links** – Access configured family resources

Availability of options may vary based on plan configuration.

Submit a Claim*

Your ability to submit a claim through this portal depends on your network's rules. If you don't see the option to submit a claim, your network requires that claims be submitted directly to them first.

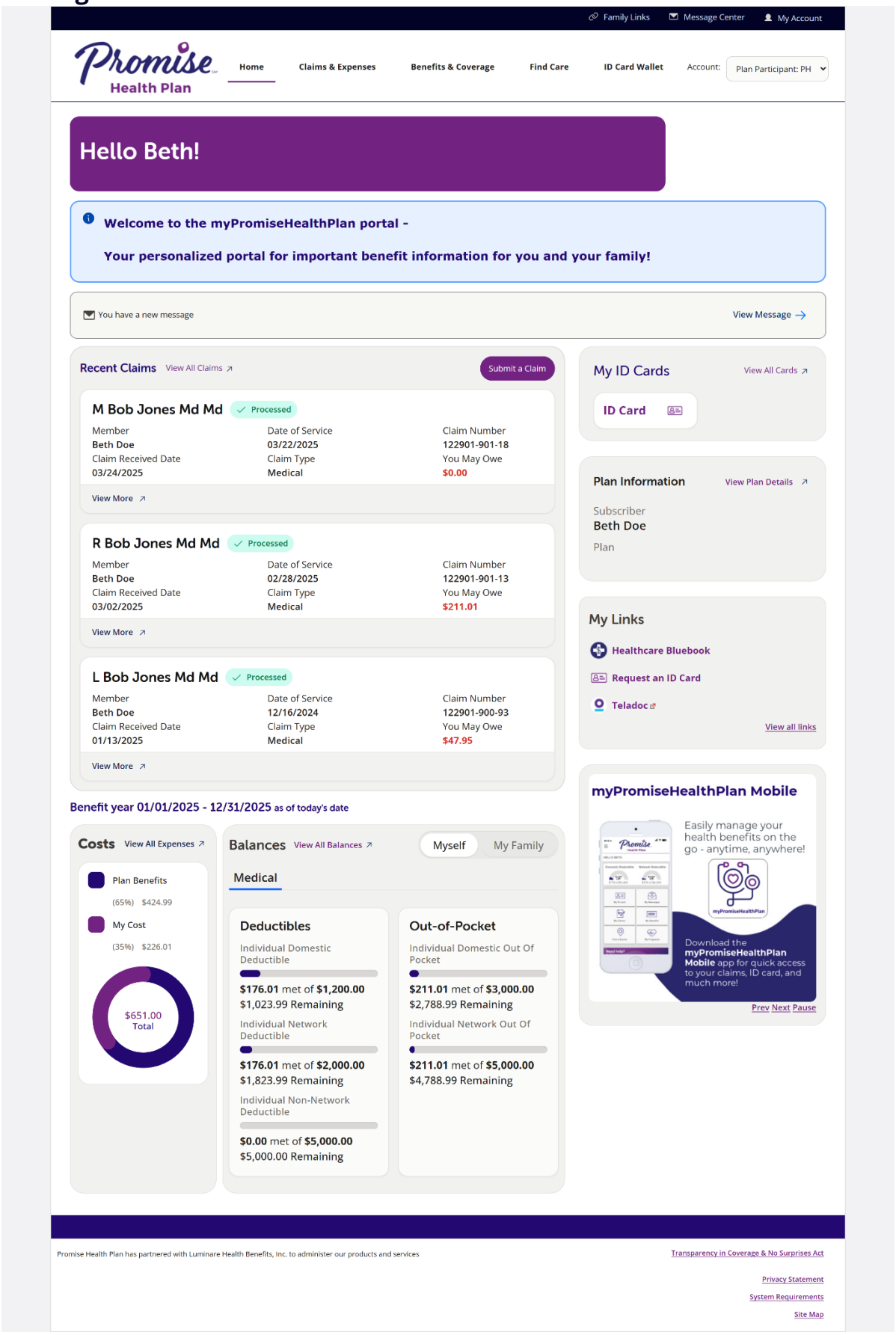
Dashboard (Home)

The Dashboard is the homepage of the portal. It provides a summary of recent activity, benefit information, and important updates.

From the Dashboard, you can:

- Review recent claims
- Access ID cards
- View deductibles and out-of-pocket progress
- Access secure messages
- Navigate to other portal sections

Dashboard Page



Welcome & Alerts
The top of the page displays a personalized greeting and may include important announcements or time-sensitive updates.

Messages
If new messages are available, they will appear near the top of the page for quick access.

Recent Claims
The Recent Claims section displays:

- Provider name
- Claim status
- Date of service
- Estimated member responsibility

Select **View More** for additional details or **View All Claims** to access the full claims history.

ID Cards
Access your medical, dental, and vision ID cards digitally. You can view or request cards as needed.

Plan Information
View details about your current plan, including:

- Plan name
- Covered members
- Subscriber ID

This section helps confirm you're viewing the correct coverage information.

Costs & Balances
The Costs & Balances section displays:

- Deductible progress
- Out-of-pocket maximum progress
- Total plan costs compared to member responsibility

You may toggle between individual and family views when applicable.

Quick Links
Use the links on the right side of the page to quickly access helpful tools such as finding a provider, requesting an ID card, or using cost transparency resources.

Claims & Expenses

Claims & Expenses Summary

The Claims & Expenses page displays claim history and allows you to review claim status, costs, and benefit application.

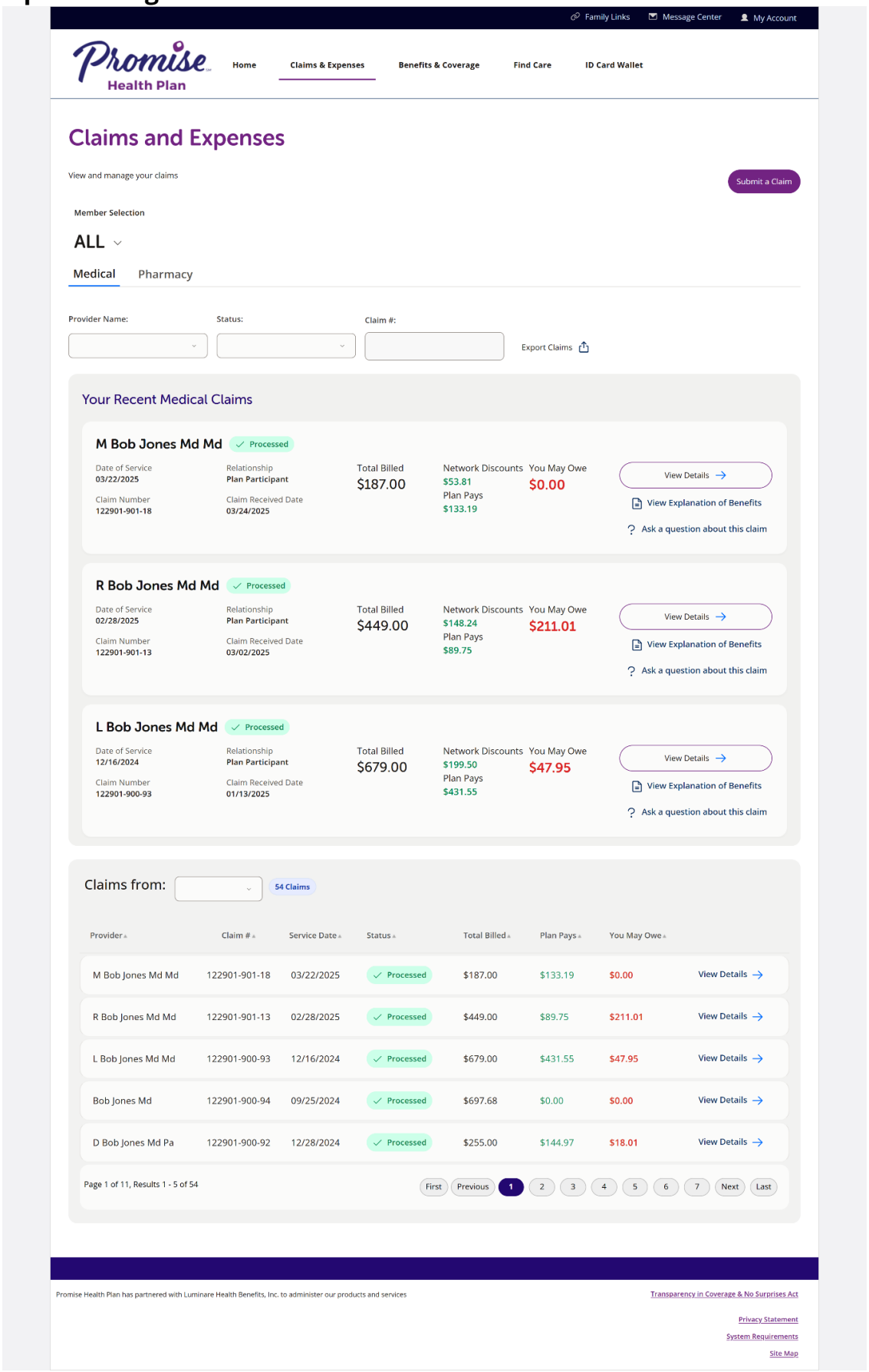
From this page, you can:

- Filter and sort claims
- View detailed claim information
- Submit a new claim*
- Access Explanation of Benefits (EOB) documents

Submit a Claim*

Your ability to submit a claim through this portal depends on your network's rules. If you don't see the option to submit a claim, your network requires that claims be submitted directly to them first.

Claims & Expenses Page



Member & Coverage Selection
At the top of the page, you can select which member you're viewing and select the type of coverage. This helps ensure you're seeing the correct claims.

Filters & Sorting
Use the filters to narrow down your claims by:

- Service type
- Provider
- Claim status

You can also sort claims by date to find the most recent activity first.

Submit a Claim
Select **Submit a Claim** to start the process of submitting a new claim if you received services that haven't yet been filed.

Understanding your claims
Each claim card displays:

- Provider name
- Date of service
- Claim status
- Estimated member responsibility

Select View Details to review the full claim record.

View Claim Details
Select **View Details** to see a full breakdown of the claim, including line-item services and how your benefits were applied.

Explanation of Benefits (EOB)
Select **View Explanation of Benefits** to review your EOB, which explains how the claim was processed and what portion you're responsible for.

Questions About a Claim
If something doesn't look right, use **Ask a Question About This Claim** to get help or clarification.

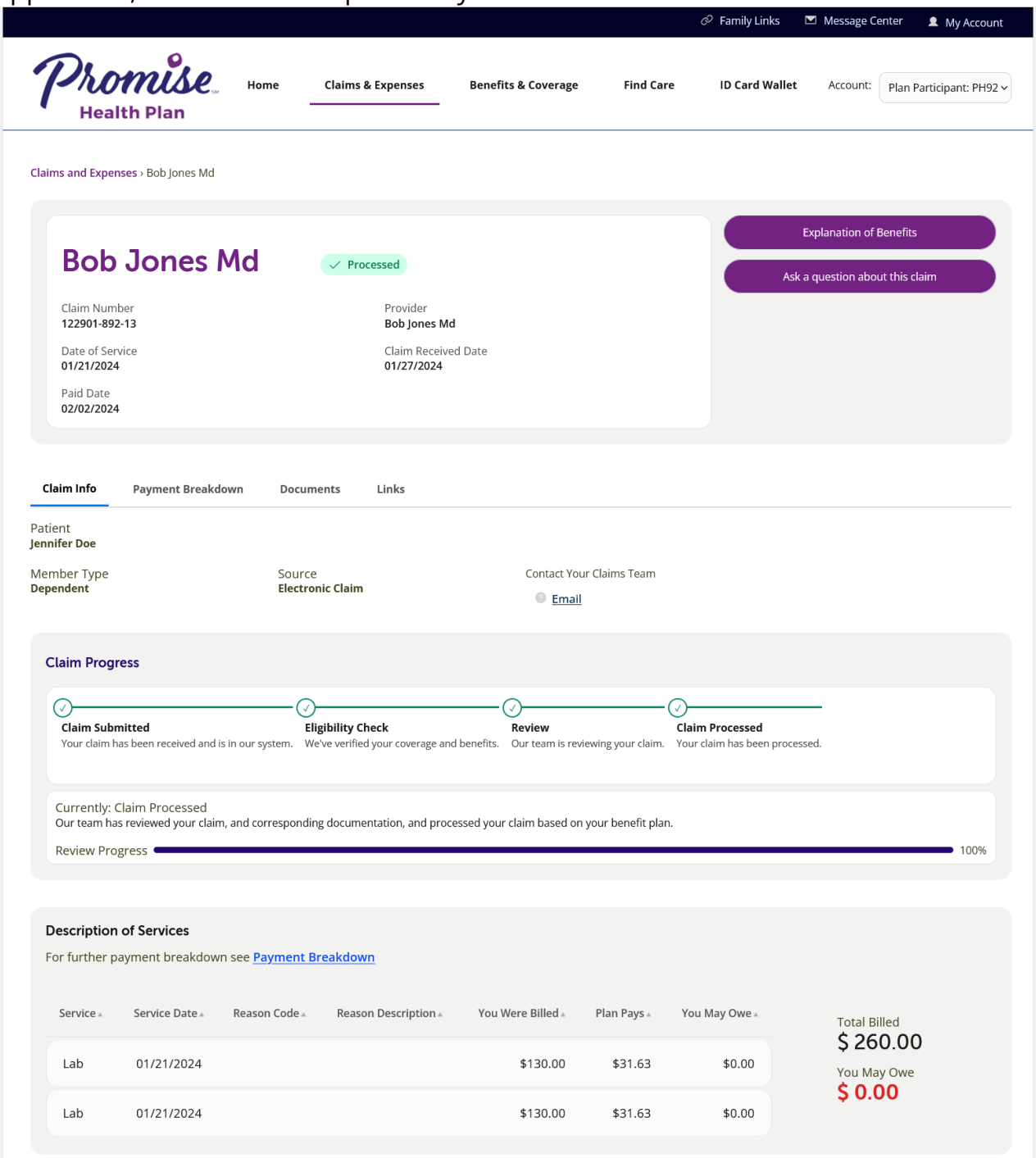
Claims list view
Below the claim cards, you'll find a list view that shows multiple claims at once. This view is helpful if you want to:

- Scan several claims quickly
- Compare amounts
- Access details for older claims

You can also export your claims to excel for your records.

Claim Details

The Claim Details page provides a complete view of a specific claim, including processing status, benefit application, and financial responsibility.



Claim summary
At the top of the page, you'll see a snapshot of the claim, including:

- Provider name
- Claim number
- Date of service
- Claim status (such as processed or in review)

Claim progress
The Claim Progress section displays the current processing stage:

- Claim Submitted
- Eligibility Check
- Review
- Claim Processed

A progress indicator shows the current status.

Coverage tracker
The Coverage Tracker displays how the claim impacts:

- Deductible accumulations
- Out-of-pocket maximum accumulations

This information reflects processed claims only.

Description of services
This section breaks down the services included in the claim. For each service, you can see:

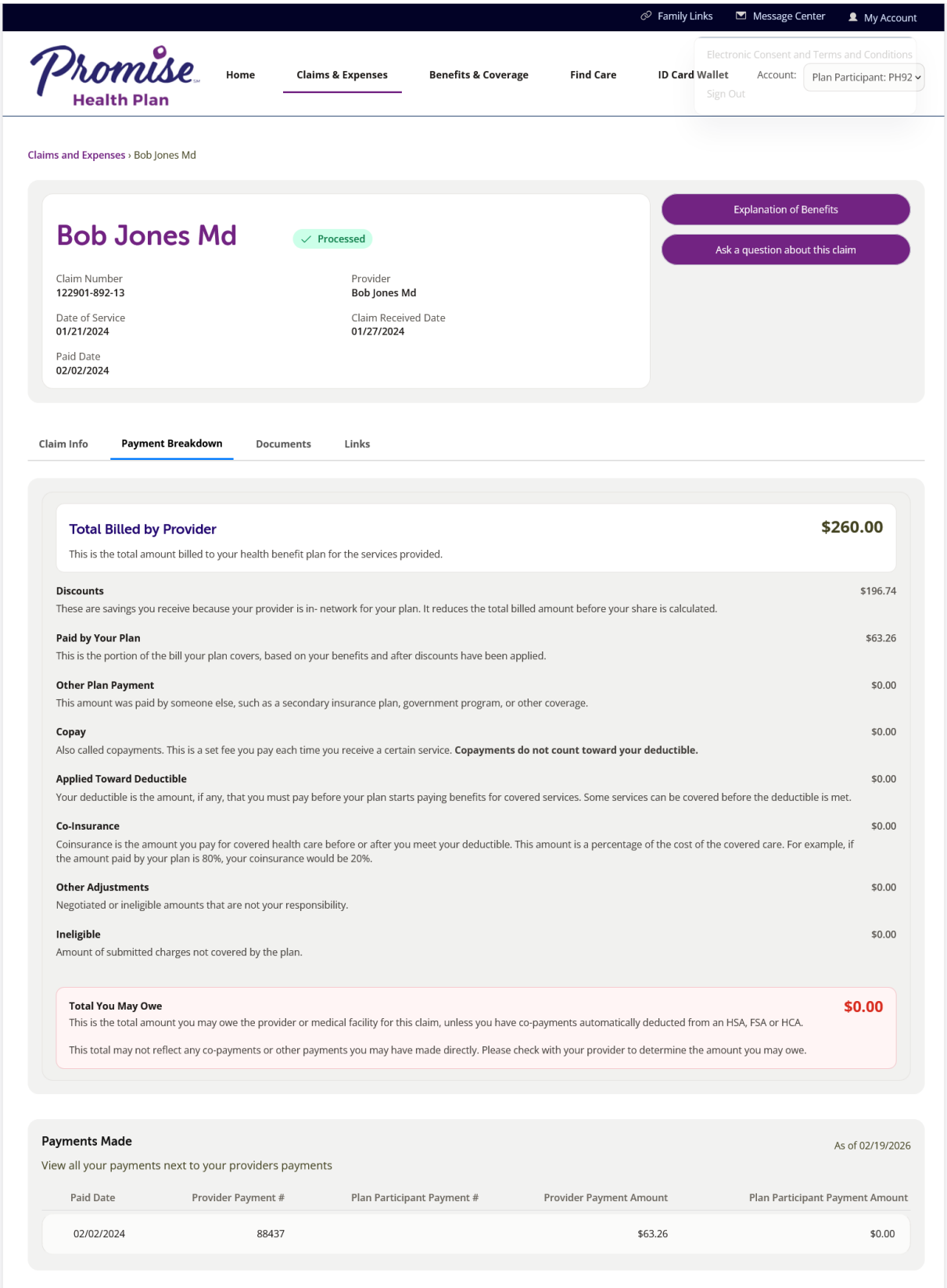
- The type of service received
- What was billed
- What your plan paid
- The amount you may owe

On the right side, you'll see a summary of the **total billed amount** and the **total you may owe** for the entire claim.

Need help?
If clarification is needed:
• Select **Ask a Question**
• Review the Explanation of Benefits

Payment Breakdown

The Payment Breakdown page provides a detailed summary of how a claim was processed and how costs were allocated.



Total Billed by Provider
This is the total amount billed to your benefit plan for the services provided.

Discounts
These are savings you receive because your provider is in- network for your plan. It reduces the total billed amount before your share is calculated.

Paid by Your Plan
This is the portion of the bill your plan covers, based on your benefits and after discounts have been applied.

Other Plan Payment
This amount was paid by someone else, such as a secondary insurance plan, government program, or other coverage.

Ineligible
Amount of submitted charges not covered by the plan.

Copay
Also called copayments. This is a set fee you pay each time you receive a certain service. Copays do not count towards your deductible.

Applied Towards Deductible
Your deductible is the amount, if any, that you must pay before your plan starts paying benefits for covered services. Some services can be covered before the deductible is met.

Co-Insurance
Coinsurance is the amount you pay for covered health care before or after you meet your deductible. This amount is a percentage of the cost of the covered care. For example, if the amount paid by your plan is 80%, your coinsurance would be 20%.

Total You May Owe
The **Total You May Owe** section summarizes the amount you may need to pay your provider for this claim.
This amount:

- Reflects how your benefits were applied
- May not include payments you've already made directly to the provider
- May change if adjustments are made to the claim

It's always a good idea to compare this amount with your provider's bill.

Payments made

The Payments Made section shows any payments related to this claim, including:

- Payments made by your benefit plan
- Payments you may have already made
- Dates and payment reference numbers

This helps you track what has already been paid and avoid duplicate payments.

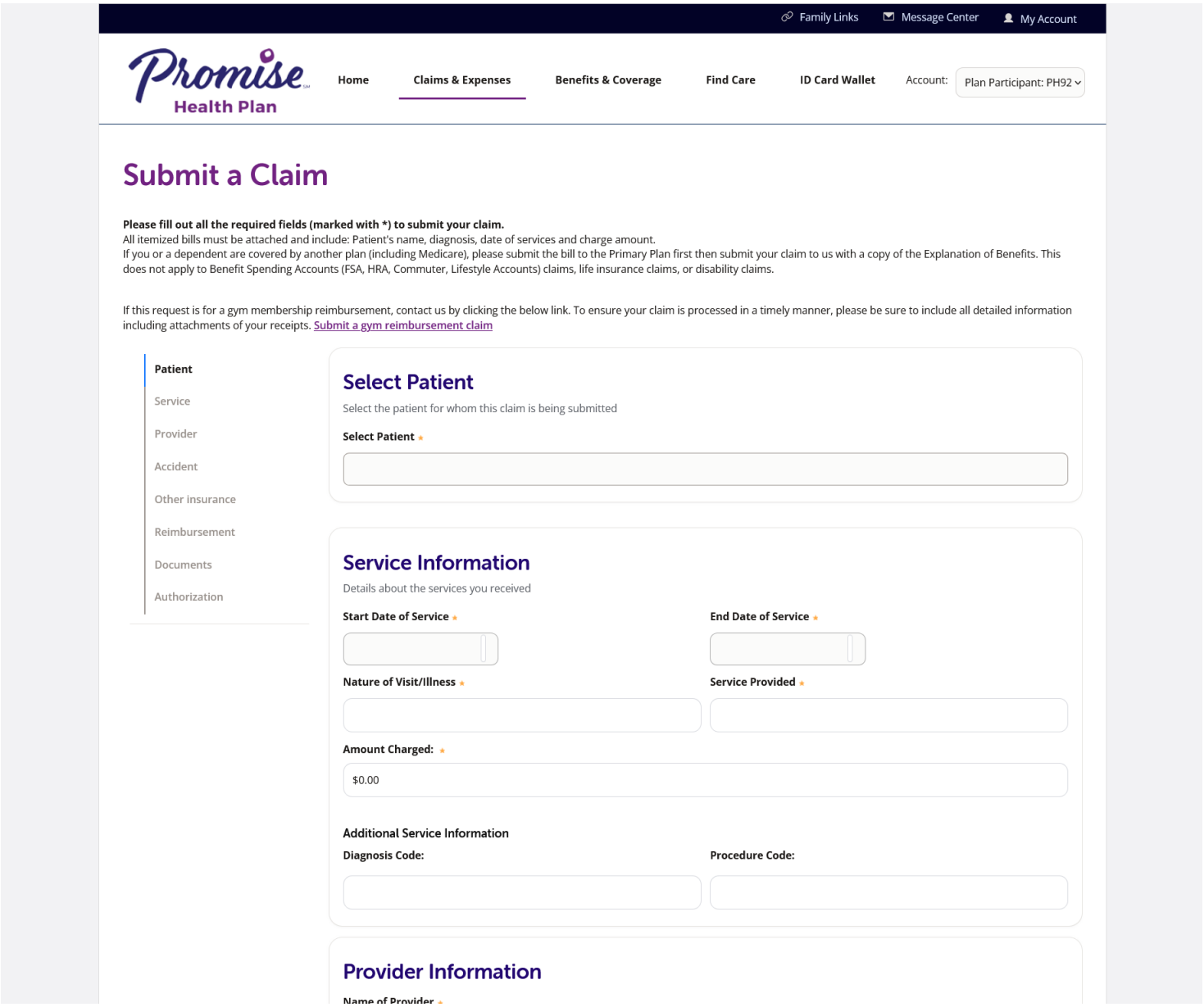
Submit a Claim

The Submit a Claim page allows you to submit a manual claim for eligible healthcare services. Required fields are marked with an asterisk (*).

Before You Begin

Have the following information available:

- Patient name
- Dates of service
- Provider name and details
- Total amount charged for the service
- Copies of receipts or itemized bills



Claim Information Sections
The claim form is divided into sections to make it easier to complete. Use the navigation on the left side of the page to move between sections.

Patient Information
Select the patient for whom the claim is being submitted.

Service Information
Enter details about the services you received, including the dates of service and the type of visit.

Documents
Upload any required receipts or supporting documentation related to your claim.

Authorization
Review and acknowledge the required authorizations before submitting your claim.

Completing the Form
You may move between sections as needed using the left-hand navigation. Be sure all required fields are completed before submitting your claim.

After You Submit
After submission, the claim will be reviewed for processing. Claim status can be monitored in the **Claims & Expenses** section.

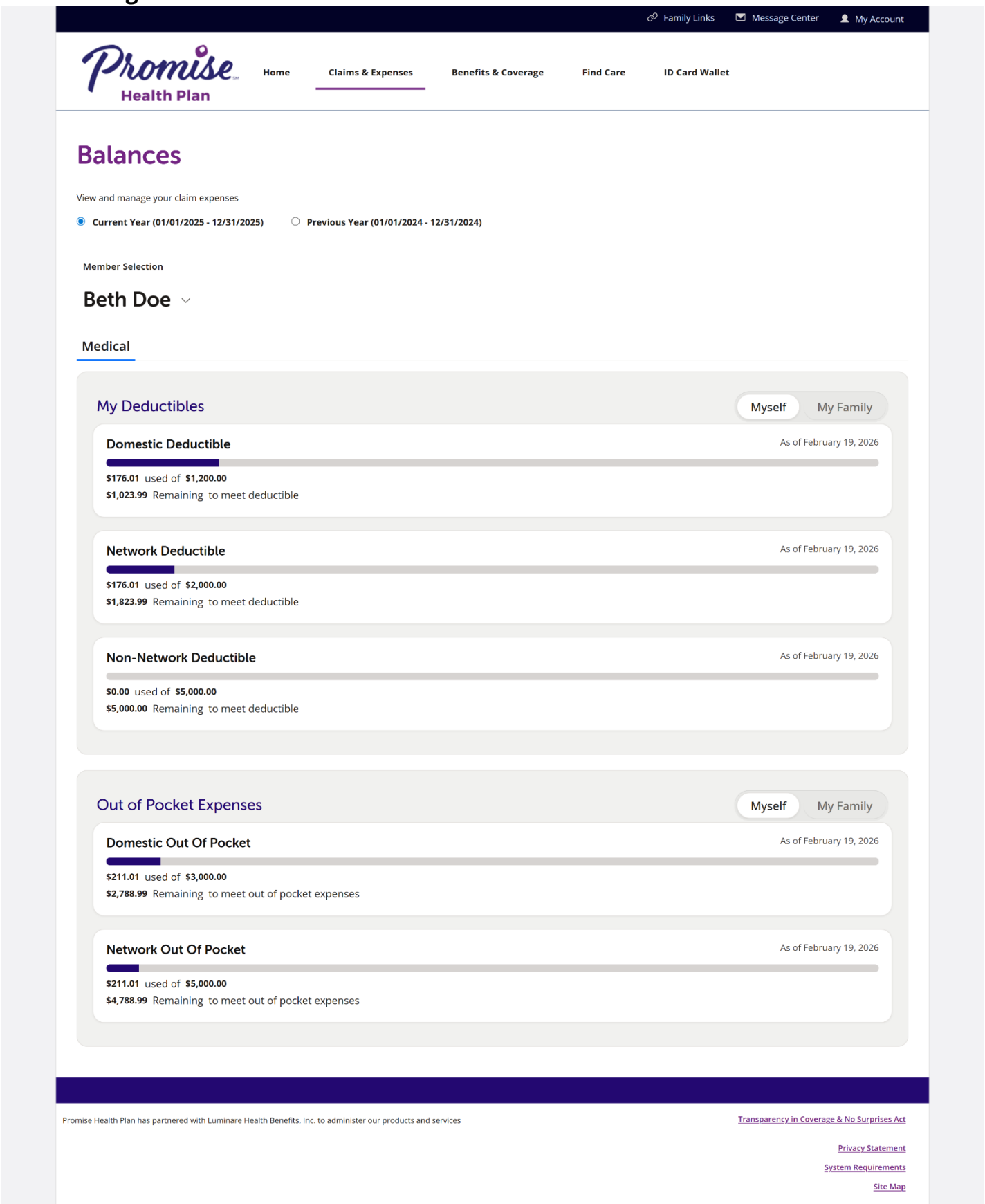
Note: Fields marked with an asterisk (*) are required to submit your claim.
Your ability to submit a claim through this portal depends on your network's rules. If you don't see the option to submit a claim, your network requires that claims be submitted directly to them first.

View Balances

Use the **View Balances** page to track how much you've paid, and how much remains, for your healthcare expenses throughout the plan year.

This page helps you understand your **deductibles** and **out-of-pocket maximums** at a glance.

Balances Page



What You'll Find on the View Balances Page

Member & Year Selection
At the top of the page, you can:

- Select the member whose expenses you want to view
- Toggle between the **current year** and **previous year**

Deductibles
The **My Deductibles** section shows how much of your deductible has been met and how much remains.

Each tracker includes:

- A progress bar showing how close you are to meeting your deductible
- The amount used so far
- The remaining amount needed to meet your deductible

You can also toggle between **Myself** and **My Family**, if applicable.

Out-of-Pocket Expenses
The **Out-of-Pocket Expenses** section shows how much you've paid toward your out-of-pocket maximum.

This section helps you understand:

- How much you've paid so far
- How much remains before your plan pays 100% of covered services

Like deductibles, this information may be shown for:

- Preferred providers
- In-network services
- Out-of-network services

Helpful Tips

- Progress bars update as claims are processed
- Amounts shown reflect claims processed as of the date displayed on the page
- Hovering over progress bars may provide additional detail

Benefits & Coverage Personal Information

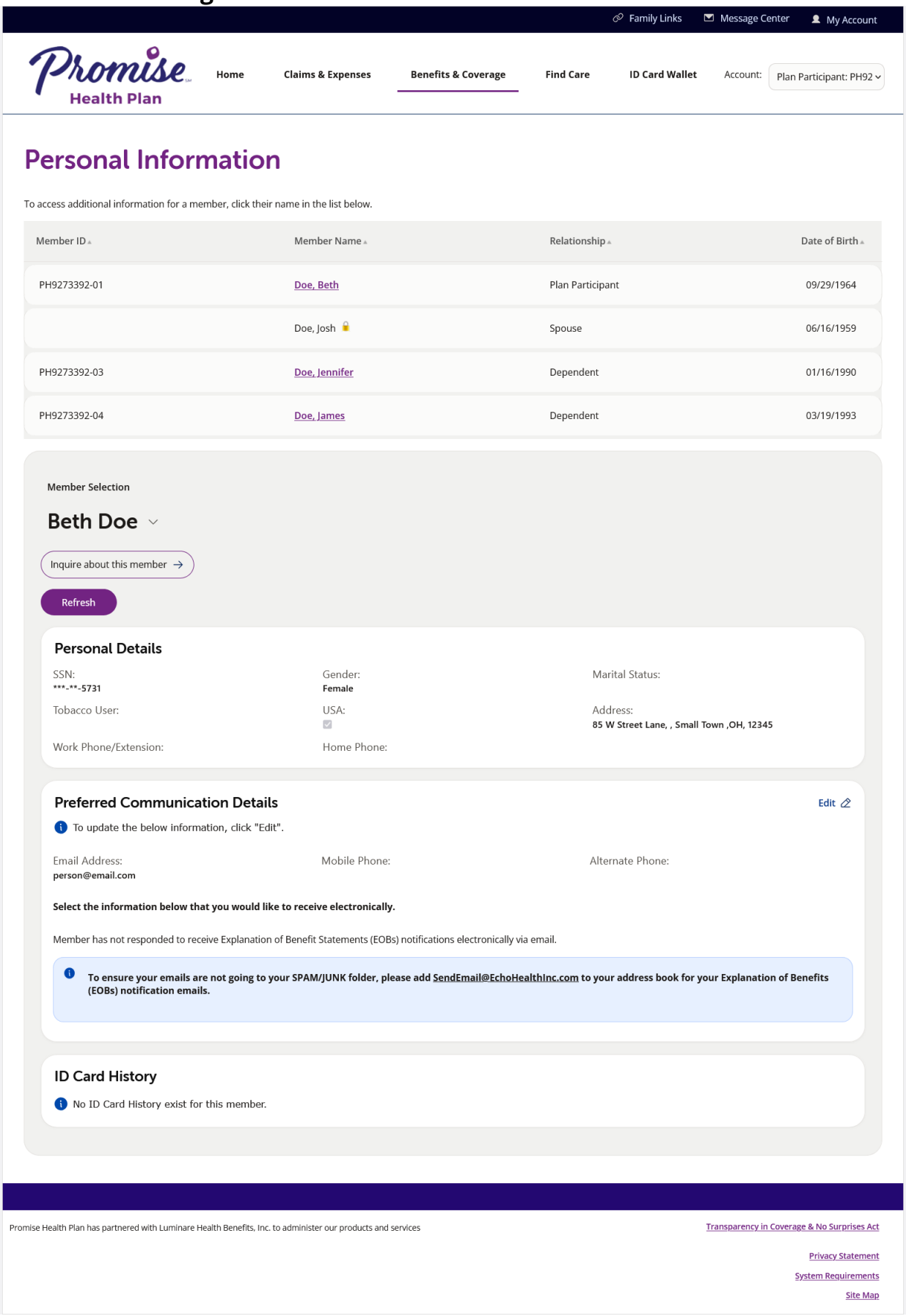
Personal Information

The Personal Information page displays identifying, contact, and employment information for covered members.

Select a member to view details.

Some information may be partially masked for security.

Personal Information Page



What You'll Find on the Personal Information Page

Members
At the top of the page, you'll see a list of members covered under your plan.
This section includes:

- Member ID
- Member name
- Relationship to the Plan Participant
- Date of birth

This helps you confirm who is covered and select the correct member when viewing details.

Member Selection
Select a member from the list to view their personal information.

Once selected, the page will update to display details for that specific member.
You can also select **Inquire about this member** if you have questions related to their information. This allows you to communicate securely with our team via the Message Center.

Personal Details
The **Personal Details** section displays important identifying and contact information for the selected member.

This may include:

- Partially masked Social Security number
- Gender
- Marital status
- Tobacco use status
- Home address
- Work and home phone numbers

For privacy and security, certain information may be partially hidden.

Employment Information
This section shows employment details associated with your health plan, such as:

- Employer name
- Location or division

Preferred Communication Details
Your **Preferred Communication Details** indicate how you receive important updates and notifications.

This includes:

- Email address
- Mobile phone number
- Alternate phone number

Select **Edit** to update your contact information.

Helpful Tips
Keeping your contact details up to date helps ensure you receive important notifications, including Explanation of Benefits (EOB) emails.

ID Card History
The **ID Card History** section shows past ID card requests for the selected member, including:

- Request date
- Print date
- Mail date

This helps you track when ID cards were issued and mailed.

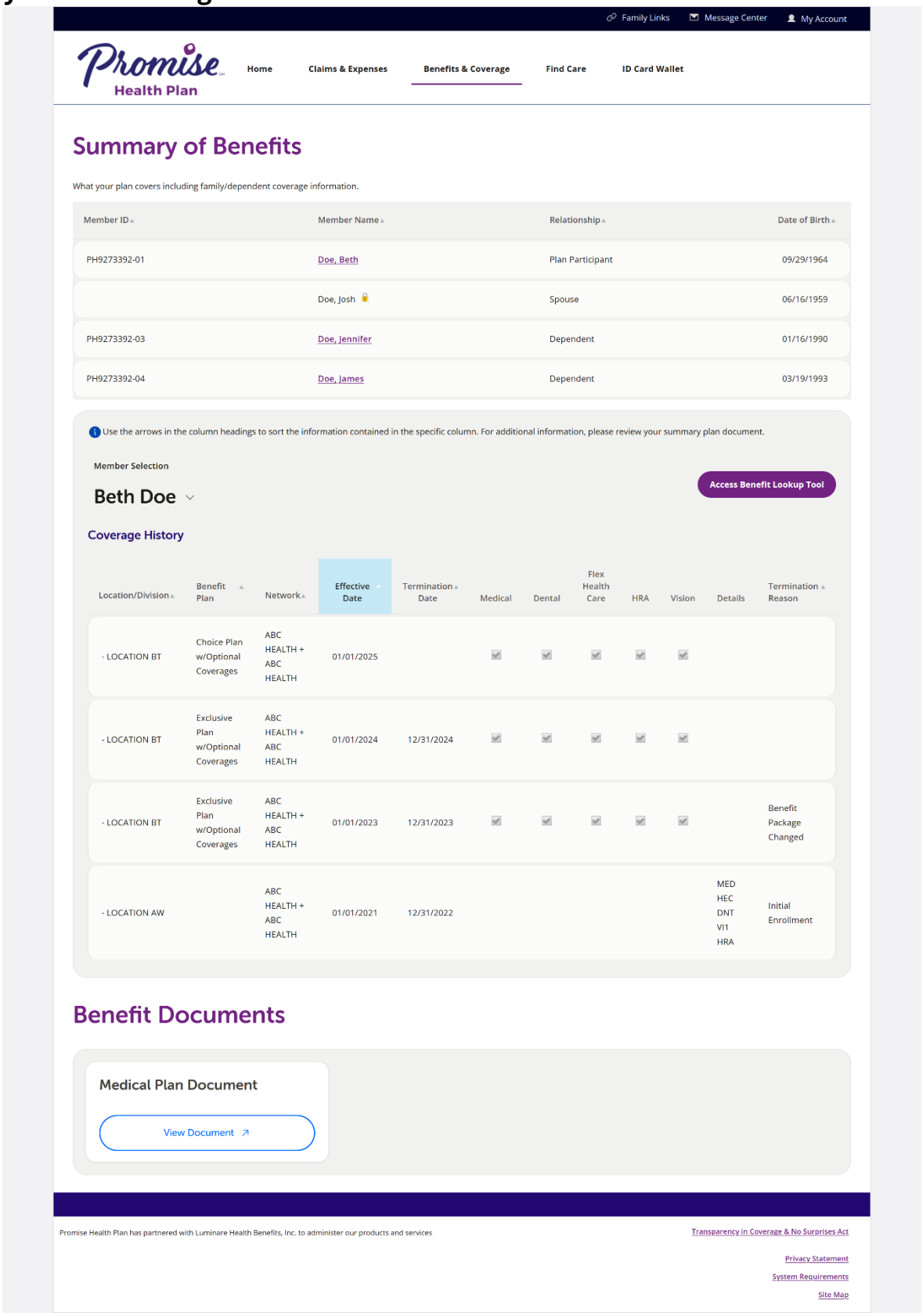
Summary of Benefits

The Summary of Benefits page displays coverage details and coverage history for each covered member.

You can:

- Review current and historical coverage
- Filter by date range
- Confirm effective and termination dates

Summary of Benefits Page



What You'll Find on the Summary of Benefits Page

Members
At the top of the page, you'll see a list of members covered under your plan.
This section includes:

- Member name
- Relationship to you
- Date of birth

Select a member to view their benefit information.

Member Selection
Once you select a member, the page updates to show coverage details specific to that individual.
You can also select **Access Benefit Lookup Tool** for additional benefit information.

Coverage History
The **Coverage History** section shows your benefit coverage over time.

You can:

- Filter coverage by date range
- Review current and past coverage periods
- See when coverage began or ended

This is helpful if you need to confirm coverage during a specific time period.

Coverage Details Table
The table provides a summary of benefit information, which may include:

- Plan name
- Network type
- Effective dates
- Coverage indicators for medical, dental, vision, pharmacy, and other benefits
- Termination reasons, if applicable

Use the column headings to sort information as needed.

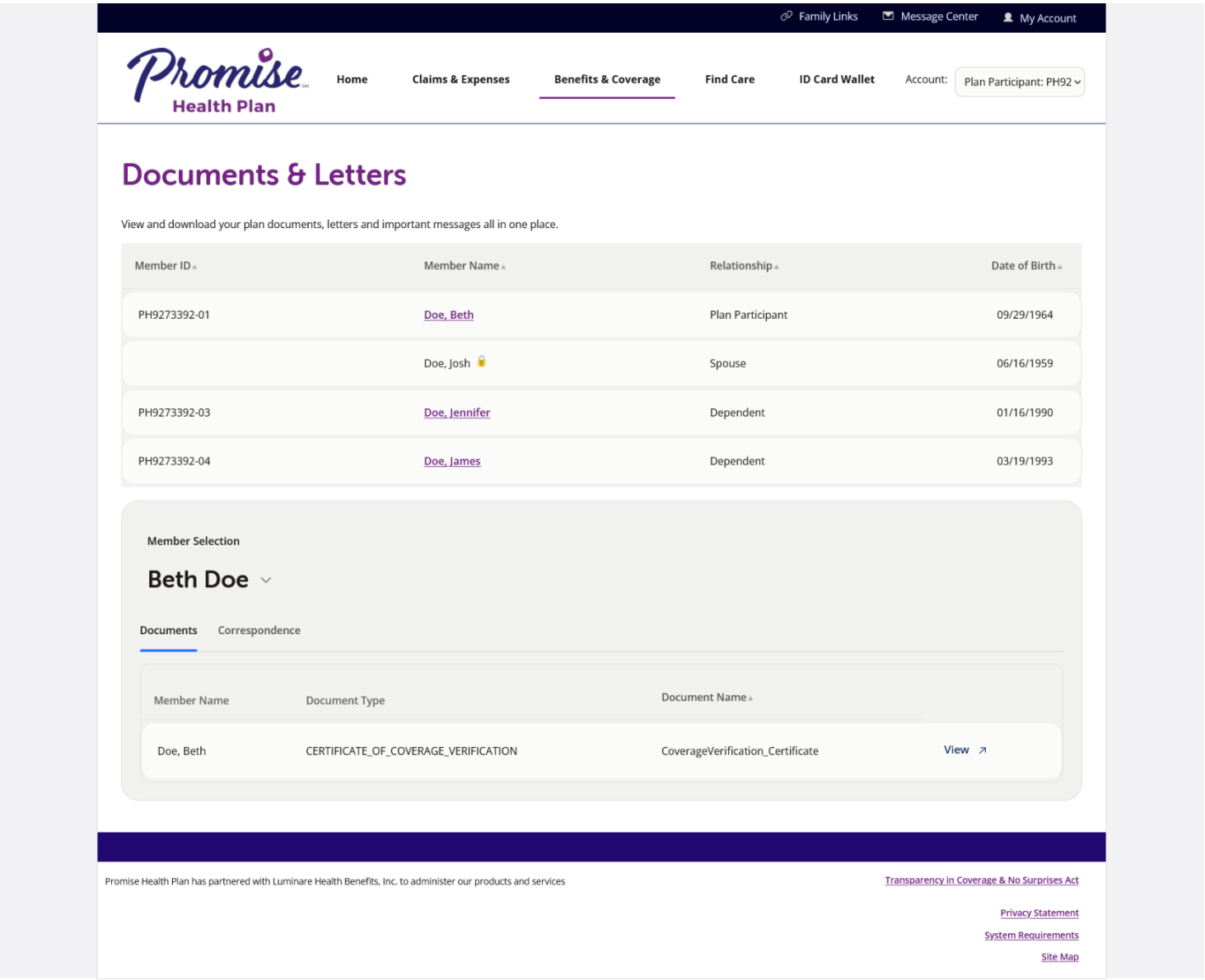
Helpful Tips

- Coverage details may vary by member
- Some benefit indicators show whether coverage is included, not how much is covered
- For the most detailed benefit information, refer to your official plan documents

Documents & Letters

The Documents & Letters page provides access to official plan documents and correspondence. Documents are organized by member.

Select **View** to open a document.



What You'll Find on the Documents & Letters Page

Member List
At the top of the page, you'll see a list of covered members on your plan.

This section includes:

- Member name
- Relationship to you
- Date of birth

Use this information to confirm you're viewing documents for the correct person.

Member Selection
Select a member to view documents associated with that individual.
Once selected, the page will update to show documents for that member only.

Documents
The **Documents** tab displays official plan documents available for the selected member.

For each document, you'll see:

- Member name
- Document type
- Document name

Select **View** to open the document.

Correspondence
The **Correspondence** tab includes letters and notifications sent to you regarding your coverage or claims.

This may include:

- Notices related to claims or benefits
- Other official communications

Helpful Tips

- Documents are organized by member for easy access
- Some documents may appear more than once if they were issued at different times
- You can return to this page anytime to review past documents and letters

Benefit Lookup Tool

The **Benefit Lookup Tool** allows you to explore how specific services are covered under your health plan.

This tool provides an estimate of your plan benefits based on your current coverage, including coinsurance, copayments, and deductible information.

You can use the Benefit Lookup Tool to understand coverage for common services such as:

- Preventive care
- Specialist visits
- Diagnostic services
- Prescription medications
- Allergy testing and treatments
- Mental health services

The information displayed is intended to help you better understand your benefits before receiving care.

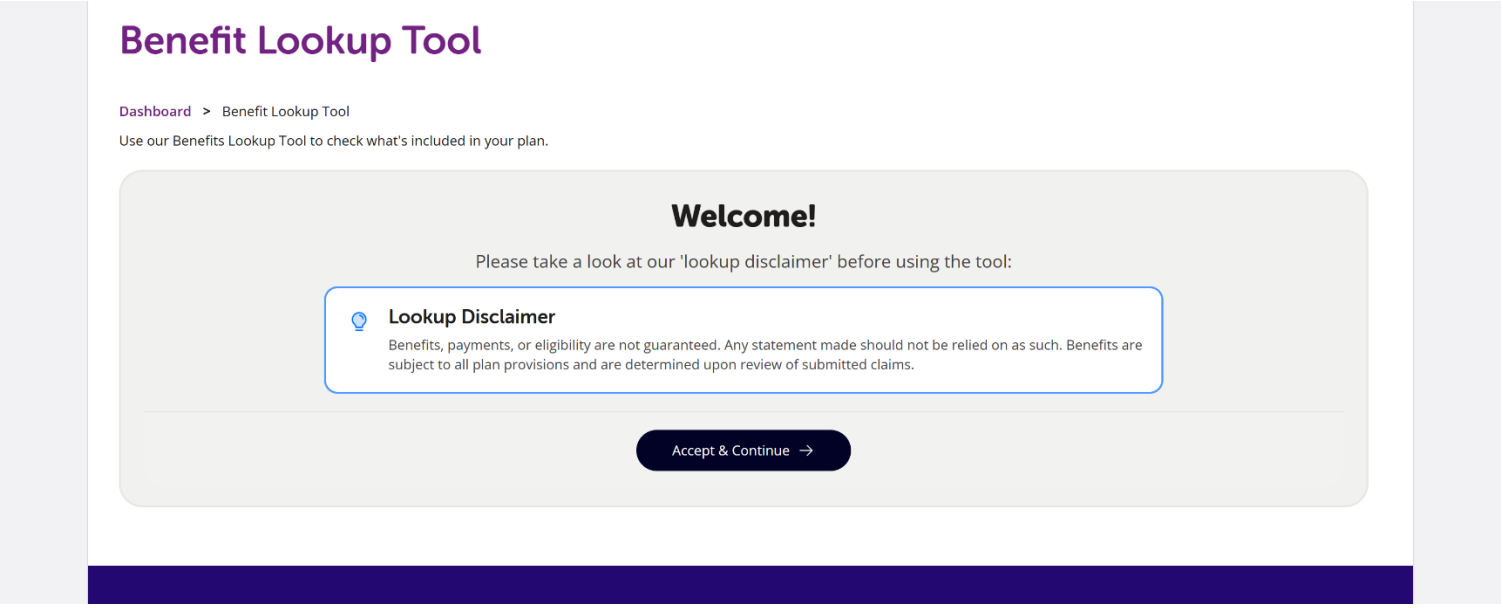
Helpful Tip: The Benefit Lookup Tool helps you understand how a service may be covered under your plan. Actual benefit payments may vary depending on factors such as provider network status, medical necessity, and how the claim is processed.

Access to the Benefit Lookup Tool is based on plan configuration and may not be available to all users.

Accessing the Benefit Lookup Tool

1. Select **Benefits & Coverage** from the main navigation menu.
2. Select **Benefit Lookup Tool**.
3. Review the **Lookup Disclaimer**.
4. Select **Accept & Continue** to proceed.

The disclaimer explains that the information provided by the tool is an estimate and that final benefit determinations are based on the terms of your health plan and the processing of submitted claims.

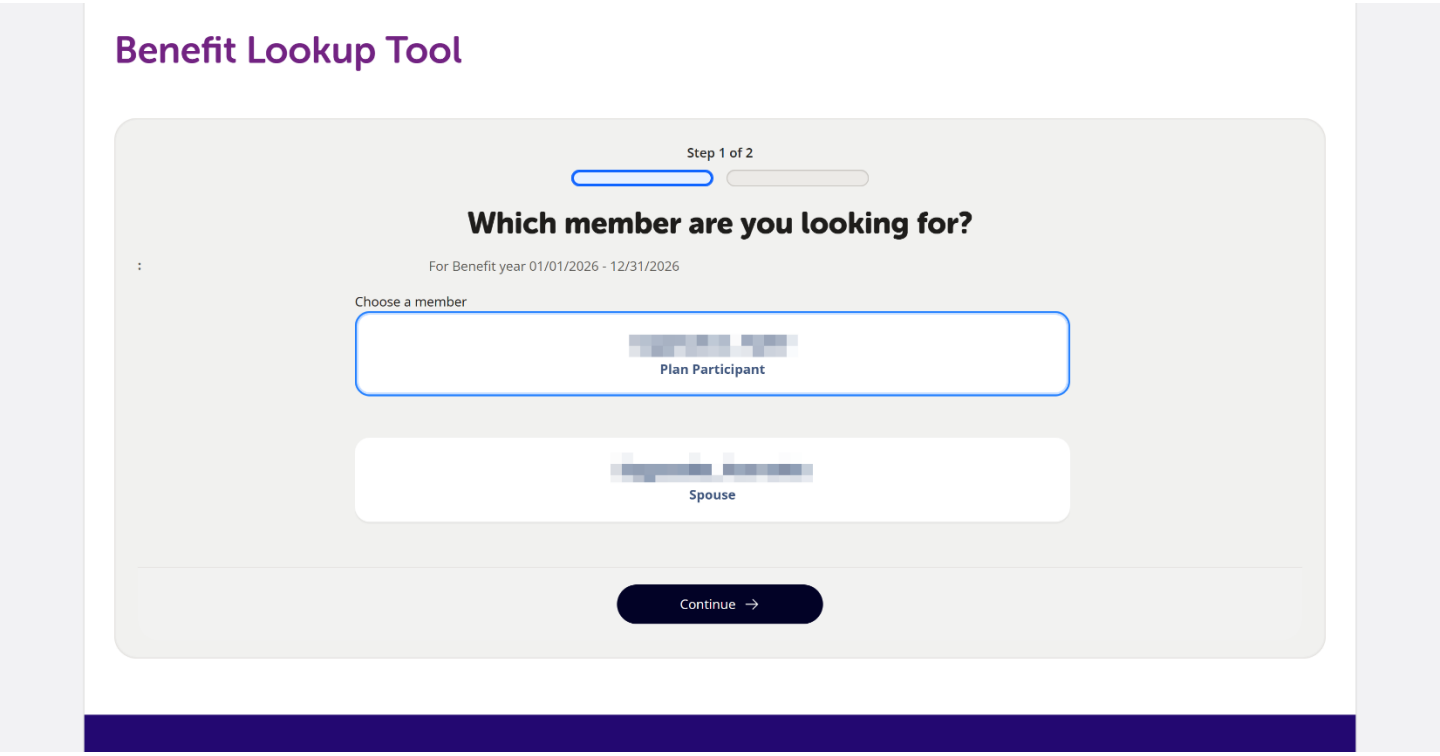


Step 1: Select a Member

If your plan includes family members, you will first be asked to select the individual whose benefits you want to review.

1. Choose the **Plan Participant or Dependent** from the list.
2. Select **Continue**.

The benefit lookup results will reflect the selected member's coverage and accumulators.

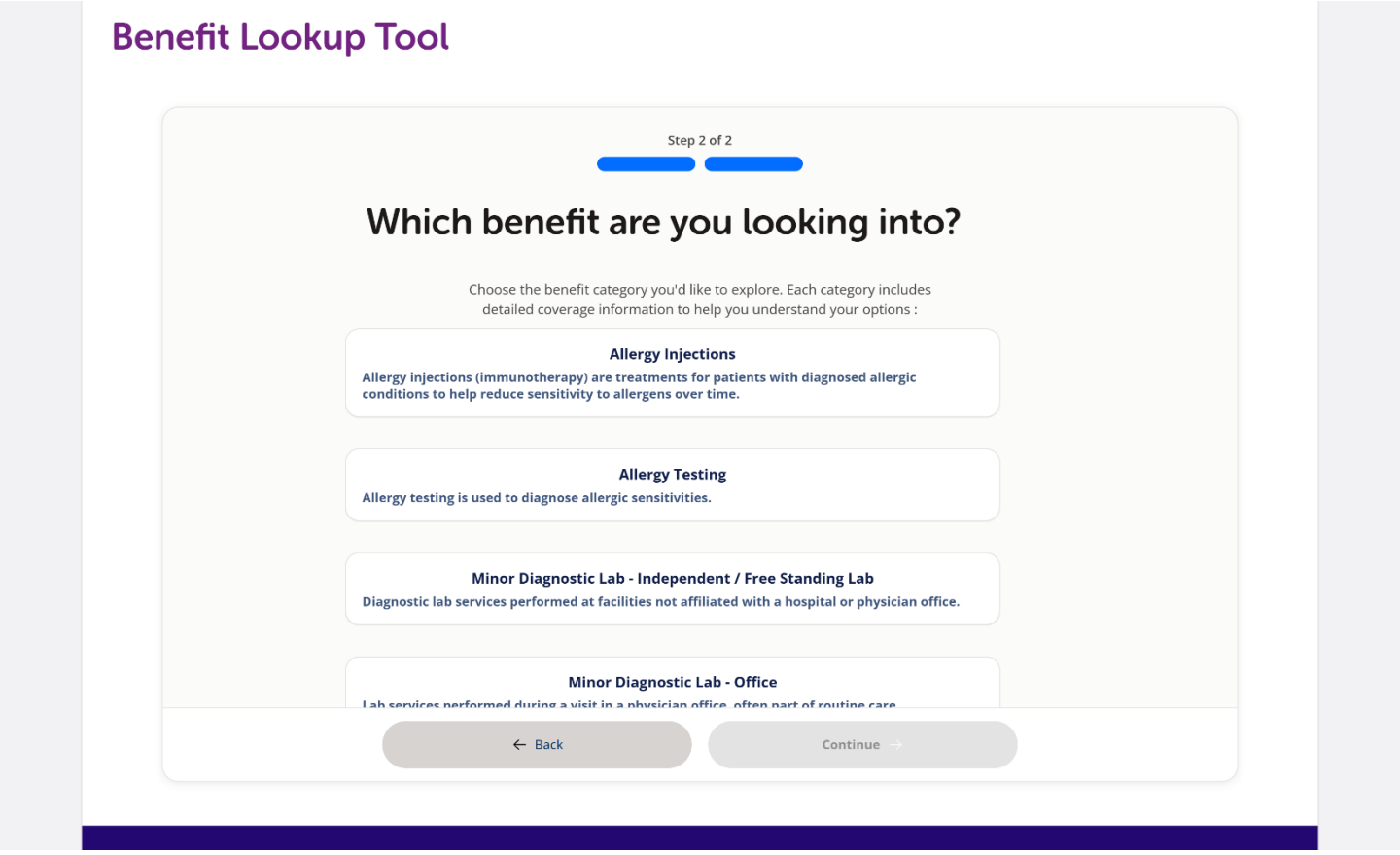


Step 2: Choose a Benefit Category
Next, select the type of service you want to review.
The available options represent common healthcare services and categories covered under your plan.

Examples may include:

- Allergy Injections
- Allergy Testing
- Diagnostic Laboratory Services
- Imaging Services
- Preventive Care Services

Each category includes a short description to help you identify the appropriate benefit.
Select the category you would like to explore and select **Continue** to proceed.



Viewing Benefit Details
After selecting a benefit category, the Benefit Lookup Tool displays an overview of how the service is covered under your plan.

This may include:

- In-Network Coverage
- Out-of-Network Coverage
- Domestic or Tier Coverage
- Copayment or Coinsurance Amounts
- Pre-certification Requirements

For each coverage tier, the tool may show:

- The percentage you pay
- The percentage your plan pays
- Any applicable copayment amount
- Whether pre-certification is required

Deductible and Out-of-Pocket Information
The Benefit Lookup Tool may also display your current deductible and out-of-pocket accumulator balances, including:

- Individual Deductible
- Family Deductible
- Individual Out-of-Pocket Maximum
- Family Out-of-Pocket Maximum

These values help you understand how much of your deductible or out-of-pocket limit has already been met for the current benefit year.

Searching for Another Benefit
To review a different service:

1. Select **Search for Another Benefit**.
2. Choose another benefit category.
3. Review the coverage details.

Important Notes

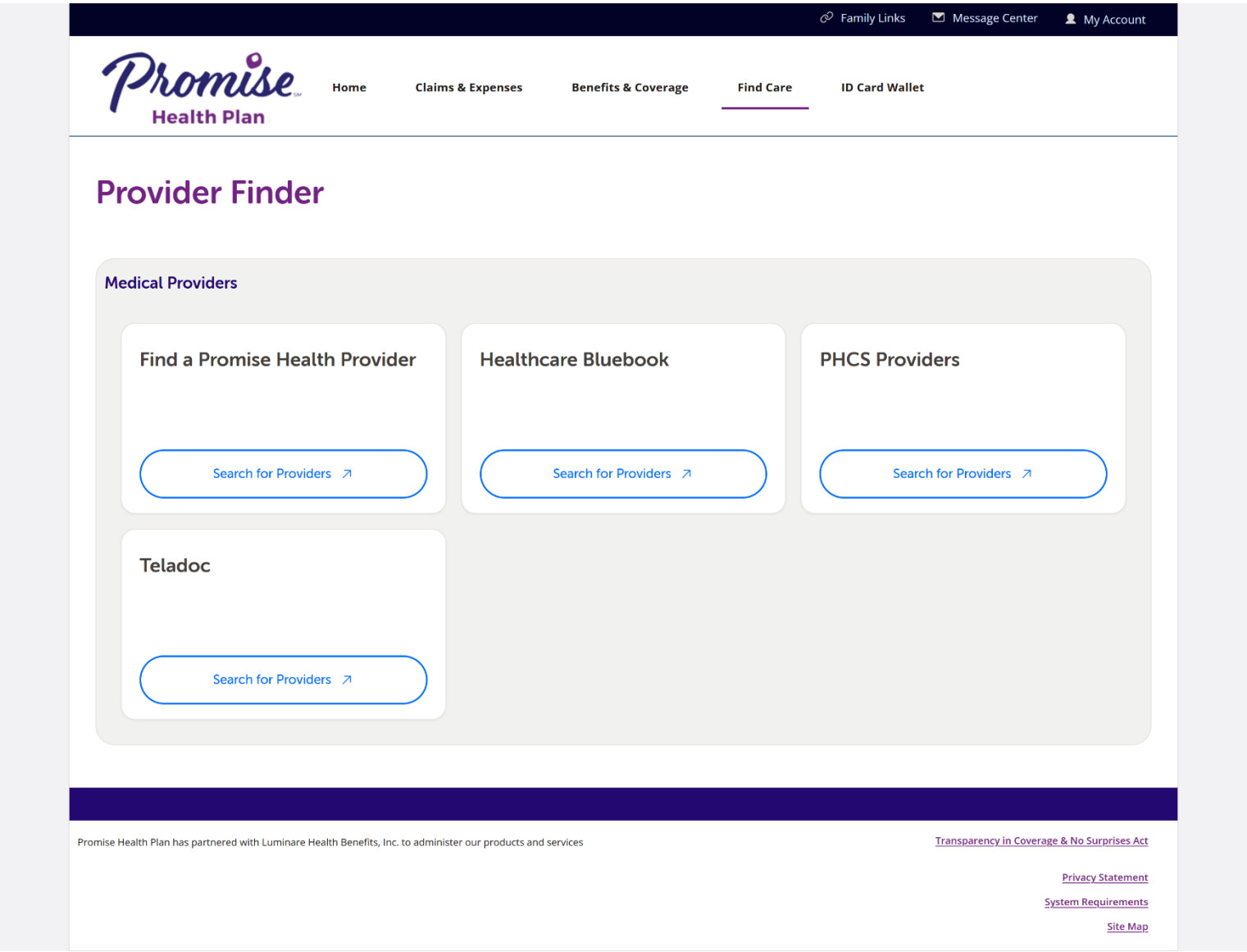
- The Benefit Lookup Tool provides **estimated coverage information only**.
- Final benefits are determined when a claim is submitted and processed.

If you have questions about your coverage, you can contact us through the **Message Center** or by calling the number on the back of your ID card.

Find Care

Provider Finder

The Find Care page provides access to provider search tools based on your plan configuration. Select **Search for Providers** to begin.



What You'll Find on the Find Care Page

Provider Search Options
You may see one or more provider search links, depending on your plan.

Each option allows you to:

- Search for in-network doctors, specialists, clinics, and hospitals
- View important details such as contact information and network status

Select **Search for Providers** to begin your search.

Helpful Tips

- Provider availability and network status can change, so it's a good idea to confirm details before scheduling care

ID Card Wallet

The ID Card Wallet allows you to view digital ID cards for covered members.

Select **View Card** to open the digital ID.

What You'll Find on the ID Card Wallet Page

Member Selection
At the top of the page, select the member whose ID card you want to view.

If you have dependents on your plan, you can switch between members to access their ID cards as well.

See ID Cards
The **See My ID Card** section lets you open a digital version of the selected member's ID card.

From here, you can:

- View your ID card online
- Access cards for dependents (if applicable)
- Use your digital card when visiting a provider or pharmacy

Select **View Card** to open the ID card.
ID Card History
The **ID Card History** section shows past ID card requests for the selected member.

This includes:

- The date the card was requested
- When it was printed
- When it was mailed

This helps you track previous ID card activity.

Helpful Tips

- Digital ID cards can be used in place of physical cards in many situations
- If your coverage changes, your ID card may update automatically
- Keep your ID card handy for appointments, prescriptions, and billing questions

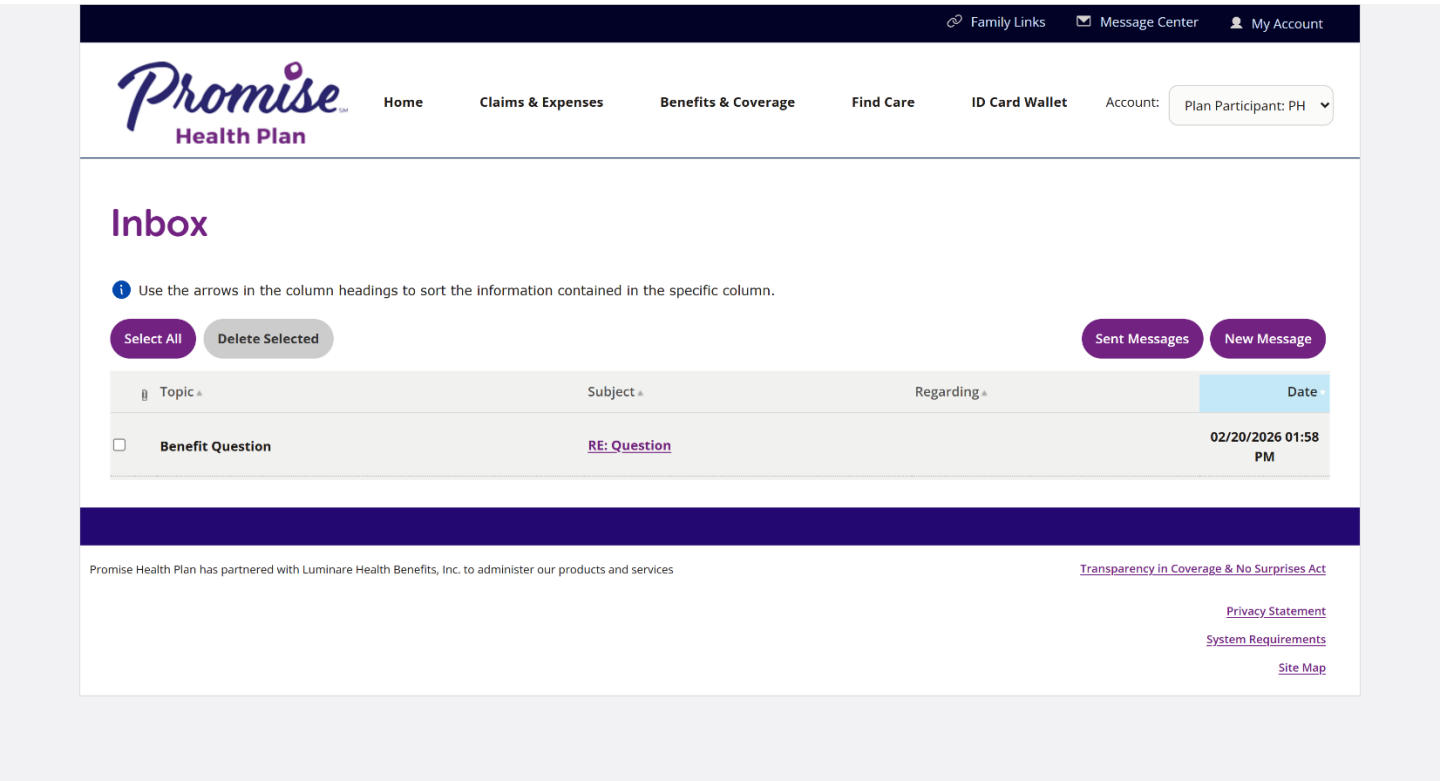
Message Center

The Message Center allows secure communication related to your health plan.

You can:

- View received messages
- Send new messages
- Reply to existing messages
- Attach supporting documentation

All messages are securely stored within the portal.



What You'll Find in the Message Center

Inbox

Your **Inbox** displays messages you've received.

From this view, you can:

- Review previous messages and correspondence
- Sort messages using the column headings
- Select and delete messages you no longer need

Sent Messages
Select **Sent Messages** to view messages you've previously sent through the portal.

This allows you to track:

- Topics you've contacted us about
- When a message was sent
- Any responses received

Sending a New Message
Select **New Message** to contact us securely.

When composing a message, you'll be asked to:

- Select a **Topic** to help route your message to the correct department
- Enter a **Subject**
- Add your message details

Attachments (Optional)
You may include supporting documents with your message, such as:

- Explanation of Benefits (EOBs)
- Receipts
- Forms or other documentation

Attachments can be uploaded by dragging and dropping files or browsing your device.

Secure Communication
All messages sent through the Message Center are:

- Secure and private
- Routed to the appropriate department
- Stored within the portal for future reference

You can also reply directly to messages you receive, keeping all related communication in one place.

My Account

User Profile

The User Profile page allows you to update:

- Password
- Email address
- Mobile phone number

Maintain accurate contact information to ensure timely communication.