NIS
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Employee Benefits:
Answers to Common Issues

Understanding your benefits can feel overwhelming, especially when bills, claims or coverage don't work the way you expect.

These Q&As break down common employee benefits questions so you can better understand what's going on behind the scenes when you have issues with your insurance, providers and coverage.

Q: Why did I get a bill when I have insurance?

A: Receiving a bill doesn't always mean something is wrong. Sometimes your provider sends a bill before your claim is fully processed. Other times, parts of your visit may be subject to a copay, deductible or coinsurance. It can also happen if the provider didn't send the correct information to the insurance company, or if the service isn't fully covered under your plan. Many billing surprises come from coding, timing or benefit rules.

Q: Why was I charged for preventive care?

A: Preventive care is usually covered at 100%, but only when the visit is strictly preventive. If your provider adds services, such as additional labs, tests or treatment to treat a condition, the visit may be billed differently. While it is normal and often correct, there are other reasons you could still be charged. Charges can also happen if the provider or lab wasn't in network or if the appointment wasn't coded correctly. It's best practice to check for errors or mistakes when you are charged.

Q: My provider is in network. Why was my claim denied?

A: Even with an in-network provider, claims can be denied for several reasons. Some services need preauthorization, referrals or specific documentation. Your provider might be in network, but the lab, imaging center or facility they used may not be. Sometimes a claim is denied simply because information was missing or the service isn't covered under your specific plan.

Q: Why isn't my dependent covered anymore?

A: Dependent coverage may end for several reasons, such as missing documentation, incomplete enrollment during open enrollment, timing requirements related to life events like marriage or birth, or dependents aging out under the plan. In some cases, dependents must be verified annually. While coverage lapses often relate to an administrative step that needs follow up, it's important to note that under Affordable Care Act compliant plans, federal mandates do not require coverage beyond age 26 and allow coverage to end midyear, which can also explain why coverage ends unexpectedly. Some employer-sponsored plans cover individuals through the end of the month they turn 26; others, like Marketplace plans, continue coverage through the end of the year. In certain states, some plans are required to offer coverage to qualified dependents to a later age, such as 29 or 30, so age limit requirements vary.

Q: Who do I call when something goes wrong?

A: Managing your employee benefits can involve several different contacts. Knowing who to reach out to can save time and frustration. Start with the option that best fits your situation:

- **Your insurance company**—Contact your medical or prescription insurance carrier for questions about claims, coverage details, billing issues, prior authorizations or denied services.
- **Your voluntary benefits provider**—Benefits like dental, vision, life or disability insurance are often offered through separate companies. Each provider has its own customer service team to help with coverage questions, claims, or payment issues related to those benefits.
- **Your HR or benefits team**—Reach out to your HR or benefits team for help with enrollment, eligibility changes, required documentation or general guidance on how your benefits work.
- **Your health care provider**—Your doctor's office or health care provider is the best resource for questions about treatment plans, appointment scheduling, referrals or medical advice specific to your care.

This is not an exhaustive list of issues that may arise, but it does offer insight into common problems you may face.

Your benefits are meant to support you and your family. If you have questions about claims, billing, coverage or eligibility, your insurance provider can explain how services were processed and what your plan covers. If you ever feel uncertain, overwhelmed or not sure where to begin, contact your primary care provider or your HR team.