

Know Your Benefits

Navigating Common Health Benefits Issues

Health insurance is one of the most expensive and widely used employee benefits, yet many remain confused about how it works. In fact, only around two-thirds of employees say they understand their benefits well, according to a [report](#) from Benefitfocus.

This lack of clarity can lead to costly and frustrating issues such as surprise bills, delayed care or denied claims. Learning how to address these challenges can help you avoid unnecessary expenses and make informed decisions about your care.

This article answers common health benefits questions and offers ways to get the most out of your coverage.

Why Do You Get a Bill When You Have Insurance?

Sometimes your provider may send a bill before your claim is fully processed. Other times, parts of your visit may be subject to a copay, deductible or coinsurance. Charges 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.

Why Were You Charged for Preventive Care?

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, such as if the provider or lab isn't in network or if the appointment isn't coded correctly. It's best practice to verify charges before paying.

Why Does a Claim With an In-network Provider Get Denied?

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.

Why Does a Dependent Lose Coverage?

Dependent coverage may end for various 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.

Who Should You Call for Assistance?

You can reach out to several different contacts depending on your situation:

- **Your medical or prescription insurance carrier** for any questions about claims, coverage details, billing issues, prior authorizations or denied services.

- **Your voluntary benefits provider** for questions, claims, or payment issues related to dental, vision, life or disability insurance.
- **Your HR or benefits team** for help with enrollment, eligibility changes, required documentation or general guidance on how your benefits work.
- **Your doctor's office or healthcare provider** for information about treatment plans, appointment scheduling, referrals or medical advice specific to your care.

further questions about your benefits, contact your HR or benefits team.

How to Get the Most Out of Your Health Benefits

A few simple actions can help you avoid unnecessary costs and maximize your coverage:

- **Review your explanation of benefits (EOB).** Compare each EOB against any bills from your provider to confirm the services, dates and amounts match. Catching errors can save you from paying charges you don't owe.
- **Verify provider network status before each appointment.** Networks change throughout the year, so confirm status directly with your carrier. Be sure to ask whether any labs, imaging centers or specialists involved in your care are also in-network.
- **Keep dependent documentation current.** Submit marriage certificates, birth certificates and other supporting documents promptly during qualifying life events. Respond quickly to verification requests from your HR team or carrier to prevent a lapse in coverage.
- **Ask questions during open enrollment.** Use this annual window to compare plans, check premiums and deductibles, and clarify any questions before selecting a plan. Doing so may prevent confusion and unexpected costs later.
- **Track deadlines and life event windows.** Many benefits changes must be made within 30 or 60 days of a qualifying life event, such as marriage, birth or a change in employment status. If you miss it, you may have to wait until the next open enrollment period to make changes.

Summary

Many health benefits issues can be resolved by knowing where to look and who to ask. It's important to review your plan carefully so you can get the most value from it. For