

Benefits Insights

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Helping Employees Navigate Common Benefits Issues

Throughout the year, employees are likely to run into issues with their benefits. These may include denied claims, billing issues or questions about coverage. While plan details and coverage vary by insurer, employees often encounter similar concerns regardless of their plan. Some may be about understanding employee benefits, while others could be due to system or human error. According to a 2026 report from Gitnux, almost 80% of medical bills contained at least one error, including duplicate charges, spelling errors and incorrect codes, which can cause inaccurate billing or confusion. Billing errors, denied claims, inaccurate information and other coverage obstacles can create pain points for employees.

By addressing these pain points, employers can help employees understand their benefits and set clear expectations. Keep in mind that the most accurate response will vary by employer, depending on the type of benefit and the plan's details, as well as the employee's specific situation.

This article outlines five common benefits-related issues employees encounter and provides ways employers can help navigate them.

1. "Why did I get a bill from my provider when I have insurance?"

Unexpected medical bills are one of the most common employee concerns. Employees often assume that if they have health insurance, they won't owe anything for care. However, even with insurance, employees may receive medical bills for a variety of reasons, such as:

- The deductible hasn't been met.
- Coinsurance or copays apply.

- The service was only partially covered.
- The bill was sent before the claim was fully processed.

To prevent surprise medical bills, employers can encourage employees to review their explanation of benefits (EOB) to understand what and how much insurance covers. If the bill does not correspond with the EOB, the employee should contact the provider or carrier, as the issue may be related to provider billing or claim processing. In addition, providing year-round benefits education is an effective way to manage employees' expectations. For example, they may not realize that out-of-pocket costs are still common with insurance, especially early in the plan year.

2. "Why did I get charged for preventive care?"

Under the Affordable Care Act, most health insurance plans and issuers must cover a set of recommended preventive services conducted by an in-network provider at no cost to insureds. However, coverage details (e.g., visit frequency limits or which screenings are included) may vary by insurance company or plan, affecting how a visit is billed. Charges for preventive visits may occur when:

- The visit includes diagnostic services.
- New or ongoing medical concerns are evaluated.
- Additional tests, imaging or treatments are ordered.
- Services fall outside the scope of preventive care or are coded as diagnostic.



Employers can encourage employees to take the following measures to ensure their preventive care is covered:

- Review your insurance plan and your summary of benefits to understand your plan's coverage.
- Verify your provider is in network.
- Ask your provider in advance of your appointment which services are considered diagnostic.

If employees receive an unexpected bill for their preventive care visit, they can ask for an itemized bill to review charges and consult their health care provider or insurer about any errors.

3. "I checked that my provider was in network. Why was my claim denied?"

Providers that are in an insurance network are typically covered under that carrier's plan. Unfortunately, seeing an in-network provider doesn't always guarantee insurance coverage. In fact, a KFF report found that 19% of 496 million claims were denied in 2024. Factors that may lead to a denied claim include:

- Services not covered by the plan
- Missing referrals or prior authorization requirements
- Billing or coding errors
- Other parties (such as labs, facilities or specialists) being out of network

Employees should contact the carrier to understand the reason for their claim's denial and determine whether it can be corrected or appealed. As part of benefits education, employers can emphasize that plan rules, such as authorization requirements, apply regardless of network status.

4. "Who do I call if something goes wrong?"

When employees have a benefits-related issue or feel like their benefits aren't "working," they may feel overwhelmed and unsure who to go to for answers. Employers may offer several types of benefits—such as medical, dental, vision and voluntary benefits (e.g., accident, critical illness, disability insurance)—each administered by different carriers and

subject to different rules. As a result, employees may not know which benefit they need to address.

That's why it's important for employers to provide contact information and benefits resources in a centralized location. This can help employees identify the appropriate contact, reduce frustration and help them resolve their issue quickly. Easy and clear guidance can also prevent overloading HR or benefits teams with unnecessary escalations.

5. "Why isn't my dependent covered anymore?"

Dependent eligibility issues can be stressful for employees. After all, if a dependent individual isn't eligible under their plan or they miss deadlines, that dependent may be without coverage for the upcoming plan year.

Several circumstances, including the following, can make a dependent ineligible for coverage under an employee's plan:

- The dependent turns 26 (some exceptions apply).
- The dependent becomes eligible for group health coverage through another employer.
- The dependent graduates, is no longer disabled or otherwise loses eligibility.
- Required dependent documentation has not been completed.

Employers should clarify their plan's dependent eligibility requirements and highlight the importance of reporting status changes and submitting documentation promptly. Furthermore, they should inform employees of their coverage continuation options for when a dependent loses eligibility. Under federal law (i.e., the Consolidated Omnibus Budget Reconciliation Act), dependents may be able to continue coverage for up to 36 months, and state law may also offer some form of continued coverage. Employees should contact HR as soon as a qualifying midyear eligibility change event occurs so that they can begin these processes.

Conclusion

Benefits issues can be complex and overwhelming for employees, as they often impact both their finances and health. Although employers cannot prevent every issue, they can play a key role in helping employees navigate their

benefits by explaining plan rules, managing expectations and guiding them to resources.

By proactively addressing common pain points, employers can reduce confusion and frustration, improve the benefits experience and enhance the effectiveness of their benefits plans. Contact us for more information.