# More frequently asked questions

Stephanie Stewart

Continuing from my July article, I would like to explore more of the commonly asked questions received at the NALC Health Benefit Plan (the Plan). Knowing that everyone has unique needs and circumstances, we've tried to compile a variety of commonly asked questions. Although some of the subjects are more specific to certain demographics, the information should be useful to all members of the Plan.

With that said, let's dive into more of the trending questions and answers.

**Q: Why was my medical claim denied?**

A: Although every medical claim is different, some reasons for denial may include other/primary coverage not processed, missing information, incomplete medical records, the services are not deemed medically necessary, failure to follow pre-authorization guidelines, or services are not a covered benefit.

Other helpful tools include the NALC HBP member portal. To understand why you received a denial, review the description listed at the bottom of the explanation of benefits (EOB) associated with the date of service in question.

**Q: Why was my prescription or refill denied?**

A: If the denial is related to a prescription, you may be able to speak with someone at the pharmacy to determine the reason for denial (e.g., prior authorization clinical criteria not met, refill too soon, prescription defined as over-the-counter medication, step therapy is required, or other).

However, if you are unable to determine the reason for denial at the pharmacy level, make sure to reach out the Plan, or log in to your CVS Caremark app, where you can review the status of your medication request.

**Q: What if I don't agree with the Plan's denial?**

A: Within six months of our initial decision, you may ask us in writing to review or reconsider our denial. It is important that you include a statement as to why you believe our initial decision was wrong based on our official provisions in the brochure, and include copies of physicians' letters, operative reports, bills, and/or medical records to support your claim.

**Q: My EOB from the Plan shows a balance under patient liability. Where do I send this money?**

A: Keep in mind that the EOB from the Plan is not an invoice. Once you have carefully reviewed the EOB statement for accuracy, any balance due should be sent to the rendering provider or facility. If you suspect the provider has charged you for services that you did not receive, or duplicated charges for the same service, reach out to the billing office, as there might be an error.

**Q: Once my enrollment is processed in the SilverScript Prescription Drug Program, when will my coverage begin?**

A: Normally processing may take up to 45 days. Once finalized, coverage will begin on the first day of the following month.

**Q: What is the difference between a physician who has opted out of Medicare and a physician who is non-participating in Medicare?**

A: Per cms.gov, opt-out and non-participating providers are defined as follows:

- "Doctors or other health care providers who don't want to work with the Medicare program may 'opt out' of Medicare."
- "Some providers who don't accept assignment still choose to accept the Medicare-approved amount for services on a case-by-case basis. These providers are called 'non-participating'."

**Q: My provider has opted out of Medicare. What will my patient responsibility be?**

A: When you utilize an opt-out provider, the Plan does not waive our deductible and will limit our payment to 20 percent of the Plan allowance after the deductible has been met.

**Q: My provider is a non-participating (non-par) Medicare provider, meaning they have chosen not to accept the Medicare assignment and can charge 15 percent above the Medicare-approved amount. How will this affect me?**

A: As stated above, non-pars may choose to accept or not accept the Medicare-approved amount. If they do not accept, the Plan will pay the Medicare coinsurance in addition to the 15 percent above the Medicare-approved amount, which is commonly referred to as the "Medicare limiting charge."

**Understandably, a Q&A will never be able to address** every problem that arises, but I hope these have been a good start. Also, please don't hesitate to reach out to one of our knowledgeable representatives should you need further assistance.