NALC Health Benefit Plan-2025 Seminar

Your Plan in Action: From Explanation of Benefits to Approvals to Appeals

Delivering 75 Years of Service – One Step at a Time

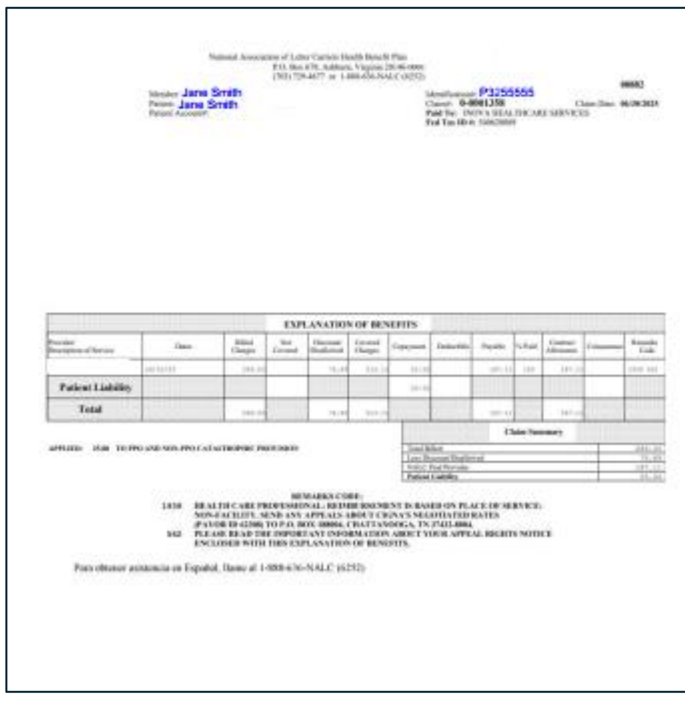
What is an
Explanation of
Benefits (EOB)?

Answer

An EOB is the form produced after a claim is paid. It serves two purposes. It informs the provider what we paid and what is the member's responsibility. It also protects our members by advising them of what they actually owe their provider and informs them of services that were billed under their health insurance policy.

Where do I get my EOBs?

NALC HBP provides our members with mailed copies of the EOBs and provides an electronic version through our member portal.

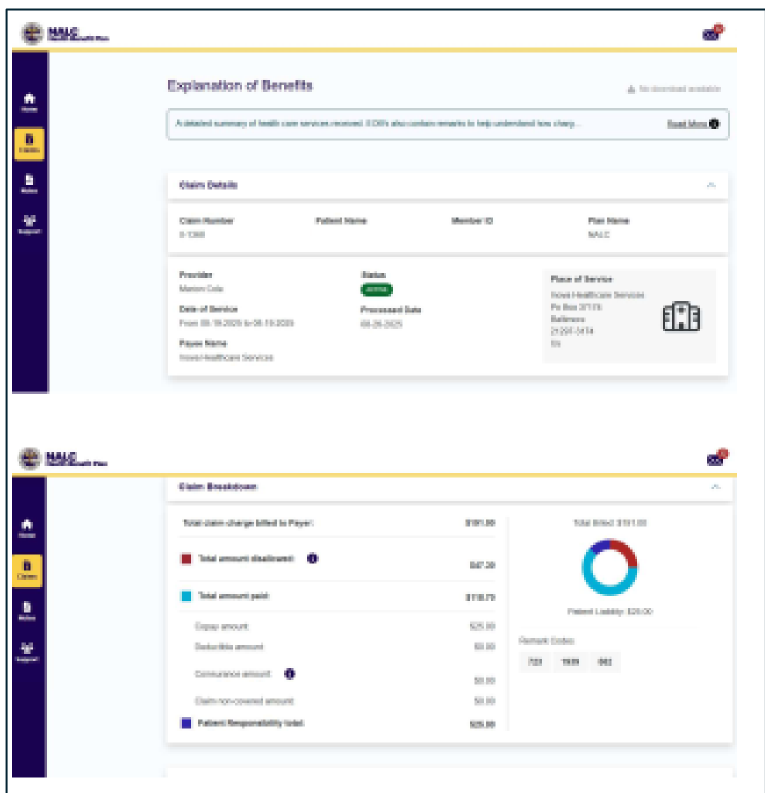


Jane Smith
Jane Smith
P3255555

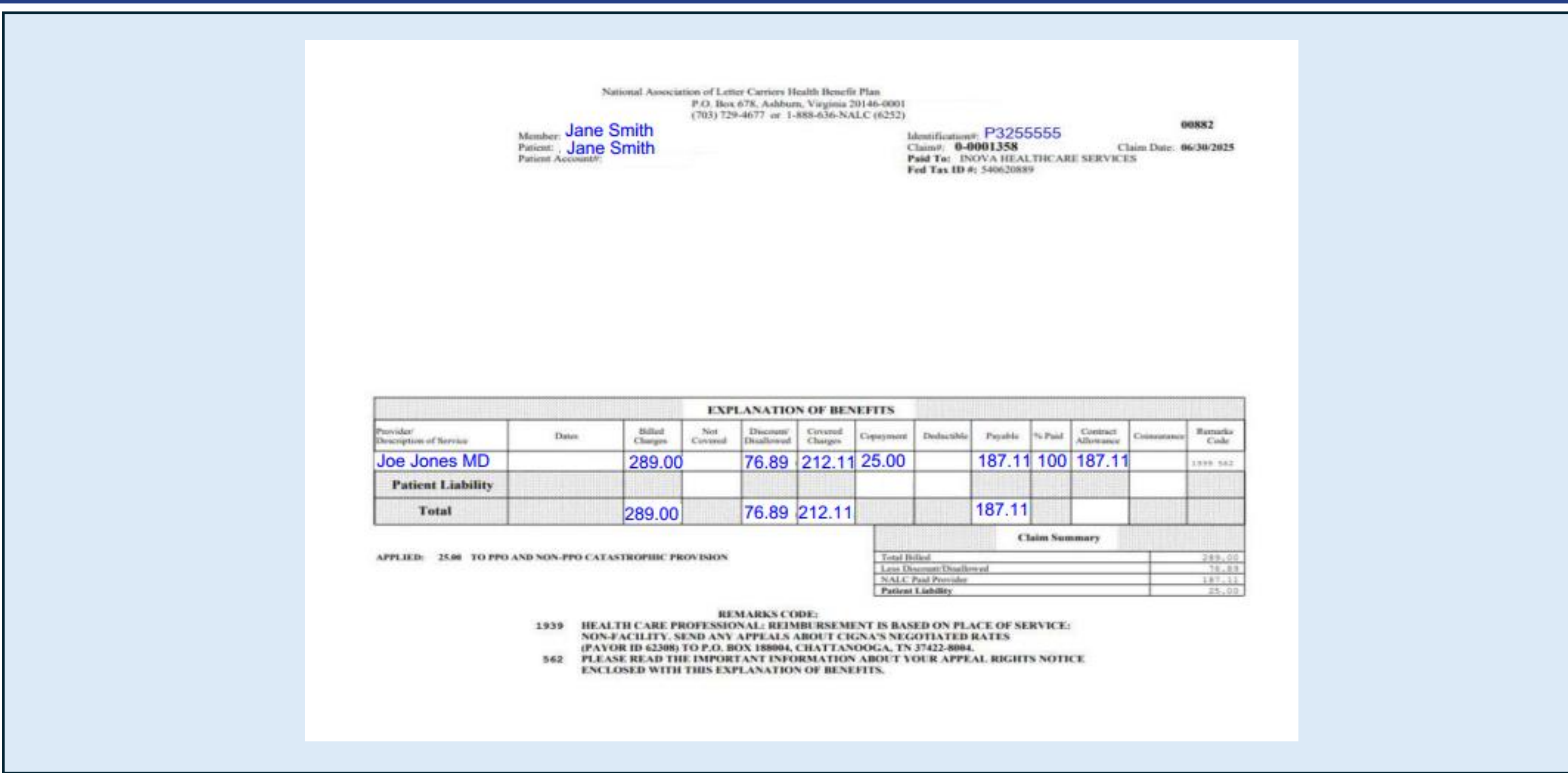
EXPLANATION OF BENEFITS

Patient Liability
Total

Claim Summary



EOBs You Receive in the Mail



National Association of Letter Carriers Health Benefit Plan
P.O. Box 678, Ashburn, Virginia 20146-0001
(703) 729-4677 or 1-888-636-NALC (6252)

00882

Member: Jane Smith
Patient: Jane Smith
Patient Account#:

Identification#: P3255555
Claim#: **0-0001358** Claim Date: **06/30/2025**
Paid To: INOVA HEALTHCARE SERVICES
Fed Tax ID #: 540620889

EXPLANATION OF BENEFITS

Provider/ Description of Service	Dates	Billed Charges	Not Covered	Discount/ Disallowed	Covered Charges	Copayment	Deductible	Payable	% Paid	Contract Allowance	Coinsurance	Remarks Code
Joe Jones MD		289.00		76.89	212.11	25.00		187.11	100	187.11		1939 562
Patient Liability												
Total		289.00		76.89	212.11			187.11				

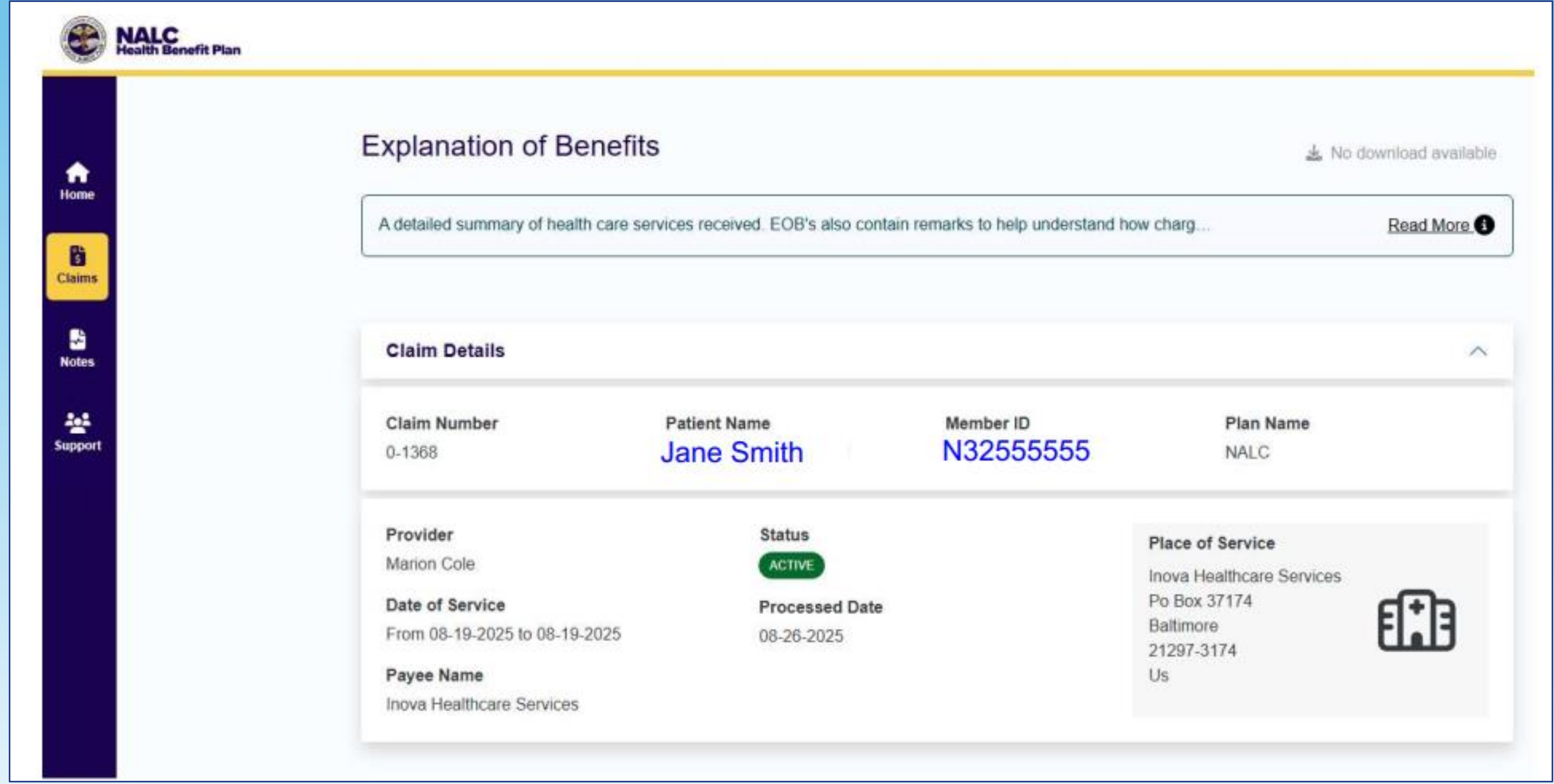
APPLIED: 25.00 TO PPO AND NON-PPO CATASTROPHIC PROVISION

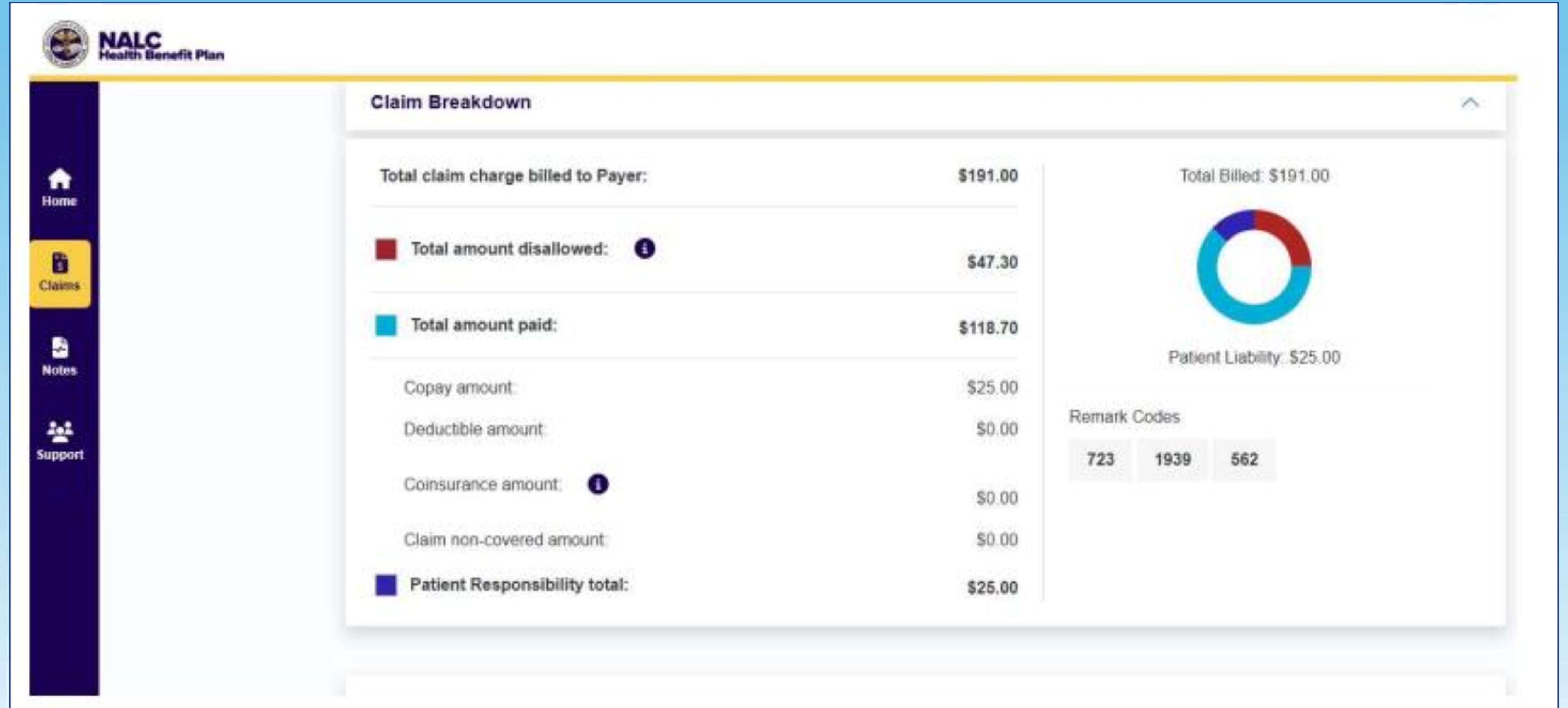
Claim Summary	
Total Billed	289.00
Less Discount/Disallowed	76.89
NALC Paid Provider	187.11
Patient Liability	25.00

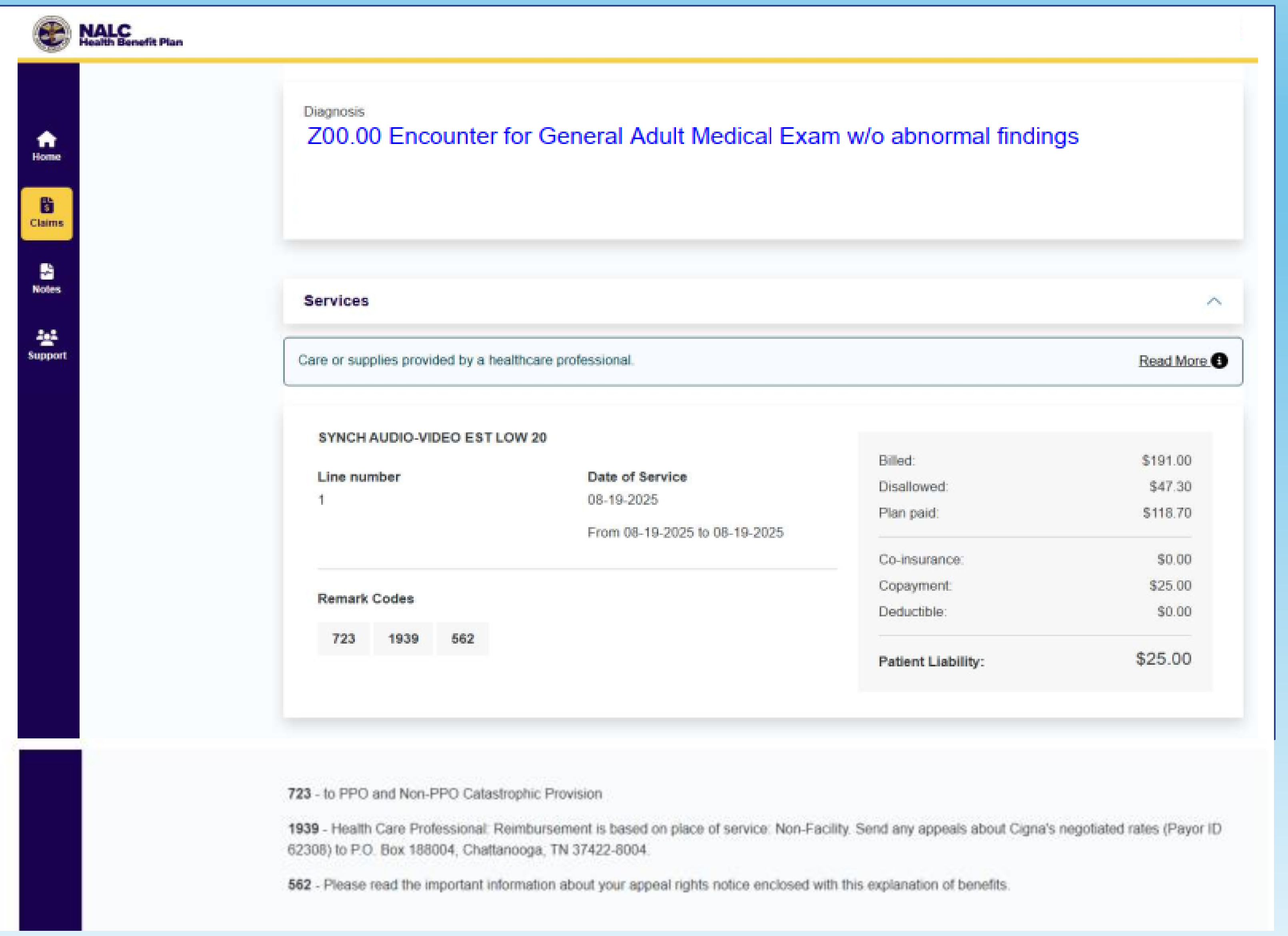
REMARKS CODE:

1939 HEALTH CARE PROFESSIONAL: REIMBURSEMENT IS BASED ON PLACE OF SERVICE: NON-FACILITY. SEND ANY APPEALS ABOUT CIGNA'S NEGOTIATED RATES (PAYOR ID 62308) TO P.O. BOX 188004, CHATTANOOGA, TN 37422-8004.

562 PLEASE READ THE IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS NOTICE ENCLOSED WITH THIS EXPLANATION OF BENEFITS.


NALC
Health Benefit Plan
Home
Claims
Notes
Support
Explanation of Benefits
No download available
A detailed summary of health care services received. EOB's also contain remarks to help understand how charg...
Read More
Claim Details
Claim Number
0-1368
Patient Name
Jane Smith
Member ID
N32555555
Plan Name
NALC
Provider
Marion Cole
Status
ACTIVE
Date of Service
From 08-19-2025 to 08-19-2025
Processed Date
08-26-2025
Payee Name
Inova Healthcare Services
Place of Service
Inova Healthcare Services
Po Box 37174
Baltimore
21297-3174
Us


NALC
Health Benefit Plan
Claim Breakdown
Home
Claims
Notes
Support
Total claim charge billed to Payer: $191.00
Total amount disallowed: $47.30
Total amount paid: $118.70
Copay amount: $25.00
Deductible amount: $0.00
Coinsurance amount: $0.00
Claim non-covered amount: $0.00
Patient Responsibility total: $25.00
Total Billed: $191.00
Patient Liability: $25.00
Remark Codes
723
1939
562


NALC
Health Benefit Plan
Home
Claims
Notes
Support
Diagnosis
Z00.00 Encounter for General Adult Medical Exam w/o abnormal findings
Services
Care or supplies provided by a healthcare professional.
Read More
SYNCH AUDIO-VIDEO EST LOW 20
Line number
1
Date of Service
08-19-2025
From 08-19-2025 to 08-19-2025
Remark Codes
723
1939
562
Billed: $191.00
Disallowed: $47.30
Plan paid: $118.70
Co-insurance: $0.00
Copayment: $25.00
Deductible: $0.00
Patient Liability: $25.00
723 - to PPO and Non-PPO Catastrophic Provision
1939 - Health Care Professional: Reimbursement is based on place of service: Non-Facility. Send any appeals about Cigna's negotiated rates (Payor ID 62308) to P.O. Box 188004, Chattanooga, TN 37422-8004.
562 - Please read the important information about your appeal rights notice enclosed with this explanation of benefits.

Exclusion Codes & What They Mean

We Need Something

646: We need the patient's other insurance company's payment voucher.

630/634: The Medicare Summary Notice (MSN) is needed to process this charge.

772: Our records show you have not notified us of your Medicare coverage. Resubmit the information to NALCHBP at the address listed above.

660: It appears Medicare/other company has denied this charge incorrectly. Please refile it with them and ask for a review.

More Things We Might Need

475: To process nursing visit charges, we need the number of hours or the start and end times for each visit.

262: In order to process this ambulance claim, we must have a copy of the run sheet.

309: Medical records are needed to consider this charge. Please forward them to the attention of the Claims Department.

We Don’t Cover the Service as Billed

395: We do not cover charges for routine checkups or those services listed as non covered in the brochure.

350: Treatment for this condition is not covered.

251: These services and/or supplies, under these conditions, are not covered.

450: The claims filing limit has been exceeded. See Section 7. Filing a claim for covered services.

180/910: This is a duplicate to a previously considered charge.

Denials That Will Require an Appeal

278: This service or supply was not medically necessary. See Section 6. General Exclusions.

2370: No precertification obtained for this surgery. The provider is prohibited from billing these services. If you are asking for denied claims to be reviewed, please mail your request to CareAllies.

1066: No precertification obtained for this procedure. If you are asking for denied claims to be reviewed, please contact eviCore.

Approvals

What services need approval and where does the approval come from?

- Medications-Caremark and SilverScript
- Mental Health and Substance Use Disorder-Optum
- Inpatient Admissions-Cigna
- High Tech Radiology and Musculoskeletal Procedures-Cigna
- Genetic Testing-Cigna

How Do I Know What Needs Approval?

1) Check *Section 3. How You Get Care* in the Plan brochure.
2) Call the Plan. To get the most out of your call, have your doctor give you the procedure code and diagnosis code.
3) Send a message through the member portal.

Who Gets the Approvals?

Normally your doctor will obtain the authorization or approval for the service they are requesting or the resulting inpatient admission. Most of the time, in order to determine if a service is medically necessary, we will need medical records or in some cases your doctor may need to speak to a physician from the insurance company.

What if My Doctor Says I Need a Predetermination?

Sometimes your provider may be concerned about coverage and request this type of review. Common reasons are:

- New procedures
- New procedure codes
- Experiences with other plans

A Look Behind the Curtain

NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN
20547 Waverly Court, Ashburn, Virginia 20149
Brian L. Renfroe, President • Stephanie M. Stewart, Director

Durable Medical Equipment (DME) Prior Authorization Form
Fax: 703-729-8128

☐	Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan a minimum of fourteen (14) days prior to the date the requested services will be performed.

Physician Signature Validating Request	Date Signed

MEMBER INFORMATION

Last Name		First Name	
Member ID		DOB	
Member Address			
Member Contact Information			

ORDERING PHYSICIAN INFORMATION

Last Name		First Name	
NPI		Tax ID	
Group Name			
Address			
Phone		Fax	

VENDOR PROVIDING DME

Vendor Name			
Address			
Phone		Fax	
NPI		Tax ID	

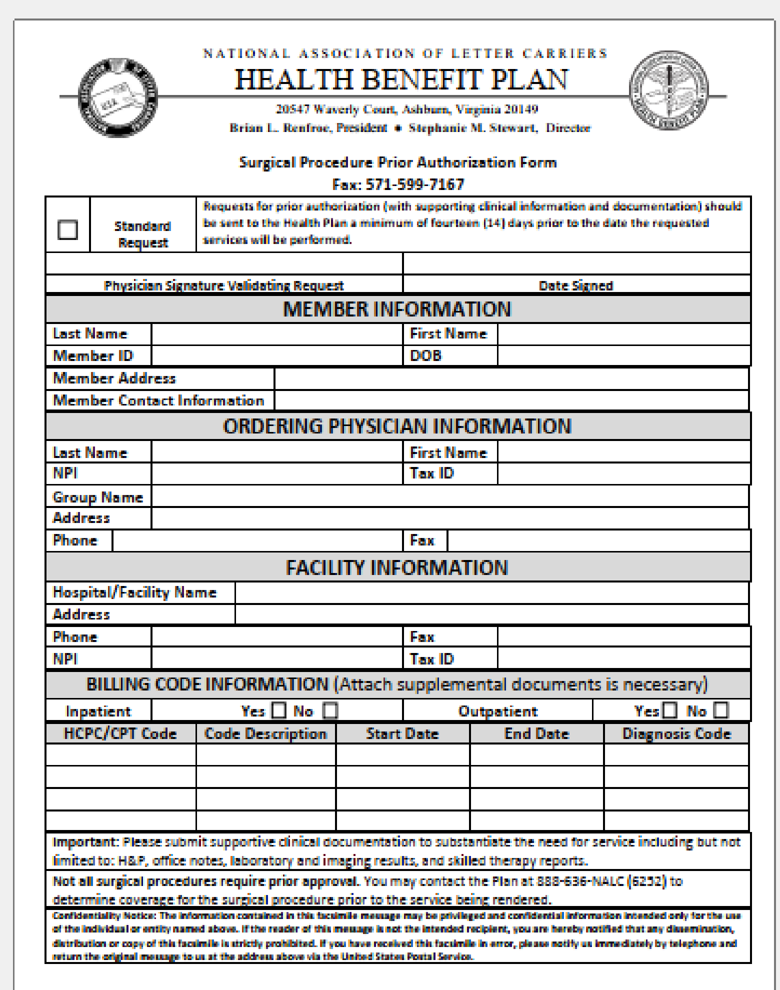
BILLING CODE INFORMATION (Attach supplemental documents is necessary)

Purchase	Y ☐ N ☐	Rental	Y ☐ N ☐	Initial Request	Y ☐ N ☐	Replacement	Y ☐ N ☐

HCPC/CPT Code	Code Description	Start Date	End Date	Number of Units and Cost

Important: The Plan requires a letter of medical necessity, or a copy of the prescription, from the prescribing physician which details the medical necessity to consider charges for the purchase or rental of DME. Please submit supportive clinical documentation to substantiate the need for DME including but not limited to: H&P, office notes, laboratory and imaging results, and skilled therapy reports.

Confidentiality Notice: The information contained in this facsimile message may be privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone and return the original message to us at the address above via the United States Postal Service.



NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN
20547 Waverly Court, Ashburn, Virginia 20149
Brian L. Renfroe, President • Stephanie M. Stewart, Director

Surgical Procedure Prior Authorization Form
Fax: 571-599-7167

☐	Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan a minimum of fourteen (14) days prior to the date the requested services will be performed.

Physician Signature Validating Request	Date Signed

MEMBER INFORMATION

Last Name		First Name	
Member ID		DOB	
Member Address			
Member Contact Information			

ORDERING PHYSICIAN INFORMATION

Last Name		First Name	
NPI		Tax ID	
Group Name			
Address			
Phone		Fax	

FACILITY INFORMATION

Hospital/Facility Name			
Address			
Phone		Fax	
NPI		Tax ID	

BILLING CODE INFORMATION (Attach supplemental documents is necessary)

Inpatient	Yes ☐ No ☐	Outpatient	Yes ☐ No ☐

HCPC/CPT Code	Code Description	Start Date	End Date	Diagnosis Code

Important: Please submit supportive clinical documentation to substantiate the need for service including but not limited to: H&P, office notes, laboratory and imaging results, and skilled therapy reports.

Not all surgical procedures require prior approval. You may contact the Plan at 888-636-NALC (6252) to determine coverage for the surgical procedure prior to the service being rendered.

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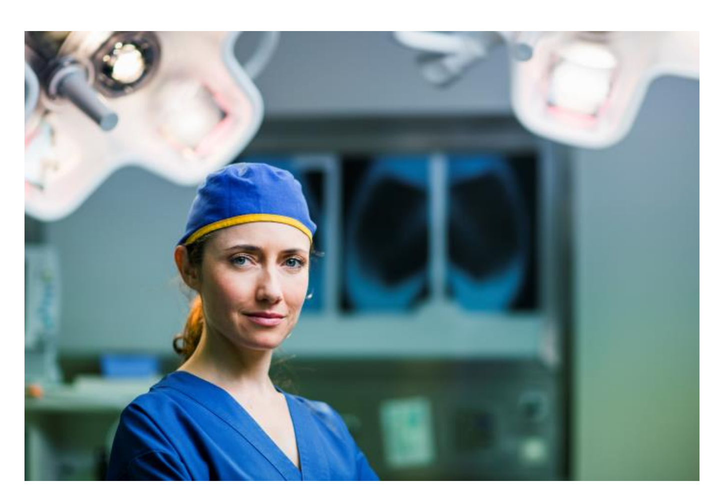
Approvals Handled By Our Vendors

Medications

High Tech Radiology

Inpatient Admissions

Mental Health



Appeals: When You Don't Get the Answer You Were Hoping for

NALC Health Benefit Plan

www.nalchbp.org

Customer Service: 888-636-6252

2026

A Fee-for-Service Plan (High Option and Consumer Driven Health Plan) with a Preferred Provider Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8, *PSHB Facts* for details. This plan is accredited. See page 13, Section 1. *How This Plan Works.*

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 16
- Summary of Benefits: Page 220

Sponsored and administered by: the National Association of Letter Carriers (NALC), American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)

Who may enroll in this Plan: Postal Service employees and Postal annuitants eligible to enroll in the Postal Service Health Benefits Program

To become a member or associate member: If you are a Postal Service employee, you must be a dues-paying member of an NALC local branch. If you are a retired Postal Service employee, survivor annuitant, or TCC enrollee, and are not a member of NALC, you become an associate member of NALC when you enroll in the NALC Health Benefit Plan. See page 186, Non-PSHB Benefits Available to Plan Members for more details.

Membership dues: NALC dues vary by local branch for Postal employees. Associate members will be billed by the NALC for the $36 annual membership fee, except where exempt by law. Call Membership at 202-662-2856 for inquiries regarding membership, union dues, fees, or information on the NALC union. To enroll, you must be or become a member of the National Association of Letter Carriers.

Enrollment codes for this Plan:

77A High Option – Self Only
77C High Option – Self Plus One
77B High Option – Self and Family
77D Consumer Driven Health Plan (CDHP) – Self Only
77F Consumer Driven Health Plan (CDHP) – Self Plus One
77E Consumer Driven Health Plan (CDHP) – Self and Family

Authorized for distribution by the:

PSHB

United States Office of Personnel Management

Healthcare and Insurance http://www.opm.gov/insure

RI 71-024

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8a. Medicare PDP EGWP Disputed Claims Process.

Please follow this Postal Service Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149 or calling 888-636-NALC (6252).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the CDHP fiduciary regarding the administration of a PCA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: • Write to us within 6 months from the date of our decision; and • Send your request to us at: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149; and • Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and • Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. • Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Figuring Out Your Next Step: Asking What & Why

You will receive written notification explaining what was denied and why. The information in this letter will guide you to the next step.

1) Are we just missing information that can be easily provided?
2) Are the services being denied because they're a Plan exclusion?
3) Are the services being denied because they aren't medically necessary?

Missing Information: The Easiest Fix

REMARKS CODE:

772 OUR RECORDS SHOW YOU HAVE NOT NOTIFIED US OF YOUR MEDICARE COVERAGE. RESUBMIT THE INFORMATION TO NALCHBP, AT THE ADDRESS LISTED ABOVE.

934 UNDER THE PRIVACY RULE, WE CANNOT RELEASE INFORMATION ABOUT YOU TO ANYONE WITHOUT YOUR CONSENT. THIS CAN BE DONE BY COMPLETING A PERSONAL AUTHORIZATION FORM. THIS FORM IS AVAILABLE AT WWW.NALCHBP.ORG. VERBAL CONSENT IS FOR ONE TIME ONLY AND MUST BE VERIFIED THROUGH YOU. WITHOUT YOUR WRITTEN CONSENT, WE WILL ONLY ADVISE THE CALLER IF A CLAIM HAS BEEN RECEIVED OR PROCESSED.

REMARKS CODE:

630 THE MEDICARE SUMMARY NOTICE (MSN) IS NEEDED TO PROCESS THIS CHARGE. RESUBMIT THE INFORMATION TO NALCHBP, AT THE ADDRESS LISTED ABOVE.

Dear Provider:

We need additional information or clarification. Please return a copy of this letter and provide the information listed below when you resubmit the charges.

- the CPT/HCPCS codes for the procedure(s) and/or a description of service for each charge

Dear Provider:

We have received medical records requested for the above referenced patient. Unfortunately, all the information needed was not provided.

So we may complete our review, please mail the following information to us at the above address.

- Admitting History and Physical reports
- Physician orders
- Copy of the Operative Report
- Letter of Medical Necessity

Please include the member identification number on all correspondence regarding this request.

NALC Health Benefit Plan
Claims Processing Department

What is a Plan Exclusion?

See Section 6. General Exclusions or check the end of the applicable section in the brochure

Not covered:

- Services we have not approved
- Outdoor residential programs
- Wilderness treatment or equine therapy
- Educational therapy or educational classes
- Bio-feedback
- Outward Bound Programs
- Personal comfort items, such as guest meals, beauty and barber services
- Respite care

Not covered:

- Over-the-counter medications, vitamins, minerals, and supplies, except as listed above

Not covered:

- Bathroom equipment, such as whirlpool baths, grab bars, shower chairs, commode chairs, and shower commode chairs
- Sun or heat lamps, shower commode chairs, and similar household equipment
- Exercise equipment, such as treadmills, exercise bicycles, stair climbers, and free weights
- Car seats of any kind

Not Medically Necessary?

Medical Necessity is defined in Section 10. of the brochure as:

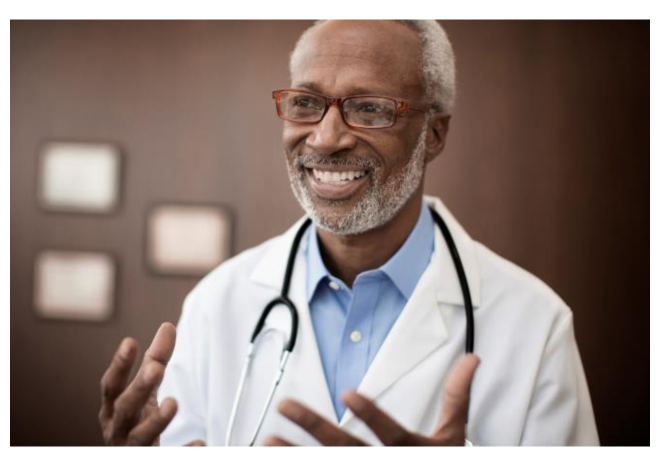
Services, drugs, supplies, or equipment provided by a hospital or covered provider of healthcare services that we determine:

- Are appropriate to diagnose or treat your conditions, illness, or injury
- Are consistent with standards of good medical practice in the United States
- Are not primarily for the personal comfort or convenience of you, your family, or your provider
- Are not related to your scholastic education or vocational training
- In the case of inpatient care, cannot be provided safely on an outpatient basis

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug, or equipment does not, in itself, make it medically necessary.

Who Determines if Something is Medically Necessary?

- The Health Benefit Plan's Medical Director
- Medical Directors employed by our vendors
- Independent Medical Reviewers



OPM: When We Still Don’t Agree

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote us—if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, NW, Room 3443, Washington, DC 20415

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claims, such as physicians’ letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

What Am I Taking Back to My Fellow Plan Members?

- A denial is not a full stop answer.
- You have appeal rights! Use them!
- If you don’t understand something, call us or send a message through the portal.
- When in doubt, refer to the brochure.

Together on the Journey

Ask Me About It!

Support the NALC this open season, promote your health benefit plan!