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Leidos-Sponsored Medical Coverage

KNOW YOUR RIGHTS

Know Your Rights

Did you ever get a medical bill you weren't expecting? Did the cost of a medical service or procedure surprise you? Or were you denied coverage of healthcare services that you thought should be covered?

This Know Your Rights article provides information to help you better understand your rights and how to ask questions about your medical bills. It will help you to recognize "balance billing"—and when it may be inappropriate—what actions to take in the event you get a surprise medical bill you think is incorrect or unfair, and how to avoid surprise medical bills or denials of coverage in the future.

What is Balance Billing?

Balance billing is when an out-of-network healthcare provider bills you for the difference between their charge and what your insurance carrier covers. There may be times when you unknowingly receive care from an out-of-network healthcare provider. In such cases, the bill for the additional amount may be an unwelcome surprise. Here are some examples of when unexpected "balance billing" might happen:

- **Emergencies:** You visit an in-network hospital. However, the ambulance that takes you, there or the doctor on staff who treats you in the Emergency Department is out-of-network.
- **Non-Emergencies:** You schedule surgery at an in-network hospital with an in-network surgeon. However, you receive a radiology scan or anesthesia from a provider that is out-of-network.

Helpful Tip

Compare the medical insurance **Explanation of Benefits (EOB)** that you receive from your insurance carrier to the invoice received from your provider, to help better understand what services you're being charged for – whether in-network or out-of-network – and how much they cost.

How do I know that I have been balance billed?
Hint: When you receive two different bills for the same service or procedure.

What Should I Do if I Receive an Invoice That I think is Wrong or Unreasonable?

1. **Call your insurance carrier.** If you think you've been incorrectly or unfairly billed by the out-of-network provider, you can ask your insurance carrier to adjust the bill or cover the cost of the "balance bill". Have a copy of your bill ready before you call.

	Member Services
Aetna	1-800-843-9126
Aetna Innovation Health	1-800-531-5506
Anthem	1-866-403-6183
Tricare	1-800-638-2610

	Member Services
Kaiser	1-800-777-7902 (DC) 1-808-432-5955 (HI, Oahu) 1-800-966-5955 (HI) 1-800-464-4000 (CA)
Cigna International	1-800-441-2668

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2. **Request an appeal.** If your insurance carrier says the bill was processed correctly and they deny payment, you can request an appeal either online or by mail. Contact your insurance carrier using the information below.

Insurance	Website	Mailing Address
Aetna	www.aetna.com	Aetna Grievances & Appeals Attn: National Account CRT P. O. Box 14463 Lexington, KY 40512
Anthem	www.anthem.com/leidos (The appeal may be submitted through the secure message center.)	Anthem Grievances & Appeals P.O. Box 54159 Los Angeles, CA 90054
Aetna Innovation Health	www.innovationhealth.com	Aetna Grievances & Appeals Attn: National Account CRT P. O. Box 14463 Lexington, KY 40512
Tricare	www.tricareonline.com	Dependent on location, refer to website https://tricare.mil/ContactUs/FileComplaint/AppealsAddresses
Cigna International	www.CIGNAenvoy.com	Cigna ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850
Kaiser	www.kp.org	CA Region Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623 Mid-Atlantic Region Kaiser Permanente Attn: Appeal and Complaint Resolution 2101 E. Jefferson St. Rockville, MD 20852 HI Region Kaiser Foundation Health Plan, Inc. Attn: Regional Appeals Office 711 Kapiolani Blvd Honolulu, HI 96814

What Should I Do if the Insurance Carrier Denies Coverage of Certain Covered Healthcare Services?

In some cases, healthcare services you receive may not be covered under your plan. For example, they may not be deemed medically necessary, or prior authorization/precertification was required, but was not obtained before services were rendered. In cases like this, you have the right to file an appeal.

Here are some examples of when you might consider appealing a benefits decision that negatively affects you:

In What Instances Might I Consider Filing an Appeal?	What's My Deadline for Filing the Appeal?	When Will I Get a Response?
My claim for urgent care services was denied.	180 days 90 days for Tricare N/A for Kaiser plans	As soon as possible taking into account medical emergencies, but not later than 72 hours after receipt of request for review
My request to obtain medical services that my doctor prescribed was denied **BEFORE** I received care.	180 days 90 days for Tricare	30 days
I received medical services, and coverage for the services was denied **AFTER** I received care.	180 days 90 days for Tricare 365 days for Cigna N/A for Kaiser	60 days

This chart highlights certain deadlines only. You may also have the right to a second level appeal and/or an external appeal.

How Can I Avoid Surprise Medical Bills or Denial of Coverage?

1. **Stay in-network.** Make sure any doctor or facility you use accepts your insurance plan and is in-network. You won't get "balance billed" by in-network providers. You can use your insurance carrier's website to find an in-network provider. And if you are a member of one of our Healthy Focus medical plans, you can use Grand Rounds, a service for Leidos employees, to find high-quality in-network providers.
2. **Know your urgent care center inside and out.** Freestanding emergency centers may look similar to urgent care centers, but they're significantly more expensive. Call in advance to confirm your preferred facility is in-network and a true urgent care center.
3. **Estimate cost of care ahead of time.** Visit your insurance carrier website and click "Find Care & Pricing or Cost Estimate" to search for in-network providers and costs. It's especially important to get a cost estimate in advance if you need to use an out-of-network provider.

Helpful Tip

Usually, your in-network healthcare provider initiates prior authorizations with your carrier, as well as for appeals for prior authorizations that are denied. However, you can file an appeal yourself if your provider doesn't.

More Information

Refer to your medical plan Summary Plan Description (SPD) or Evidence of Coverage (EOC) for information on claims decisions and appeal procedures for these kinds of scenarios and more.