

Imagine you go to a hospital for a routine procedure. You've made sure your hospital and doctor are covered by your insurance. The procedure goes well and you head home to recover. Two weeks later, you get the bill, but instead of the copay you expected, you get a bill for nearly \$4,000. Turns out, the anesthesiologist who assisted with your procedure was "out of network" and your insurance won't cover that bill as expected. You've received a surprise medical bill and now owe the difference between what your insurance will pay the out-of-network anesthesiologist and what you were billed.

What is a "surprise" medical bill?

You receive a surprise medical bill when, through no fault of your own, you are treated by providers outside of your insurance network. These out-of-network providers can charge exorbitant rates which are only revealed after the bill arrives. An average emergency room surprise bill is [around \\$600](#), but these bills can range into the [tens of thousands of dollars](#). When out-of-network providers charge these high rates, it drives up costs for everyone. Consumers are burdened with higher bills that they had no way to avoid. And when insurers have to pay their share of this higher charge, they're likely to pass on that cost to everyone by raising premiums.

Consumer protections for some, but not all

Most states have laws to protect patients from receiving some of these bills. But there are no consumer protections for most people in these [17 states](#): Alabama, Alaska, Arkansas, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Montana, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Wisconsin, and Wyoming. In these states, only patients with insurance coverage through Medicare, Medicaid, or are on Veterans Affairs Health Care are protected from surprise medical bills.

What can you do if your state or health coverage plan does not protect you from surprise medical bills?

First, do your best to prevent a surprise medical bill.

There are some steps you can take to prevent receiving a surprise medical bill.

1. Check with your insurer to make sure you are choosing a provider that is covered by your insurance. Make sure that the hospital or health care facility (lab, diagnostic center, surgery center) is in your insurance network before receiving treatment.
2. When planning hospitalizations at an in-network facility, check with the facility to ensure that all providers (surgeons, anesthesiologists, and others), lab services (such as blood work) and imaging services (such as X-rays, MRIs) are covered by your insurance plan. Be specific in requesting that all services you may need are covered by your insurer.
3. Know where your nearest in-network emergency room is for those times when it is possible to choose.

Second, try to reduce the amount you owe.

If you were not able to prevent an out-of-network charge, use these tips to attempt to lower a medical bill.

1. Ask for an itemized bill and check that you are not being mistakenly billed for treatment you did not receive.
2. Compare the itemized bill to your Explanation of Benefits to see whether your insurer is paying its share. Sometimes patients are billed for services because their provider sent the wrong billing code to the insurer.
3. Contact your provider and ask about anything you don't understand.
4. Contact your insurer to see if any mistakes were made on their end. Ask them to explain any charges you don't understand.
5. Even if there are no mistakes, you can try to negotiate with your provider. Many hospitals have patient advocate departments to help you manage your bills.
6. If you have a problem with your insurance company, contact your state's insurance department to file a complaint. If you have a complaint about your hospital's billing, contact your state's health department or consumer affairs office. They may be able to help you fight the bill.
7. Keep careful notes of all conversations you have. Get the names of the people you are speaking to. Keep your files in one place for easy access.
8. Be patient and clear in your requests.
9. Don't delay in handling concerns and questions so that the bill does not go into collections.

Special information during the COVID-19 pandemic

Testing for COVID-19 is free for both insured and uninsured consumers. Health plans are required to cover the cost of testing (even if you don't have symptoms or have not been exposed to someone with COVID). This means that if you want to be tested for any reason, such as before visiting a family member, your insurance must pay for the test and cannot bill you for any copay, coinsurance, or deductible.

Even though the test is free, many people have been billed for other fees, such as a "facility fee." When you choose a testing site, call to be sure there are no additional fees the site will charge. There are sites in each state that offer testing with no additional fees. The federal government has a [list of locations](#). To find out more about COVID testing in your state, use this [resource](#).

All plans are required to pay for any approved COVID vaccine and any administration costs. You are not required to pay any cost-sharing (copay, coinsurance, or deductible) related to getting a vaccine against the COVID-19 virus.

Good news! Consumer protections are coming in January 2022

In a victory for consumers, Congress passed the [No Surprises Act](#) to expand surprise billing protections to all insured Americans beginning in January 2022. The federal protections will protect patients from surprise out-of-network bills for emergency treatment and from surprise bills for non-emergency treatment at in-network hospitals. The law will also prevent air ambulances from sending out-of-network surprise bills.