Module

FFC_US

Display

Funding your Fertility Treatment

Backend Name: FFC_US_01_Intro

Source Video:

Section Copy: @IFF_US_01_Intro

Funding your fertility treatment. For most patients, the cost of fertility treatment is a significant concern, especially for patients with limited or no insurance coverage. Our financial coordinator will provide you with a personalized, good faith estimate outlining the costs associated with your overall treatment plan, and they will help you understand the extent of your insurance. This includes related costs like diagnostic tests, prescription drugs, and procedure fees. Our coordinators may offer several financial programs that can help you manage costs. We can also direct you to additional financial resources if needed. Our team will be here to support you throughout your fertility journey, offering guidance along the way as you determine the option that works best for both your clinical and financial needs..

Insurance Explained

Backend Name: FFC_US_02_Coverage

Source Video:

Section Copy: @UIC_US_01_Coverage

Insurance Explained. You can still access fertility-related benefits from your medical insurance plan even if you don’t also have comprehensive fertility coverage.. Many insurance companies will only cover the costs for services by providers, pharmacies, and suppliers who have negotiated prices with them. These groups are referred to as “in-network,” and insurance companies may not cover, or may only partially cover, services performed by others that are out-of-network. Most insurance plans won’t begin to cover your medical expenses until after you’ve met your deductible, or the amount you will pay out-of-pocket before your insurance company will pay a claim. This amount resets at the end of the insurance plan year, which is not always the beginning of a new calendar year. You can confirm when your deductible resets with your insurance company. Some insurance plans have an out-of-pocket maximum, which is the most you'll have to pay for covered services in a plan year. The member service phone number on the back of your insurance card will direct you to reliable resources about your plan details. A common out-of-pocket medical cost you might encounter is a copayment, or copay. A copay is the fixed amount you would pay for a covered health care service, usually paid at the time you receive the service. Generally, copayments don't count toward your deductible but may count towards your out of pocket maximum. Some insurance plans will not charge you a copay until you've met your deductible. This copay amount can vary and is typically determined by the type of covered health care service you receive and the type of clinician providing the service. You may want to confirm if your insurance plan has a higher co-pay for fertility specialists. Coinsurance is another common out-of-pocket medical cost some may need to consider. Often, coinsurance does not apply until after you have met your deductible. Coinsurance is calculated as the percentage you will pay out-of-pocket for a covered health care service, and your insurance company will cover the remaining balance. Coinsurance may also count towards your out-of-pocket maximum. It can take up to a month or longer for you to receive an explanation of benefits, or EOB, which will detail any additional costs and the amount covered.. . . An EOB is not a bill. If you proceed with fertility testing and treatment, you may receive multiple EOBs from your insurance company, as well as corresponding medical bills from your clinic for the remaining balance..

Insurance Coverage for Diagnostic Testing

Backend Name: FFC_US_03_Diagnostic

Source Video:

Section Copy: @UIC_US_02_Diagnostic

Insurance Coverage for Diagnostic Testing. Even if your insurance plan does not provide fertility treatment coverage, the majority of insurance plans do provide coverage for diagnostic testing. Diagnostic testing refers to the fertility assessments conducted by your medical team which help to determine what factors may be contributing to your fertility challenges. Diagnostic testing can include ultrasounds, blood work, and diagnostic procedures to assess the uterine cavity, fallopian tubes, or a semen analysis. Your insurance plan may require that you complete some or all of these diagnostic tests within a specific time frame before fertility treatment coverage is approved. Ask your clinic's financial coordinator to determine how to meet the criteria outlined in your insurance plan. Diagnostic testing may come with deductibles, copays, coinsurance, and other out-of-pocket costs.. .

Meeting Criteria for Fertility Benefits

Backend Name: FFC_US_04_Criteria

Source Video:

Section Copy: @UFC_US_01_Criteria

Meeting Criteria for Fertility Benefits. If your insurance plan includes fertility benefits, you may find that those benefits are restricted to certain types of treatments or only in situations when specific infertility-related criteria are met. Insurance companies may also define their infertility criteria differently than others. However, most define infertility as attempting pregnancy without success for a 6- to 12-month period. Some insurance plans require you to demonstrate infertility by attempting a specific number of intrauterine inseminations, or IUIs, before qualifying for coverage for other fertility treatments, like IVF. If you don't engage in the type of intercourse that can lead to pregnancy and have no other infertility diagnoses, unfortunately, you may not be able to meet your insurance plan's definition of infertility if you haven't attempted IUI first. Insurance plans may also have other limitations in place as part of their fertility coverage criteria. Often, patients who have had sterilization procedures, like a vasectomy or a bilateral tubal ligation, may not qualify for the same coverage as those experiencing infertility as the result of another diagnosis, even if a sterilization reversal procedure isn't successful. If you have treatment coverage to create embryos, this often does not cover the cost of third-party reproduction, like donor eggs or the use of gestational carrier services. The purchase of donor sperm is also rarely covered. If your insurance company has criteria you must meet, they will likely require a prior authorization before treatment coverage is provided. If this is the case, prior authorization for treatment coverage could take up to 30 days or more unless there is a life-threatening illness such as a cancer diagnosis. Additional prior authorizations may be required for fertility medication coverage. Some employers may offer fertility-specific benefits in addition to your medical insurance plan. These plans typically cover a set number of treatments or provide reimbursement for fertility care up to a certain dollar amount..

Medication Coverage

Backend Name: FFC_US_05_Medications

Source Video:

Section Copy: @UFC_US_02_Medications

Medication Coverage. While a few fertility medications may be purchased from a standard walk-in pharmacy, the majority will need to be filled by a specialty pharmacy. If you have medication coverage, your insurance company likely has a preferred, or in-network, specialty pharmacy, as well as an approved list of fertility medications they will cover. A medication or pharmacy can be restricted even if your healthcare provider documents its medical necessity. Several fertility medications are available under different brand names. For instance, Gonal-F and Follistim are two types of injectable medications containing FSH that can be used interchangeably in your treatment. If the pharmacy in your insurance network does not carry the medications prescribed for your treatment or if they are not approved by your insurance company, you can speak with your healthcare provider to see if there is a suitable replacement medication that meets your insurance coverage requirements. If no

replacement is available, you may need to pay for the medications out-of-pocket. An easy way to confirm if your health insurance plan includes medication coverage is to review your insurance card for an Rx BIN, PCN, and GRP number. These numbers are used by your pharmacy to confirm your medication coverage. If these numbers are not included on your insurance card, you should call the member services phone number listed on the back of your insurance card to learn more about the medication coverage your insurance company provides. Be sure to take notes when you speak to your insurance company to share with your financial coordinator. Even with insurance coverage, you will likely need to pay some out-of-pocket costs for your fertility medications. This amount can vary based on your insurance plan, whether you've met your deductible, if you have copay or coinsurance requirements, and other factors that your pharmacy can help explain when your prescriptions are processed and ready for purchase.

Paying for Medication

Backend Name: FFC_US_06_Self-Pay

Source Video:

Section Copy: @UFC_US_03_Self-Pay

Paying for Medication. Your insurance coverage may have a lifetime maximum dollar amount set aside for fertility benefits; using it for medications may exhaust your coverage, leaving insufficient funds to cover the costs of treatment ~~so you may want to reserve your coverage for treatment costs rather than medications~~

. If you do need to pay out-of-pocket for medications, ask your clinic for a list of pharmacies they frequently work with. Specialty pharmacies often offer heavily discounted prices for medications purchased without insurance coverage, and there are also income-based assistance programs and manufacturer coupons that may be available. Military discounts for both active duty and veterans may also be an option. Keep in mind that some offers only apply to specific medications that may not be part of your prescribed treatment plan. You can compare out-of-pocket prices by asking the pharmacies for a quote. Your care team might recommend ordering a limited supply of medications to start, and ordering refills as needed throughout your cycle. Medications can't be returned, and your clinic and pharmacy will not reimburse you for any unused medications. It's important that you follow the instructions provided by both your clinic and your pharmacy to ensure your prescriptions are delivered in time for your treatment..

Special Considerations

Backend Name: FFC_US_07_Consider

Source Video:

Section Copy: @UFC_US_04_Consider

Special Considerations. You and your clinic's financial coordinator will evaluate your estimated out-of-pocket costs for your fertility treatment and determine your plan for ~~a~~ payment ~~plan~~. If you need financial assistance, there are multiple different financing programs for fertility treatments that you may be eligible to participate in. You may qualify for fertility-specific grants if you have limited insurance coverage or no fertility insurance benefits at all. You may also qualify if you belong to a specific population experiencing fertility needs, like LGBTQIA+ patients, active military members, or veterans. Some grants have explicit rules for how the funds can be used, so it's important to read the terms and conditions of each grant application carefully. Your financial coordinator may be able to guide you to potential grants or support your application process. Your clinic may also have a partnership with a lending program or other resources that they can connect you with to fund your treatment. If you qualify for a loan, you or your loan service provider will need to provide details to your clinic's financial coordinator prior to beginning treatment to avoid any delays. You should contact your clinic's financial coordinator if you have additional questions about financing your fertility treatment..