



# Understanding Your Insurance Coverage

Frequently Asked Questions

## Introduction

We know navigating insurance can feel overwhelming. This guide breaks down the most common questions in plain language so you can focus on what matters most: your care.



# The Basics

## What is cost sharing?

Cost sharing is the portion of your medical bills that you're responsible for paying: the costs you "share" with your insurance company. It includes your deductible, coinsurance, and copays. Essentially, insurance rarely covers 100% of everything; cost sharing is your piece of the bill.

## What do deductible, coinsurance, and out-of-pocket maximum mean?

### Deductible

The amount you pay out of pocket before your insurance starts covering costs. For example, if your deductible is \$2,000, you pay the first \$2,000 of covered services yourself. After that, insurance kicks in.

### Coinsurance

Once you've met your deductible, you and your insurance split costs. If your coinsurance is 20%, you pay 20% of the bill and insurance pays 80%.

### Out-of-pocket maximum (OOP)

The most you'll ever have to pay in a single plan year. Once you hit this number, insurance covers 100% of authorized and in-network covered services for the rest of the year. This is your financial safety net.

## Do I have to pay a copay at every appointment?

It depends on your specific plan. Some plans charge a flat copay (a set dollar amount, like \$30 or \$50) for each visit. Others apply your deductible and coinsurance instead, meaning you won't have a copay, but you'll be billed based on your remaining deductible.

Your Financial Coordinator can help you understand how your plan is structured.

## The Basics

### What is a lifetime maximum?

Some insurance plans cap the total dollar amount they'll pay for fertility treatments over the lifetime of that specific insurance plan coverage. This is referred to as the lifetime maximum (LTM). Once you hit that limit, insurance will no longer cover those services.

**Note:** If you switch employers after reaching your lifetime maximum, it will reset, as it is solely based on your new employer's insurance plan coverage. If you switch insurance plans (but stay with the same employer), the lifetime maximum accumulation may transfer.

Not all plans have a lifetime maximum, but it's important to know if yours does. Your Financial Coordinator will advise if a fertility lifetime maximum is applicable to your fertility benefits. It is recommended for you to contact your insurance plan to confirm this.

### What is a cycle limit?

A cycle limit is a cap on the number of fertility treatments your insurance will pay for during your lifetime or plan year. This typically covers procedures like IVF, IUI, or ovulation induction. While every plan varies, many provide coverage for 3 to 6 rounds of IUI or ovulation induction, and 2 to 3 cycles of IVF.

### What specific treatments are covered – IVF, IUI, embryo transfer?

Coverage varies widely by plan. Certain policies may limit coverage to ovulation induction and IUI only. Others include a broader range of services like IVF and embryo transfers.

**Note:** While we can verify your benefits, we cannot guarantee that your insurance will pay for every service. Final claim determination is made by your carrier based on your active coverage on the date of your appointment.

## Starting Your Cycle

### **Why do I have to pre-pay my deductible before starting a cycle?**

Fertility treatment involves a significant number of services in a short window of time – monitoring appointments, lab work, procedures, and more.

Rather than billing you after each visit, we collect an estimated deductible upfront so there are no surprises mid-cycle. If we overcollect, you'll receive a refund. If your actual costs are higher, we'll reconcile the difference at the end.

### **Is there a waiting period before I can start treatment?**

Some insurance plans require you to be enrolled for a certain length of time before fertility benefits become active. This is called a waiting period. It varies by plan. Your employer's Human Resources representative can confirm this for you. Your Financial Coordinator will verify whether your plan has one and, if so, how long it is.

### **Does my insurance require a specific order of procedures or a timeline I must follow?**

Yes, some plans require patients to try less intensive treatments (like timed intercourse or IUI) before they'll cover more advanced procedures like IVF. This is sometimes called a "step therapy" or "treatment ladder" requirement. We'll review your plan details with you and request a prior authorization to determine coverage. This allows you to know exactly what's required before insurance kicks in and starts covering your costs.

### **What qualifies as a "cycle" according to my insurance?**

Insurance plans define a "cycle" in different ways. Some count a full IVF retrieval and transfer as one cycle; others count each individual procedure separately. This matters because many plans cover only a limited number of cycles.

We'll review your specific plan language so you understand exactly what counts and how much of your benefit you've used.

## Starting Your Cycle

### What are plan requirements?

Plan requirements are the conditions your insurance sets before it will cover fertility treatment. These can include things like a diagnosis of infertility, a minimum number of months trying to conceive, a specific age range, prior authorization, or a required treatment sequence. We review these with every patient before treatment begins.

#### Important information for same-sex couples, single parents by choice, those pursuing elective fertility preservation, or patients who had previous sterilization procedures:

- 1 Your insurance company may require** that you meet their clinical criteria for infertility to utilize your fertility benefit. Infertility is defined as a disease or condition resulting in the abnormal function of the reproductive system. This definition applies to all individuals regardless of sexual orientation or the presence of a reproductive partner.
- 2 Infertility may also be established by** demonstrating a disease of the reproductive tract that makes timed egg-sperm contact ineffective. Voluntary sterilization procedures are typically excluded from coverage.
- 3 It's important to call your insurance** to determine if you meet their clinical criteria before starting any treatment, including diagnostic testing.

## Coverage & Authorization

### Does my plan cover the initial diagnosis?

Your insurance may cover consultations and testing when they are used to determine the underlying cause of infertility. Many insurance plans cover diagnostic testing (like blood work, semen analysis, or ultrasound) even if they don't cover treatment itself. Coverage for the initial workup is often billed under general medical benefits rather than fertility benefits. We'll verify what's covered under your plan before you come in.

Please note, once an infertility diagnosis is established, some plans do not continue to cover additional diagnostic testing. This means future labs, imaging, or procedures could be your financial responsibility, even if similar testing was previously covered.

### What specific treatments are covered – IVF, IUI, embryo transfer?

Coverage varies widely by plan. Some plans cover IUI only; others include IVF, frozen embryo transfers (FETs), and egg freezing. A few cover very little beyond diagnostic testing. After we verify your benefits, we'll give you a clear picture of exactly what your plan includes, and what you'll be paying out of pocket.

### Is egg freezing covered by insurance?

Elective egg freezing (freezing eggs for future family planning, not due to a medical diagnosis) is typically not covered by insurance. However, if egg freezing is recommended for a medical reason (such as a cancer diagnosis), it may be covered under your oncofertility benefits. We'll help you check your specific plan's policy on egg freezing.

### Is pre-authorization or pre-certification required?

Many plans require pre-authorization (also called prior authorization or pre-cert) before certain treatments, especially IVF. This means your insurance needs to formally approve the treatment before we proceed. Without it, they may deny the claim entirely. The standard turnaround time is up to 15 business days from date of submission. It is important to wait for an authorization determination so you know what your insurance plan approves and can avoid unexpected out-of-pocket costs.

## Coverage & Authorization

### **Who handles the pre-certification?**

Your Illume Financial Coordinator works with our internal Authorization Team to start the precertification process for you. They'll communicate directly with your insurance company to obtain the necessary approvals before treatment begins. You don't need to handle this yourself.

Once the Authorization Team receives a determination from your insurance plan, your Financial Coordinator will reach out to you to confirm financial clearance.

### **Are there specific definitions of infertility that must be met for coverage?**

Yes, most insurance plans define infertility in specific terms: for example, 12 months of unprotected intercourse without conception for patients under 35, or 6 months for those 35 and older.

Same-sex couples and single patients may have different documentation requirements. We'll review your plan's exact language to make sure you meet the criteria before treatment starts.

## Costs & Medications

### How much will medications cost out-of-pocket?

Medication costs vary based on your treatment type and your pharmacy benefits. Timed intercourse and IUI protocols typically involve lower medication doses and lower costs than IVF. Medications for IVF stimulation, trigger shots, and progesterone support can add up quickly.

Please note, over-the-counter medications may apply a copay, and specialty pharmacy medications may be applicable to your deductible and/or coinsurance.

### What additional expenses are excluded from self-pay plans?

Illuminate offers specialized self-pay plans for patients without insurance coverage.

Certain services are not bundled into our self-pay packages, including medications, which are handled and paid for directly through your specialty pharmacy. While costs fluctuate based on your unique protocol, self-pay patients generally expect to spend between \$4,500 and \$5,000 for one IVF cycle.

After you receive financial clearance, our Nursing Team can provide a detailed list of medications so you can request a quote from your pharmacy. If you need assistance selecting a provider, your clinical team can offer a list of specialty pharmacy options.

### How do I find out how much money I have for medications?

While we cannot provide specific advice on which prescriptions your insurance covers, our clinical team works with third-party partners to request medication authorization once you are cleared for treatment. During your initial review, we will check if prescription costs count toward your fertility lifetime maximum based on your benefit verification notes.

Some patients also qualify for medication assistance programs, and we're happy to help you explore those options.

## Costs & Medications

### **Can I submit services to my partner's insurance if they have better coverage?**

Possibly! To utilize a partner's insurance benefits, you must be officially enrolled as a dependent on their policy. Please note that when you are covered by multiple plans, the order of coverage is established by standard insurance regulations rather than individual choice. Typically, a plan provided through your own employer is designated as your primary coverage automatically.

The coordination of benefits (COB) process dictates the sequence in which providers are billed. Your primary insurer must process and adjudicate the claim first; following their determination, the secondary plan will then evaluate any remaining costs.

You must manage and update your COB status directly with your insurance carriers, as this is a personal policy requirement that our team cannot modify on your behalf.

## State Mandates & Legal Protections

### **What are state fertility insurance mandates, and how do they work?**

Some states have passed laws requiring insurance plans to cover fertility diagnosis and/or treatment. Connecticut and New York, for example, both have a fertility insurance mandate. These laws set minimum standards for what insurers must cover, but they don't apply equally to all plans.

Employer-sponsored plans that are self-funded (meaning the employer pays claims directly rather than through an insurer) are generally exempt from state mandates.

Your Financial Coordinator will review whether your plan is subject to a state mandate.

### **Does my insurance have to cover infertility treatment?**

It depends on your plan and your state. If you're in Connecticut or New York and your plan is subject to the state mandate, your insurer is required to provide some level of fertility coverage.

However, if your plan is self-funded through your employer, state laws may not apply. Federal law doesn't currently require coverage of infertility treatment. We'll verify your specific situation during your benefits review.

## Billing & Codes

### What are ICD and CPT codes, and why do they matter?

ICD codes are diagnosis codes: they tell your insurance company why you're receiving treatment (for example, a specific infertility diagnosis).

CPT codes are procedure codes: they describe what services were performed (like an ultrasound, egg retrieval, or embryo transfer). Insurance companies use these codes to determine what's covered under your plan.

Below are some commonly used CPT codes. If you need a list of codes for your specific cycle, your Financial Coordinator can provide them.

CPT Code	Procedure
76830	Transvaginal ultrasound (monitoring)
58321	IUI procedure
89260	Sperm wash and prep for IUI
58970	Egg retrieval
89280	ICSI (sperm injection per oocyte)
89250	Embryo culture
58974	Fresh embryo transfer
58976	Frozen embryo transfer
89352	Thawing of frozen embryo(s)
89337	Egg freezing
89258	Embryo freezing
89290	Preimplantation Genetic Testing (PGT Biopsy)
89342	Embryo Storage (1 year)

**Questions?** Your Illume Financial Coordinator is here to help. Every patient's insurance situation is unique. The information in this guide is general. Your Financial Coordinator will review your specific plan with you before treatment begins.