PATIENT ACCOUNTS & INSURANCE POLICIES
INFORMATIONAL ONLY
Copy to Patient

To help you understand and anticipate any difficulties in insurance benefits you may encounter, please review this document.

Insurance coverage in this area of medicine is not as straightforward as in most other areas. For example;

- Many times there is coverage for testing to determine why you are experiencing infertility issues, but there is not coverage for the treatment of infertility.
- Many times payment depends on why the service was performed. For instance, if we do an ultrasound of your ovaries to ensure that an ovarian cyst is shrinking, it will be paid; but if we do an ultrasound to track your response to fertility medications, it will not be paid.
- Many times the information we get from your insurer is incorrect or incomplete.

To serve you best, we have developed the following approach:

Determination of Insurance Benefits

We will contact your insurance carrier to obtain information regarding your plan's coverage for infertility care. We have developed a list of questions that we ask to get a picture of the nature and extent of your coverage. We will provide you with a copy of this information. Please review, and if you think you have different coverage, or a different level of benefits, please notify our Business office staff, so we can clarify the information with your carrier. We also suggest that you contact your insurance carrier directly and request a statement of coverage and benefits.

Unfortunately, this "verification" of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that a verification of your coverage is:

- NOT a guarantee of payment, and is
- NOT a guarantee of what is actually covered and/or not covered

As a result, even if your carrier advises our office that a service is covered, they are not obligated to pay as quoted. The true determination of service coverage is made at the time the claim is received by the insurance company. Whether they pay is dependent on whether:

- The service you received is covered by your plan/policy
- The reason the service (the diagnosis) is covered by your plan
- The appropriate deductibles, cost share, and co-pays have been met
- "pre-existing condition" exclusions apply

Further complicating payment is that some plans require that:

- You have experienced infertility for a specified amount of time before services will be covered, or
- The infertility is not due to prior elective sterilization, or
- Certain treatment steps be taken before other treatment steps will be covered. This may not always be consistent with the course of treatment that we believe best for you. For instance, some companies will pay for IVF treatment, but only after three tries of gonadotropin cycles (ovulation induction) have failed.

There may be occurrences where your insurance company denies payment and deems that a service "is not consistent with the diagnosis" assigned to you.

Claims Filing

• For insurance Companies/Networks With Which We (The New Hope Center) Are Contracted

We will file a claim for coverage of rendered services with your insurance company if you have insurance with a network with which we participate, and if your plan provides benefits for the service provided for the reason it was provided, and if there are no other restrictions on covered services of which we are aware. We will collect any required co-payment at the time of your visit.

If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures/services rendered, then full payment is required at each visit. We expect all balances to be settled on the day it occurs.

Currently, we participate in the following networks:

- Anthem Blue Cross/Blue Shield (PPO, POS)
- Cigna (all policies) – HMO requires a referral
- Aetna (PPO, POS, EPO)
- Mamsi / MDIPA / Optimum Choice (requires referral and pre-authorization)
- Alliance / First Health
- Optima / Sentara (all except Medicare and Medicaid programs) (all polices require referral from PCP)
- Great West Health Care
- Champ VA

• For Insurance Companies/Networks With Which we are Not Contracted

If we do not contract with your insurer, then full payment for all services rendered is required at the time of your visit. These patients are classified as "Self Pay" or "Cash", and are required to sign a "Cash Payment Agreement" at their first office visit. As noted above, we require that each patient's balance be settled on the day it occurs. To be eligible for a potential "cash" discount, or one of The New Hope Center's discount programs, please see our "FINANCIAL STATEMENTS" Policy form. Our office will provide you with a statement or description of your charges, that you can submit to your own insurance company for reimbursement directly to you.

Other Items

Infertility treatment can be expensive, and we do not want to let you get "in over your head". Thus, we collect in full for each service as it is rendered, except in the case of IVF services, which is discussed further below. We strive to anticipate how much each service will cost you for each visit (by calculating your portion of charges after insurance is applied), and expect that costs be paid at that visit. On occasion, this is not possible, and in some cases the actual charge can only be estimated (as in surgery). In other cases, we discover monies owed after a visit has occurred. These situations and how we handle such, are described below.

• All ART Cycles

Fees for all ART Cycles (including IVF, Frozen Embryo Transfers, Egg Recipient/Donor Cycles, etc.) are collected in advance of the cycle start.

• Surgery

We calculate an estimate of the charges you will be responsible to pay, based on your "in" and "out" of network status and based on the information provided by your insurance carrier. Payment is required prior to the surgery, at a minimum it must be paid at your pre-op visit. We will file the claim(s) with your insurance carrier, and if you are "in" network, you are responsible for

any patient balances after the insurance adjustments have been applied. If you are "out" of network, you are responsible for the difference between what we charge and what your insurance pays.

• Additional Services Rendered

Occasionally, when the doctor reviews lab results, he/she will determine that another test is needed to make a complete evaluation. When this occurs, the charges for the additional test will be posted to your account at the time the test is ordered. Our audits occasionally detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or a balance.

• Settling of Balances

As discussed above, there are times when insurance companies process a claim in a manner different than expected. In these cases,

- a claim may be completely denied as not covered, with no payment being made, thereby making you entirely responsible for the charge;
- a claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected;
- even though your insurance company communicated to us and we in turn communicated to you that a given service or set of services is covered, this is NOT A GUARANTEE BY US of your insurance company's coverage for that service or set of services. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the
- verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not responsible for any statement made by your insurance company, or any statement made by us to you based on the information given to us by your insurance company. It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim.

When this occurs, we will first try to understand why: Was the claim processed correctly? Were the appropriate diagnoses used? Were benefits incorrectly stated to us at verification? Typically an insurance company will send an EOB "Explanation of Benefits" that outlines what they paid and did not pay and why. If we believe there are errors in the claim, we will resubmit it. If you receive an EOB that processed your claim differently than you expected, please call your insurance company to clarify. If the insurance company states that they processed the claim incorrectly, please obtain the name of the person you spoke with, and call us with that information so we can note this in your account. If your insurance company reprocessed the claim, when you receive the corrected EOB showing payment was made to us, please call us to issue a refund to you.

If, however, there are no errors, we will make the corresponding adjustments to your account, determine the portion of the charge you are responsible for, and post this portion to your account.

As stated previously, there are times when an insurance company states that the test or procedure performed is not consistent with the diagnosis assigned to you. The providers at NHC perform or order services to be performed when they determine that they are important in the diagnosis and treatment of the patient for the particular circumstances of the patient. When your insurance company denies payment and renders the decision that the services are "not consistent with the diagnosis," it has decided otherwise.

When services have been performed by/ordered by an NHC provider, and your insurance deems the services to be "inconsistent with the diagnosis," your physician has deemed them to be important in your diagnosis and treatment and for your

particular circumstances. Your signature below acknowledges your agreement that you will be responsible for the payment for these services, should your insurance company deny payment and state that these services are "inconsistent with the diagnosis" assigned to you.

• Insurance Company Look Back Periods

Insurance companies often perform audits of paid claims. These audits can be performed for up to two (2) years with Commercial Carriers) and up to five (5) years with Governmental Carriers/Policies (i.e. Tricare, Medicare, Medicaid, Federal BC/BS, etc.) from the latter of the following (a) the date of service; (b) the receipt of the claim; (c) the payment of the claim; or (d) the receipt of an appeal. When an insurance company performs an audit of and determines that claims were paid in error and should not have been, the insurance company contacts us for a refund of the monies they paid. They then direct us to collect for these services from the patient. Unfortunately this may mean that for a period of up to two years after any one of the above listed events your insurance company may reverse their decision. If this should occur we will then contact you for payment of these services.

• Interest on Unpaid Balances

Should you have any outstanding balance on your account that is your responsibility and that is greater than 30 days old, we will assess simple interest on the unpaid balance at the rate of 1.5% per month. This represents an annual interest of 18%.

• Administrative Billing Fee When Your Co-Pay, Co-Insurance or Patient Responsibility Balance Is Not Paid at the Time of Service

When your co-pay, co-insurance, or patient responsibility balance for that day's visit is not paid at the time of service delivery, we will assess a $25.00 administrative billing fee and subsequently bill you for the unpaid amount.

• Fees for Medical Records

A reasonable charge may be made for the service of maintaining, retrieving, reviewing and preparing such copies. Except for copies of x-ray photographs, however, such charges shall not exceed:

- Fifty cents per page for up to fifty pages;
- Twenty-five cents a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process;
- One dollar per page for copies from microfilm or other micrographic process;
- Plus all postage and shipping costs and a search and handling fee not to exceed ten dollars;
- Copies of hospital, nursing facility, physician's, or other health care provider's records or papers wil be furnished within fifteen days of such request.

• Credit Card Authorizations

As you may now understand, there are instances of charges being generated or recognized on days when there is no office visit scheduled. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, it is our office's policy to require a credit card authorization be maintained on file so that your balance can be settled as they occur. Our patients like this strategy for convenience. When these cases arise:

- We will call you before making any charge in excess of $500.
- We will call you before making any charges to a debit card, regardless of the amount.
- We will call you before making any charge for a service provided more than 6 months ago.

We will mail you a copy of your credit card receipt and your statement on the day the charge is made.

- **Account Representatives & Financial Counselors**

We understand that infertility is a challenging problem. Unfortunately, managing insurance benefits is often troublesome in this area. We have Patient Account Representatives who are well trained to help you navigate these often troubled waters, as well as Financial Counselors to assist you in securing the funds needed for your treatment plan. In addition, these representatives can assist you with the necessary information to file for your applicable tax credits based on qualifying medical treatment deductions. Please feel free to work with them, they are here for your benefit!

Thank you