Internal Use:
Fertility Center: _____ Date: _____

LIVESTRONG fertility

Agreement to Participate in
LIVE STRONG Fertility Discount Program for Women

Dear LIVE**STRONG** Fertility Partner,

Thank you for agreeing to participate in the LIVE**STRONG** Fertility Discount Program for Women (the "Program"). Made possible through a donation from EMD Serono, Inc. and the generous participation of fertility centers and cryobanks such as your center ("Participant"), the Program helps defray the costs of fertility preservation for qualified female cancer patients ("Patients").

Under the terms of this Agreement, Participant agrees to accept Patients approved by LIVE**STRONG** through the Program and accept from Patients the discounted rate noted below for the services outlined below (the "Rate" or "Rates").

In order to ensure success of the Program and fair rates to Patients, LIVE**STRONG** has recommended guidelines for establishing reduced rates, which can be found in the LIVE**STRONG** Fertility Discount Program for Women Manual. Participants' reduced rates must be at least 25% less than normal rates OR no more than $5500 for the outlined services.

Outline of Rates and Services
Embryo Cryopreservation
Participant will provide embryo freezing at the following discounted rate agreed upon by Participant and LIVE**STRONG**:

Normal Rate:	Discounted Rate:
$	$

OR Check if participant will NOT provide a discount on embryo freezing services: ____
The following embryo freezing services are included in the discounted rate outlined above:

SERVICE (Please provide quantity where requested)	INCLUDED IN RATE (Please check yes or no)	
Consultations (Enter number of consultations:_____)	___Yes	___No
Monitoring Services	___Yes	___No
Anesthesia	___Yes	___No
Lab work	___Yes	___No
Preimplantation Genetic Diagnosis	___Yes	___No
Procedures necessary for egg retrieval	*Required	
Processes necessary for creation of embryos	*Required	
Freezing	*Required	
First year of storage	___Yes	___No
Additional years of storage after one year (Quantity:____)	___Yes	___No

If applicable, please list any additional ancillary services (i.e. doctor's fees, facility fees) that may also be included in Participant's discounted rate for an embryo freezing cycle:

Oocyte Cryopreservation

Participant will provide egg freezing at the following discounted rate agreed upon by Participant and LIVE**STRONG**:

Normal Rate:	Discounted Rate:
$	$

OR Check if participant will NOT provide a discount on egg freezing services: ____

The following egg freezing services are included in the discounted rate outlined above:

SERVICE (Please provide quantity where requested)	INCLUDED IN RATE (Please check yes or no)	
Consultations (Quantity:___)	___Yes	___No
Monitoring Services	___Yes	___No
Anesthesia	___Yes	___No
Lab work	___Yes	___No
Preimplantation Genetic Diagnosis	___Yes	___No
Procedures necessary for egg retrieval	*Required	
Freezing	*Required	
First year of storage	___Yes	___No
Additional years of storage after one year (Quantity:____)	___Yes	___No

If applicable, please list any ancillary costs (i.e. physician fees, facility fees) that may also be included in Participant's discounted rate for an egg freezing cycle:

If Participant has multiple locations that will provide the same discounted rates stated above, Participant must make these locations known by noting all locations, their address and contact information for the individual to receive communication from LIVE**STRONG** in the space provided below or in an attachment. If any location has different costs or procedures offered than noted above, a separate agreement must be completed for that location.

Location Address	Contact Name	Contact Phone	Contact Email

General

This Agreement is in effect for the remainder of the calendar year in which this Agreement is fully executed, effective the date of counter-signature by LIVE**STRONG**. This Agreement will renew automatically on the first day of each successive calendar year thereafter for a renewal term of one (1) year, provided that either party may elect not to renew this Agreement by providing ten (10) days prior written notice of such election. Participant will provide LIVE**STRONG** with an annual notice of current Rates not later than January 31st during each renewal term.

In the event of any change in the terms of Participant's involvement in the Program, including but not limited to the Participant's center closing, a service in this Agreement being made no longer available, Participant no longer being able to support the cost of providing a discount, an adjustment of the Rates, or for any other reason, Participant will inform LIVE**STRONG** in writing of any such change within thirty (30) days thereof. Regardless of any change to Participant's involvement in the Program, Participant agrees to continue to treat any existing Patients currently enrolled or accepted through the Program under the terms and rates set forth herein. Adjustment of Rates will require the execution of a specific amendment to this agreement.

EMD Serono, Inc. will provide certain samples of infertility drugs that it has manufactured for Participant to prescribe, free of charge, to qualified female cancer Patients accepted into the Program.

To the extent any relevant infertility drugs necessary for treatment are not among those manufactured and donated by EMD Serono, Inc. as a part of the Program, Participant agrees to inform the Patient of this fact. Participant may prescribe additional and/or alternative drugs necessary or advisable for treatment and the Patient will be required to pay for these drugs. Participant also agrees to inform the Patient of possible risks and side effects of treatments to be used.

As part of its screening process, LIVE**STRONG** may refer interested Patients to Participant for discussion of the fertility preservation options best suited for them, if any. If the Patient would like to move forward with one of the above services offered by Participant and is in financial need, the Patient may apply to the Program. The Program application includes forms to be completed and signed by the Patient, the Patient's Oncologist and the Patient's Reproductive Endocrinologist associated with Participant. Additionally, a copy of the Patient's most recent 1040 Federal Tax Forms or proof of unemployment is required for qualified income verification.

LIVE**STRONG** approves applicants who meet all eligibility criteria to participate in the Program. Upon approval, LIVE**STRONG** will notify the Participant, EMD Serono, Inc., and the Patient.

By signing below, Participant acknowledges it has been given the opportunity to review the criteria used by LIVE**STRONG** to approve Patients and understand that neither LIVE**STRONG** nor EMD Serono, Inc. is a medical provider. Participant agrees that neither LIVE**STRONG,** EMD

Serono, Inc. nor the Patients in the Program shall have liability to Participant. This Agreement supersedes all communication, negotiations, and other Agreements between Participant and LIVE**STRONG.**

To confirm Participant's understanding of its involvement in the Program as set forth in this letter agreement, please sign this letter where indicated below and return the executed copy by:

Mail	Email	Fax
LIVE**STRONG** Foundation Attn: LIVE**STRONG** Fertility 2201 East 6th Street Austin, Texas 78702	ashley.koenings@livestrong.org	512-309-5515

Upon receipt, LIVE**STRONG** will sign and return a final executed copy to Participant. Please keep a copy for any and all records. Note: Applicants requesting a discount from Participant will not be approved until an Agreement has been executed.

Again, thank you for agreeing to participate in the LIVE**STRONG** Fertility Discount Program for Women. Your support makes a meaningful difference in the lives of cancer patients. If you would like any further information on the Program as well as additional services and support that patients and health care professionals can access through LIVE**STRONG**, please feel free to contact us at 1-855-220-7777.

Sincerely,

Ashley Koenings
Fertility Services Manager
LIVE**STRONG** Foundation
(512) 279.8363 ashley.koenings@livestrong.org

Signature: _____

Date: _____

Agreed to and Acknowledged By:

Name:_____

Signature: _____

Date: _____

Fertility Center: _____

_____

Primary Address: _____

_____

Phone: _____

Fax: _____

Email: _____

*Email for Approval Notifications:
(if different from above):

_____