KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852
301-816-2424

2015 GROUP BENEFITS AMENDMENT

This Amendment is effective as of the date of your Group Agreement and Group Evidence of Coverage, or July 1, 2015, whichever is later, and shall terminate the date your Agreement terminates.

SECTION 3 – Benefits are amended to include the following:

INFERTILITY SERVICES

The "Infertility Services" subsection is replaced in its entirety with the following:

A. "We cover the following Services for diagnosis and treatment of infertility including, Medically Necessary, non-Experimental/ Investigational artificial insemination /intrauterine insemination, in vitro fertilization and fertility drugs administered as a part of in vitro fertilization treatment, as follows:

1. [Artificial insemination[.] [;] [and]] [Intrauterine Insemination]

   a. We cover when:

   1) For a Member whose spouse is of the opposite sex:
      a) The Member and the Member's spouse have a history of the inability to conceive after one (1) year of unprotected vaginal intercourse and the Member's Spouse's sperm is used; and,
      b) The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination; and,
      c) The Member's spouse's sperm is used.

   2) For a Member whose Spouse is of the same sex, the Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination.

   b. Benefits will not be provided for costs incurred by Member in obtaining donor sperm/eggs.

2. [In- Vitro Fertilization (IVF)
   a. We cover when:
   1) Member Spouse is of the opposite sex, the oocytes (eggs) are physically produced by the Member and fertilized with sperm physically produced by the Member's Spouse.
   2) The Member and the Member's Spouse have a history of involuntary infertility, which may be demonstrated by a history of:
      a) if the Member and the Member's spouse are of opposite sex, an inability to conceive after at least two (2) years of unprotected vaginal intercourse failing to result in pregnancy; or
      b) if the Member and the Member's spouse are of the same sex, six (6) attempts of artificial insemination over the course of two (2) years failing to result in pregnancy; or
   3) The infertility is associated with any of the following:
      a) endometriosis;
      b) exposure in utero to diethylstilbestrol, commonly known as DES;
      c) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
      d) abnormal male factors, including oligospermia, contributing to the infertility;
   4) the Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC Agreement; and
   5) the in vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.
      - [Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;] [and]
      - [Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines[.]
      - [Gamete intrafallopian transfers (GIFT)[.][;] [and]]
      - [Zygote intrafallopian transfers (ZIFT).]
3. For a Member whose Spouse is of the opposite sex, any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. For a Member whose Spouse is of the same sex, benefits will not be provided for costs incurred by the Member in obtaining donor sperm.

Note: Diagnostic procedures and drugs administered by or under the direct supervision of a Plan Provider are covered under this provision.

[Infertility Limitations:

- [Coverage for in-vitro fertilization embryo transfer cycles [, including frozen embryo transfer (FET) procedure], is limited to three (3) attempts per live birth[, not to exceed a maximum lifetime benefit of $100,000].
- Coverage for in-vitro fertilization embryo transfer cycles, is limited to three attempts per live birth.
- Coverage for artificial insemination is limited to six attempts.

Infertility services Exclusions: [Artificial Insemination] and [Intrauterine Insemination]

- When the Member or Spouse has undergone elective sterilization with or without reversal.
- Surrogates and gestational carriers are not covered in any case.
- For a Member whose Spouse is of the opposite sex, when the service involves the use of donor egg(s), donor sperm or donor embryo(s).
- When the service involves the participation of a Domestic Partner or common law Spouse, except in states that recognize the legality of those relationships.
- When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.
- [Infertility Services, except for covered Services for in vitro fertilization, when the Member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.]
- [Services to reverse voluntary, surgically induced infertility.]
- Outpatient prescription drugs for home use.
- [Assisted reproductive technologies and procedures other than those described above], including, but not limited to: [[gamete intrafallopian transfers (GIFT);] [zygote intrafallopian transfers (ZIFT);] assisted hatching and [prescription drugs related to such procedures.]]

Additionally, artificial insemination and intrauterine insemination benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

Infertility services Exclusions: [In-vitro fertilization]

- When the Member or Spouse has undergone elective sterilization with or without reversal.
- Surrogates and gestational carriers are not covered in any case.
  - For a Member whose Spouse is of the opposite sex, when the service involves the use of donor egg(s), donor sperm or donor embryo(s).
  - [Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.]
  - When the service involves the participation of a Domestic Partner or common law Spouse, except in states that recognize the legality of those relationships.
  - When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.
  - [Infertility Services, except for covered Services for in vitro fertilization, when the Member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.]
  - [Services to reverse voluntary, surgically induced infertility.]
  - [Infertility Services when the infertility is the result of an elective male or female surgical sterilization procedure.]
  - [Assisted reproductive technologies and procedures other than those described above], including, but not limited to: [gamete intrafallopian transfers (GIFT)]; [zygote intrafallopian transfers (ZIFT)];assisted hatching and prescription drugs related to such procedures.]]"
  - [Outpatient prescription drugs for home use.]

Additionally, in·vitro fertilization benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg {s), or embryo(s).

This Amendment is subject to all the terms and conditions of the Group Agreement and Group Evidence of Coverage to which this Amendment is attached. This Amendment does not change any of those terms and conditions, as specifically stated herein.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

[Signature]

By: ________________________________

[Name]

[Title]