CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT C
SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

CareFirst BlueChoice pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Coinsurance or Copayment. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst BlueChoice considers all provisions of the Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced.

Benefit Period: Benefit Period is a [calendar] year.

Service	Limit on Benefits	Member Payment
SECTION 1 – OUTPATIENT AND OFFICE SERVICES		
Office Visits	[Office visits to CareFirst BlueChoice Specialists require written referral from a Primary Care Physician (PCP), except as otherwise provided in the Description of Covered Services.]	$30 per visit (PCP) $40 per visit (Specialist)
Laboratory Tests and X-rays		No Copayment or Coinsurance
Other Diagnostic Testing (except as otherwise provided)		$30 per visit (PCP) $40 per visit (Specialist)
Preventive Care		
Prostate Cancer Screening	In accordance with the most current American Cancer Society guidelines	Subject to office visit Copayment.
Colorectal Cancer Screening	In accordance with the most current American Cancer Society guidelines	Subject to office visit Copayment.

Service	Limit on Benefits	Member Payment
Routine Pap Smear	A minimum of one annual pap smear, including tests performed using FDA approved gynecological cytology screening technologies. Additional Medically Necessary pap smear tests, as determined appropriate by CareFirst BlueChoice.	Subject to office visit Copayment.
Mammography		No Copayment or Coinsurance.
Well Child Care		$30 per visit (PCP)
Adult Preventive Care		$30 per visit (PCP) $40 per visit (Specialist)
Treatment Services		
Allergy Treatment	Number of visits not limited	$30 per visit (PCP) $40 per visit (Specialist)
Eye Care (Medical Treatment)		$30 per visit (PCP) $40 per visit (Specialist)
Rehabilitation Services (includes Physical Therapy, Occupational Therapy and Speech Therapy)	Prior authorization is not required for Rehabilitation Services or for any other service provided by the same provider on the same day as these services. Limited to 30 visits per condition per Benefit Period.	$40 per visit
Chemotherapy		$40 per visit
Habilitative Services	Limited to Members under the age of 21.	$40 per visit
Spinal Manipulation Services	Prior authorization is not required for Spinal Manipulation Services or for any other service provided by the same provider on the same day as these services. Limited to 20 visits per Benefit Period Benefits are limited to Members who are twelve (12) years of age or older.	$40 per visit
Limited Service Immediate Care		$40 per visit
Cardiac Rehabilitation	Limited to 90 visits per Benefit Period. Prior authorization is not required.	$40 per visit

Service	Limit on Benefits	Member Payment
Pulmonary Rehabilitation	Limited to one (1) pulmonary rehabilitation program per lifetime. Prior authorization is not required.	$40 per visit
Infertility Services		
Artificial Insemination	Limited to 6 attempts per live birth.	$40 per visit
Maternity Care		
Maternity Care	The Member maximum payment per pregnancy for PCP or Specialist care applies only to care performed by the Member's attending obstetrician(s). The Member maximum payment does not apply to any other Covered Services provided by a PCP or Specialist who is not the attending obstetrician.	$300 per pregnancy or $30 per PCP office visit up to Member maximum payment of $300 per pregnancy if no live birth $400 per pregnancy or $40 per Specialist office visit up to Member maximum payment of $400 per pregnancy if no live birth.
Hair Prosthesis		
Hair Prosthesis	Limited to a maximum CareFirst BlueChoice payment of $350 for one hair prosthesis per Benefit Period.	No Copayment or Coinsurance
Outpatient Facility and Professional Services		
Outpatient Hospital or Ambulatory Care Facility Services		No Copayment or Coinsurance
Outpatient Medical and Surgical Professional Services Provided at an Outpatient Hospital or Ambulatory Care Facility		$30 per visit (PCP) $40 per visit (Specialist)
SECTION 2 – INPATIENT HOSPITAL SERVICES		
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	No prior authorization required for routine maternity admissions. Hospitalization solely for Rehabilitation limited to 90 days per Benefit Period.	$300 per admission

Service	Limit on Benefits	Member Payment
Inpatient Professional Services		No Copayment or Coinsurance
SECTION 3 – SKILLED NURSING FACILITY SERVICES		
Skilled Nursing Facility Services	Number of covered days not limited	No Copayment or Coinsurance
SECTION 4 – HOME HEALTH SERVICES		
Home Health Services	Number of visits not limited	No Copayment or Coinsurance
SECTION 5 – HOSPICE CARE SERVICES		
Hospice Care Services – Limited to the Hospice Eligibility Period. See Section 5.3 of the Description of Covered Services.		
Hospice Care	Unlimited visits during Hospice Eligibility Period	No Copayment or Coinsurance
Respite Care	Limited to 3 periods of 48 hours during the Hospice Eligibility Period	No Copayment or Coinsurance
Bereavement Services	Limited to the 90-day period following the patient's death with a maximum of 3 visits.	No Copayment or Coinsurance
SECTION 6 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Services		
Mental Health		$40 per visit
Substance Abuse		$40 per visit
Medication Management		$30 per visit (PCP) $40 per visit (Specialist)
Inpatient Services		
Mental Health		
Inpatient Facility Services		$300 per admission

Service	Limit on Benefits	Member Payment
Inpatient Professional Services		No Copayment or Coinsurance
Substance Abuse		
Inpatient Facility Services		$300 per admission
Inpatient Professional Services		No Copayment or Coinsurance
Partial Hospitalization Program		No Copayment or Coinsurance
SECTION 7 – EMERGENCY SERVICES AND URGENT CARE		
Contracting Provider Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services	$40 per visit
Hospital Emergency Room or Non-Contracting Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services	$50 per visit, waived if admitted as inpatient
Other Emergency Services or urgently required services provided by a Non-Contracting Physician	Limited to unexpected, urgently required services	$40 per visit
SECTION 8 – MEDICAL DEVICES AND SUPPLIES		
Medical Devices and Supplies	Limited to a maximum CareFirst BlueChoice payment of $7500 per Benefit Period.	25% of the Allowed Benefit

MAXIMUM ANNUAL COPAYMENT AND COINSURANCE	
If the Group offering includes **two** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:	If the Group offering includes **three** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:
Individual $1,300* Family $2,600	Individual $1,300* Individual and Adult or Individual and Child $2,600 Family $2,600
If the Group offering includes **four** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:	If the Group offering includes **five** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:
Individual $1,300* Individual and Child $2,600 Individual and Adult $2,600 Family $2,600	Individual $1,300* Individual and Child $2,600 Individual and Adult $2,600 Individual and Children $2,600 Family $2,600

* If Coverage is complementary to Medicare, the Maximum Annual Copayment and Coinsurance is $1,300.

Except as provided below, total Copayments and Coinsurance paid during a Benefit Period by a Subscriber and, if applicable, his or her Dependents are subject to the Maximum Annual Copayment and Coinsurance established for the Type of Coverage in which the Member is enrolled (e.g., Individual or Family) as set forth in the table above. The Subscriber's Maximum Annual Copayment and Coinsurance applies on a Benefit Period basis even though the Member may have been enrolled for less than a Benefit Period.

If the Subscriber is enrolled under Family coverage, Individual and Children coverage, or, if applicable, Individual and Adult or Individual and Child coverage, the Maximum Annual Copayment and Coinsurance may be met if the individual Copayments and Coinsurance exceed the Maximum Annual Copayment and Coinsurance established for Individual coverage. In addition, if the total Copayments and Coinsurance of all covered family members exceed the Maximum Annual Copayment and Coinsurance for the Type of Coverage in which the Subscriber is enrolled, all covered family members will be deemed to have met the Maximum Annual Copayment and Coinsurance. However, an individual family member cannot contribute more than the Maximum Annual Copayment and Coinsurance for Individual coverage.

CareFirst BlueChoice will notify the Member if the Maximum Annual Copayment and Coinsurance is reached, based on billing and claims information in CareFirst BlueChoice's records. If the Maximum Annual Copayment and Coinsurance is satisfied, the Member will be entitled to a refund of any excess Copayments and Coinsurance paid and, for the remainder of the Benefit Period, will not be required to pay additional Copayments and Coinsurance for services that are subject to the Maximum Annual Copayment and Coinsurance.

The Maximum Annual Copayment and Coinsurance limit does <u>not</u> apply to charges or Copayments and Coinsurance in connection with any of the following:

- Charges for services that are not covered under this Evidence of Coverage or which exceed the maximum number of covered visits/days under the Member's coverage.
- Copayments and Coinsurance required under any riders to this Evidence of Coverage, unless the rider specifically states otherwise.

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MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AMENDMENT REVISED

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

I. The introduction to Section 6, Mental Health and Substance Abuse Services, of the Description of Covered Services, is deleted and replaced with the following:

SECTION 6
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physician's offices or in other CareFirst BlueChoice approved facilities	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.
In a CareFirst BlueChoice approved hospital or Qualified Substance Abuse Treatment Facility, when admitted under the care of a Contracting Physician.	Coverage for the services listed below. The coverage is subject to the limitations, if any, described in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

II. Section 6.2, Outpatient Mental Health and Substance Abuse Services, of the Description of Covered Services is deleted and replaced with the following:

6.2 Outpatient Mental Health and Substance Abuse Services. CareFirst BlueChoice will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the Medical Necessity and appropriateness of the services. CareFirst BlueChoice will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment. Benefits will be provided for:

A. Coverage of mental illness, emotional disorders, drug abuse and alcohol abuse is provided for Medically or Psychologically Necessary evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse and drug abuse will be covered in the same manner as medication management visits for physical illnesses and will not be counted as outpatient mental health or substance abuse treatment visits. Members are not required to obtain prior authorization for methadone maintenance treatment.

C. Coverage of Medically or Psychologically Necessary services for substance abuse and related mental health conditions include detoxification and rehabilitative services in a CareFirst BlueChoice designated program.

D. Other covered medical and medical Ancillary Services for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Partial hospitalization provided through a Qualified Partial Hospitalization Program.

III. Schedule of Benefits, Section 6, Mental Health and Substance Abuse Services, is deleted and replaced as follows:

Service	Limit on Benefits	Member Payment
SECTION 6 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Mental Health and Substance Abuse Services		
Office Visits	Number of visits not limited	No Copay or Coinsurance
Outpatient Facility	Number of visits not limited	No Copay or Coinsurance
Professional Services Provided at an Outpatient Facility	Number of visits not limited	No Copay or Coinsurance
Medication Management Office Visits	Number of visits not limited	No Copay or Coinsurance
Methadone Maintenance	Number of visits not limited	No Copay or Coinsurance
Inpatient Mental Health and Substance Abuse Services		
Inpatient Mental Health and Substance Abuse Facility Services	Number of days not limited	Benefits are available to the same extent as benefits provided for inpatient hospital services for treatment of other illnesses.
Inpatient Mental Health and Substance Abuse Professional Services	Number of visits not limited	Benefits are available to the same extent as benefits provided for inpatient medical or surgical care at an inpatient hospital for treatment of other illnesses.
Partial Hospitalization Program		
Partial Hospitalization Program Facility Services	Number of visits not limited.	No Copay or Coinsurance

Service	Limit on Benefits	Member Payment
Professional Services Provided in a Partial Hospitalization Program	Number of visits not limited.	No Copay or Coinsurance

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

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MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AMENDMENT REVISED

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

I. The introduction to Section 6, Mental Health and Substance Abuse Services, of the Description of Covered Services, is deleted and replaced with the following:

SECTION 6
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physician's offices or in other CareFirst BlueChoice approved facilities	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.
In a CareFirst BlueChoice approved hospital or Qualified Substance Abuse Treatment Facility, when admitted under the care of a Contracting Physician.	Coverage for the services listed below. The coverage is subject to the limitations, if any, described in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

II. Section 6.2, Outpatient Mental Health and Substance Abuse Services, of the Description of Covered Services is deleted and replaced with the following:

6.2 Outpatient Mental Health and Substance Abuse Services. CareFirst BlueChoice will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the Medical Necessity and appropriateness of the services. CareFirst BlueChoice will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment. Benefits will be provided for:

A. Coverage of mental illness, emotional disorders, drug abuse and alcohol abuse is provided for Medically or Psychologically Necessary evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse and drug abuse will be covered in the same manner as medication management visits for physical illnesses and will not be counted as outpatient mental health or substance abuse treatment visits. Members are not required to obtain prior authorization for methadone maintenance treatment.

C. Coverage of Medically or Psychologically Necessary services for substance abuse and related mental health conditions include detoxification and rehabilitative services in a CareFirst BlueChoice designated program.

D. Other covered medical and medical Ancillary Services for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Partial hospitalization provided through a Qualified Partial Hospitalization Program.

III. Schedule of Benefits, Section 6, Mental Health and Substance Abuse Services, is deleted and replaced as follows:

Service	Limit on Benefits	Member Payment
SECTION 6 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Mental Health and Substance Abuse Services		
Office Visits	Number of visits not limited	Benefits are available to the same extent as benefits provided for office visits for treatment of other illnesses in a Primary Care Physician's office
Outpatient Facility	Number of visits not limited	No Copay or Coinsurance
Professional Services Provided at an Outpatient Facility	Number of visits not limited	No Copay or Coinsurance
Medication Management Office Visits	Number of visits not limited	Benefits are available to the same extent as benefits provided for office visits for treatment of other illnesses in a Primary Care Physician's office
Methadone Maintenance	Number of visits not limited	No Copay or Coinsurance
Inpatient Mental Health and Substance Abuse Services		
Inpatient Mental Health and Substance Abuse Facility Services	Number of days not limited	Benefits are available to the same extent as benefits provided for inpatient hospital services for treatment of other illnesses.
Inpatient Mental Health and Substance Abuse Professional Services	Number of visits not limited	Benefits are available to the same extent as benefits provided for inpatient medical or surgical care at an inpatient hospital for treatment of other illnesses.
Partial Hospitalization Program		
Partial Hospitalization Program Facility Services	Number of visits not limited.	No Copay or Coinsurance

Service	Limit on Benefits	Member Payment
Professional Services Provided in a Partial Hospitalization Program	Number of visits not limited.	No Copay or Coinsurance

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

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WOMEN'S PREVENTIVE HEALTH SERVICES AMENDMENT REVISED

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

I. Section 1.1.L of the Description of Covered Services is deleted and replaced with the following:

L. Family Planning Services.

1. Covered Benefits.

a) Contraceptive counseling. Patient education and counseling for all female Members with reproductive capacity.

b) Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that is approved by the FDA, for use by women, as a contraceptive.

c) Benefits will also be provided for contraceptive devices or drugs that are approved by the FDA, for use by women, as a contraceptive that must be administered to the Member in the course of a covered outpatient or inpatient treatment.

d) Elective sterilization services. See the Schedule of Benefits for benefit limitations, if any.

2. Limitations

Contraceptive devices and drugs that do not require administration by or under the direction of a physician or drugs and devices that can be self-administered by the patient or an average individual who does not have medical training are not covered under the Description of Covered Services. Benefits for contraceptive devices and drugs that do not require administration by or under the direction of a physician or drugs and devices that can be self-administered by the patient or an average individual who does not have medical training may be covered under the Prescription Drug Benefits Rider purchased by the Group and attached to this Evidence of Coverage.

II. Section 1.7 of the Description of Covered Services is deleted and replaced with the following:

1.7 Maternity Services.

A. Preventive Services

1. Routine outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one post-partum office visit;

2. Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the

current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration, including screening for gestational diabetes; and

3. Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B," the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening.

4. Breastfeeding support, supplies and consultation.

5. These services, except for breastfeeding equipment, are covered without any Deductible, Copayment or Coinsurance. Breastfeeding equipment is covered as stated in the Schedule of Benefits.

B. Non-Preventive Services.

1. Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including prenatal and post-partum office visits and Ancillary Services provided during those visits, including Medically Necessary laboratory tests and diagnostic services.

2. Birthing classes, one course per pregnancy, at a CareFirst BlueChoice approved facility.

3. Coverage for a hospital stay, including professional services for delivery.

4. Coverage for care rendered at a CareFirst BlueChoice approved licensed birthing center.

5. Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section 2.6 in the Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent Child.

6. Elective abortion.

C. Postpartum Home Visits. See Section 4.4C., Home Health Services.

III. Schedule of Benefits– Outpatient and Office Services, Maternity Care section, the following text is added to the "Limit on Benefits" column:

Preventive prenatal services as stated in the Description of Covered Services, other than breastfeeding equipment, are covered without any Deductible, Copayment or Coinsurance. Breastfeeding equipment is covered as separately stated in this Schedule of Benefits.

IV. The Schedule of Benefits is amended to add the following:

Service	Limit on Benefits	Member Payment
Contraceptive Methods and Counseling for Women	Benefits available to female Members with reproductive capacity, only.	No Copayment or Coinsurance
Breastfeeding Equipment	In conjunction with each birth	No Copayment or Coinsurance

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

[Name]
[Title]

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PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

A. Definitions

The following definitions have the following meaning in this amendment:

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Essential Health Benefits has the meaning found in section 1302 of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with CareFirst BlueChoice to provide health care services to Members.

B. Annual Dollar Limits

Any annual dollar limit on Essential Health Benefits in the Evidence of Coverage is deleted. The annual dollar limitation on hair prostheses shall not be affected by this amendment.

C. Rescission

Any provision of the Evidence of Coverage that describes the right of CareFirst BlueChoice to rescind or void the Evidence of Coverage is amended to permit CareFirst BlueChoice to rescind or void the coverage of a Member only if (1) the Member performs an act, practice, or omission that constitutes fraud; or (2) the Member makes an intentional misrepresentation of material fact.

Any provision of the Evidence of Coverage that provides for a notice of rescission of coverage is amended to provide 30-days advance written notice of any rescission of coverage.

D. Preventive Services

In addition to any other preventive benefits provided in the Evidence of Coverage, CareFirst BlueChoice shall cover the following preventive services and shall not impose any cost-sharing requirements, such as Deductibles or Copayment or Coinsurance amounts to any Member receiving any of the following benefits for services received from participating providers:

1. Evidenced-based items or services that have in effect a rating of "A" or "B' in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

CareFirst BlueChoice shall update new recommendations to the preventive services listed above pursuant to the schedule established by the Secretary of the United States Department of Health and Human Services.

E. Emergency Services

Any provision of the Evidence of Coverage that provides benefits with respect to services in an emergency department of a hospital is amended to provide Emergency Services:

1. Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Participating Provider;

2. Without regard to whether the health care provider furnishing the Emergency Services is a participating provider with respect to the services; and

3. If the Emergency Services are provided by a Non-Participating Provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from participating providers.

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

CareFirst BlueChoice, Inc.

[Signature]

[Name]
[Title]