CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE AMENDMENT

CareFirst of Maryland, Inc., doing business as CareFirst BlueCross BlueShield (hereafter referred to as "CareFirst") hereby issues this Evidence of Coverage Amendment (the "Amendment") to:

State of Maryland (SLEOLA)

(Hereafter referred to as "Group")

The Exclusive Preferred Option Evidence of Coverage for the contract year July 1, 2012 through June 30, 2013 is amended as follows effective July 1, 2013.

Deleting the "Benefit Period" definition from the Definitions section and replacing it with the following:

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: July 1st through December 31st.

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Adding the following section immediately after the Inter-Plans Arrangements Disclosure section of the Evidence of Coverage:

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs);
2. Medical Devices and Supplies; and
3. Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care).

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider/BlueCard PPO Network Provider/BlueCard Traditional Network Provider.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	**The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:**	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: • Shipped to; or • Purchased at a retail store.	
Specialty Prescription Drugs	Ordering/prescribing physician is located.	

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Deleting the "Allowed Benefit" definition from the Definitions section and replacing it with the following:

Allowed Benefit means:

1. Contracted Health Care Provider: For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. For a Health Care Provider that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is, as follows:

    a. Non-contracted health care practitioner: For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.

    b. Non-contracted hospital or health care facility: For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.

3. Non-contracted Emergency Services Health Care Provider: CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:

    a. The Allowed Benefit stated in paragraph 2., above.

    b. The amount negotiated with Contracted Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Contracted Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

    c. The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Contracted Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

d. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

Deleting the "Over-the-Counter" definition from the Definitions section and replacing it with the following:

Over-the-Counter means any item or supply, as determined by CareFirst that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

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Deleting the Habilitative Services paragraph from the Rehabilitative and Habilitative Services subsection of the Description of Covered Services section and replacing it with the following:

Habilitative Services (Dependent child under the age of 19)
Benefits are available for Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect to enhance the Dependent child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder, cerebral palsy, intellectual disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disability.

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Deleting the following exclusion from the Exclusions section:

- Contraceptive devices and drugs, including insertion or removal and related examination unless otherwise stated.

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Deleting the following exclusion from the Exclusions section and replacing it with the following:

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; family planning and contraception products; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

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Deleting in its entirety the Prescription Drug subsection of the Description of Covered Services section and replacing it with the following:

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs.	**Contraceptives**: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.
Contraceptives: Benefits are available for Pharmacy-dispensed injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider.	**Contraceptives**: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.

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Deleting in its entirety the Preventive and wellness services table and replacing it with the following:

<table>
<tr><th>Covered Service</th><th>CareFirst Payment: In-Network</th></tr>
<tr><td rowspan="2">Preventive and wellness services</td><td>Limitations
Benefits for child preventive and routine care are limited to twelve (12) visits for Members newborn through thirty-six (36) months, and one (1) visit per Benefit Period for Members aged three (3) years old through twenty-one (21) years old.

Benefits for adult preventive care are limited to one visit per Benefit Period.

Benefits for Human Papillomavirus testing are limited to one (1) screening every three (3) years for Members thirty (30) years old and older.

Benefits for counseling for sexually transmitted infections are limited to one (1) visit per Benefit Period.</td></tr>
<tr><td>Primary purpose of the office visit is preventive and wellness services</td></tr>
<tr><td>Child preventive and routine care (newborn through age 21)</td><td rowspan="11">Office visit and related preventive and wellness services, regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider

100% of Allowed Benefit</td></tr>
<tr><td>Well child immunizations</td></tr>
<tr><td>Child related diagnostic services</td></tr>
<tr><td>Adult preventive and routine gynecological care (for a Member 22 years of age or older)</td></tr>
<tr><td>Adult immunizations</td></tr>
<tr><td>Adult related diagnostic services</td></tr>
<tr><td>Chlamydia and Human Papillomavirus Screening</td></tr>
<tr><td>Breast Cancer Screening</td></tr>
<tr><td>Osteoporosis Prevention</td></tr>
<tr><td>Prostate Cancer Screening</td></tr>
</table>

Deleting in its entirety the Maternity and Newborn Care table from the Schedule of Benefits and and replacing it with the following:

Covered Service	CareFirst Payment
	In-Network
Maternity services and newborn care	Benefits are provided for the following: • Subscriber • Spouse • Dependent children. Benefits for gestational diabetes screening are available between 24-28 weeks gestation.
	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; breastfeeding supplies and equipment	**Limitations** Benefits for breast pump rentals are only covered when provided by In-Network Durable Medical Equipment providers. The breast pump supplies are excluded.
	No Deductible required 100% of Allowed Benefit

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Deleting the "Contraceptive Exam, insertion and removal" row from the Schedule of Benefits and replacing it with the following:

Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit

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Deleting the "Elective Sterilization" row from the Schedule of Benefits and replacing it with the following:

Female elective sterilization	No Deductible required 100% of Allowed Benefit
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.

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Deleting its entirety the Prescription Drugs table from the Schedule of Benefits and replacing it with the following:

Covered Service	CareFirst Payment
	In-Network
Prescription Drugs	
Prescription Drugs	**Limitations** Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.
	Benefits are available to the same extent as benefits provided for other illnesses.
Injectable Prescription Drugs that require administration by a Health Care Provider Prescription Drug contraceptives and contraceptive devices	Benefits are available to the same extent as benefits provided for other illnesses.
Injectable Prescription Drug contraceptives and contraceptive devices	Benefits are available to the same extent as benefits provided for other illnesses.

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This amendment is issued to be attached to the Evidence of Coverage. All remaining terms and conditions of the Group Contract shall remain in full force and effect. Where the provisions of this amendment and the Evidence of Coverage vary, the provisions of this amendment will prevail over the Evidence of Coverage. Where the provisions of this amendment and a previously effective amendment vary, the provisions of this amendment will prevail.