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

An independent licensee of the Blue Cross and Blue Shield Association

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]