Piedmont Community Healthcare HMO, Inc.
2316 Atherholt Rd., Lynchburg, VA 24501

AMENDMENT

As of the effective date of the Evidence of Coverage, this amendment becomes part of Your Evidence of Coverage and amends Your Schedule of Benefits. It is issued in exchange for payment of Premium to Piedmont on Your behalf.

Schedule of Benefits

Prescription Drugs

Deductible

Allowable Charges for Covered Services for Prescription Drug services are subject to Your Deductible. This means that Piedmont applies the Allowable Charges for covered Prescription Drug services that You receive, both as an Inpatient or Outpatient, toward Your Deductible in the same manner as Piedmont applies Allowable Charges for other Covered Services, provided that the claims for the services are submitted in the manner that the Evidence of Coverage requires. The Evidence of Coverage explains Your Deductible and Our claims submission requirements. When Your Deductible is satisfied, You pay the Copayments listed in the next paragraph for covered Outpatient Prescription Drug services.

Copayments or Coinsurance for Outpatient Prescription Drug Services

Once You satisfy the Deductible, You pay the following Copayments or Coinsurance for the covered Outpatient Prescription Drug services that You receive for the remainder of the period to which the Deductible applies (typically a Benefit Year):

Retail 30	Tier 1 – Generic	$10 Copayment
(up to 30-day or	Tier 2 – Preferred Brand Name	$40 Copayment
(100 unit supply)	Tier 3 - Non-Preferred Brand Name	$70 Copayment
	Tier 4 – Specialty	20% Coinsurance Up to $300 maximum per script
Retail 90	Tier 1 – Generic	$25 Copayment
(90-day or	Tier 2 – Preferred Brand Name	$100 Copayment
(300 unit supply)	Tier 3 - Non-Preferred Brand Name	$175Copayment
	Tier 4 – Specialty	Not Available
Mail Order 90	Tier 1 – Generic	$25 Copayment
(90-day or	Tier 2 – Preferred Brand Name	$100 Copayment
(300 unit supply)	Tier 3 - Non-Preferred Brand Name	$175Copayment
	Tier 4 – Specialty	Not Available

[1] Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy

Note: When Prescription Drugs are purchased from a non-participating Out-of-Network retail Pharmacy who has previously agreed in writing on its own behalf or through an intermediary to accept reimbursement for its services at rates applicable to participating In-Network retail Pharmacies, You will not be required to make payment for the full cost of the drug at point of service; You will only be required to make any Copayment or other applicable charge that is consistently imposed for In-Network retail Pharmacies. **In all other cases, Prescription Drugs purchased from a non-participating Out-of-Network retail Pharmacy are Not Covered.**

Note: The Cost-Sharing payment for a covered Prescription insulin Drug is limited to a $50 maximum per 30-day supply, and any Deductible is waived.

Out-of-Pocket Limit

Allowable Charges that You pay for covered Prescription Drug services are applied toward Your Out-of-Pocket Limit. This means that We will apply the Allowable Charges that You pay for covered Prescription Drug services, both as part of the Deductible or as a Copayment, toward Your Out-of-Pocket Limit in the same manner that We apply the Allowable Charges that You pay for other Covered Services, provided that the claims for the services are submitted as the Evidence of Coverage requires. The Evidence of Coverage explains Your Out-of-Pocket Limit and Our claims submission requirements. When You (or Your other family members, if a Family Unit Out-of-Pocket Limit applies) reach the Out-of-Pocket Limit, covered Prescription Drug services are paid at 100% of Allowable Charges for the remainder of the period to which the Out-of-Pocket Limit applies (typically a Benefit Year).