

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

Annual Deductible \$0/Person
 \$0/Family Unit

Retail 30 (up to 30-day or 100 unit supply)	Tier 1 – Generic	\$15 Copayment
	Tier 2 – Preferred Brand Name	\$50 Copayment
	Tier 3 – Non-Preferred Brand Name	\$85 Copayment
	Tier 4 – Specialty ¹	20% Coinsurance up to \$300 maximum per script

Retail 90 (90-day or 300 unit supply)	Tier 1 – Generic	\$38 Copayment
	Tier 2 – Preferred Brand Name	\$125 Copayment
	Tier 3 – Non-Preferred Brand Name	\$213 Copayment
	Tier 4 – Specialty ¹	Not Available

Mail Order 90 (90-day or 300 unit supply)	Tier 1 – Generic	\$38 Copayment
	Tier 2 – Preferred Brand Name	\$125 Copayment
	Tier 3 – Non-Preferred Brand Name	\$213 Copayment
	Tier 4 – Specialty ¹	Not Available

¹ Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy, unless another Pharmacy or its intermediary has sent previous notification to plan or PBM of its agreement to accept reimbursement for its services at rates applicable to the PBM'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.

“Generic Drugs” means non-brand drugs (including specialty drugs and therapeutic biological products), sold at a lower cost. A generic drug is the therapeutic equivalent of a brand name drug, i.e. contains the same active

ingredients and is identical in strength, concentration, and dosage form.

“Preferred Drugs” are brand name drugs (including specialty drugs and therapeutic biological products) listed on the formulary as 2nd tier drugs. These drugs have been reviewed by a Pharmacy and Therapeutics Committee to insure high standards for clinical efficacy and safety. These are the lower cost brand name drugs in a therapeutic category.

“Non-Preferred Drugs” are brand name drugs (including specialty drugs and therapeutic biological products) listed on the formulary as 3rd tier drugs. These drugs are classified as higher cost drugs in a therapeutic category. Non-preferred products are usually those for which there is a preferred alternative or generic option available.

“Specialty Drugs” are higher cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions and are on the formulary as 4th tier drugs. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. The specialty pharmacy will fill only 30-day retail and mail order prescriptions; 90-day retail and 90-day mail order prescriptions are Not Available.

AD = After Deductible