

## SUMMARY of MATERIAL MODIFICATION

### AMENDMENT # 1

to the

### NATIONAL FRANCHISEE ASSOCIATION HEALTH +

### MINIMUM ESSENTIAL COVERAGE PLAN

The National Franchisee Association Health + Minimum Essential Coverage Plan is hereby amended, effective 05/01/15. This amendment affects all claims for services incurred on or after the effective date of this amendment. The terms of this amendment are as follows:

- I. The “General Information” section will be replaced in its entirety with the attached.
- II. The “Preferred Plan Schedule of Benefits” will be deleted in its entirety.
- III. The “Choice Plan Schedule of Benefits” will be replaced in its entirety with the attached.
- IV. The “Reinstatement of Coverage” section will be replaced in its entirety with the following:

#### REINSTATEMENT OF COVERAGE

If coverage terminates due to termination of employment and the employee returns to work within 91 days after the date of termination, the employee may (depending on the method by which the Plan Sponsor determines employee eligibility for Plan benefits under the Employer Shared Responsibility Regulations) be eligible for reinstatement of coverage as soon as administratively practicable following the date on which the employee returns to work. If the Plan Sponsor is an educational institution, if coverage terminates due to termination of employment, and the employee returns to work within 182 days of the date of termination, the employee may (depending on the method by which the Plan Sponsor determines employee eligibility for Plan benefits under the Employer Shared Responsibility Regulations) be eligible for reinstatement of coverage as soon as administratively practicable following the date on which the employee returns to work. In each case, when the employee returns to work, the employee’s coverage (if any) will be on the same basis as that being provided on the date of the employee’s termination. However, any limitations on the employee’s coverage which were in effect before the employee’s termination will continue to apply. If the employee does not return to work within the periods set forth above, or if coverage terminates for any reason except termination of employment, the employee will be treated as a new employee.

- V. Under the “Plan Details” section, the following item will be added in its entirety:

**Inpatient Pre-Admission Certification Penalty (only applies to Choice Plan option):** The Plan requires that all non-emergency hospital admissions be pre-certified and authorized by the Contract Administrator. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the employee or dependent be admitted to a hospital, **it is the employee’s responsibility** to notify the Plan and to obtain pre-certification and authorization of the hospital admission. **It is the employee’s responsibility** to be sure that in the event of an **emergency admission**, the Contract Administrator is notified within **forty-eight (48)** hours. In the event that an employee or dependent incur expenses for services which have not been pre-certified and authorized, a thorough review will be conducted of the services to determine medical necessity at the point of claim. If the review process identifies care which is not medically necessary, services will not be covered under the Plan.

In order for the Plan to approve the inpatient stay, the attending physician must certify to the Contract Administrator that, in the physician's professional opinion, the stay is necessary for the condition. The Plan reserves the right to request an independent medical opinion by a physician of the Plan's choice.

**VI. Under the "Plan Details" section, the corresponding items will be replaced in their entirety:**

**Preventive Services:** Charges for preventive care services are covered expenses. Please see page 8 and 9 for a list of services. The list of preventive care services covered under this benefit may change periodically based upon the recommendation of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Information on the recommendations of these agencies can be found at: <https://www.healthcare.gov/preventive-care-benefits/>. Please see the applicable "Schedule of Benefits" to determine payment level.

**Retail Prescription Drug Program:** The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty (30) day supply. The Plan pays up to the amounts listed below.

**Basic Plan:**

<u>Generic</u>	<u>Preferred Brand</u>	<u>Non-Preferred Brand</u>
Plan pays \$10/script	Plan pays \$25/script	Plan pays \$40/script

**Choice Plan:**

<u>Generic</u>	<u>Preferred Brand</u>	<u>Non-Preferred Brand</u>
Plan pays \$15/script	Plan pays \$75/script	Plan pays \$100/script

A list of participating pharmacies can be obtained by visiting [www.magellanrx.com](http://www.magellanrx.com).

Prescriptions purchased at non-participating pharmacies are not covered expenses.

Compound drugs that are not available from a participating pharmacy will be considered a covered expense subject to the applicable benefit listed above.

When filling a prescription for which a generic drug is available and the covered person chooses the brand name drug, the covered person will be responsible for the difference in cost between the generic and the brand name drug.

All prescribed FDA approved generic oral contraceptives for women are covered at 100% when received from a participating pharmacy or in-network provider. The brand version will be covered at 100% when received from a participating pharmacy or in-network provider only if medically necessary or a generic equivalent is not available.

Some prescription drugs may be subject to quantity limits, based on criteria developed by the Prescription Benefit Manager or upon Food and Drug Administration (FDA) approved dosing and usage guidelines. The same quantity limit requirements apply to both mail order and retail pharmacies.

**Mail Order Maintenance Prescription Drug Program:** Maintenance drugs to treat illnesses should be purchased through the mail order program. These illnesses usually include: diabetes, epilepsy, anemia, chronic constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply. The Plan pays up to the amounts listed below.

**Basic Plan:**

<u>Generic</u> Plan pays \$10/script	<u>Preferred Brand</u> Plan pays \$25/script	<u>Non-Preferred Brand</u> Plan pays \$40/script
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**Choice Plan:**

<u>Generic</u> Plan pays \$15/script	<u>Preferred Brand</u> Plan pays \$75/script	<u>Non-Preferred Brand</u> Plan pays \$100/script
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**VII. Under the “Medical Covered Expenses” section, the corresponding items will be replaced in their entirety:**

28. **Preventive Care:** Charges for routine physical examinations, well-baby care, and well-adult care are covered expenses. Charges can include examinations (including breast and pelvic), gynecological exams, immunizations, vaccinations, inoculations, consultations, routine x-ray and laboratory services (e.g. cholesterol screenings, TSH, resting EKG’s, fecal occult blood tests and double contrast barium enemas), pap smears (including laboratory fees), routine vision exams including refractions, x-rays, mammograms, prostate cancer screenings (including PSA tests and digital rectal exams), sterilization procedures for women, and EKG’s. The list of preventive care services covered under this benefit may change periodically based upon the recommendation of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Information on the recommendations of these agencies can be found at: <https://www.healthcare.gov/preventive-care-benefits/>.
32. Charges for smoking cessation treatment to include counseling, office visits, prescription and over-the-counter medication will be covered at 100% when received from an In-Network provider or participating pharmacy. Prescription and over-the-counter smoking cessation aids will be covered under the prescription drug plan.
35. Charges for non-narocotic analgesics for the treatment of migraines (e.g. Amerge, Frova, Imitrex, Maxalt, Relpax, and Zomig).
36. Charges for female libido enhancement drugs and male impotence medications, including Viagra.
37. Charges for Stadol Nasal Spray.
39. Charges for Prozac Weekly. Prior authorization may apply.



## GENERAL INFORMATION

**Plan Sponsor:**

**Federal Tax Identification Number:** [PLACE STICKER HERE]

**Name of the Plan:**

**Plan Number:**

**Plan Administrator:** Plan Sponsor, acting through its exclusive agent, Allison Hazen, Trustee of the NFA Member Plan Master Trust and exclusive agent of the Sponsor:  
61 Overlook Drive  
South Burlington, VT 05403-7887  
Phone: 802-865-5291  
Cell: 802-922-3548

**Group Number:** 50704

**Benefits Covered:** Medical benefits under the National Franchisee Association Health + Minimum Essential Coverage Plan

**Plan Effective Date:** May 1, 2014

**Plan Anniversary Date:** May 1<sup>st</sup>

**Plan Year Ends:** April 30<sup>th</sup>

**Contract Administrator/Pre-Certification Administrator:**

Comprehensive Benefits Administrator, Inc. dba CBA Blue  
P.O. Box 2365  
South Burlington, VT 05407-2365  
Customer Service & Pre-Certification: (888) 222-9206

**Agency for Service of Legal Process:** Allison Hazen, Trustee of the NFA Member Plan Master Trust and exclusive agent of the Sponsor  
61 Overlook Drive  
South Burlington, VT 05403-7887  
Phone: 802-865-5291  
Cell: 802-922-3548

**Contributions:** The Plan is contributory.

**Eligibility Requirements:** All employees working an average of twenty (20) hours or more per week.

The Plan Sponsor will identify those employees who have performed sufficient hours of service to be considered “full-time” employees eligible to participate in the Plan. To do so, the Plan Sponsor may use any method permitted by the final “Employer Shared Responsibility” regulations issued by the IRS and the Department of Treasury (the Employer Shared Responsibility Regulations) under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). Depending on the Plan Sponsor's application of the Employer Shared Responsibility Regulations, in certain circumstances, an employee may be eligible for coverage under the Plan during periods in which the employee performed fewer than thirty (30) hours of service per week. Contact the Plan Sponsor if you have questions about your eligibility to receive coverage under the Plan.

**Dependent Children's Coverage:** Married or unmarried dependent children up to twenty-six (26) years of age.

**Eligibility Date:** First day of the month following sixty (60) days of continuous employment unless the waiting period is waived as a condition of employment.

**Termination Date:** See “Termination of Benefits” section.



## National Franchisee Association Health+ Choice Plan

Benefit	
<b>INPATIENT CARE (PER DIEM BENEFIT)</b>	
<b>Daily Hospital Confinement</b> Requires pre-certification.	Plan pays \$2,000 per day \$4,000 per day for ICU
<b>Inpatient Mental Health/Substance Abuse</b> Requires pre-certification.	Plan pays \$200 per day
<b>Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility</b> Requires pre-certification.	Plan pays \$200 per day
<b>Anesthesia Services</b>	Plan pays \$300 per day
<b>SURGERY (PER SURGERY BENEFIT)</b>	
<b>Inpatient</b>	Plan pays \$3,000 per surgery
<b>Outpatient</b>	Plan pays \$2,000 per surgery
<b>Office Visit</b>	Plan pays \$175 per surgery
<b>PHYSICIAN'S SERVICES (PER VISIT BENEFIT)</b>	
<b>Preventive Care (only covered when received from an in-network provider)</b>	Plan pays 100% See Schedule on page 8
<b>Physician's Office Visits (Non-Wellness)</b>	Plan pays \$60 per visit
<b>Specialist Office Visits (Non-Wellness)</b>	Plan pays \$80 per visit
<b>Chiropractic Care</b>	Plan pays \$35 per visit
<b>Outpatient Physical Therapy</b>	Plan pays \$35 per visit
<b>EMERGENCY CARE</b>	
<b>Ambulance Services</b>	Plan pays \$150 (Ground) \$750 (Air)



## National Franchisee Association Health+ Choice Plan

<b>EMERGENCY CARE continued</b>	
<b>Emergency Room Services</b>	Plan pays \$200 per visit
<b>Urgent Care Services</b>	Plan pays \$60 per visit
<b>OUTPATIENT DIAGNOSTIC IMAGING (PER SERVICE BENEFIT)</b>	
<b>Labs</b>	Plan pays \$15 per service
<b>X-Ray/Ultrasound</b>	Plan pays \$75 per service
<b>PET</b>	Plan pays \$225 per service
<b>CT Scan</b>	Plan pays \$300 per service
<b>MRI</b>	Plan pays \$500 per service
<b>PRESCRIPTION DRUGS – 30 DAY SUPPLY RETAIL; 90 DAY SUPPLY MAIL ORDER (PER SCRIPT BENEFIT)</b>	
<b>Prescription Drug Benefits</b>	Plan pays up to \$15 per script - Generic Plan pays up to \$75 per script - Preferred Brand Plan pays up to \$100 per script – Non-Preferred Brand

### NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit. Preventive care benefits are only covered when received from an in-network provider.
3. All other benefits not listed above will not be covered.
4. The Plan pays up to the dollar amount listed on the Schedule of Benefits. With the exception of prescription drug benefits, if reimbursement to the provider totals less than the dollar amounts listed, the covered person will be reimbursed the difference.