SUMMARY of MATERIAL MODIFICATION

AMENDMENT # 1

to the

NATIONAL FRANCHISEE ASSOCIATION

HEALTH + MEDICAL PLAN

The National Franchisee Association Health + Medical 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 "Schedule of Benefits" section will be replaced in its entirety with the attached.

III. 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.

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

Preventive Services: Charges for preventive care services are covered expenses. Charges can include routine physical 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), x-rays, routine vision exams including refraction, mammograms, prostate cancer screenings (including PSA tests and digital rectal exams), and sterilization procedures for women. 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.

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. Please see the applicable "Schedule of Benefits" to determine payment level.

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 paying the brand name drug copayment plus the difference in cost between the generic and the brand name drug.

Specialty Pharmacy medications are recommended to manage specific high cost medications. Services include access to, and support for, most pharmaceutical and biologic products that have high acquisition costs, are difficult to manage, and present reimbursement challenges. These medications are payable at 80% to a maximum of $150 copayment per prescription.

There is no copayment for Prilosec OTC™ and OTC Loratadine, however, a physician's prescription is required.

There is no copayment for OTC Zaditor® and Alaway®, however, a physician's prescription is required.

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.

When applicable, the retail and mail order prescription plan year deductible is combined for both retail and mail order prescriptions.

Step Therapy Program: The Plan has implemented a Step Therapy program in order to control overall plan costs and to assure members access to clinically appropriate medications to treat all conditions.

The Step Therapy program establishes an order of drug therapy options within select categories for covered persons to follow that may affect their access to, and out-of-pocket costs for, medications covered under the Step Therapy program.

The Step Therapy program ensures that the covered person receives clinically appropriate, cost-effective medication based on their prescription history. Step Therapy guidelines maintain open access for covered persons and encourages the utilization of lower cost medications.

The order of medication usage will include generic and selected over-the-counter drugs first at the lowest copayments for the covered person to preferred brand name drugs at the middle copayment, and finally non-preferred brand name drugs at the highest copayment. The goal of the Plan is to achieve successful treatment outcomes at the most efficient cost to the plan.

The covered person will receive communication from Magellan or their pharmacist if a prescription is written for them in one of the covered categories listed above.

V. Under the "Medical Covered Expenses" section, the corresponding items will be replaced in their entirety:

37. **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/.

44. 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.

52. Charges for non-naroctic analgesics for the treatment of migraines (e.g. Amerge, Frova, Imitrex, Maxalt, Relpax, and Zomig).

53. Charges for female libido enhancement drugs and male impotence medications, including Viagra.

54. Charges for Stadol Nasal Spray.

56. Charges for Prozac Weekly. Prior authorization may apply.

VI. Under the "Miscellaneous Provisions" section, the following item will be added in its entirety:

Assignments of Benefits: The covered person cannot assign any benefit or monies due from this health plan to any person, corporation, or other organization without the Contract Administrators written consent. Any assignment by the covered person will be void. Assignment means the transfer of the covered person's rights to the benefits provided by this health plan to another person or organization. There is one exception. If Medicaid has already paid the health plan provider, the covered person can assign their benefits to Medicaid.

VII. Under the "Definitions" section, the corresponding item will be replaced in its entirety:

Out-of-Pocket Maximum: Under the terms of this Plan, the maximum amount any individual covered under the Plan would be required to pay toward the maximum allowable benefit on all covered expenses during a plan year. The out-of-pocket maximum will be determined by adding the medical deductible, prescription drug deductible, employee share of coinsurance amounts, medical and prescription drug copayments as set forth by this Plan.

APPROVED AND ACCEPTED

This Plan Amendment # 1 to the National Franchisee Association Health + Medical Plan, is hereby executed:

South Burlington, VT on 5/15/2015

(City) (State) (Date)

BY: _____

Trustee

(Title)

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 + Medical Plan

Plan Effective Date: May 1, 2010

Plan Anniversary Date: May 1st

Plan Year Ends: April 30th

Plan Revision Date: May 1, 2014 – This document replaces the previous Employee Health Plan Document in its entirety. All claims incurred prior to May 1, 2014 will be governed by the terms of the Plan in effect prior to this revision date.

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 salaried employees and all full-time hourly employees working an average of thirty (30) hours 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 + Medical Plan
Schedule of Medical Benefits
Platinum Choice Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$500 per individual $1,000 per family	$1,000 per individual $2,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$1,050 per individual $2,100 per family	$2,100 per individual $4,200 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	$20 copayment for PCP $30 copayment for specialist	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of $3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$30 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$40 copayment	Deductible; 60%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Platinum Choice Plan

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	$150 copayment, deductible; then 80%	$150 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible, 60%
Inpatient Hospital Services:	$200 copayment per visit; then deductible and 80%	$200 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$200 copayment per visit; then deductible and 80%	$200 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care	$200 copayment per visit; then deductible and 80%	$200 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$20 PCP/$30 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible, 60%
Dialysis Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$200 copayment per visit; then deductible and 80%	$200 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$20 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $10 copayment Preferred Brand: $30 copayment Non-Preferred Brand: $55 copayment	Not Covered

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Platinum Choice Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $20 copayment Preferred Brand: $60 copayment Non-Preferred Brand: $110 copayment	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $50 individual/$100 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Gold Basic Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$1,000 per individual $2,000 per family	$2,000 per individual $4,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$5,750 per individual $11,500 per family	$11,500 per individual $23,000 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $25 copayment Specialist: $45 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of $3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$45 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$45 copayment	Deductible; 60%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Gold Basic Plan

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	$200 copayment, deductible; then 80%	$200 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Inpatient Hospital Services:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$25 PCP/$45 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$25 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $20 copayment Preferred Brand: $45 copayment Non-Preferred Brand: $75 copayment	Not Covered

CBA Blue

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Gold Basic Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Preferred Brand: $90 copayment Non-Preferred Brand: $150 copayment	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $50 individual/$100 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Gold Preferred Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$1,500 per individual $3,000 per family	$3,000 per individual $6,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$2,750 per individual $5,500 per family	$5,500 per individual $11,000 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $20 copayment Specialist: $30 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of $3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$30 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$40 copayment	Deductible; 60%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Gold Preferred Plan

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	$150 copayment, deductible; then 80%	$150 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Inpatient Hospital Services:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$20 PCP/$30 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis: Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$20 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $20 copayment Preferred Brand: $45 copayment Non-Preferred Brand: $75 copayment	Not Covered

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Gold Preferred Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Preferred Brand: $90 copayment Non-Preferred Brand: $150 copayment	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $50 individual/$100 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Silver Basic Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$3,000 per individual $6,000 per family	$6,000 per individual $12,000 per family
Plan Coinsurance:	70%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$6,600 per individual $13,200 per family	$13,200 per individual $26,400 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $30 copayment Specialist: $60 copayment	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	50% to a maximum of $3,000 per plan year; then deductible and 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 70%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$60 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 70%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 70%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 70%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 70%	Deductible; 50%
Urgent Care Services:	$75 copayment	Deductible; 50%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Silver Basic Plan

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	$250 copayment, deductible; then 70%	$250 copayment, in-network deductible; then 70%
Ambulance Services:	Deductible; 70%	In-Network deductible, then 70%
Anesthesiology Services:	Deductible; 70%	Deductible, 50%
Inpatient Hospital Services:	$300 copayment per visit; then deductible and 70%	$300 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$300 copayment per visit; then deductible and 70%	$300 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$300 copayment per visit; then deductible and 70%	$300 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	$30 PCP/$60 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 70%	Deductible; 50%
Durable Medical Equipment:	Deductible; 70%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 70%	Deductible; 50%
Dialysis: Maximum of 40 visits per plan year.	Deductible; 70%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$300 copayment per visit; then deductible and 70%	$300 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	$30 copayment	Deductible; 50%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply)	Deductible: $75 per individual/$150 per family per plan year; then 70% coinsurance	Not Covered

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Silver Basic Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $75 per individual/$150 per family per plan year; then 70% coinsurance	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 70% in-network and 50% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $75 individual/$150 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Silver Choice Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$2,000 per individual $4,000 per family	$4,000 per individual $8,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$6,600 per individual $13,200 per family	$13,200 per individual $26,400 per family
Preventive Services:	100%	Deductible; 60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: $30 copayment Specialist: $50 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of $3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 80%	Deductible; 60%
Chiropractic Care: Maximum of $1,000 per plan year.	$50 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	Deductible; 80%	Deductible; 60%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	$50 copayment	Deductible; 60%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Silver Choice Plan

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	$200 copayment, deductible; then 80%	$200 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible, 60%
Inpatient Hospital Services:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Inpatient Rehabilitation Hospital Care:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Prenatal Maternity Care:	$30 PCP/$50 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis: Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	$300 copayment per visit; then deductible and 80%	$300 copayment per visit; then deductible and 60%
Outpatient Mental Health/Substance Abuse:	$30 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $20 copayment Preferred Brand: $50 copayment Non-Preferred Brand: $80 copayment	Not Covered

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Silver Choice Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $40 copayment Preferred Brand: $100 copayment Non-Preferred Brand: $160 copayment	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $50 individual/$100 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Bronze Basic Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$5,500 per individual $11,000 per family	$11,000 per individual $22,000 per family
Plan Coinsurance:	50%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$6,600 per individual $13,200 per family	$13,200 per individual $26,400 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits:	Combined total of 1 visit paid at 100% (combined with urgent care); then subject to deductible; 50%	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	50% to a maximum of $3,000 per plan year; then deductible and 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 50%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$50 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 50%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 50%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 50%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 50%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 50%	Deductible; 50%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Bronze Basic Plan

Benefit	In-Network	Out-of-Network
Urgent Care Services:	Combined total of 1 visit paid at 100% (combined with PCP/specialist physician's office visits); then subject to deductible; 50%	Deductible; 50%
Emergency Room Services: Copayment waived if admitted.	$350 copayment, deductible; then 50%	$350 copayment, in-network deductible; then 50%
Ambulance Services:	Deductible; 50%	In-Network deductible, then 50%
Anesthesiology Services:	Deductible; 50%	Deductible; 50%
Inpatient Hospital Services:	$400 copayment per visit; then deductible and 50%	$400 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$400 copayment per visit; then deductible and 50%	$400 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$400 copayment per visit; then deductible and 50%	$400 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	Deductible; 50% applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 50%	Deductible; 50%
Durable Medical Equipment:	Deductible; 50%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 50%	Deductible; 50%
Dialysis: Maximum of 40 visits per plan year.	Deductible; 50%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$400 copayment per visit; then deductible and 50%	$400 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	Combined total of 1 visit paid at 100% (combined with physician's office visit and urgent care); then subject to deductible; 50%	Deductible; 50%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Bronze Basic Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Retail – 30 Day Supply)	Deductible: $200 per individual/$400 per family per plan year; then 50% coinsurance	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $200 per individual/$400 per family per plan year; then 50% coinsurance	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 50%.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $200 individual/$400 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Bronze Preferred Plan

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	$4,000 per individual $8,000 per family	$8,000 per individual $16,000 per family
Plan Coinsurance:	70%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (includes medical deductible, prescription drug deductible, medical copayments, and prescription drug copayments).	$6,600 per individual $13,200 per family	$13,200 per individual $26,400 per family
Preventive Services:	100%	Deductible; 50%
Physician's Office Visits:	Primary Care Physician: $40 copayment Specialist: $60 copayment	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	50% to a maximum of $3,000 per plan year; then deductible and 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	Deductible; 70%	Deductible; 50%
Chiropractic Care: Maximum of $1,000 per plan year.	$60 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	Deductible; 70%	Deductible; 50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 70%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 70%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 70%	Deductible; 50%
Urgent Care Services:	$75 copayment	Deductible; 50%

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Bronze Preferred Plan

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	$300 copayment, deductible; then 70%	$300 copayment, in-network deductible; then 70%
Ambulance Services:	Deductible; 70%	In-Network deductible, then 70%
Anesthesiology Services:	Deductible; 70%	Deductible; 50%
Inpatient Hospital Services:	$400 copayment per visit; then deductible and 70%	$400 copayment per visit; then deductible and 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	$400 copayment per visit; then deductible and 70%	$400 copayment per visit; then deductible and 50%
Inpatient Rehabilitation Hospital Care:	$400 copayment per visit; then deductible and 70%	$400 copayment per visit; then deductible and 50%
Prenatal Maternity Care:	$40 PCP/$60 Specialist applies to first visit to confirm pregnancy; then 100% thereafter	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 70%	Deductible; 50%
Durable Medical Equipment:	Deductible; 70%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 70%	Deductible; 50%
Dialysis: Maximum of 40 visits per plan year.	Deductible; 70%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	$400 copayment per visit; then deductible and 70%	$400 copayment per visit; then deductible and 50%
Outpatient Mental Health/Substance Abuse:	$40 copayment	Deductible; 50%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 58 for a list of these services)	$500 non-compliance penalty	$500 non-compliance penalty

CBA Blue

National Franchisee Association Health + Medical Plan
Schedule of Medical Benefits
Bronze Preferred Plan

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Retail – 30 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $25 copayment Preferred Brand: $55 copayment Non-Preferred Brand: $80 copayment	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	Deductible: $50 per individual/$100 per family per plan year; then Generic: $50 copayment Preferred Brand: $110 copayment Non-Preferred Brand: $160 copayment	N/A

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.
3. All other covered benefits not listed above will be subject to deductible, then payable at 70% in-network and 50% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are not combined.
6. All medical and prescription drug copayments are applied to the out-of-pocket maximum.
7. Precertification penalties are not applied to the deductible or out-of-pocket maximum.
8. The $50 individual/$100 family prescription drug plan year deductible is a combined deductible for both retail and mail order prescriptions.