

EXHIBIT B - Medical

	Medical Plan Options					
	BRONZE PLAN		SILVER PLAN		GOLD PLAN	
	First Choice Health Network (& Out of Area)	Out of Network	First Choice Health Network (& Out of Area)	Out of Network	First Choice Health Network (& Out of Area)	Out of Network
Deductible (Individual/Family)	\$2,600 / \$7,800	\$5,200 / \$15,600	\$600 / \$1,800	\$1,200 / \$3,600	\$300 / \$900	\$600 / \$1,800
Coinsurance (Plan Pays/Member Pays)	80 / 20%	60 / 40%	80 / 20%	60 / 40%	80 / 20%	60 / 40%
Out of Pocket Max (Includes Deductible, Coinsurance and Copays)	\$6,550 / \$13,100	\$13,100 / \$26,200	\$3,000 / \$9,000	\$6,000 / \$18,000	\$1,800 / \$5,400	\$3,600 / \$10,800
Office Visits						
Primary Care	Deductible then 20%	Deductible then 40%	\$25 Copay	Deductible then 40%	\$20 Copay	Deductible then 40%
Specialists	Deductible then 20%	Deductible then 40%	\$45 Copay	Deductible then 40%	\$40 Copay	Deductible then 40%
Preventive Care	Covered in Full	Deductible then 40%	Covered in full	Deductible then 40%	Covered in full	Deductible then 40%
Diagnostic Lab & X-Ray	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%
Hospital						
Inpatient Facility	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%
Outpatient Surgery	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%	Deductible then 20%	Deductible then 40%
Emergency Room	Deductible then 20%		Deductible then 20%		Deductible then 20%	
Prescriptions	(Generic/Brand Name Formulary/ Brand Name Non-Formulary)		(Generic/Brand Name Formulary/ Brand Name Non-Formulary)		(Generic/Brand Name Formulary/ Brand Name Non-Formulary)	
Retail (30-Day Supply)	Deductible then 20%	Deductible then 40%	\$10 / \$30 / \$60		\$10 / \$25 / \$50	
Mail Order (90-Day Supply)	Deductible then 20%	Not Covered	\$20 / \$60 / \$120	Not Covered	\$20 / \$50 / \$100	Not Covered
Monthly Rates	BRONZE PLAN		SILVER PLAN		GOLD PLAN	
Employee	\$0		\$23.18		\$72.12	
Employee + Spouse	\$0		\$53.32		\$165.87	
Employee + Child	\$0		\$37.09		\$115.39	
Employee + Children	\$0		\$60.05		\$186.78	
Employee + Spouse + Child(ren)	\$0		\$76.51		\$237.98	

All health insurance premiums are taken pre-tax. The net effect on an employee's paycheck will be less than the premiums stated above.

Medical Plan Highlights:

Bronze Plan: High deductible plan – typically associated with a Health Saving Account (“HSA”).

- Monthly premium cost sharing = \$0.
- Preventive care is covered at 100%, not subject to the deductible.
- The company will contribute \$600 each year to an employee's HSA to pay for out-of-pocket healthcare expenses. Similar to a 401(k) plan match, the employee may keep the \$600 contribution once it goes into the employee's account. This money grows tax-free as long as it is used for qualified health care expenses, and it may be rolled over from year-to-year if it is not used.

Silver Plan: Traditional medical plan

- Monthly premium cost sharing = \$23.18/single to \$76.51/family.
- Preventive care is covered at 100%, not subject to the deductible.
- Office co-pays, including chiropractic and acupuncture, have a \$25 co-pay, not subject to the deductible.
- Prescription co-pays are as low as \$10, not subject to the deductible.

Gold Plan: Traditional medical plan

- Monthly premium cost sharing = \$72.12/single to \$237.98/family.
- Preventive care is covered at 100%, not subject to the deductible.
- Office co-pays, including chiropractic and acupuncture, have a \$20 co-pay, not subject to the deductible.
- Prescription co-pays are as low as \$10, not subject to the deductible.
- Same plan structure as the Silver Plan, with lower deductibles.

EXHIBIT C - Dental & Vision

Dental Plan	
Annual Maximum (Per person)	\$1,500
Deductible (Waived for Preventive)	\$25 per individual
Preventive (Plan pays/Individual pays)	100% / 0%
Basic (Plan pays/Individual pays)	90% / 10%
Major (Plan pays/Individual pays)	60% / 40%
Orthodontia (Dependents to age 26 only)	50% to \$2,000 / Lifetime
Monthly Rates	Dental Monthly Premium Cost Sharing
Employee Only	\$4.30
Employee + Spouse	\$8.59
Employee + Child	\$6.83
Employee + Children	\$9.45
Employee + Family	\$12.89

Vision Plan		
	In Network	Out of Network
Copays		
Exam		\$10 Copay
Hardware		\$25 Copay
Contact Lens Exam		Up to \$60
Exam - every 12 months	Covered in full	Reimbursed to \$50
Hardware		
Frames - every 24 months	Covered to \$130	Reimbursed to \$70
Lenses - every 12 months		
Single	Covered in full	Reimbursed to \$50
Bifocal	Covered in full	Reimbursed to \$75
Trifocal	Covered in full	Reimbursed to \$100
Lenticular	Covered in full	Reimbursed to \$125
Contacts (instead of lenses & frames)		
Medically Necessary	Covered in full	Reimbursed to \$210
Elective	Covered to \$130	Reimbursed to \$105
Monthly Rates	Vision Monthly Premium Cost Sharing	
Employee	\$0.86	
Employee + 1 Dependent	\$1.38	
Employee + Child(ren)	\$1.40	
Employee + Family	\$2.26	

- 10% employee premium cost sharing for both dental and vision coverage.
- 100% preventive care coverage and 90% basic coverage on dental, which are increased benefits over current plans.

	Employee Only	Employee + Spouse	Employee + Family
Cost of current Enhanced Plans	\$17.00	\$34.00	\$68.00
Cost of Hecla's Offered Plans	\$ 5.16	\$ 9.97	\$15.15
Monthly Premium Savings	\$11.84	\$24.03	\$52.85