

# Benefit Selections Report

## Hecla Greens Creek Mining Company

Group Number: 1036812

Effective Date: 05/01/2008

AK HeritagePlus - HP \$250/10%/\$1500/\$15	Specifications and Benefit Limits	In Network	Out of Network
<b>Cost Share</b>			
Individual Deductible PCY	Family Deductible 3x Individual	\$250 PCY	\$500 PCY
Fourth Quarter Deductible Carry-Over	No		
Coinsurance	Member's percentage of costs after deductible based on allowable charges	10%	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Individual Out of Pocket Maximum PCY, Excludes Copay	Family OOP Max 3x Individual	\$1,500 PCY	\$3,000 PCY
Office Visit Cost Share		\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
Lifetime Maximum		\$2,000,000	Shared with In-Network Lifetime Maximum
<b>Facility Care Options</b>			
Inpatient Facility		Deductible/ Coinsurance	Hospital/CD Facility: 30%; Other Facilities: Same as In-Network Cost Share
Outpatient Surgery Facility		Deductible/ Coinsurance	Hospital/CD Facility: Deductible/ Coinsurance; Other Facilities: Same as In-Network Cost Share
Skilled Nursing Facility	60 days PCY	Deductible/ Coinsurance	Hospital/CD Facility: 30%; Other Facilities: Same as In-Network Cost Share
<b>Emergency Care Options</b>			
Emergency Care	Always subject to deductible and coinsurance.	Deductible/ Coinsurance	Same as In-Network Deductible/ Coinsurance
Ambulance Transportation		Deductible/ Coinsurance	Same as In-Network Deductible/ Coinsurance
Air Ambulance	Unlimited	Deductible/ Coinsurance	Same as In-Network Deductible/ Coinsurance
Air or Surface Transportation	Standard Option - 1 way transportation for sudden, life-endangering illness or injury	Deductible/ Coinsurance	Same as In-Network Deductible/ Coinsurance
<b>Diagnostic Service Options</b>			
Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA, Preventive		Covered in Full	Hospital/CD Facility & MD/DO/DPM: Deductible/ Coinsurance; Other Facilities & Professionals: Same as In-Network Cost Share
Other Professional Diagnostic Imaging and Laboratory Services		Deductible/ Coinsurance	Hospital/CD Facility & MD/DO/DPM: Deductible/ Coinsurance; Other Facilities & Professionals: Same as In-Network Cost Share
Mammography		Covered in Full	Hospital/CD Facility & MD/DO/DPM: Deductible/ Coinsurance; Other Facilities & All Professionals: Same as In-Network Cost Share

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<b>Preventive Care Options and Health Education</b>			CONTINUED
Preventive Office Visit	Unlimited	Office Visit Cost Share	Deductible/ Coinsurance
Immunizations	Unlimited	Covered in Full	MD/DO/DPM: Deductible/ Coinsurance; Other Facilities: Same as In-Network Immunization Cost Share
Health Education (HE)	HE: Unlimited; CW: \$250 PCY; ND: \$250 PCY; DE: Unlimited	Covered in Full	Covered in Full
Community Wellness, Prevention and Safety Programs (CW)	\$250 PCY	Covered in Full	Covered in Full
Nicotine Dependency Programs (ND)	\$250 PCY	Covered in Full	Covered in Full
Diabetes Health Education (DE)	Unlimited	Covered in Full	Covered in Full
<b>Professional Care</b>			
Professional Office Visit Including Urgent Care		\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
Inpatient Professional Services		Deductible/ Coinsurance	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Contraceptive Management	Unlimited	\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
<b>Other Services</b>			
Infertility	Not Covered	Not Covered	Not Covered
Mental Health Inpatient Facility Care	Inpatient: 30 days PCY; Outpatient: 45 visits PCY	Covered as Any Other Service	Covered as Any Other Service
Mental Health Outpatient Professional Care	30 days	Covered as Any Other Service	Covered as Any Other Service
Acupuncture	Acupuncture: 12 visits PCY; Manipulation: 30 Visits PCY; NT: 4 visits PCY	\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
Manipulations (spinal and other)	Acupuncture: 12 visits PCY; Manipulation: 30 Visits PCY; NT: 4 visits PCY	\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
Naturopathy	Acupuncture: 12 visits PCY; Manipulation: 30 Visits PCY; NT: 4 visits PCY	\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
Nutritional Therapy	Acupuncture: 12 visits PCY; Manipulation: 30 Visits PCY; NT: 4 visits PCY	\$15 Copay	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share
Psychological & Neuropsychological Testing and Evaluation (Shared with Rehab, Neurodev & Mental Health)	12 hours PCY	Deductible/ Coinsurance	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Rehab Inpatient Facility	Inpatient: 30 days PCY; Outpatient: 45 visits PCY	Deductible/ Coinsurance	Hospital/CD Facility: 30%; Other Facilities: Same as In-Network Cost Share
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain	45 visits PCY	Covered as Any Other Service	MD/DO/DPM: 30%; Other Professionals: Same as In-Network Cost Share

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<b>Other Services</b>			CONTINUED
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth)	MS: \$10,000 PCY; ME: \$10,000 PCY Shared with MS; Pro: \$10,000 PCY Shared with MS; Orth: \$300 PCY, Shared with ME	Deductible/ Coinsurance	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Chemical Dependency	\$16,380 per 24 Months; \$32,750 per Lifetime	Covered as Any Other Service	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Home Health Care	130 visits PCY	Deductible/ Coinsurance	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Hospice	Inpatient: 10 days; Respite: 240 hours; 6 month limit	Deductible/ Coinsurance	Hospital/CD Facility & MD/DO/DPM: 30%; Other Facilities & Professionals: Same as In-Network Cost Share
Transplants	\$250,000 per lifetime; combined inpatient and outpatient limit	Covered as Any Other Service	Not Covered
TMJ Disorders	Not Covered	Not Covered	Not Covered
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
Allergy/Therapeutic Injections		Deductible/ Coinsurance	MD/DO/DPM: Deductible/ Coinsurance; Other Professionals: Same as Injection In-Network Cost Share
<b>Supplemental Benefits</b>			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Hardware	Not Covered	Not Covered	Not Covered
<b>Administrative Options</b>			
BlueCard Program	BlueCard PPO (ZKR)	Same as in-state coverage	Same as in-state coverage
Domestic Partner Covered/Eligible for COBRA	Yes/Yes		
Obstetrical Care for Dependent Daughters	Yes		
Group Size and Funding Arrangement	Self Funded		

### COVERAGE SELECTIONS AGREEMENT

I affirm that the coverage selections and corresponding rates are correct and I am authorized to sign on behalf of the group.

Signature of Group's Representative \_\_\_\_\_ Date \_\_\_\_\_

Group's Representative (Print Name) \_\_\_\_\_ Title \_\_\_\_\_

**Benefit Selections Report**  
**Hecla Greens Creek Mining Company**

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Effective Date: 05/01/2008

3-Tier Rx Copay Plans - RX \$10/\$20/\$50 MO 2x	Specifications and Benefit Limits
<b>Cost Share</b>	
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Retail Cost Shares	\$10/\$20/\$50
Mail Cost Shares	\$20/\$40/\$100
Out of Pocket Max	Unlimited
Non-Participating	Cost Share, then 0% (to allowable)
Annual Benefit Max	Unlimited
Covered/Excluded	Standard

**COVERAGE SELECTIONS AGREEMENT**

I affirm that the coverage selections and corresponding rates are correct and I am authorized to sign on behalf of the group.

Signature of Group's Representative \_\_\_\_\_ Date \_\_\_\_\_

Group's Representative (*Print Name*) \_\_\_\_\_ Title \_\_\_\_\_