NMMIP COMPARISON SUMMARY TABLE

	$500 Plan	$1,000 Plan	$2,000	$5,000
ANNUAL DEDUCTIBLE	$500	$1,000	$2,000	$5,000
OUT-OF-POCKET ANNUAL MAXIMUM (includes deductible)	$5,000	$5,500	$6,000	$7,350
OFFICE VISITS				
■ **PCP**	$20 copay*	$25 copay*	$30 copay*	$35 copay*
■ **Specialist**	$40 copay*	$45 copay*	$50 copay*	$55 copay*
PREVENTIVE CARE	No Charge	No Charge	No Charge	No Charge
MATERNITY CARE				
■ **Prenatal**	No Charge	No Charge	No Charge	No Charge
■ **Delivery and newborn care**	20%	20%	30%	40%
PRESCRIPTION DRUGS				
■ **Generic**	$10 copay*	$10 copay*	$10 copay*	$10 copay*
■ **Pref brand**	$35 copay*	$35 copay*	$50 copay*	$50 copay*
■ **Non-pref brand**	$70 copay*	$70 copay*	$100 copay*	$100 copay*
■ **Specialty**	30% up to $400	30% up to $400	30% up to $400	30% up to $400
INPATIENT HOSPITAL	20%	20%	30%	40%
OUTPATIENT SURGERY	20%	20%	30%	40%
DIAGNOSTICS				
■ **Lab**	$20 copay*	$25 copay*	$30 copay*	$35 copay*
■ **X-Ray**	$20 copay*	$25 copay*	$30 copay*	$35 copay*
■ **MRI, CT, PET**	20%	20%	30%	40%
PHYSICIAN SERVICES	20%	20%	30%	40%
EMERGENCY ROOM	$250 copay*	$300 copay*	$350 copay*	$400 copay*
AMBULANCE	20%	20%	30%	40%
URGENT CARE	$40 copay*	$45 copay*	$50 copay*	$55 copay*
MENTAL HEALTH OP (Non-Intensive)	No Charge	No Charge	No Charge	No Charge
MENTAL HEALTH OP (Intensive)	No Charge	No Charge	No Charge	No Charge
MENTAL HEALTH IP	No Charge	No Charge	No Charge	No Charge
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY (outpatient)	$20 copay*	$25 copay*	$30 copay*	$35 copay*
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY (inpatient)	20%	20%	30%	40%
DURABLE MEDICAL EQUIPMENT	20%	20%	30%	40%
ORGAN TRANSPLANT TRAVEL BENEFIT	$10,000 maximum per transplant	$10,000 maximum per transplant	$10,000 maximum per transplant	$10,000 maximum per transplant
HOME HEALTH CARE	No Charge Max 100 visits per yr	No Charge Max 100 visits per yr	No Charge Max 100 visits per yr	No Charge Max 100 visits per yr
HOSPICE CARE	20%	20%	30%	40%
SKILLED NURSING CARE	20% Max 60 days per yr	20% Max 60 days per yr	30% Max 60 days per yr	40% Max 60 days per yr
DENTAL CARE	Children no charge	Children no charge	Children no charge	Children no charge
VISION CARE	Children no charge	Children no charge	Children no charge	Children no charge
CHIROPRACTIC CARE	20% 20 visits per year	20% 20 visits per year	30% 20 visits per year	40% 20 visits per year
ACUPUNCTURE	20% 20 visits per year	20% 20 visits per year	30% 20 visits per year	40% 20 visits per year

*Deductible does not apply.