

**NMMIP COMPARISON SUMMARY TABLE**

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

\*Deductible does not apply.