Greater Tompkins County Municipal Health Insurance Consortium
2018 and 2019 PPO Medical Benefit Plan Options and Rates

Benefit Plan Description		$10.00 PPO Plan (PPO1)		$15.00 PPO Plan (PPO2)		$20.00 PPO Plan (PPO3)		"Teamster Lookalike" PPO Plan (PPOT)	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Number of Sub-Groups		**4**		**6**		**2**		**6**	
Number of County of Tompkins Sub-Groups		**19**		**0**		**0**		**0**	
Deductible *(Must be Met Before Benefits Pay)*	**Individual**	n/a	$250.00	n/a	$500.00	n/a	$750.00	n/a	
	Family	n/a	$750.00	n/a	$1,500.00	n/a	$2,250.00	n/a	
Out-of-Pocket Maximum *(includes all deductible, coinsurance amounts, and copayment amounts)*	**Individual**	$1,000.00	$1,000.00	$1,500.00	$1,500.00	$2,000.00	$2,000.00	$1,000.00	$1,000.00
	Family	$3,000.00	$3,000.00	$4,500.00	$4,500.00	$6,000.00	$6,000.00	$3,000.00	$3,000.00
Inpatient Hospital Patient Cost Sharing		Covered In Full	Deductible then 20% Coinsurance	Covered In Full	Deductible then 20% Coinsurance	Covered In Full	Deductible then 30% Coinsurance	Covered In Full	Deductible then 20% Coinsurance
Emergency Room Patient Cost Sharing		$35.00	$35.00	$35.00	$35.00	$35.00	$35.00	$100.00	$100.00
Office Visit Patient Cost Sharing	**Primary Care Physician**	$10.00	Deductible then 20% Coinsurance	$15.00	Deductible then 20% Coinsurance	$20.00	Deductible then 30% Coinsurance	$10.00	Deductible then 20% Coinsurance
	Specialist	$10.00	Deductible then 20% Coinsurance	$15.00	Deductible then 20% Coinsurance	$20.00	Deductible then 30% Coinsurance	$10.00	Deductible then 20% Coinsurance
Diagnostic Lab and X-Ray Patient Cost Sharing		$0.00	Deductible then 20% Coinsurance	$0.00	Deductible then 20% Coinsurance	$0.00	Deductible then 30% Coinsurance	$0.00	Deductible then 20% Coinsurance
Retail Pharmacy Patient Cost Sharing	**Tier 1**	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
	Tier 2	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
	Tier 3	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
	Days Supply Limit	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
Mail-Order Pharmacy Patient Cost Sharing	**Tier 1**	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
	Tier 2	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
	Tier 3	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
	Days Supply Limit	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered	Varies	Not Covered
2018 Premium Rates	**Individual**	**$700.39**		**$690.58**		**$677.97**		**$724.20**	
	Family	**$1,515.96**		**$1,494.75**		**$1,467.46**		**$1,569.63**	
2019 Premium Rates	**Individual**	**$735.41**		**$725.11**		**$711.87**		**$760.41**	
	Family	**$1,591.76**		**$1,569.49**		**$1,540.83**		**$1,648.11**	
Premium % Increase	**5.00%**								