Greater Tompkins County Municipal Health Insurance Consortium Standard Metal Level Plans
2024 Medical and Prescription Drug Benefit Options and Rates

Benefit Plan Description		Platinum		Gold		Silver		Bronze	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
2024 Premium Rates		Individual	$838.41	Individual	$709.12	Individual	$557.79	Individual	$459.56
		Family	$2,179.90	Family	$1,843.72	Family	$1,450.24	Family	$1,194.84
Deductible *(Must be Met Before Benefits Pay)*	Individual	n/a	$500.00	$1,800.00	$2,700.00	$3,000.00	$4,500.00	$7,000.00	$10,500.00
	Family	n/a	$1,500.00	$3,600.00	$5,400.00	$6,000.00	$9,000.00	$14,000.00	$21,000.00
Out-of-Pocket Maximum *(includes all deductible, coinsurance amounts, and copayment amounts)*	Individual	$2,000.00	$3,000.00	$3,600.00	$5,400.00	$7,500.00	$11,250.00	$7,000.00	$10,500.00
	Family	$6,000.00	$9,000.00	$7,200.00	$10,800.00	$15,000.00	$22,500.00	$14,000.00	$21,000.00
Inpatient Hospital Patient Cost Sharing		$250.00	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 0% Coinsurance	Deductible then 0% Coinsurance
Emergency Room Patient Cost Sharing		$150.00	$150.00	Deductible then 20% Coinsurance	$1,800 Deductible then 40% Coinsurance	Deductible then 20% Coinsurance	$3,000 Deductible then 40% Coinsurance	Deductible then 0% Coinsurance	$7,000 Deductible then 0% Coinsurance
Office Visit Patient Cost Sharing	Primary Care Physician	$15.00	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 0% Coinsurance	Deductible then 0% Coinsurance
	Specialist	$25.00	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 0% Coinsurance	Deductible then 0% Coinsurance
Diagnostic Lab and X-Ray Patient Cost Sharing		$25.00	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance	Deductible then 0% Coinsurance	Deductible then 0% Coinsurance
Retail Pharmacy Patient Cost Sharing	Tier 1	$5.00	Not Covered	Deductible then $5.00 Copayment	Not Covered	Deductible then $5.00 Copayment	Not Covered	Deductible then Covered In Full	Not Covered
	Tier 2	$35.00	Not Covered	Deductible then $35.00 Copayment	Not Covered	Deductible then $35.00 Copayment	Not Covered	Deductible then Covered In Full	Not Covered
	Tier 3	$70.00	Not Covered	Deductible then $70.00 Copayment	Not Covered	Deductible then $70.00 Copayment	Not Covered	Deductible then Covered In Full	Not Covered
	Days Supply Limit	30 Days Per Fill	Not Covered	30 Days Per Fill	Not Covered	30 Days Per Fill	Not Covered	30 Days Per Fill	Not Covered
Mail-Order Pharmacy Patient Cost Sharing	Tier 1	$10.00	Not Covered	Deductible then $10.00 Copayment	Not Covered	Deductible then $10.00 Copayment	Not Covered	Deductible then Covered In Full	Not Covered
	Tier 2	$70.00	Not Covered	Deductible then $70.00 Copayment	Not Covered	Deductible then $70.00 Copayment	Not Covered	Deductible then Covered In Full	Not Covered
	Tier 3	$140.00	Not Covered	Deductible then $140.00 Copayment	Not Covered	Deductible then $140.00 Copayment	Not Covered	Deductible then Covered In Full	Not Covered
	Days Supply Limit	90 Days Per Fill	Not Covered	90 Days Per Fill	Not Covered	90 Days Per Fill	Not Covered	90 Days Per Fill	Not Covered