Greater Tompkins County Municipal Health Insurance Consortium
2024 Indemnity Medical Benefit Plan Options and Rates

Benefit Plan Description		Medicare Supplement (MS3)		Medicare Supplement (MS4)	
		MS-3	MS-3	MS-4	MS-4
		Standard Medicare Benefit	Supplemental Benefit	Standard Medicare Benefit	Supplemental Benefit
Deductible *(only applies to "major medical" services)*	**Individual**	Changes Year to Year	Covers Medicare A & B Deductibles	Changes Year to Year	Covers Medicare A & B Deductibles
	Family	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum *(includes only "major medical" coinsurance amounts*	**Individual**	N/A	N/A	N/A	N/A
	Family	N/A	N/A	N/A	N/A
Inpatient Hospital Patient Cost Sharing		Medicare Part A Deductible then 20%	Balance after Medicare Covered in Full	Medicare Part A Deductible then 20%	Balance after Medicare Covered in Full
Emergency Room Patient Cost Sharing		Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full	Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full
Office Visit Patient Cost Sharing	**Primary Care Physician**	Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full	Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full
	Specialist	Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full	Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full
Diagnostic Lab and X-Ray Patient Cost Sharing		Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full	Medicare Part B Deductible then 20%	Balance after Medicare Covered in Full
Retail Pharmacy Patient Cost Sharing	**Tier 1**	$10.00	Not Covered	$15.00	Not Covered
	Tier 2	$25.00	Not Covered	$30.00	Not Covered
	Tier 3	$40.00	Not Covered	$45.00	Not Covered
	Days Supply Limit	30-Days	Not Covered	30-Days	Not Covered
Mail-Order Pharmacy Patient Cost Sharing	**Tier 1**	$20.00	Not Covered	$30.00	Not Covered
	Tier 2	$50.00	Not Covered	$60.00	Not Covered
	Tier 3	[	Not Covered	$90.00	Not Covered
	Days Supply Limit	90-Days	Not Covered	90-Days	Not Covered
2024 Premium Rates	**Individual**	**$904.93**		**$730.44**	
	Family	**N/A**		**N/A**	