Manatee BOCC
Renewal Evaluation - Medical
Effective Date: January 1, 2027

GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

	Current				2027 Plan Renewal			
Schedule of Benefits	**Aetna - Standard**		**Aetna - Premium**		**Aetna - Standard**		**Aetna - Premium**	
	In Network	***Out of Network***	***In Network***	***Out of Network***	***In Network***	***Out of Network***	***In Network***	***Out of Network***
Deductible (Calendar Year)								
Single	$250	$750	$0	$500	**$500**	$1,000	**$250**	$500
Family	**$500**	**$1,500**	$0	**$1,000**	**$1,000**	$2,000	**$500**	$1,000
Coinsurance	20%	20%	0%	20%	20%	**30%**	**10%**	20%
Out of Pocket Maximum (OOPM)	**Includes Copays, Ded, Coinsurance, Inpatient Hospital, Mental Health and Rx**		**Includes Copays, Ded, Coinsurance, Inpatient Hospital, Mental Health and Rx**		**Includes Copays, Ded, Coinsurance, Inpatient Hospital, Mental Health and Rx**		**Includes Copays, Ded, Coinsurance, Inpatient Hospital, Mental Health and Rx**	
Single	**$3,600**	**$10,000**	**$2,800**	**$5,600**	**$4,000**	$10,000	**$3,600**	$6,000
Family	**$7,200**	**$20,000**	**$5,600**	**$11,200**	**$8,000**	$20,000	**$7,200**	$12,000
Office Visits								
Virtual Visit (PCP/Sp/Telamynd for BH)	$30	20% after CYD	$30	20% after CYD	$30 PCP/**$60** Sp/$30 BH	**30% after CYD**	**$25** PCP/**$50** Sp/**$25** BH	20% after CYD
Teladoc	$30	Not Covered	$30	Not Covered	**$0**	Not Covered	**$0**	Not Covered
Preventive Annual Visit	$0	20% after CYD	$0	20% after CYD	$0	**30% after CYD**	$0	20% after CYD
Primary Care Physician Office Visit	$30	20% after CYD	$30	20% after CYD	$30	**30% after CYD**	**$25**	20% after CYD
Specialist Office Visit	$30	20% after CYD	$30	20% after CYD	**$60**	**30% after CYD**	**$50**	20% after CYD
Lab / X-Ray	20% after CYD	20% after CYD	$0	20% after CYD	20% after CYD	**30% after CYD**	**10% after CYD**	20% after CYD
Advanced Imaging (MRI, PET, CAT scans)	20% after CYD	20% after CYD	$0	20% after CYD	20% after CYD	**30% after CYD**	**10% after CYD**	20% after CYD
Urgent Care Center	20% after CYD	20% after CYD	$30	20% after CYD	**$90**	**30% after CYD**	**$75**	20% after CYD
Hospital								
Inpatient	**$250 copay + 20% after CYD**	**20% after CYD**	$0	20% after CYD	**20% after CYD**	**30% after CYD**	**10% after CYD**	20% after CYD
Outpatient Surgery	20% after CYD	20% after CYD	$0	20% after CYD	20% after CYD	**30% after CYD**	**10% after CYD**	20% after CYD
Emergency Room Visit (In and OON) [1]	$200 copay + 20% after CYD	$200 copay + 20% after CYD	$150	$150	**20% after In-Network CYD**		**10% after In-Network CYD**	
Pregnancy & Childbirth								
Prenatal Initial Office Visit	20% after CYD	20% after CYD	$100 copay per pregnancy	20% after CYD	**$30 copay then 100%**	**30% after CYD**	**$25 copay then 100%**	20% after CYD
Childbirth/Delivery Professional Services	20% after CYD	20% after CYD	$100 copay per pregnancy	20% after CYD	20% after CYD	**30% after CYD**	**10% after CYD**	20% after CYD
Childbirth - Delivery Facility	**$250 copay + 20% after CYD**	**20% after CYD**	$100 copay per pregnancy	20% after CYD	**20% after CYD**	**30% after CYD**	**10% after CYD**	20% after CYD
Mental Health / Substance Abuse	**Included in OOPM**		**Included in OOPM**		**Included in OOPM**		**Included in OOPM**	
Inpatient	No Charge	20% after CYD	No Charge	20% after CYD	**20% after CYD**	**30% after CYD**	**10% after CYD**	20% after CYD
Outpatient Mental Health Counselor (LAMP & Samaritan only)	Visits 1-5 $0; then $15 per visit	20% after CYD	Visits 1-5 $0; then $15 per visit	20% after CYD	Visits 1-5 $0; then $15 per visit	**30% after CYD**	Visits 1-5 $0; then $15 per visit	20% after CYD
Outpatient Mental Health Counselor	Visits 1-5 $0; then $30 per visit	20% after CYD	Visits 1-5 $0; then $30 per visit	20% after CYD	$30	**30% after CYD**	$25	20% after CYD
Prescription Drugs	**Included in OOPM**		**Included in OOPM**		**Included in OOPM**		**Included in OOPM**	
Tier 1	$10	Not Covered	$10	Not Covered	$10	Not Covered	$10	Not Covered
Tier 2	$15 or 25% whatever is greater; $100 max		$15 or 25% whatever is greater; $100 max		**$20 or 25% whatever is greater; $100 max**		**$20 or 25% whatever is greater; $100 max**	
Tier 3	$40 or 45% whatever is greater; $100 max		$40 or 45% whatever is greater; $100 max		**$50 or 45% whatever is greater; $150 max**		**$50 or 45% whatever is greater; $150 max**	
Tier 4 (Specialty)	25% or $150 max		25% or $150 max		**30% or $250 max**		**30% or $250 max**	
Mail Order (90 day supply)	2-3x for 60,90 days		2-3x for 60,90 days		2-3x for 60,90 days		2-3x for 60,90 days	

CYD = Calendar Year Deductible
OOPM = Out of Pocket Maximum

[1] Ambulance benefit must match Emergency Room
Physical, Occupational, Speech Therapy subject to combined 90 visit maximum per calendar year. $60 copay per visit for Standard and $50 copay per visit for Premium.
Massage Therapy, Acupuncture, Chiropractic office visits subject to 20 visit maximum each per calendar year. Both plans subject to a $30 copay.