2027 Plan Year Annual Enrollment

Highlights/Updates for 2027

- **YourChoice Medical Plan - Standard and Premium:** As a self-funded county health plan, we are responsible for covering the actual cost of medical claims. With healthcare expenses continuing to rise across the industry, the Premium Plan will have a premium rate increase, while the rates for the Standard Plan will remain unchanged, beginning January 1, 2027. These increases support the ongoing financial stability of the plan.
- **Primary Care and Teladoc:** Copays for Primary Care Provider (PCP) visits under the Premium Plan have been lowered to $25. Additionally, telehealth services through Teladoc only will have a $0 copay in both the Standard and Premium Plans.
- **Urgent Care and Emergency Room Visits:** Urgent care copays are increasing to $75 in the Premium Plan and $90 in the Standard Plan. Emergency room visits under both Standard and Premium Plans are subject to coinsurance after meeting the calendar year deductible.
- **Child Preventive Dental:** Beginning January 1, 2027, the medical plan will no longer include any preventive dental coverage for children. Employees with child dependents in need of dental coverage are urged to enroll them in the dental plan.
- **Physical Therapy:** Beginning January 1, 2027, the first five physical therapy visits (per year) are no longer covered at a $0 copay in the Premium Plan.
- **Dental and Vision:** Dental premium rates will increase by 16% in 2027. Vision rates are unchanged in 2027.
- **Additional Term Life - Special Enrollment Opportunity:** For this plan year only, employees who are already participating in the Additional Term Life Insurance benefit can increase it by one coverage level (example: 1x to 2x) without any Evidence of Insurability requirement.
- ***NEW* Supplemental Plans:** Beginning January 1, 2027, The Hartford is offering new voluntary supplemental Accident, Critical Illness, and Hospital Indemnity insurance plans. The Hartford continues to offer Short Term Disability and Long Term Disability.

Medical Premium Rates

Medical Plan Tier	Standard Plan		Premium Plan	
	Employee Per Pay	Employer Per Pay	Employee Per Pay	Employer Per Pay
Employee Only	$36.30	$395.13	$50.34	$395.13
Employee Plus Spouse	$154.51	$722.16	$189.66	$722.16
Employee Plus Children	$132.43	$619.00	$162.56	$619.00
Employee Plus Family	$183.30	$1,055.33	$230.09	$1,055.33

Dental Premium Rates*

Tier	Employee Per Pay
Employee Only	$19.72
Employee Plus One	$31.90
Employee Plus Two or More	$43.50

** Does not apply to employees of the Clerk of Court's office. Contact the Clerk's HR office for details about dental coverage.*

Vision Premium Rates

Tier	Employee Per Pay
Employee Only	$2.46
Employee Plus Spouse	$4.68
Employee Plus Children	$4.92
Employee Plus Family	$7.24

Annual Enrollment: October 13th – November 13th

Deadline: 11:00 pm Eastern Time on November 13th!

What Happens If You Don't Enroll?

Failure to make your Medical Plan elections will result in the default options below:

- ***Currently enrolled in the Premium Plan?*** **You will default to the Standard Plan**
- ***Currently enrolled in the Standard Plan?*** **You will default to the Standard Plan**
- ***Not currently enrolled in medical coverage?*** **You will default to no medical coverage**

Medical Plan Coverage Comparison

CYD = Calendar Year Deductible

Medical Service	Standard Plan	Premium Plan
Deductible / Coinsurance	• In Network Deductible - Individual: $500; Family: $1,000 • Out of Network Deductible - Individual: $1,000; Family $2,000 • In Network Coinsurance - 20% • Out of Network Coinsurance - 30%	• In Network - Individual: $250 • In Network - Family: $500 • In Network Coinsurance - 10% • Out of Network - Individual: $500 • Out of Network - Family: $1,000 • Out of Network Coinsurance - 20%
Out of Pocket Maximum (includes deductible, copays, inpatient hospital, mental health/substance abuse, and prescriptions)	• In Network - Individual: $4,000 • In Network - Family: $8,000 • Out of Network - Individual: $10,000 • Out of Network - Family: $20,000	• In Network - Individual: $3,600 • In Network - Family: $7,200 • Out of Network - Individual: $6,000 • Out of Network - Family: $12,000
Teladoc	• In Network $0 Copay (Deductible does not apply) • Out of Network - Not Covered	• In Network $0 Copay (Deductible does not apply) • Out of Network - Not Covered
Primary Care Provider Office Visit or Virtual Visit	• In Network $30 Copay (Deductible does not apply) • Annual Preventive Care/Screening $0 • Out of Network - 30% after CYD	• In Network $25 Copay (Deductible does not apply) • Annual Preventive Care/Screening $0 • Out of Network - 20% after CYD
Specialist Office Visit or Virtual Visit	• In Network $60 Copay (Deductible does not apply) • Out of Network - 30% after CYD	• In Network $50 Copay (Deductible does not apply) • Out of Network - 20% after CYD
Diagnostic Testing (X-Ray, Blood Work)	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - 10% after CYD • Out of Network - 20% after CYD
Imaging (CT/PET Scan, MRI)	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - 10% after CYD • Out of Network - 20% after CYD
Outpatient Surgery Facility Fees	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - 10% after CYD • Out of Network - 20% after CYD
Emergency Room	• In and Out of Network 20% after In Network CYD	• In and Out of Network 10% after In Network CYD
Urgent Care	• In Network $90 Copay (Deductible does not apply) • Out of Network - 30% after CYD	• In Network $75 Copay (Deductible does not apply) • Out of Network - 20% after CYD
Inpatient Hospital Stay	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - 10% after CYD • Out of Network - 20% after CYD
Pregnancy Office Visits	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - $100 Copay per pregnancy • Out of Network - 20% after CYD
Childbirth/Delivery Professional Services	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - 10% after CYD • Out of Network - 20% after CYD
Childbirth/Delivery Facility	• In Network - 20% after CYD • Out of Network - 30% after CYD	• In Network - 10% after CYD • Out of Network - 20% after CYD
Prescription Drugs - Tier 1	• $10 Copay	• $10 Copay
Prescription Drugs - Tier 2	• $20 or 25% (whatever is greater); $100 maximum	• $20 or 25% (whatever is greater); $100 maximum
Prescription Drugs - Tier 3	• $50 or 45% (whatever is greater); $150 maximum	• $50 or 45% (whatever is greater); $150 maximum
Prescription Drugs - Tier 4 (Speciality)	• 30% or $250 maximum	• 30% or $250 maximum

Scan the QR Code for a full overview of our benefits or visit: manateeyourchoice.com



Questions? Contact Employee Health Benefits

941-748-4501, x6249 *benefits@mymanatee.org*