RETIREE RATE SHEET 2027

Manatee YourChoice Medical Monthly Premiums
*Retirees with over 10+ years please refer to rate with premium assitance

Plan Tier	Standard Plan	Standard Plan with Premium Assistance	Premium Plan Rate	Premium Plan with Premium Assistance
Retiree Only	$862.86	$733.86	$890.94	$761.94
Retiree + Spouse	$1,753.34	$1,624.34	$1,823.64	$1,694.64
Retiree + Child(ren)	$1,502.86	$1,373.86	$1,563.12	$1,434.12
Retiree + Family	$2,477.26	$2,348.26	$2,570.84	$2,441.84
Spouse Only (Retiree is on Transamerica)	$890.48	N/A	$932.70	N/A
Child(ren) Only (Retiree is on Transamerica)	$640.00	N/A	$672.18	N/A
Spouse and Child(ren) (Retiree is on Transamerica)	$1,614.40	N/A	$1,555.48	N/A

TransAmerica Medicare Supplement Plan

Retirees Age 65+ with 10+ Years	$200
Retirees Age 65+ without 10+ Years and Spouses	Rate Based on Age and Location

Dental

Retiree Only	$39.44
Retiree + 1	$63.80
Retiree + 2 or More	$87.00

Vision

Retiree Only	$4.92
Retiree + Spouse	$9.36
Retiree + Child(ren)	$9.84
Retiree + Family	$14.48

Important: You can only elect coverage you are currently enrolled in. If you are not currently enrolled in Medical, Dental, or Vision, that coverage cannot be added during this enrollment period.

Medical Plan Coverage Comparison

*Plan changes are required for the stability of the self - funded health plan, please review carefuuly

Your Choice MANATEE HEALTH PLAN

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 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

CYD = Calendar Year Deductible

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*

Revised 10.13.2026