City of Cooper City
RFP Evaluation
Meeting Packet

August 14, 2026

CITY OF
Cooper City
Someplace Special

GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

RFP Response List

City of Cooper City
2026-2027 RFP Response List

GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

Carrier	Medical	HSA	COBRA	DTQ	Comments
Aetna				⊘	
Ameriflex		✓	✓		
Associated Bank		✓	✓		
BASIC				⊘	
Benecon	✓				
BBP Admin		✓	✓		
Cigna	✓				
Diversified Administration, Inc.				⊘	No Response
Eagles Benefits				⊘	No Response
Eflex group				⊘	No Response
Employee Benefits Corporation				⊘	
Florida Blue	✓	✓			Incumbent & Incumbents HSA partner
FMIT				⊘	
HealthEquity			✓		
HSA Bank		✓	✓		
Lively		✓	✓		
MEDCOM		✓	✓		
Melody Benefits				⊘	No Response
MetLife				⊘	
P&A Group		✓	✓		
PrimePay				⊘	No Response
Sentara (AvMed)	✓				
TASC/Flexcorp				⊘	No Response
UpSwing		✓	✓		
Voya				⊘	No Response
Unum				⊘	No Response

Medical
RFP Evaluation

City of Cooper City
Medical Insurance RFP Evaluation
Effective Date: October 1, 2026

GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

			Current				Renewal			
			Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191		Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191	
Lifetime Maximum			Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits			**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)			Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single			$250	$1,000	$1,650	$3,300	$250	$1,000	**$1,700**	**$3,400**
Family			$750	$3,000	$3,300	$6,600	$750	$3,000	**$3,400**	**$6,800**
Coinsurance			0%	50%	20%	40%	0%	50%	20%	40%
Out-of-Pocket Maximum			*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*	
Single			$3,000	$6,000	$4,800	$9,600	$3,000	$6,000	$4,800	$9,600
Family			$6,000	$12,000	$7,050 / $9,200	$18,400	$6,000	$12,000	$7,050 / $9,200	$18,400
Physician Services										
Physician Office Visit			VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD
Specialist Visit			VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD
Laboratory			No Charge	50% After CYD	0% After CYD	40% After CYD	No Charge	50% After CYD	0% After CYD	40% After CYD
Advanced Imaging			$200	50% After CYD	20% After CYD	40% After CYD	$200	50% After CYD	20% After CYD	40% After CYD
Urgent Care Center			VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD
Preventative Care										
Adult Wellness			No Charge	50%	No Charge	40%	No Charge	50%	No Charge	40%
Hospital										
Inpatient			$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD
Outpatient			$300	50% After CYD	20% After CYD	40% After CYD	$300	50% After CYD	20% After CYD	40% After CYD
Physician Services			$50	$50	20% After CYD	20% After INN CYD	$50	$50	20% After CYD	20% After INN CYD
Emergency Room Visit			$200	$200	20% After CYD	20% After INN CYD	$200	$200	20% After CYD	20% After INN CYD
Mental Health & Substance Abuse Services										
Inpatient			No Charge	50%	20% After CYD	20% After INN CYD	**$700**	50% After **CYD**	20% After CYD	20% After INN CYD
Outpatient (OV/Other)			No Charge	50%	20% After CYD	40% After CYD	**$20** / **$300**	50% After **CYD**	20% After CYD	40% After CYD
Prescription Drugs										
Generic			$10		$10 after CYD		$10		$10 after CYD	
Brand Name			$50	50%	$50 after CYD	50% After INN CYD	$50	50%	$50 after CYD	50% After INN CYD
Non-Preferred Brand			$80		$80 after CYD		$80		$80 after CYD	
Specialty			20%	Not Covered	Tier 1-3	Not Covered	20%	Not Covered	Tier 1-3	Not Covered
Mail Order (90-Day Supply)			2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD
	P1	**P2**								
EE Only	**47**	**3**	$951.73		$776.02		$1,055.71		$870.84	
EE + Spouse	**7**	**1**	$2,169.95		$1,769.32		$2,407.03		$1,985.51	
EE + Child(ren)	**10**	**1**	$1,903.47		$1,552.03		$2,111.42		$1,741.67	
EE + Family	**24**	**2**	$3,045.54		$2,483.25		$3,462.74		$2,856.35	
Monthly Premium	**88**	**7**	**$152,049**		**$10,616**		**$170,688**		**$12,052**	
Annual Premium	**95**		**$1,824,583**		**$127,391**		**$2,048,250**		**$144,629**	
Total Monthly Premium			**$162,665**				**$182,740**			
Total Annual Premium			**$1,951,974**				**$2,192,879**			
Total $ Change			**N/A**				**$240,905**			
Total % Change			**N/A**				**12.3%**			

City of Cooper City
Medical Insurance RFP Evaluation
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GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

			Current				Alternative #1 (Fully)			
			Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191		AvMed In Network ONLY - AIM LH 075 w/RX 8013		AvMed Choice HSAQ CK 410 w/RX 6539	
Lifetime Maximum			Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits			**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)			Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single			$250	$1,000	$1,650	$3,300	**$500**	**N/A**	**$1,750**	**$5,250**
Family			$750	$3,000	$3,300	$6,600	**$1,000**	**N/A**	**$7,000**	**$21,000**
Coinsurance			0%	50%	20%	40%	0%	**N/A**	**0%**	**0%**
Out-of-Pocket Maximum			*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*					
Single			$3,000	$6,000	$4,800	$9,600	**$3,500**	**N/A**	**$1,750**	**$5,250**
Family			$6,000	$12,000	$7,050 / $9,200	$18,400	**$7,000**	**N/A**	**$7,000**	**$21,000**
Physician Services										
Physician Office Visit			VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	**$25**	**N/A**	CYD	CYD
Specialist Visit			VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	**$50**	**N/A**	CYD	CYD
Laboratory			No Charge	50% After CYD	0% After CYD	40% After CYD	**$100** / **$200**	**N/A**	CYD	CYD
Advanced Imaging			$200	50% After CYD	20% After CYD	40% After CYD	$200 / **$300**	**N/A**	CYD	CYD
Urgent Care Center			VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	$50	$50	CYD	CYD
Preventative Care										
Adult Wellness			No Charge	50%	No Charge	40%	No Charge	**N/A**	No Charge	**CYD**
Hospital										
Inpatient			$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	**CYD**	**N/A**	CYD	CYD
Outpatient			$300	50% After CYD	20% After CYD	40% After CYD	**$400** / **$500**	**N/A**	CYD	CYD
Physician Services			$50	$50	20% After CYD	20% After INN CYD	**CYD**	**N/A**	CYD	CYD
Emergency Room Visit			$200	$200	20% After CYD	20% After INN CYD	**$250**	**$250**	CYD	INN CYD
Mental Health & Substance Abuse Services										
Inpatient			No Charge	50%	20% After CYD	20% After INN CYD	**CYD**	**N/A**	CYD	CYD
Outpatient (OV/Other)			No Charge	50%	20% After CYD	40% After CYD	**$25**	**N/A**	CYD	CYD
Prescription Drugs										
Generic			$10		$10 after CYD		$10 - **$25**		CYD	
Brand Name			$50	50%	$50 after CYD	50% After INN CYD	$40	**N/A**	CYD	**Not Covered**
Non-Preferred Brand			$80		$80 after CYD		$80		CYD	
Specialty			20%	Not Covered	Tier 1-3	Not Covered	30%	**N/A**	CYD	Not Covered
Mail Order (90-Day Supply)			2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	**N/A**	CYD	**Not Covered**
	P1	**P2**								
EE Only	**47**	**3**	$951.73		$776.02		$966.24		$1,033.38	
EE + Spouse	**7**	**1**	$2,169.95		$1,769.32		$2,203.02		$2,356.12	
EE + Child(ren)	**10**	**1**	$1,903.47		$1,552.03		$1,932.47		$2,066.77	
EE + Family	**24**	**2**	$3,045.54		$2,483.25		$3,091.95		$3,306.83	
Monthly Premium	**88**	**7**	**$152,049**		**$10,616**		**$154,366**		**$14,137**	
Annual Premium	**95**		**$1,824,583**		**$127,391**		**$1,852,391**		**$169,640**	
Total Monthly Premium			**$162,665**				**$168,503**			
Total Annual Premium			**$1,951,974**				**$2,022,031**			
Total $ Change			**N/A**				**$70,057**			
Total % Change			**N/A**				**3.6%**			

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			Current				Alternative #2 (Level-Funded)			
			Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191		Benecon Choice Plus PPO		Benecon Choice Plus PPO HSA	
Lifetime Maximum			Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits			**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)			Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single			$250	$1,000	$1,650	$3,300	$250	$1,000	**$1,700**	**$3,400**
Family			$750	$3,000	$3,300	$6,600	$750	$3,000	**$3,400**	**$6,800**
Coinsurance			0%	50%	20%	40%	0%	50%	20%	40%
Out-of-Pocket Maximum			*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*	
Single			$3,000	$6,000	$4,800	$9,600	$3,000	$6,000	$4,800	$9,600
Family			$6,000	$12,000	$7,050 / $9,200	$18,400	$6,000	$12,000	$7,050 / $9,200	$18,400
Physician Services										
Physician Office Visit			VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD
Specialist Visit			VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD
Laboratory			No Charge	50% After CYD	0% After CYD	40% After CYD	No Charge	50% After CYD	0% After CYD	40% After CYD
Advanced Imaging			$200	50% After CYD	20% After CYD	40% After CYD	$200	50% After CYD	20% After CYD	40% After CYD
Urgent Care Center			VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD
Preventative Care										
Adult Wellness			No Charge	50%	No Charge	40%	No Charge	50%	No Charge	40%
Hospital										
Inpatient			$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD
Outpatient			$300	50% After CYD	20% After CYD	40% After CYD	$300	50% After CYD	20% After CYD	40% After CYD
Physician Services			$50	$50	20% After CYD	20% After INN CYD	$50	$50	20% After CYD	20% After INN CYD
Emergency Room Visit			$200	$200	20% After CYD	20% After INN CYD	$200	$200	20% After CYD	20% After INN CYD
Mental Health & Substance Abuse Services										
Inpatient			No Charge	50%	20% After CYD	20% After INN CYD	No Charge	50%	20% After CYD	20% After INN CYD
Outpatient (OV/Other)			No Charge	50%	20% After CYD	40% After CYD	No Charge	50%	20% After CYD	40% After CYD
Prescription Drugs										
Generic			$10		$10 after CYD		$10		$10 after CYD	
Brand Name			$50	50%	$50 after CYD	50% After INN CYD	$50	50%	$50 after CYD	50% After INN CYD
Non-Preferred Brand			$80		$80 after CYD		$80		$80 after CYD	
Specialty			20%	Not Covered	Tier 1-3	Not Covered	20%	Not Covered	Tier 1-3	Not Covered
Mail Order (90-Day Supply)			2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD
	P1	**P2**								
EE Only	**47**	**3**	$951.73		$776.02		$1,086.30		$974.62	
EE + Spouse	**7**	**1**	$2,169.95		$1,769.32		$2,172.59		$1,949.24	
EE + Child(ren)	**10**	**1**	$1,903.47		$1,552.03		$1,748.94		$1,569.14	
EE + Family	**24**	**2**	$3,045.54		$2,483.25		$3,139.39		$2,816.65	
Monthly Premium	**88**	**7**	**$152,049**		**$10,616**		**$159,099**		**$12,076**	
Annual Premium	**95**		**$1,824,583**		**$127,391**		**$1,909,188**		**$144,906**	
Total Monthly Premium			**$162,665**				**$171,175**			
Total Annual Premium			**$1,951,974**				**$2,054,094**			
Total $ Change			**N/A**				**$102,120**			
Total % Change			**N/A**				**5.2%**			

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BROWN & BROWN PUBLIC SECTOR

			Current				Alternative #3 (Level-Funded)			
			Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191		Benecon (Choice Plus Plan 1)		Benecon (HSA Choice Plus Plan 5)	
Lifetime Maximum			Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits			**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)			Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single			$250	$1,000	$1,650	$3,300	$250	**$500**	**$1,700**	**$3,400**
Family			$750	$3,000	$3,300	$6,600	**$500**	**$1,000**	**$3,400**	**$6,800**
Coinsurance			0%	50%	20%	40%	0%	**30%**	**10%**	**30%**
Out-of-Pocket Maximum			*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*					
Single			$3,000	$6,000	$4,800	$9,600	**$2,000**	**$4,000**	**$3,750**	**$7,500**
Family			$6,000	$12,000	$7,050 / $9,200	$18,400	**$4,000**	**$8,000**	$7,500	**$15,000**
Physician Services										
Physician Office Visit			VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	**$15**	**30%** After CYD	**10%** After CYD	**30%** After CYD
Specialist Visit			VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	**$30**	**30%** After CYD	**10%** After CYD	**30%** After CYD
Laboratory			No Charge	50% After CYD	0% After CYD	40% After CYD	No Charge	**30%** After CYD	**10%** After CYD	**30%** After CYD
Advanced Imaging			$200	50% After CYD	20% After CYD	40% After CYD	**$100**	**30%** After CYD	**10%** After CYD	**30%** After CYD
Urgent Care Center			VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	$50	**30%** After CYD	**10%** After CYD	**30%** After CYD
Preventative Care										
Adult Wellness			No Charge	50%	No Charge	40%	No Charge	**Not Covered**	No Charge	**Not Covered**
Hospital										
Inpatient			$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	**0%** After **CYD**	**30%** After CYD	**10%** After CYD	**30%** After CYD
Outpatient			$300	50% After CYD	20% After CYD	40% After CYD	**$100**	**30%** After CYD	**10%** After CYD	**30%** After CYD
Physician Services			$50	$50	20% After CYD	20% After INN CYD	0% After **CYD**	**30%** After **CYD**	**10%** After CYD	**30%** After CYD
Emergency Room Visit			$200	$200	20% After CYD	20% After INN CYD	**$125**	**$125**	**10%** After CYD	**10%** After INN CYD
Mental Health & Substance Abuse Services										
Inpatient			No Charge	50%	20% After CYD	20% After INN CYD	0% After **CYD**	**30%** After **CYD**	**10%** After CYD	**30%** After CYD
Outpatient (OV/Other)			No Charge	50%	20% After CYD	40% After CYD	**$15** / 0% After **CYD**	**30%** After **CYD**	**10%** After CYD	**30%** After CYD
Prescription Drugs										
Generic			$10		$10 after CYD		$10		$10 After CYD	
Brand Name			$50	50%	$50 after CYD	50% After INN CYD	**$35**	Tier 1-3 Copay + any amount over the allowed amount	**$35** After CYD	Tier 1-3 Copay + any amount over the allowed amount
Non-Preferred Brand			$80		$80 after CYD		**$60**		**$60** After CYD	
Specialty			20%	Not Covered	Tier 1-3	Not Covered	Tier 1-3	Not Covered	Tier 1-3	Not Covered
Mail Order (90-Day Supply)			2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered
	P1	**P2**								
EE Only	**47**	**3**	$951.73		$776.02		$1,098.90		$1,008.52	
EE + Spouse	**7**	**1**	$2,169.95		$1,769.32		$2,197.81		$2,017.04	
EE + Child(ren)	**10**	**1**	$1,903.47		$1,552.03		$1,769.24		$1,623.72	
EE + Family	**24**	**2**	$3,045.54		$2,483.25		$3,175.83		$2,914.63	
Monthly Premium	**88**	**7**	**$152,049**		**$10,616**		**$160,945**		**$12,496**	
Annual Premium	**95**		**$1,824,583**		**$127,391**		**$1,931,343**		**$149,947**	
Total Monthly Premium			**$162,665**				**$173,441**			
Total Annual Premium			**$1,951,974**				**$2,081,290**			
Total $ Change			**N/A**				**$129,316**			
Total % Change			**N/A**				**6.6%**			

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BROWN & BROWN PUBLIC SECTOR

			Current				Alternative #4 (Fully)			
			Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191		AvMed Choice CM 175 w/RX 8013		AvMed Choice HSAQ CK 410 w/RX 6539	
Lifetime Maximum			Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits			**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)			Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single			$250	$1,000	$1,650	$3,300	**$1,750**	**$5,250**	**$1,750**	**$5,250**
Family			$750	$3,000	$3,300	$6,600	**$3,500**	**$10,500**	**$7,000**	**$21,000**
Coinsurance			0%	50%	20%	40%	0%	50%	**0%**	**0%**
Out-of-Pocket Maximum			*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*					
Single			$3,000	$6,000	$4,800	$9,600	**$8,000**	**$24,000**	**$1,750**	**$5,250**
Family			$6,000	$12,000	$7,050 / $9,200	$18,400	**$16,000**	**$48,000**	**$7,000**	**$21,000**
Physician Services										
Physician Office Visit			VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	**$25**	50% After CYD	CYD	CYD
Specialist Visit			VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	**$50**	50% After CYD	CYD	CYD
Laboratory			No Charge	50% After CYD	0% After CYD	40% After CYD	**$75** / **$150**	50% After CYD	CYD	CYD
Advanced Imaging			$200	50% After CYD	20% After CYD	40% After CYD	$200 / **$400**	50% After CYD	CYD	CYD
Urgent Care Center			VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	$50	**50%** After CYD	CYD	CYD
Preventative Care										
Adult Wellness			No Charge	50%	No Charge	40%	No Charge	50% After **CYD**	No Charge	**CYD**
Hospital										
Inpatient			$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	**CYD**	50% After CYD	CYD	CYD
Outpatient			$300	50% After CYD	20% After CYD	40% After CYD	**$400** / **$500**	50% After CYD	CYD	CYD
Physician Services			$50	$50	20% After CYD	20% After INN CYD	**CYD**	50% After **CYD**	CYD	CYD
Emergency Room Visit			$200	$200	20% After CYD	20% After INN CYD	**$500**	**$500**	CYD	INN CYD
Mental Health & Substance Abuse Services										
Inpatient			No Charge	50%	20% After CYD	20% After INN CYD	**CYD**	50% After **CYD**	CYD	CYD
Outpatient (OV/Other)			No Charge	50%	20% After CYD	40% After CYD	**$25**	50% After **CYD**	CYD	CYD
Prescription Drugs										
Generic			$10		$10 after CYD		$10 - **$25**		CYD	
Brand Name			$50	50%	$50 after CYD	50% After INN CYD	**$40**	**Not Covered**	CYD	**Not Covered**
Non-Preferred Brand			$80		$80 after CYD		$80		CYD	
Specialty			20%	Not Covered	Tier 1-3	Not Covered	**30%**	Not Covered	CYD	Not Covered
Mail Order (90-Day Supply)			2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	**Not Covered**	CYD	**Not Covered**
	P1	**P2**								
EE Only	**47**	**3**	$951.73		$776.02		$1,057.06		$1,033.38	
EE + Spouse	**7**	**1**	$2,169.95		$1,769.32		$2,410.09		$2,356.12	
EE + Child(ren)	**10**	**1**	$1,903.47		$1,552.03		$2,114.12		$2,066.77	
EE + Family	**24**	**2**	$3,045.54		$2,483.25		$3,382.59		$3,306.83	
Monthly Premium	**88**	**7**	**$152,049**		**$10,616**		**$168,876**		**$14,137**	
Annual Premium	**95**		**$1,824,583**		**$127,391**		**$2,026,510**		**$169,640**	
Total Monthly Premium			**$162,665**				**$183,013**			
Total Annual Premium			**$1,951,974**				**$2,196,150**			
Total $ Change			**N/A**				**$244,176**			
Total % Change			**N/A**				**12.5%**			

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GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

			Current				Alternative #5 (Fully)			
			Florida Blue - BlueOptions Predictable Cost 03768		Florida Blue - BlueOptions HSA Compatible 05190/05191		AvMed In Network ONLY - ACH LH 060 w/RX 8013		AvMed Choice HSAQ CK 410 w/RX 6539	
Lifetime Maximum			Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits			**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)			Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single			$250	$1,000	$1,650	$3,300	$250	N/A	$1,750	$5,250
Family			$750	$3,000	$3,300	$6,600	$500	N/A	$7,000	$21,000
Coinsurance			0%	50%	20%	40%	10%	N/A	0%	0%
Out-of-Pocket Maximum			*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*					
Single			$3,000	$6,000	$4,800	$9,600	$3,500	N/A	$1,750	$5,250
Family			$6,000	$12,000	$7,050 / $9,200	$18,400	$7,000	N/A	$7,000	$21,000
Physician Services										
Physician Office Visit			VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	$15	N/A	CYD	CYD
Specialist Visit			VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	$30	N/A	CYD	CYD
Laboratory			No Charge	50% After CYD	0% After CYD	40% After CYD	$50 / $100	N/A	CYD	CYD
Advanced Imaging			$200	50% After CYD	20% After CYD	40% After CYD	$200 / $400	N/A	CYD	CYD
Urgent Care Center			VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	$75	$75	CYD	CYD
Preventative Care										
Adult Wellness			No Charge	50%	No Charge	40%	No Charge	N/A	No Charge	CYD
Hospital										
Inpatient			$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	10% After CYD	N/A	CYD	CYD
Outpatient			$300	50% After CYD	20% After CYD	40% After CYD	10% After CYD	N/A	CYD	CYD
Physician Services			$50	$50	20% After CYD	20% After INN CYD	10% After CYD	N/A	CYD	CYD
Emergency Room Visit			$200	$200	20% After CYD	20% After INN CYD	$250	$250	CYD	INN CYD
Mental Health & Substance Abuse Services										
Inpatient			No Charge	50%	20% After CYD	20% After INN CYD	10% After CYD	N/A	CYD	CYD
Outpatient (OV/Other)			No Charge	50%	20% After CYD	40% After CYD	$15	N/A	CYD	CYD
Prescription Drugs										
Generic			$10		$10 after CYD		$10 - $25		CYD	
Brand Name			$50	50%	$50 after CYD	50% After INN CYD	$40	N/A	CYD	Not Covered
Non-Preferred Brand			$80		$80 after CYD		$80		CYD	
Specialty			20%	Not Covered	Tier 1-3	Not Covered	30%	N/A	CYD	Not Covered
Mail Order (90-Day Supply)			2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	N/A	CYD	Not Covered
	P1	**P2**								
EE Only	**47**	**3**	$951.73		$776.02		$1,130.85		$1,033.38	
EE + Spouse	**7**	**1**	$2,169.95		$1,769.32		$2,578.33		$2,356.12	
EE + Child(ren)	**10**	**1**	$1,903.47		$1,552.03		$2,261.69		$2,066.77	
EE + Family	**24**	**2**	$3,045.54		$2,483.25		$3,618.71		$3,306.83	
Monthly Premium	**88**	**7**	**$152,049**		**$10,616**		**$180,664**		**$14,137**	
Annual Premium	**95**		**$1,824,583**		**$127,391**		**$2,167,970**		**$169,640**	
Total Monthly Premium			**$162,665**				**$194,801**			
Total Annual Premium			**$1,951,974**				**$2,337,611**			
Total $ Change			**N/A**				**$385,636**			
Total % Change			**N/A**				**19.8%**			

City of Cooper City
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GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

	Current				Alternative #6 (Fully)			
	Florida Blue - BlueOptions Predictable Cost 03768		**Florida Blue - BlueOptions HSA Compatible 05190/05191**		**AvMed Choice CM 075 w/RX 8013**		**AvMed Choice HSAQ CK 362 w/RX 6540**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single	$250	$1,000	$1,650	$3,300	**$500**	**$1,500**	**$3,500**	**$10,500**
Family	$750	$3,000	$3,300	$6,600	**$1,000**	$3,000	**$7,000**	**$21,000**
Coinsurance	0%	50%	20%	40%	0%	**30%**	20%	**50%**
Out-of-Pocket Maximum	*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*					
Single	$3,000	$6,000	$4,800	$9,600	**$3,500**	**$10,500**	**$6,500**	**$19,500**
Family	$6,000	$12,000	$7,050 / $9,200	$18,400	**$7,000**	**$21,000**	**$13,000**	**$39,000**
Physician Services								
Physician Office Visit	VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	**$25**	**30%** After CYD	20% After CYD	**50%** After CYD
Specialist Visit	VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	**$50**	**30%** After CYD	20% After CYD	**50%** After CYD
Laboratory	No Charge	50% After CYD	0% After CYD	40% After CYD	**$100** / **$200** After **CYD**	**30%** After CYD	**20%** After CYD	**50%** After CYD
Advanced Imaging	$200	50% After CYD	20% After CYD	40% After CYD	$200 / **$300** After **CYD**	**30%** After CYD	20% After CYD	**50%** After CYD
Urgent Care Center	VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	$50	**30%** After CYD	20% After CYD	**50%** After CYD
Preventative Care								
Adult Wellness	No Charge	50%	No Charge	40%	No Charge	**30% After CYD**	No Charge	**50%** After **CYD**
Hospital								
Inpatient	$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	**CYD**	**30%** After CYD	20% After CYD	**50%** After CYD
Outpatient	$300	50% After CYD	20% After CYD	40% After CYD	**$500** After **CYD**	**30%** After CYD	20% After CYD	**50%** After CYD
Physician Services	$50	$50	20% After CYD	20% After INN CYD	**CYD**	**30%** After **CYD**	20% After CYD	**50%** After **CYD**
Emergency Room Visit	$200	$200	20% After CYD	20% After INN CYD	**$250**	**$250**	20% After CYD	20% After INN CYD
Mental Health & Substance Abuse Services								
Inpatient	No Charge	50%	20% After CYD	20% After INN CYD	**CYD**	**30%** After **CYD**	20% After CYD	**50%** After **CYD**
Outpatient (OV/Other)	No Charge	50%	20% After CYD	40% After CYD	**$25**	**30%** After **CYD**	20% After CYD	**50%** After CYD
Prescription Drugs								
Generic	$10		$10 after CYD		$10 - **$25**		$10 - **$20**	
Brand Name	$50	50%	$50 after CYD	50% After INN CYD	**$40**	**Not Covered**	$50	**Not Covered**
Non-Preferred Brand	$80		$80 after CYD		$80		**$100**	
Specialty	20%	Not Covered	Tier 1-3	Not Covered	**30%**	Not Covered	30%	Not Covered
Mail Order (90-Day Supply)	2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	**Not Covered**	2.5x Retail Copay	**Not Covered**
	P1 **P2**							
EE Only	**47** **3**	$951.73		$776.02		$1,209.62		$743.03
EE + Spouse	**7** **1**	$2,169.95		$1,769.32		$2,757.94		$1,694.11
EE + Child(ren)	**10** **1**	$1,903.47		$1,552.03		$2,419.24		$1,486.07
EE + Family	**24** **2**	$3,045.54		$2,483.25		$3,870.79		$2,377.71
Monthly Premium	**88** **7**	**$152,049**		**$10,616**		**$193,249**		**$10,165**
Annual Premium	**95**	**$1,824,583**		**$127,391**		**$2,318,989**		**$121,976**
Total Monthly Premium		**$162,665**				**$203,414**		
Total Annual Premium		**$1,951,974**				**$2,440,965**		
Total $ Change		**N/A**				**$488,991**		
Total % Change		**N/A**				**25.1%**		

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GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

	Current				Alternative #7 (Level-Funded)			
	Florida Blue - BlueOptions Predictable Cost 03768		**Florida Blue - BlueOptions HSA Compatible 05190/05191**		**Cigna OAP PPO**		**Cigna HSA OAP**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Single	$250	$1,000	$1,650	$3,300	$250	$1,000	**$1,700**	**$3,400**
Family	$750	$3,000	$3,300	$6,600	$750	$3,000	**$3,400**	$6,600
Coinsurance	0%	50%	20%	40%	0%	50%	20%	40%
Out-of-Pocket Maximum	*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*			
Single	$3,000	$6,000	$4,800	$9,600	$3,000	$6,000	$4,800	$9,600
Family	$6,000	$12,000	$7,050 / $9,200	$18,400	$6,000	$12,000	$7,050 / $9,200	$18,400
Physician Services								
Physician Office Visit	VCP: $0/ PCP: $20	50% After CYD	VCP: CYD/ PCP: 20% After CYD	40% After CYD	$20	50% After CYD	20% After CYD	40% After CYD
Specialist Visit	VCS: $20/ Specialist: $45	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD	$45	50% After CYD	20% After CYD	40% After CYD
Laboratory	No Charge	50% After CYD	0% After CYD	40% After CYD	No Charge	50% After CYD	0% After CYD	40% After CYD
Advanced Imaging	$200	50% After CYD	20% After CYD	40% After CYD	$200	50% After CYD	20% After CYD	40% After CYD
Urgent Care Center	VCP: $0 1-2 Visits/ Urgent Care: $50	$50 After CYD	VCP: CYD / Urgent Care: 20% After CYD	20% After CYD	$50	**50%** After CYD	20% After CYD	**40%** After CYD
Preventative Care								
Adult Wellness	No Charge	50%	No Charge	40%	No Charge	50% After **CYD**	No Charge	40% After **CYD**
Hospital								
Inpatient	$700 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD	$700 Per Admission	50% After CYD	20% After CYD	40% After CYD
Outpatient	$300	50% After CYD	20% After CYD	40% After CYD	$300	50% After CYD	20% After CYD	40% After CYD
Physician Services	$50	$50	20% After CYD	20% After INN CYD	**CYD**	**50%** After **CYD**	20% After CYD	**40%** After CYD
Emergency Room Visit	$200	$200	20% After CYD	20% After INN CYD	$200	$200	20% After CYD	20% After CYD
Mental Health & Substance Abuse Services								
Inpatient	No Charge	50%	20% After CYD	20% After INN CYD	No Charge	50% After **CYD**	20% After CYD	**40%** After CYD
Outpatient (OV/Other)	No Charge	50%	20% After CYD	40% After CYD	No Charge	50% After **CYD**	20% After CYD / CYD	40% After CYD
Prescription Drugs								
Generic	$10		$10 after CYD		$10 after **CYD**		$10 after CYD	
Brand Name	$50	50%	$50 after CYD	50% After INN CYD	$50 after **CYD**	50%	$50 after CYD	50% After INN CYD
Non-Preferred Brand	$80		$80 after CYD		$80 after **CYD**		$80 after CYD	
Specialty	20%	Not Covered	Tier 1-3	Not Covered	20% after **CYD**	Not Covered	Tier 1-3	Not Covered
Mail Order (90-Day Supply)	2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD	2.5x Retail Copay	50%	2.5x Retail Copay	50% After INN CYD
	P1 **P2**							
EE Only	**47** **3**	$951.73		$776.02		$1,271.62		$1,155.79
EE + Spouse	**7** **1**	$2,169.95		$1,769.32		$2,899.29		$2,635.20
EE + Child(ren)	**10** **1**	$1,903.47		$1,552.03		$2,543.25		$2,311.58
EE + Family	**24** **2**	$3,045.54		$2,483.25		$4,069.20		$3,698.53
Monthly Premium	**88** **7**	**$152,049**		**$10,616**		**$203,154**		**$15,811**
Annual Premium	**95**	**$1,824,583**		**$127,391**		**$2,437,854**		**$189,735**
Total Monthly Premium		**$162,665**				**$218,966**		
Total Annual Premium		**$1,951,974**				**$2,627,588**		
Total $ Change		**N/A**				**$675,614**		
Total % Change		**N/A**				**34.6%**		

Dental Renewal

City of Cooper City
PPO Dental Renewal Evaluation
Effective Date: October 1, 2026

GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

		CURRENT		RENEWAL OPTION #1		RENEWAL OPTION #2	
Schedule of Benefits		**Humana**		**Humana**		**Humana**	
Plan Basics		***In Network***	***Out of Network***	***In Network***	***Out of Network***	***In Network***	***Out of Network***
Calendar Year Maximum		Unlimited		Unlimited		Unlimited	
Deductibles							
Single		$50	$50	$50	$50	$50	$50
Family		$150	$150	$150	$150	$150	$150
Deductible Waived for Preventive Svcs		Yes	Yes	Yes	Yes	Yes	Yes
Benefits							
Preventive		100%	80%	100%	80%	100%	80%
Basic		80%	50%	80%	50%	80%	50%
Major		50%	50%	50%	50%	50%	50%
Orthodontia (To Age 19)		50%	50%	50%	50%	50%	50%
Service Information							
Out of Network Benefits		MAF		MAF		MAF	
Waiting Period (Timely Entrants)		None		None		None	
Orthodontia Lifetime Max		$1,500		$1,500		$1,500	
Endodontics/Periodontics		Basic		Basic		Basic	
Rate Guarantee Period		**Expires 09/30/2026**		**Expires 09/30/2028**		**Expires 09/30/2027**	
Employee	70	$32.80		$34.76		$34.05	
Family	60	$101.62		$107.72		$105.48	
Monthly Premium	**130**	**$8,393**		**$8,896**		**$8,712**	
Annual Premium		**$100,718**		**$106,757**		**$104,548**	
$ Increase		**N/A**		**$6,038**		**$3,829**	
% Increase		**N/A**		**6.0%**		**3.8%**	

**Two year rate guarentee is contingent on both the dental and vision renewing with Humana.*

Vision Renewal

City of Cooper City
Vision Insurance Renewal Evaluation
Effective Date: October 1, 2026

GEHRING GROUP
BROWN & BROWN PUBLIC SECTOR

		CURRENT		RENEWAL		RENEWAL OPTION #1	
Schedule of Benefits		**Humana Vision 160**		**Humana Vision 160**		**Humana Vision 160**	
		In Network	***Out of Network***	***In Network***	***Out of Network***	***In Network***	***Out of Network***
Eye Exam		$10 Copay	Up to $30	$10 Copay	Up to $30	$10 Copay	Up to $30
Contact Lens Fit & Follow-Up Exam (Standard)		No Charge	Up to $30	No Charge	Up to $30	No Charge	Up to $30
Frequency							
Exam Copay		12 Months		12 Months		12 Months	
Lenses		12 Months		12 Months		12 Months	
Frames		24 Months		24 Months		24 Months	
Benefits Payable		***Copay***	***Reimbursement***	***Copay***	***Reimbursement***	***Copay***	***Reimbursement***
Single Lenses		$10	Up to $25	$10	Up to $25	$10	Up to $25
Bifocal Lenses		$10	Up to $40	$10	Up to $40	$10	Up to $40
Trifocal Lenses		$10	Up to $60	$10	Up to $60	$10	Up to $60
Lenticular Lenses		$10	Up to $100	$10	Up to $100	$10	Up to $100
Lenses and Frames		***Retail Allowance***	***Allowance***	***Retail Allowance***	***Allowance***	***Retail Allowance***	***Allowance***
Contact Lenses (Elective)		$160, then 15% discount	$128	$160, then 15% discount	$128	$160, then 15% discount	$128
Contact Lenses(Medically Necessary)		No Charge	$210	No Charge	$210	No Charge	$210
Frames		$160, then 20% discount	$80	$160, then 20% discount	$80	$160, then 20% discount	$80
Rate Guarantee Period		**Expires 09/30/2026**		**Expires 09/30/2027**		**Expires 09/30/2028**	
Employee	65	$7.24		$7.24		$7.24	
Employee + Family	61	$18.46		$18.46		$18.46	
Monthly Premium	**126**	**$1,597**		**$1,597**		**$1,597**	
Annual Premium		**$19,160**		**$19,160**		**$19,160**	
$ Increase		**N/A**		**$0**		**$0**	
% Increase		**N/A**		**0.0%**		**0.0%**	