City of Cooper City

Medical Insurance Renewal Evaluation 2-Tier

Effective Date: October 1, 2025

	Current 2024-2025					
	FMIT - UHC Choice Plus Plan 1		**FMIT - UHC Choice Plus Plan 2**		**FMIT - UHC Choice HSA Plus Plan 5**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year	
Single	$250	$500	$250	$500	$1,600	$2,500
Family	$500	$1,000	$500	$1,000	$3,200	$5,000
Coinsurance	**0%**	**30%**	**10%**	**30%**	**10%**	**30%**
Out-of-Pocket Maximum	*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*	
Single	$2,000	$4,000	$2,500	$5,000	$3,750	$7,500
Family	$4,000	$8,000	$5,000	$10,000	$7,500	$15,000
Physician Services						
Physician Office Visit	$15	30% After CYD	$15	30% After CYD	10% After CYD	30% After CYD
Specialist Visit	$30	30% After CYD	$30	30% After CYD	10% After CYD	30% After CYD
Laboratory	No Charge	30% After CYD	No Charge	30% After CYD	10% After CYD	30% After CYD
Advanced Imaging	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Urgent Care Center	$50	30% After CYD	$50	30% After CYD	10% After CYD	30% After CYD
Preventative Care						
Adult Wellness	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Hospital						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Physician Services	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Emergency Room Visit	$125	$125	$125	$125	10% After CYD	10% After INN CYD
Mental Health & Nervous						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient (OV/Other)	$15/ 0% After CYD	30% After CYD	$15/ 10% After CYD	30% After CYD	10% After CYD	30% After CYD
Prescription Drugs					*(Rx Copays After CYD)*	
Generic	$10		$10		$10	
Brand Name	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount
Non-Preferred Brand	$60		$60		$60	
Mail Order (90-Day Supply)	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered
EE Only	$1,264.89		$1,195.08		$1,064.92	
EE + Family	$2,612.49		$2,468.31		$2,199.48	
Monthly Premium	**$170,605**		**$23,175**		**$4,329**	
Annual Premium	**$2,047,257**		**$278,105**		**$51,952**	
Total Monthly Premium			**$198,109**			
Total Annual Premium			**$2,377,314**			
Total $ Change			**N/A**			
Total % Change			**N/A**			

RISK strategies | GEHRING GROUP A RISK STRATEGIES COMPANY

	Renewal 2025-2026					
	FMIT - UHC Choice Plus Plan 1		**FMIT - UHC Choice Plus Plan 2**		**FMIT - UHC Choice HSA Plus Plan 5**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**

Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year	
Single	$250	$500	$250	$500	**$1,650**	$2,500
Family	$500	$1,000	$500	$1,000	**$3,300**	$5,000
Coinsurance	**0%**	**30%**	**10%**	**30%**	**10%**	**30%**
Out-of-Pocket Maximum	*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*	
Single	$2,000	$4,000	$2,500	$5,000	$3,750	$7,500
Family	$4,000	$8,000	$5,000	$10,000	$7,500	$15,000
Physician Services						
Physician Office Visit	$15	30% After CYD	$15	30% After CYD	10% After CYD	30% After CYD
Specialist Visit	$30	30% After CYD	$30	30% After CYD	10% After CYD	30% After CYD
Laboratory	No Charge	30% After CYD	No Charge	30% After CYD	10% After CYD	30% After CYD
Advanced Imaging	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Urgent Care Center	$50	30% After CYD	$50	30% After CYD	10% After CYD	30% After CYD
Preventative Care						
Adult Wellness	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Hospital						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Physician Services	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Emergency Room Visit	$125	$125	$125	$125	10% After CYD	10% After INN CYD
Mental Health & Nervous						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient (OV/Other)	$15/ 0% After CYD	30% After CYD	$15/ 10% After CYD	30% After CYD	10% After CYD	30% After CYD
Prescription Drugs					*(Rx Copays After CYD)*	
Generic	$10		$10		$10	
Brand Name	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount
Non-Preferred Brand	$60		$60		$60	
Mail Order (90-Day Supply)	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered
EE Only	$1,769.58		$1,671.92		$1,489.82	
EE + Family	$3,654.87		$3,453.17		$3,077.07	
Monthly Premium	**$238,676**		**$32,422**		**$6,057**	
Annual Premium	**$2,864,110**		**$389,070**		**$72,681**	
Total Monthly Premium	**$277,155**					
Total Annual Premium	**$3,325,860**					
Total $ Change	**$948,546**					
Total % Change	**39.9%**					

	Alternative #1					
	BlueOptions Predictable Cost 03768		**BlueOptions Predictable Cost 03766**		**BlueOptions HSA Compatible 05190/05191**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year	
Single	$250	**$1,000**	**$0**	$500	**$1,650**	**$3,300**
Family	**$750**	**$3,000**	**$0**	**$1,500**	**$3,300**	**$6,600**
Coinsurance	**0%**	**50%**	**20%**	**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**	$2,500	$5,000	**$4,800**	**$9,600**
Family	**$6,000**	**$12,000**	$5,000	$10,000	$7,500 / **$9,200**	**$18,400**
Physician Services						

Physician Office Visit	VCP: $0/ PCP: $20	50% 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: $20/ Specialist: $40	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD
Laboratory	$50	50% After CYD	$50	50% After CYD	20% After CYD	40% After CYD
Advanced Imaging	$200	50% After CYD	$150	50% After CYD	20% After CYD	40% After CYD
Urgent Care Center	VCP: $0 1-2 Visits/ Urgent Care: $50	50% After $50	VCP: $0 1-2 Visits/ Urgent Care: $45	50% After $45	VCP: CYD / Urgent Care: 20% After CYD	40% After CYD
Preventative Care						
Adult Wellness	No Charge	50% After CYD	No Charge	50% After CYD	No Charge	40%
Hospital						
Inpatient	$700 Per Admission	50% After CYD	$600 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD
Outpatient	$300	50% After CYD	$200	50% After CYD	20% After CYD	40% After CYD
Physician Services	$50	$50	$0	$0	20% After CYD	20% After INN CYD
Emergency Room Visit	$200	$200	$100	$100	20% After CYD	20% After INN CYD
Mental Health & Nervous						
Inpatient	$0	50%	$0	50%	20% After CYD	20% After INN CYD
Outpatient (OV/Other)	$0	50%	$0	50%	20% After CYD	40% After CYD
Prescription Drugs					*(Rx Copays After CYD)*	
Generic	$10		$10		$10	
Brand Name	$50	50%	$50	50%	$50	50%
Non-Preferred Brand	$80		$80		$80	
Mail Order (90-Day Supply)	2.5x Retail Copay	50%	2.5x Retail Copay	50%	2.5x Retail Copay	50%
EE Only	$1,019.99		$1,041.02		$830.59	
EE + Family	$2,631.57		$2,685.84		$2,141.93	
Monthly Premium	**$160,669**		**$23,402**		**$3,803**	
Annual Premium	**$1,928,024**		**$280,826**		**$45,637**	
Total Monthly Premium			**$187,874**			
Total Annual Premium			**$2,254,487**			
Total $ Change			**-$122,826**			
Total % Change			**-5.2%**			

City of Cooper City

Medical Insurance Renewal Evaluation 4-Tier

Effective Date: October 1, 2025

	Current					
	FMIT - UHC Choice Plus Plan 1		**FMIT - UHC Choice Plus Plan 2**		**FMIT - UHC Choice HSA Plus Plan 5**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year	
Single	$250	$500	$250	$500	$1,600	$2,500
Family	$500	$1,000	$500	$1,000	$3,200	$5,000
Coinsurance	**0%**	**30%**	**10%**	**30%**	**10%**	**30%**
Out-of-Pocket Maximum	*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*	
Single	$2,000	$4,000	$2,500	$5,000	$3,750	$7,500
Family	$4,000	$8,000	$5,000	$10,000	$7,500	$15,000
Physician Services						
Physician Office Visit	$15	30% After CYD	$15	30% After CYD	10% After CYD	30% After CYD
Specialist Visit	$30	30% After CYD	$30	30% After CYD	10% After CYD	30% After CYD
Laboratory	No Charge	30% After CYD	No Charge	30% After CYD	10% After CYD	30% After CYD
Advanced Imaging	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD

Urgent Care Center	$50	30% After CYD	$50	30% After CYD	10% After CYD	30% After CYD
Preventative Care						
Adult Wellness	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Hospital						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Physician Services	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Emergency Room Visit	$125	$125	$125	$125	10% After CYD	10% After INN CYD
Mental Health & Nervous						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient (OV/Other)	$15/ 0% After CYD	30% After CYD	$15/ 10% After CYD	30% After CYD	10% After CYD	30% After CYD
Prescription Drugs					*(Rx Copays After CYD)*	
Generic	$10		$10		$10	
Brand Name	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount
Non-Preferred Brand	$60		$60		$60	
Mail Order (90-Day Supply)	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered
EE Only	$1,264.89		$1,195.08		$1,064.92	
EE + Spouse	N/A		N/A		N/A	
EE + Child(ren)	N/A		N/A		N/A	
EE + Family	$2,612.49		$2,468.31		$2,199.48	
Monthly Premium	**$170,605**		**$23,175**		**$4,329**	
Annual Premium	**$2,047,257**		**$278,105**		**$51,952**	
Total Monthly Premium			**$198,109**			
Total Annual Premium			**$2,377,314**			
Total $ Change			**N/A**			
Total % Change			**N/A**			

RISK strategies | GEHRING GROUP A RISK STRATEGIES COMPANY

	Renewal					
	FMIT - UHC Choice Plus Plan 1		**FMIT - UHC Choice Plus Plan 2**		**FMIT - UHC Choice HSA Plus Plan 5**	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year	
Single	$250	$500	$250	$500	**$1,650**	$2,500
Family	$500	$1,000	$500	$1,000	**$3,300**	$5,000
Coinsurance	**0%**	**30%**	**10%**	**30%**	**10%**	**30%**
Out-of-Pocket Maximum	*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*		*Includes Coins, Ded, and Rx Copays*	
Single	$2,000	$4,000	$2,500	$5,000	$3,750	$7,500
Family	$4,000	$8,000	$5,000	$10,000	$7,500	$15,000
Physician Services						
Physician Office Visit	$15	30% After CYD	$15	30% After CYD	10% After CYD	30% After CYD
Specialist Visit	$30	30% After CYD	$30	30% After CYD	10% After CYD	30% After CYD
Laboratory	No Charge	30% After CYD	No Charge	30% After CYD	10% After CYD	30% After CYD
Advanced Imaging	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Urgent Care Center	$50	30% After CYD	$50	30% After CYD	10% After CYD	30% After CYD
Preventative Care						
Adult Wellness	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Hospital						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient	$100	30% After CYD	$100	30% After CYD	10% After CYD	30% After CYD
Physician Services	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD

Emergency Room Visit	$125	$125	$125	$125	10% After CYD	10% After INN CYD
Mental Health & Nervous						
Inpatient	0% After CYD	30% After CYD	10% After CYD	30% After CYD	10% After CYD	30% After CYD
Outpatient (OV/Other)	$15/ 0% After CYD	30% After CYD	$15/ 10% After CYD	30% After CYD	10% After CYD	30% After CYD
Prescription Drugs					*(Rx Copays After CYD)*	
Generic	$10		$10		$10	
Brand Name	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount	$35	Tier 1-3 Copay + any amount over the allowed amount
Non-Preferred Brand	$60		$60		$60	
Mail Order (90-Day Supply)	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered	2.5x Retail Copay	Not Covered
EE Only	$1,420.35		$1,341.96		$1,195.80	
EE + Spouse	$3,053.75		$2,885.21		$2,570.97	
EE + Child(ren)	$2,698.66		$2,549.72		$2,272.02	
EE + Family	$4,403.08		$4,160.07		$3,706.98	
Monthly Premium	**$239,258**		**$31,469**		**$4,664**	
Annual Premium	**$2,871,093**		**$377,627**		**$55,963**	
Total Monthly Premium			**$275,390**			
Total Annual Premium			**$3,304,684**			
Total $ Change			**$927,370**			
Total % Change			**39.0%**			

Alternative #1

	BlueOptions Predictable Cost 03768		BlueOptions Predictable Cost 03766		BlueOptions HSA Compatible 05190/05191	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Schedule of Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible (CYD)	Calendar Year		Calendar Year		Calendar Year	
Single	$250	$1,000	$0	$500	$1,650	$3,300
Family	$750	$3,000	$0	$1,500	$3,300	$6,600
Coinsurance	0%	50%	20%	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	$2,500	$5,000	$4,800	$9,600
Family	$6,000	$12,000	$5,000	$10,000	$7,500 / $9,200	$18,400
Physician Services						
Physician Office Visit	VCP: $0/ PCP: $20	50% 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: $20/ Specialist: $40	50% After CYD	VCS: CYD/ Specialist: 20% After CYD	40% After CYD
Laboratory	$50	50% After CYD	$50	50% After CYD	20% After CYD	40% After CYD
Advanced Imaging	$200	50% After CYD	$150	50% After CYD	20% After CYD	40% After CYD
Urgent Care Center	VCP: $0 1-2 Visits/ Urgent Care: $50	50% After $50	VCP: $0 1-2 Visits/ Urgent Care: $45	50% After $45	VCP: CYD / Urgent Care: 20% After CYD	40% After CYD
Preventative Care						
Adult Wellness	No Charge	50% After CYD	No Charge	50% After CYD	No Charge	40%
Hospital						
Inpatient	$700 Per Admission	50% After CYD	$600 Per Admission	50% After CYD	20% After CYD	$500 PAD + 40% After CYD
Outpatient	$300	50% After CYD	$200	50% After CYD	20% After CYD	40% After CYD
Physician Services	$50	$50	$0	$0	20% After CYD	20% After INN CYD
Emergency Room Visit	$200	$200	$100	$100	20% After CYD	20% After INN CYD
Mental Health & Nervous						
Inpatient	$0	50%	$0	50%	20% After CYD	20% After INN CYD
Outpatient (OV/Other)	$0	50%	$0	50%	20% After CYD	40% After CYD
Prescription Drugs					*(Rx Copays After CYD)*	
Generic	$10		$10		$10	
Brand Name	$50	50%	$50	50%	$50	50%
Non-Preferred Brand	$80		$80		$80	

Mail Order (90-Day Supply)	2.5x Retail Copay	50%	2.5x Retail Copay	50%	2.5x Retail Copay	50%
EE Only	$951.73		$971.25		$776.02	
EE + Spouse	$2,169.95		$2,214.44		$1,769.32	
EE + Child(ren)	$1,903.47		$1,942.50		$1,552.03	
EE + Family	$3,045.54		$3,107.99		$2,483.25	
Monthly Premium	**$164,650**		**$23,388**		**$3,104**	
Annual Premium	**$1,975,794**		**$280,652**		**$37,249**	
Total Monthly Premium	**$191,141**					
Total Annual Premium	**$2,293,695**					
Total $ Change	**-$83,619**					
Total % Change	**-3.5%**					