

September 8, 2020

Workshop Meeting
12:00 Noon

****Teleconference as allowed under Executive Order 20-69****

App-Zoom

Phone # 1-646-876-9923

Meeting ID: 899 7142 0823

Password: 351427

City Commission Chambers
2775 Garrison Avenue
Port St. Joe, Florida



City of Port St. Joe

Rex Buzzett, Mayor-Commissioner
Eric Langston, Commissioner, Group I
David Ashbrook, Commissioner, Group II
Brett Lowry, Commissioner, Group III
Scott Hoffman, Commissioner, Group IV

[All persons are invited to attend these meetings. Any person who decides to appeal any decision made by the Commission with respect to any matter considered at said meeting will need a record of the proceedings, and for such purpose may need to ensure that a verbatim record of the proceedings is made, which record includes the testimony and evidence upon which the appeal is to be based. The Board of City Commission of the City of Port St. Joe, Florida will not provide a verbatim record of this meeting.]

BOARD OF CITY COMMISSION

Workshop Meeting

12:00 Noon

****Teleconference as allowed under Executive Order 20-69****

App- Zoom

PHONE #1-646-876-9923

Meeting ID: 899 7142 0823

Password: 351427

2775 Garrison Avenue

Tuesday September 8, 2020

Call to Order

Agenda

- 2020-2021 Budget

Pages 1-14

Citizens to be Heard

Discussion Items by Commissioners

Motion to Adjourn

2020-2021 Budget Review

9/15/2020

<u>Ad Valorem Tax</u>	<u>Millage</u>	<u>Amount</u>		<u>Variance</u>
		<u>Levied</u>		
2019-20	3.5914	\$	1,018,290	
2020-21 Estimate	3.5914	\$	1,151,411	\$ 133,121
2020-21 Est 1/4 Mill	3.8414	\$	1,231,561	\$ 213,272
2020-21 Est 1 Mill	4.5914	\$	1,472,013	\$ 320,602

Outstanding Issues - Key Components:

1. Current Ad Valorem Rate = 3.5914, No Change,
2. Added Ad Valorem PSJ DRA County \$408K-\$40K Inter local Fire Dept Funds,
3. PSJ DRA Expanded Boundry \$680.95,
4. Health Insurance, 4.92% increase, \$30,000 increase, Prior Year \$755, \$42 increase \$792 per month.
5. Liability & Workers Comp Insurance, No Increase-Flat
6. Employee salary COLA 3.0% = \$71,554 total all Funds, all full time employees
7. Employee Merit Raise \$1.00 = \$20,400, 10 Total
8. Employee Certification Raise \$1.00 = \$4,080 - 2 Total
10. FRS City Retirement Cost Increase 1.50% = \$32,000,
11. BCC Garbage Rate Increase 3%,
12. Port Authority Note Due May 2021, \$190,828.50
13. Life Insurance, Current \$30K coverage reduction of \$1,822, \$50K coverage increase \$2,122 annually

Staffing Changes:

<u>Department</u>	<u>Title</u>	<u>Action</u>	<u>In Budget</u>	<u>Not In Budget</u>
City COLA 3%	All Full Time Employees	Cost of Living	\$ 71,554	\$ -
City Hall	Pierce-Lacour	Merit Raise	\$ 4,080	\$ -
Police Department	Dickey-Vanheerden	Merit Raise	\$ 4,368	\$ -
Recreation	Project Coordinator (1040 Hrs)	Part Time	\$ 28,289	\$ -
Recreation	Recreation (1560 Hrs)	Part Time	\$ 22,369	\$ -
Water Plant	Pierce-Mack-Mcclamma	Merit Raise	\$ 6,120	\$ -
Water Plant	Harmon	Class C Licence	\$ 2,040	\$ -
Streets & Hwy	Bailey-Grantland	Merit Raise	\$ 4,080	\$ -
Water Water Distr	Monroe- Added Davis	Merit Raise	\$ 4,080	\$ -
Waste Water Plant	Manley-Pettis	Merit Raise	\$ 4,080	\$ -
Total			\$ 151,060	\$ -


Revenue Generators

	<u>In Budget</u>	<u>Not In Budget</u>
Boat Ramp Fees	\$ 26,823	\$ -
Marina Rental Agreement stop Dec 2020?	\$ 7,200	\$ -
Added Capital City Bank Lease 3 months @ \$3,000 per month	\$ 9,000	\$ -
Emerald Coast Lease	\$ -	\$ 6,300
BCC Transfer Station Lease \$1,000 mo lease	\$ 10,000	\$ -
BCC Transfer Station Tonnage Fees	\$ -	\$ 38,000
Water Tower Verizon Lease	\$ 53,877	\$ -
Total	\$ 106,900	\$ 44,300

Long Ave Project

	<u>SRF Grant 80%</u>	<u>SRF Loan 20%</u>	<u>Expenses</u>
General Fund-Long Ave-State Appropriation	\$ -	\$ -	\$ 1,000,000
Water line replacement	\$ 1,400,000	\$ 350,000	\$ 1,750,000
Sewer Line replacement	\$ 2,160,000	\$ 1,620,000	\$ 2,700,000
Total	\$ 3,560,000	\$ 1,970,000	\$ 5,450,000


City of Port St. Joe
Life and AD&D Cost Analysis
 Effective date: October 1, 2020

	Current & Renewal	Alternate	Alternate Option 1	Alternate Option 2
	Humana	Humana	MetLife	MetLife
Benefits	All Eligible Employees	All Eligible Employees	All Eligible Employees	All Eligible Employees
Life Amount	\$30,000	\$50,000	\$30,000	\$50,000
Reduction Schedule	50% at age 70 of original based on in force at age 69	50% at age 70 of original based on in force at age 69	35% at age 65; 50% at age 70	35% at age 65; 50% at age 70
Other Features				
Accelerated Benefit	50% of coverage amount up to \$250,000	50% of coverage amount up to \$250,000	Up to 80% of coverage amount up to \$500,000	Up to 80% of coverage amount up to \$500,000
Waiver of Premium	Included	Included	Included	Included
Portability/Conversion	Included	Included	Included	Included
Participation Requirement Rates	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory
Volume (monthly)	\$1,830,000	\$2,975,000	\$1,708,500	\$2,847,500
Life Rate (per \$1,000)	\$0.38	\$0.44	\$0.300	\$0.265
AD&D Rate (per \$1,000)	\$0.04	\$0.03	\$0.028	\$0.028
Estimated Monthly Premium	\$768.60	\$1,398.25	\$560.39	\$834.32
Estimated Annual Premium	\$9,223.20	\$16,779.00	\$6,724.66	\$10,014.81
			2 Year Rate Guarantee	2 Year Rate Guarantee

This summary highlights the benefits. It is not a summary plan description (SPD). Official plan documents actually govern the rights and benefits including covered expenses, exclusions and limitations. If any discrepancy exists between this summary and the official documents, the official documents will prevail.


2

City of Port St. Joe
Life and AD&D Cost Analysis
 Effective date: October 1, 2020

	Current & Renewal	Alternate	Alternate Option 1	Alternate Option 2
	Humana	Humana	Unum	Unum
Benefits	All Eligible Employees	All Eligible Employees	All Eligible Employees	All Eligible Employees
Life Amount	\$30,000	\$30,000	\$30,000	\$30,000
Reduction Schedule	50% at age 70 of original based on in force at age 69	50% at age 70 of original based on in force at age 69	50% at age 70 of original	50% at age 70 of original
Other Features				
Accelerated Benefit	50% of coverage amount up to \$250,000	50% of coverage amount up to \$250,000	100% of coverage amount up to \$250,000	100% of coverage amount up to \$250,000
Waiver of Premium	Included	Included	Included	Included
Portability/Conversion	Included	Included	Included	Included
Participation Requirement	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory
Rates				
Volume (monthly)	\$1,330,000	\$2,975,000	\$1,740,000	\$2,900,000
Life Rate (per \$1,000)	\$0.38	\$0.39	\$0.350	\$0.370
AD&D Rate (per \$1,000)	\$0.04	\$0.03	\$0.025	\$0.025
Estimated Monthly Premium	\$768.60	\$1,249.50	\$652.50	\$1,145.50
Estimated Annual Premium	\$9,223.20	\$14,994.00	\$7,830.00	\$13,746.00
			2 Year Rate Guarantee	2 Year Rate Guarantee


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City of Port St. Joe
Life and AD&D Cost Analysis
 Effective date: October 1, 2020

	Current & Renewal	Alternate	Alternate Option 1	Alternate Option 2
	Humana	Humana	Guardian	Guardian
Benefits	All Eligible Employees	All Eligible Employees	All Eligible Employees	All Eligible Employees
Life Amount	\$30,000	\$50,000	\$30,000	\$50,000
Reduction Schedule	50% at age 70 of original based on in force at age 69	50% at age 70 of original based on in force at age 69	50% at age 70 of original	50% at age 70 of original
Other Features				
Accelerated Benefit	50% of coverage amount up to \$250,000	50% of coverage amount up to \$250,000	50% of coverage amount up to \$250,000	50% of coverage amount up to \$250,000
Waiver of Premium	Included	Included	Included	Included
Portability	Included	Included	Included	Included
Participation Requirement	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory
Rates				
Volume (monthly)	\$1,830,000	\$2,975,000	\$1,725,000	\$2,875,000
Life Rate (per \$1,000)	\$0.38	\$0.44	\$0.350	\$0.320
AD&D Rate (per \$1,000)	\$0.04	\$0.03	\$0.019	\$0.019
Estimated Monthly Premium	\$768.60	\$1,398.25	\$636.53	\$974.63
Estimated Annual Premium	\$9,223.20	\$16,779.00	\$7,638.30	\$11,695.50
			2 Year Rate Guarantee	2 Year Rate Guarantee


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City of Port St. Joe
Life and AD&D Cost Analysis
 Effective date: October 1, 2020

	Current & Renewal	Alternate	Alternate Option 1	Alternate Option 2
	Humana	Humana	Principal	Principal
Benefits	All Eligible Employees	All Eligible Employees	All Eligible Employees	All Eligible Employees
Life Amount	\$30,000	\$50,000	\$30,000	\$50,000
Reduction Schedule	50% at age 70 of original based on in force at age 69	50% at age 70 of original based on in force at age 69	50% at age 70 of original	50% at age 70 of original
Other Features				
Accelerated Benefit	50% of coverage amount up to \$250,000	50% of coverage amount up to \$250,000	75% of coverage amount up to \$250,000	75% of coverage amount up to \$250,000
Waiver of Premium	Included	Included	Included	Included
Portability/Conversion	Included	Included	Included	Included
Participation Requirement Rates	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory	100%, Non-Contributory
Volume (monthly)	\$1,830,000	\$2,975,000	\$1,740,000	\$2,900,000
Life Rate (per \$1,000)	\$0.38	\$0.44	\$0.303	\$0.292
AD&D Rate (per \$1,000)	\$0.04	\$0.03	\$0.036	\$0.036
Estimated Monthly Premium	\$768.60	\$1,398.25	\$589.86	\$951.20
Estimated Annual Premium	\$9,223.20	\$16,779.00	\$7,078.32	\$11,414.40
			2 Year Rate Guarantee	2 Year Rate Guarantee

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City of Port St. Joe
Dental Cost Analysis
 Effective Date October 1, 2020

		Current Humana FL Vol. PPOX MAF 09		Renewal Humana FL Vol. PPOX MAF 09		Alternate Option 1 MetLife Voluntary PPO Plan	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefits							
Deductible Individual (In-Network/Out-of-Network) Family (In-Network/Out-of-Network) Deductible Waived for Preventive Services (In-Network/Out-of-Network)		\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes
Annual Maximum		\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500	
Preventative (Type I)		100%	100%	100%	100%	100%	100%
Basic Services (Type II)		100%	100%	100%	100%	100%	100%
Major Services (Type III)		60%	50%	60%	50%	60%	50%
Benefits							
Exams		100%	100%	100%	100%	100%	100%
Cleanings		100%	100%	100%	100%	100%	100%
Fluoride		100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%
Sealants		100%	100%	100%	100%	100%	100%
Space Maintainers		100%	80%	100%	80%	100%	100%
Fillings		100%	80% / 50%	100%	80%	100%	80%
Simple and Complex Extractions/Surgery		100%	80%	100%	80%	100%	80%
Endodontics (Non-Surgical / Surgical)		100%	80%	100%	80%	100%	80%
Periodontics (Non-Surgical / Surgical)		100%	80%	100%	80%	100%	80%
Crowns, Inlays, Onlays		60%	50%	60%	50%	60%	50%
Bridges and Dentures		60%	50%	60%	50%	60%	50%
Other Features							
Waiting Periods		Late Entrants - 12 Month - Basic	Major	Late Entrants - 12 Month - Basic	Major	None	N/A
Maximum Rollover		N/A	N/A	N/A	N/A	N/A	UCR 90th
Percentile		Negotiated Fee Schedule		Negotiated Fee Schedule		Negotiated Fee Schedule	
Rate Guarantee		1 Year		1 Year		1 Year	
Rates							
Employee Only		\$42.95	\$44.02	\$44.02	\$2,719.58	\$2,198.89	\$26,388.88
Employee/Spouse		\$97.65	\$100.10	\$100.10		\$75.35	
Employee/Child(ren)		\$82.55	\$94.61	\$94.61		\$72.27	
Employee/Family		\$138.93	\$142.40	\$142.40		\$118.36	
Total Estimated Monthly Premium		\$2,653.30	\$2,719.58	\$2,719.58		\$2,198.89	
Total Annual Premium		\$31,839.60	\$32,634.96	\$32,634.96		\$26,388.88	
							63% and at least 10 enrolled employees

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City of Port St. Joe
Dental Cost Analysis
 Effective Date October 1, 2020



Benefits	Current Humana FL Vol. PPOX MAF 09		Renewal Humana FL Vol. PPOX MAF 09		Alternate Unum Active PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual (In-Network/Out-of-Network) Family (In-Network/Out-of-Network) Deductible Waived for Preventive Services (In-Network/Out-of-Network)	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes
Annual Maximum	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500	\$2,500
Preventative (Type I) Basic Services (Type II) Major Services (Type III)	100% 100% 60%	100% 80% 50%	100% 100% 60%	100% 80% 50%	100% 100% 60%	100% 80% 50%
Benefits Exams Cleanings Fluoride X-Rays Sealants Space Maintainers Fillings Simple and Complex Extractions/Surgery Endodontics (Non-Surgical / Surgical) Periodontics (Non-Surgical / Surgical) Crowns, Inlays, Outlays Bridges and Dentures	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 80% 80% / 50% 80% 80% 80% 50% 50%	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 80% 80% / 50% 80% 80% 80% 50% 50%	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 100% 80% 80% 80% 80% 50% 50%
Other Features Waiting Periods Maximum Rollover Percentage	Late Entrants - 12 Month - Basic/Major N/A Negotiated Fee Schedule	N/A Maximum Allowable Fee	Late Entrants - 12 Month - Basic/Major N/A Negotiated Fee Schedule	Maximum Allowable Fee N/A	Included Negotiated Fee Schedule	None N/A 90th Percentile
Rate Guarantees	1 Year		1 Year		1 Year	
Rates						
Employee Only	\$42.95	\$44.02	\$42.95	\$44.02	\$38.19	\$38.19
Employee/Spouse	\$97.65	\$100.10	\$97.65	\$100.10	\$73.32	\$73.32
Employee/Child(ren)	\$82.55	\$84.61	\$82.55	\$84.61	\$86.69	\$86.69
Employee/Family	\$138.83	\$142.40	\$138.83	\$142.40	\$123.54	\$123.54
Total Estimated Monthly Premium	\$2,653.30	\$2,719.58	\$2,653.30	\$2,719.58	\$2,317.88	\$2,317.88
Total Annual Premium	\$31,839.60	\$32,634.96	\$31,839.60	\$32,634.96	\$27,814.56	\$27,814.56
	59% of total eligible employees - Participation.					

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7

City of Port St. Joe
Dental Cost Analysis
 Effective Date October 1, 2020

Benefits	Current Humana FL Vol. PPOX MAF 09		Renewal Humana FL Vol. PPOX MAF 09		Alternate Option 1 Guardian Voluntary PPO (W1) Plan		Alternate Option 2 Guardian Voluntary Split Value Plan (N7)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual (In-Network/Out-of-Network) Family (In-Network/Out-of-Network) Deductible Waived for Preventive Services (In-Network/Out-of-Network)	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$100 \$300 No
Annual Maximum Preventative (Type I) Basic Services (Type II) Major Services (Type III) Benefits	\$2,500 (Extended Maximum Benefit - 30% for remainder of year) 100% 100% 60%	\$2,500 (Extended Maximum Benefit - 30% for remainder of year) 100% 80% 50%	\$2,500 (Extended Maximum Benefit - 30% for remainder of year) 100% 100% 60%	\$2,500 (Extended Maximum Benefit - 30% for remainder of year) 100% 80% 50%	\$2,500 plus Maximum Rollover 100% 100% 60%	\$2,500 plus Maximum Rollover 100% 80% 50%	\$2,500 plus Maximum Rollover 100% 80% 50%	\$2,500 plus Maximum Rollover 80% 70% 40%
Exams Cleanings Fluoride X-Rays Sealants Space Maintainers Fillings Simple and Complex Extractions/Surgery Endodontics (Non-Surgical / Surgical) Periodontics (Non-Surgical / Surgical) Crowns, Inlays, Outlays Bridges and Dentures	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 100% 80% / 50% 80% 80% 80% 50% 50%	100% 100% 100% 100% 100% 100% 100% / 50% 100% 100% 100% 60% 60%	100% 100% 100% 100% 100% 100% 80% / 50% 80% 80% 80% 50% 50%	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%	100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 60%
Other Features Waiting Periods Maximum Rollover Percentage	Late Entrants - 12 Month - Basic/Minor N/A Negotiated Fee Schedule	Late Entrants - 12 Month - Basic/Minor N/A Maximum Allowable Fee	Late Entrants - 12 Month - Basic/Minor N/A Negotiated Fee Schedule	Late Entrants - 12 Month - Basic/Minor N/A Maximum Allowable Fee	Included Negotiated Fee Schedule	None UCR 90th	Included Negotiated Fee Schedule	None N/A Negotiated Fee Schedule
Rates	1 Year		1 Year		1 Year		1 Year	
Employee Only Employee/Spouse Employee/Child(ren) Em10 ^{year} /Family Total Estimated Monthly Premium Total Annual Premium	22 7 4 5 \$42.95 \$97.65 \$82.55 \$138.93 \$2,653.30 \$31,539.60		\$44.02 \$100.10 \$84.61 \$142.40 \$2,719.58 \$32,634.96		\$27.51 \$55.85 \$59.82 \$93.12 \$1,701.05 \$20,412.60		\$17.29 \$35.10 \$37.82 \$58.77 \$1,071.21 \$12,854.52	
					59% of total eligible employees - participation.		59% of total eligible employees - participation.	


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City of Port St. Joe
Dental Cost Analysis
 Effective Date October 1, 2020

Benefits	Current Humana FL Vol. PPOX MAF 09		Renewal Humana FL Vol. PPOX MAF 09		Alternate Option 1 Principal Voluntary PPO Plan		Alternate Option 2 Principal Voluntary PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual (In-Network/Out-of-Network) Family (In-Network/Out-of-Network) Deductible Waived for Preventive Services (In-Network/Out-of-Network)	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes	\$50 \$150 Yes
Annual Maximum	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500 (Extended Maximum Benefit - 30% for remainder of year)	\$2,500	\$2,500	\$2,500	\$2,500
Preventative (Type I)	100%	100%	100%	100%	100%	100%	100%	100%
Basic Services (Type II)	100%	80%	100%	80%	100%	80%	100%	80%
Major Services (Type III)	60%	50%	60%	50%	60%	50%	60%	50%
Benefits								
Exams	100%	100%	100%	100%	100%	100%	100%	100%
Cleanings	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Sealants	100%	100%	100%	100%	100%	100%	100%	100%
Space Maintainers	100%	80%	100%	80%	100%	80%	100%	80%
Fillings	100%	80%	100%	80%	100%	80%	100%	80%
Simple and Complex Extractions/Surgery	100% / 60%	80% / 50%	100% / 60%	80% / 50%	100%	80%	100%	80%
Endodontics (Non-Surgical / Surgical)	100%	80%	100%	80%	100%	80%	100%	80%
Periodontics (Non-Surgical / Surgical)	100%	80%	100%	80%	100%	80%	100%	80%
Crowns, Inlays, Outlays	60%	50%	60%	50%	60%	50%	60%	50%
Bridges and Dentures	60%	50%	60%	50%	60%	50%	60%	50%
Other Features								
Waiting Periods	Late Entrants - 12 Month - Basic/Minor	Late Entrants - 12 Month - Basic/Minor	Late Entrants - 12 Month - Basic/Minor	Late Entrants - 12 Month - Basic/Minor	Included	None	Included	None
Maximum Rollover	N/A	N/A	N/A	N/A	N/A	UCR 90th	N/A	UCR 90th
Percentage	Negotiated Fee Schedule	Maximum Allowable Fee	Negotiated Fee Schedule	Maximum Allowable Fee	Negotiated Fee Schedule	UCR 90th	Negotiated Fee Schedule	UCR 90th
Rates	1 Year		1 Year		1 Year		1 Year	
Employee Only	22	\$42.95	22	\$44.02	22	\$32.43	22	\$28.39
Employee/Spouse	7	\$97.65	7	\$100.10	7	\$73.73	7	\$64.55
Employee/Child(ren)	4	\$82.55	4	\$84.61	4	\$62.33	4	\$54.57
Employee/Family	5	\$138.93	5	\$142.40	5	\$104.89	5	\$91.83
Total Estimated Monthly Premium	\$2,653.30	\$2,719.58	\$2,003.34	\$1,753.86	\$24,040.08	\$21,046.32	\$24,040.08	\$21,046.32
Total Annual Premium	\$31,839.60	\$32,634.96	\$24,040.08	\$21,046.32	20% or 5 lives, whichever is greater	20% or 5 lives, whichever is greater	\$31,839.60	\$28,390.00


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City of Port St. Joe
Vision Cost Analysis
 Effective date: October 1, 2020

		Current & Renewal		Alternate Option 1	
		Humana Voluntary Vision Plan 130		MetLife M130D-10/15	
Exams	In-Network	Out-of-Network	In-Network	Out-of-Network	
Exams	\$10 Copay	Up to \$30 Allowance	\$10 Copay	Up to \$45 Allowance	
Materials	\$15 Copay	See Schedule Below	\$15 Copay	See Schedule Below	
Lenses					
Single	Covered in full after \$15 Copay	Up to \$25 Allowance	Covered in full after \$15 Copay	Up to \$30 Allowance	
Bifocal	Covered in full after \$15 Copay	Up to \$40 Allowance	Covered in full after \$15 Copay	Up to \$50 Allowance	
Trifocal	Covered in full after \$15 Copay	Up to \$60 Allowance	Covered in full after \$15 Copay	Up to \$65 Allowance	
Monovision Lens	Covered in full after \$15 Copay	Up to \$100 Allowance	Covered in full after \$15 Copay	Up to \$100 Allowance	
Frames (in lieu of Elective Contact Lenses)	\$130 Allowance	Reimbursed up to \$65	\$130 Allowance, plus additional 20% off balance over allowance or \$150 Allowance on featured frames plus additional 20% off balance over allowance (Except Costco, Walmart and Sam's - \$70 Allowance)	Reimbursed up to \$70	
Contact Lenses (in lieu of Eyeglasses)					
Elective / Conventional / Disposable	\$130 Allowance	Reimbursed up to \$104	\$130 Allowance	Reimbursed up to \$105	
Medically necessary contact lenses	Paid in Full	Reimbursed up to \$200	Covered in Full after Copay	Reimbursed up to \$210	
Frequency					
Exams	Once every 12 months		Once every 12 months		
Lenses	Once every 12 months		Once every 12 months		
Frames	Once every 24 months		Once every 24 months		
Contact Lenses	Once every 12 months (in lieu of Eyeglasses)		Once every 12 months (in lieu of Eyeglasses)		
Rates					
Employee Only	24	\$6.66	6.23		
Employee + Spouse	4	\$13.32	\$12.49		
Employee + Child(ren)	1	\$12.85	\$10.58		
Family	5	\$19.89	\$17.44		
Estimated Monthly Premium		\$325.22	\$297.26		
Estimated Annual Premium		\$3,902.64	\$3,567.12		
		1 Year Rate Guarantee		2 Year Rate Guarantee, 64% of eligible employees.	


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City of Port St. Joe
Vision Cost Analysis
 Effective date: October 1, 2020

		Current & Renewal Humana Voluntary Vision Plan 130		Alternate Option 1 Unum		Alternate Option 2 Unum	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Exams	\$10 Copay	Up to \$30 Allowance	\$10 Copay	Up to \$35 Allowance	\$10 Copay	Up to \$35 Allowance	
Materials	\$15 Copay	See Schedule Below	\$15 Copay	See Schedule Below	\$25 Copay	See Schedule Below	
Lenses							
Single	Covered in full after \$15 Copay	Up to \$25 Allowance	Covered in full after \$15 Copay	Up to \$25 Allowance	Covered in full after \$25 Copay	Up to \$25 Allowance	
Bifocal	Covered in full after \$15 Copay	Up to \$40 Allowance	Covered in full after \$15 Copay	Up to \$40 Allowance	Covered in full after \$25 Copay	Up to \$40 Allowance	
Trifocal	Covered in full after \$15 Copay	Up to \$60 Allowance	Covered in full after \$15 Copay	Up to \$60 Allowance	Covered in full after \$25 Copay	Up to \$50 Allowance	
Latent/Contact Lenses	Covered in full after \$15 Copay	Up to \$100 Allowance	\$80 Allowance	Up to \$50 Allowance	\$80 Allowance	Up to \$50 Allowance	
Frames (in lieu of Elective Contact Lenses)	\$130 Allowance	Reimbursed up to \$65	\$130 Allowance	Reimbursed up to \$50	\$130 Allowance	Reimbursed up to \$50	
Contact Lenses (in lieu of Eyeglasses)							
Elective / Conventional / Disposable	\$130 Allowance	Reimbursed up to \$104	\$130 Allowance	Reimbursed up to \$100	\$130 Allowance	Reimbursed up to \$100	
Medically necessary contact lenses	Paid in Full	Reimbursed up to \$200	\$210 Allowance	Reimbursed up to \$210	\$210 Allowance	Reimbursed up to \$210	
Frequency							
Exams	Once every 12 months		Once every 12 months		Once every 12 months	Once every 12 months	
Lenses	Once every 12 months		Once every 12 months		Once every 12 months	Once every 12 months	
Frames	Once every 24 months		Once every 24 months		Once every 24 months	Once every 24 months	
Contact Lenses	Once every 12 months (in lieu of Eyeglasses)		Once every 12 months (in lieu of Eyeglasses)		Once every 12 months (in lieu of Eyeglasses)	Once every 12 months (in lieu of Eyeglasses)	
Rates	Counts						
Employee Only	24	\$6.66	\$5.76	\$4.49			
Employee + Spouse	4	\$13.32	\$11.52	\$8.97			
Employee + Child(ren)	1	\$12.65	\$12.81	\$9.96			
Family	5	\$19.99	\$20.03	\$15.59			
Estimated Monthly Premium		\$325.22	\$297.28	\$231.55			
Estimated Annual Premium		\$3,902.64	\$3,567.36	\$2,778.60			
		1 Year Rate Guarantee	2 Year Rate Guarantee; 52% of the eligible employees must enroll; network - AlwaysCare/AlwaysAssist.	2 Year Rate Guarantee; 52% of the eligible employees must enroll; network - AlwaysCare/AlwaysAssist.			

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City of Port St. Joe
Vision Cost Analysis
 Effective date: October 1, 2020

		Current & Renewal		Alternate Option 1		Alternate Option 2	
		Humana Voluntary Vision Plan 130		Guardian Davis - Full Feature - Designer B		Guardian VSP - Full Feature - Choice B	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Exams		\$10 Copay	Up to \$30 Allowance	\$10 Copay	Up to \$50 Allowance	\$10 Copay	Up to \$39 Allowance
Materials		\$15 Copay	See Schedule Below	\$15 Copay	See Schedule Below	\$15 Copay	See Schedule Below
Lenses							
Single		Covered in full after \$15 Copay	Up to \$25 Allowance	Covered in full after \$15 Copay	Up to \$48 Allowance	Covered in full after \$15 Copay	Up to \$23 Allowance
Bifocal		Covered in full after \$15 Copay	Up to \$40 Allowance	Covered in full after \$15 Copay	Up to \$67 Allowance	Covered in full after \$15 Copay	Up to \$37 Allowance
Trifocal		Covered in full after \$15 Copay	Up to \$60 Allowance	Covered in full after \$15 Copay	Up to \$96 Allowance	Covered in full after \$15 Copay	Up to \$49 Allowance
Lenticular Lens		Covered in full after \$15 Copay	Up to \$100 Allowance	Covered in full after \$15 Copay	Up to \$126 Allowance	Covered in full after \$15 Copay	Up to \$64 Allowance
Frames (in lieu of Elective Contact Lenses)		\$130 Allowance	Reimbursed up to \$65	\$130 Allowance, plus additional 20% off balance over allowance (Except Costco - \$130 Allowance)	Reimbursed up to \$48	\$130 Allowance, plus additional 20% off balance over allowance (Except Costco - \$70 Allowance)	Reimbursed up to \$46
Contact Lenses (In Lieu of Eyeglasses)							
Elective / Conventional / Disposable		\$130 Allowance	Reimbursed up to \$104	\$130 Allowance, plus additional 15% off balance over allowance (Copay Waived)	Reimbursed up to \$105	\$130 Allowance (Copay Waived)	Reimbursed up to \$100
Medically necessary contact lenses		Paid in Full	Reimbursed up to \$200	Covered in Full (Copay Waived)	Reimbursed up to \$210	Covered in Full (Copay Waived)	Reimbursed up to \$210
Frequency							
Exams			Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses			Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames			Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months	Once every 24 months
Contact Lenses			Once every 12 months (In Lieu of Eyeglasses)	Once every 12 months (In Lieu of Eyeglasses)	Once every 12 months (In Lieu of Eyeglasses)	Once every 12 months (In Lieu of Eyeglasses)	Once every 12 months (In Lieu of Eyeglasses)
Rates	Counts						
Employee Only	24	\$6.66		\$7.76		\$8.56	
Employee + Spouse	4	\$13.32		\$13.06		\$14.41	
Employee + Child(ren)	1	\$12.65		\$13.32		\$14.70	
Family	5	\$19.89		\$21.08		\$23.26	
Estimated Monthly Premium		\$325.22		\$357.20		\$394.08	
Estimated Annual Premium		\$3,902.64		\$4,286.40		\$4,728.96	
		1 Year Rate Guarantee		1 Year Rate Guarantee: 52% of the eligible employees must enroll and vision is sold with dental.		1 Year Rate Guarantee: 52% of the eligible employees must enroll and vision is sold with dental.	

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City of Port St. Joe
Vision Cost Analysis
 Effective date: October 1, 2020

		Current & Renewal Humana Voluntary Vision Plan 130		Alternate Option 1 Principal VSP - Full Feature - Choice B		Alternate Option 2 Principal VSP - Full Feature - Choice B	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Exams	\$10 Copay	Up to \$30 Allowance		\$10 Copay	Up to \$45 Allowance	\$10 Copay	Up to \$45 Allowance
Materials	\$15 Copay	See Schedule Below		\$10 Copay	See Schedule Below	\$25 Copay	See Schedule Below
Lenses							
Single		Covered in full after \$15 Copay	Up to \$25 Allowance	Covered in full after \$10 Copay	Up to \$30 Allowance	Covered in full after \$25 Copay	Up to \$30 Allowance
Bifocal		Covered in full after \$15 Copay	Up to \$40 Allowance	Covered in full after \$10 Copay	Up to \$50 Allowance	Covered in full after \$25 Copay	Up to \$50 Allowance
Tri-focal		Covered in full after \$15 Copay	Up to \$60 Allowance	Covered in full after \$10 Copay	Up to \$65 Allowance	Covered in full after \$25 Copay	Up to \$65 Allowance
Latent/ocular Lens		Covered in full after \$15 Copay	Up to \$100 Allowance	Covered in full after \$10 Copay	Up to \$100 Allowance	Covered in full after \$25 Copay	Up to \$100 Allowance
Frames (In lieu of Elective Contact Lenses)		\$130 Allowance	Reimbursed up to \$65	\$130 Allowance, plus additional 20% off balance over allowance	Reimbursed up to \$70	\$130 Allowance, plus additional 20% off balance over allowance	Reimbursed up to \$70
Contact Lenses (In Lieu of Eyeglasses)							
Elective / Conventional / Disposable		\$130 Allowance	Reimbursed up to \$104	\$130 Allowance	Reimbursed up to \$105	\$130 Allowance	Reimbursed up to \$105
Medically necessary contact lenses		Paid in Full	Reimbursed up to \$200	Covered in Full after Copay	Reimbursed up to \$210	Covered in Full after Copay	Reimbursed up to \$210
Frequency:							
Exams		Once every 12 months		Once every 12 months		Once every 12 months	
Lenses		Once every 12 months		Once every 12 months		Once every 12 months	
Frames		Once every 24 months		Once every 24 months		Once every 24 months	
Contact Lenses		Once every 12 months (In Lieu of Eyeglasses)		Once every 12 months (In Lieu of Eyeglasses)		Once every 12 months (In Lieu of Eyeglasses)	
Rates							
Employee Only	24	\$6.66		\$6.66		\$6.66	
Employee + Spouse	4	\$13.32		\$13.32		\$11.72	
Employee + Child(ren)	1	\$12.65		\$12.65		\$11.13	
Family	5	\$19.89		\$19.89		\$17.50	
Estimated Monthly Premium		\$326.22		\$325.22		\$286.15	
Estimated Annual Premium		\$3,902.64		\$3,902.64		\$3,433.80	
		1 Year Rate Guarantee		1 Year Rate Guarantee: 20% or 5 lives, whichever is greater. Vision rates are contingent upon selling with another line of coverage.		1 Year Rate Guarantee: 20% or 5 lives, whichever is greater. Vision rates are contingent upon selling with another line of coverage.	

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Group Number: **45484**

Group Name: **CITY OF PORT ST JOE**

Anniversary: **10/01/2020**

Rate Information

BlueOptions Predictable Cost 05772 Rx: (\$10/\$30/\$50)

Employee Only	Employee/Spouse	Employee Child(ren)	Employee/Family
\$835.81	\$1,989.22	\$1,604.75	\$2,674.57

BlueOptions Predictable Cost 05773 Rx: (\$10/\$30/\$50)

Employee Only	Employee/Spouse	Employee Child(ren)	Employee/Family
\$792.70	\$1,886.63	\$1,521.99	\$2,536.65

Premium amounts include an estimate of several new fees mandated by the Affordable Care Act to fund related programs and services. Depending on your coverage, these fees may include the: (a) Health insurer Fee. These fees are assessed by the Federal government on an aggregate basis based on Florida Blue's business and generally not specifically assigned to a covered employer or person.