NORTHEAST FLORIDA REGIONAL COUNCIL

EFFECTIVE JANUARY 1, 2020

BU : 5555

NEF - HEALTH

PLAN	COVERAGE	Per Pay Period

BLUE CROSS BLUE SHIELD HEALTH PLAN

HMO	ACTIVE EMPLOYEES-FULL TIME	
	Employee Only	**7.17**
	Employee & Spouse	**163.96**
	Employee & Child(ren)	**143.08**
	Employee & Family	**312.40**

FLORIDA BLUE CoPay, Deductible, Max Out of Pocket and ER Visit	CO PAY (PCP/Specialist)	DEDUCTIBLE (Individual /Family)	MAX OUT OF POCKET (Individual /Family)	ER VISIT
	$25 / 35	**$300 / 600**	**$2,500 / 5,000**	**$300 CoPay + 30%**

HD HMO	ACTIVE EMPLOYEES-FULL TIME	
	Employee Only	**7.42**
	Employee & Spouse	**146.50**
	Employee & Child(ren)	**126.79**
	Employee & Family	**286.69**

FLORIDA BLUE CoPay, Deductible, Max Out of Pocket and ER Visit	CO PAY (PCP/Specialist)	DEDUCTIBLE (Individual /Family)	MAX OUT OF POCKET (Individual /Family)	ER VISIT
	$25 / DED + 30%	**$1,500 / 3,000**	**$5,000 / 10,000**	**DED + 30%**

QPOS / PPO	ACTIVE EMPLOYEES-FULL TIME	
	Employee Only	**51.09**
	Employee & Spouse	**208.23**
	Employee & Child(ren)	**184.29**
	Employee & Family	**378.23**

FLORIDA BLUE CoPay, Deductible, Max Out of Pocket and ER Visit	CO PAY (PCP/Specialist)	DEDUCTIBLE (Individual /Family)	MAX OUT OF POCKET (Individual /Family)	ER VISIT
IN-NETWORK	**$30/ 40**	**$750 / 1,500**	**$6,000 / 12,000**	**$300 CoPay + 30%**
OUT-OF-NETWORK	**DED + 50%**	**$1,000 / 2,000**	**$9,000 / 18,000**	**$300 CoPay + 30%**

UF HEALTH DIRECT CARE PLAN

HMO	ACTIVE EMPLOYEES-FULL TIME	
	Employee Only	**7.42**
	Employee & Spouse	**146.50**
	Employee & Child(ren)	**126.79**
	Employee & Family	**286.69**

UF HEALTH DIRECTCARE CoPay, Deductible, Max Out of Pocket and ER Visit	CO PAY (PCP/Specialist)	DEDUCTIBLE (Individual /Family)	MAX OUT OF POCKET (Individual /Family)	ER VISIT
	$10 /30	**$750 / 1,500**	**$1,500 Med + 1,000 Phar** **$3,000 Med + 2,000 Phar**	**DED + 20%**

NORTHEAST FLORIDA REGIONAL COUNCIL

EFFECTIVE JANUARY 1, 2020

BU : 5555

NEF - DENTAL

PLAN	COVERAGE	Per Pay Period
DHMO	**EE Only**	**6.50**
DHMO	**EE & Spouse**	**11.38**
DHMO	**EE & Children**	**13.65**
DHMO	**EE & Family**	**20.14**
Silver DPPO	**EE Only**	**10.33**
Silver DPPO	**EE & Spouse**	**20.67**
Silver DPPO	**EE & Children**	**26.22**
Silver DPPO	**EE & Family**	**35.31**
Gold DPPO	**EE Only**	**16.53**
Gold DPPO	**EE & Spouse**	**33.07**
Gold DPPO	**EE & Children**	**41.99**
Gold DPPO	**EE & Family**	**56.46**
Platinum DPPO	**EE Only**	**21.21**
Platinum DPPO	**EE & Spouse**	**42.44**
Platinum DPPO	**EE & Children**	**53.82**
Platinum DPPO	**EE & Family**	**72.45**

NEF - VISION

PLAN	COVERAGE	Per Pay Period
VISION Plan Basic		
	Employee Only	**2.47**
	Employee & Spouse	**3.92**
	Employee & Child(ren)	**4.00**
	Employee & Family	**6.45**
VISION Plan Premier	**VISION Option Premier**	
	Employee Only	**3.77**
	Employee & Spouse	**6.10**
	Employee & Child(ren)	**5.98**
	Employee & Family	**9.84**