NORTHEAST FLORIDA REGIONAL COUNCIL

EFFECTIVE JANUARY 1, 2023

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	$250 / $ 500	$1,500 Med + 1,000 Phar $3,000 Med + 2,000 Phar	DED + 20%

NORTHEAST FLORIDA REGIONAL COUNCIL

EFFECTIVE JANUARY 1, 2023

BU : 5555

NEF - DENTAL

PLAN	COVERAGE	Per Pay Period
DHMO	EE Only	5.49
DHMO	EE & Spouse	10.97
DHMO	EE & Children	12.34
DHMO	EE & Family	19.85
Silver DPPO	EE Only	9.38
Silver DPPO	EE & Spouse	18.77
Silver DPPO	EE & Children	23.82
Silver DPPO	EE & Family	32.07
Gold DPPO	EE Only	15.02
Gold DPPO	EE & Spouse	30.03
Gold DPPO	EE & Children	38.14
Gold DPPO	EE & Family	51.28
Platinum DPPO	EE Only	19.26
Platinum DPPO	EE & Spouse	38.54
Platinum DPPO	EE & Children	48.88
Platinum DPPO	EE & Family	65.80

NEF - VISION

PLAN	COVERAGE	Per Pay Period
VISION Plan Basic		
	Employee Only	1.80
	Employee & Spouse	3.44
	Employee & Child(ren)	3.22
	Employee & Family	5.50
VISION Plan Premier	VISION Option Premier	
	Employee Only	3.50
	Employee & Spouse	5.63
	Employee & Child(ren)	5.26
	Employee & Family	8.96