

JACKSONVILLE HOUSING AUTHORITY

EFFECTIVE JANUARY 1, 2023

BU 240 & 279

JHA - HEALTH

PLAN	COVERAGE	Per Pay Period			
BLUE CROSS BLUE SHIELD HEALTH PLAN ACTIVE EMPLOYEES-FULL TIME					
FL BLUE HEALTH BLUECARE 48 HMO					
	Employee Only	15.59			
	Employee & Spouse	171.02			
	Employee & Child(ren)	147.83			
	Employee & Family	336.97			
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%	
FL BLUE HEALTH BLUECARE 65 HIGH DEDUCTIBLE HMO					
	Employee Only			-	
	Employee & Spouse			160.77	
	Employee & Child(ren)			138.93	
	Employee & Family			317.35	
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%	
FL BLUE HEALTH BLUEOPTIONS 05782 (POS/PPO)					
	Employee Only			32.81	
	Employee & Spouse			257.52	
	Employee & Child(ren)			228.22	
	Employee & Family			466.79	
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					
HMO	ACTIVE EMPLOYEES-FULL TIME				
	Employee Only			-	
	Employee & Spouse			160.77	
	Employee & Child(ren)			138.93	
	Employee & Family			317.35	
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	DED + 20%	
			\$3,000 Med + 2,000 Phar		

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JHA - DENTAL

PLAN	COVERAGE	Per Pay Period
DHMO	EE Only	0.34
DHMO	EE & Spouse	5.83
DHMO	EE & Children	7.20
DHMO	EE & Family	14.71
Silver DPPO	EE Only	2.77
Silver DPPO	EE & Spouse	12.16
Silver DPPO	EE & Children	17.21
Silver DPPO	EE & Family	25.45
Gold DPPO	EE Only	8.41
Gold DPPO	EE & Spouse	23.42
Gold DPPO	EE & Children	31.53
Gold DPPO	EE & Family	44.67
Platinum DPPO	EE Only	12.65
Platinum DPPO	EE & Spouse	31.93
Platinum DPPO	EE & Children	42.27
Platinum DPPO	EE & Family	59.19

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JHA - 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		
	Employee Only	3.50
	Employee & Spouse	5.63
	Employee & Child(ren)	5.26
	Employee & Family	8.96