JACKSONVILLE HOUSING AUTHORITY

EFFECTIVE JANUARY 1, 2024

BU 240 & 279

FLORIDA BLUE HEALTH PLAN FOR ACTIVE FULL TIME EMPLOYEES ONLY

JHA - HEALTH

PLAN	COVERAGE	PREMIUM
FLORIDA BLUE - BLUECARE 48 HMO		Per Pay Period
HMO	Employee Only	$ 14.82
	Employee & Spouse	$ 170.78
	Employee & Child(ren)	$ 147.72
	Employee & Family	$ 308.31

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%

FLORIDA BLUE - BLUECARE 65 HIGH DEDUCTIBLE HMO		Per Pay Period
HD HMO	Employee Only	-
	Employee & Spouse	161.00
	Employee & Child(ren)	139.25
	Employee & Family	290.83

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%

FLORIDA BLUE - BLUE OPTIONS 05782 (POS/PPO)		Per Pay Period
QPOS / PPO	Employee Only	$ 16.98
	Employee & Spouse	$ 195.57
	Employee & Child(ren)	$ 169.15
	Employee & Family	$ 353.08

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%

FLORIDA BLUE - UF HEALTH EPO 03768		Per Pay Period
HMO	Employee Only	$ -
	Employee & Spouse	$ 161.00
	Employee & Child(ren)	$ 139.25
	Employee & Family	$ 290.83

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	PREMIUM
		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	PREMIUM
VISION Plan Basic		Per Pay Period
	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