JACKSONVILLE HOUSING AUTHORITY

EFFECTIVE JANUARY 1, 2020 BU 240 & 279

JHA - HEALTH

PLAN		COVERAGE			Per Pay Period	
DI LIE CDOS	C DI HE CUIEI	D HEVI TH D	LAN			
HMO	BLUE SHIELD HEALTH PLAN ACTIVE EMPLOYEES-FULL TIME					
TIIVIO	Employee Only	15.59				
	Employee & Spo	NISA .			171.02	
	Employee & Chi				147.83	
	Employee & Fan	` '			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%	
HD HMO	ACTIVE EMPL	OYEES-FULL T	IMF			
	Employee Only		-			
	Employee & Spo	ouse			160.77	
	Employee & Chi				138.93	
	Employee & Fan				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%	
POS/PPO	ACTIVE EMPL	·		\$5,000 / 10,000	DED + 30%	
POS/PPO		\$25 / DED + 30% OYEES-FULL T		\$5,000 / 10,000		
POS/PPO	Employee Only	OYEES-FULL T		\$5,000 / 10,000	32.8 ²	
POS/PPO	Employee Only Employee & Spo	OYEES-FULL T		\$5,000 / 10,000	32.8 ²	
POS/PPO	Employee & Spo Employee & Chi	OYEES-FULL T		\$5,000 / 10,000	32.8 ⁴ 257.5 ² 228.2 ²	
FLORIDA BLUE Deductible, Max	Employee & Spo Employee & Chi Employee & Fan CoPay,	OYEES-FULL T		MAX OUT OF POCKET (Individual /Family)	32.8° 257.52 228.22	
FLORIDA BLUE Deductible, Max	Employee & Spo Employee & Chi Employee & Fan CoPay,	OYEES-FULL Touse Ild(ren) mily CO PAY (PCP/Specialist)	DEDUCTIBLE	MAX OUT OF POCKET	32.81 257.52 228.22 466.79 ER VISIT	
FLORIDA BLUE Deductible, Max	Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket	OYEES-FULL T Duse Ild(ren) nily CO PAY (PCP/Specialist) \$30/ 40	DEDUCTIBLE (Individual /Family)	MAX OUT OF POCKET (Individual /Family)	32.81 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK	OYEES-FULL Touse Ild(ren) mily CO PAY (PCP/Specialist) \$30/40 DED + 50%	DEDUCTIBLE (Individual /Family) \$750 / 1,500	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.81 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit UF HEALTH	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK	CO PAY (PCP/Specialist) \$30/ 40 DED + 50%	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.81 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK DIRECT CARE ACTIVE EMPL	OYEES-FULL Touse Ild(ren) mily CO PAY (PCP/Specialist) \$30/40 DED + 50%	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.8 ² 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit UF HEALTH	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK DIRECT CARE ACTIVE EMPL Employee Only	CO PAY (PCP/Specialist) \$30/ 40 DED + 50% E PLAN OYEES-FULL T	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.87 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30% \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit UF HEALTH	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK DIRECT CARE ACTIVE EMPL Employee Only Employee & Spo	COYEES-FULL T Duse Ild(ren) mily CO PAY (PCP/Specialist) \$30/ 40 DED + 50% E PLAN OYEES-FULL T	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.8 ² 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30% \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit UF HEALTH	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK DIRECT CARE ACTIVE EMPL Employee Only Employee & Spo Employee & Chi	COYEES-FULL TOUSE Ild(ren) nily CO PAY (PCP/Specialist) \$30/ 40 DED + 50% E PLAN COYEES-FULL TOUSE Ild(ren)	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.8° 257.5° 228.2° 466.7° ER VISIT \$300 CoPay + 30% \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit UF HEALTH HMO	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK DIRECT CARE ACTIVE EMPL Employee & Only Employee & Chi Employee & Fan CTCARE CoPay,	COYEES-FULL TOUSE Ild(ren) nily CO PAY (PCP/Specialist) \$30/ 40 DED + 50% E PLAN COYEES-FULL TOUSE Ild(ren)	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000	32.81 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30% \$300 CoPay + 30%	
FLORIDA BLUE Deductible, Max and ER Visit UF HEALTH HMO	Employee Only Employee & Spo Employee & Chi Employee & Fan CoPay, Out of Pocket IN-NETWORK OUT-OF-NETWORK DIRECT CARE ACTIVE EMPL Employee Only Employee & Spo Employee & Chi Employee & Fan	COYEES-FULL T Duse Ild(ren) nily CO PAY (PCP/Specialist) \$30/ 40 DED + 50% E PLAN OYEES-FULL T Duse Ild(ren) nily CO PAY	DEDUCTIBLE (Individual /Family) \$750 / 1,500 \$1,000 / 2,000	MAX OUT OF POCKET (Individual /Family) \$6,000 / 12,000 \$9,000 / 18,000	32.81 257.52 228.22 466.79 ER VISIT \$300 CoPay + 30% \$300 CoPay + 30%	

JACKSONVILLE HOUSING AUTHORITY

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JHA - DENTAL BU 240

DLAN	COVEDACE	Dan Day Danied
PLAN	COVERAGE	Per Pay Period
DHMO	EE Only	0.40
DHMO	EE & Spouse	5.28
DHMO	EE & Children	7.55
DHMO	EE & Family	14.04
Silver DPPO	EE Only	3.05
Silver DPPO	EE & Spouse	13.39
Silver DPPO	EE & Children	18.94
Silver DPPO	EE & Family	28.03
Gold DPPO	EE Only	9.25
Gold DPPO	EE & Spouse	25.79
Gold DPPO	EE & Children	34.71
Gold DPPO	EE & Family	49.18
Platinum DPPO	EE Only	13.93
Platinum DPPO	EE & Spouse	35.16
Platinum DPPO	EE & Children	46.54
Platinum DPPO	EE & Family	65.17

JHA - DENTAL BU 279

PLAN	COVERAGE	Per Pay Period
DHMO	EE Only	1.50
DHMO	EE & Spouse	6.38
DHMO	EE & Children	8.65
DHMO	EE & Family	15.14
Silver DPPO	EE Only	5.33
Silver DPPO	EE & Spouse	15.67
Silver DPPO	EE & Children	21.22
Silver DPPO	EE & Family	30.31
Gold DPPO	EE Only	11.53
Gold DPPO	EE & Spouse	28.07
Gold DPPO	EE & Children	36.99
Gold DPPO	EE & Family	51.46
Platinum DPPO	EE Only	16.21
Platinum DPPO	EE & Spouse	37.44
Platinum DPPO	EE & Children	48.82
Platinum DPPO	EE & Family	67.45

JACKSONVILLE HOUSING AUTHORITY

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JHA - 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		
	Employee Only	3.77
	Employee & Spouse	6.10
	Employee & Child(ren)	5.98
	Employee & Family	9.84