JACKSONVILLE HOUSING AUTHORITY

EFFECTIVE JANUARY 1, 2021

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	**$750 / 1,500**	**$1,500 Med + 1,000 Phar**	**DED + 20%**
			$3,000 Med + 2,000 Phar	

JACKSONVILLE HOUSING AUTHORITY

EFFECTIVE JANUARY 1, 2021

BU 240 & 279

JHA - DENTAL

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**

JACKSONVILLE HOUSING AUTHORITY

EFFECTIVE JANUARY 1, 2021

BU 240 & 279

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**