

**CITY OF NEW ORLEANS**

**2027 CHOICE HIGH-DEDUCTIBLE HEALTH PLAN (HDHP) ACTIVE SUMMARY SHEET**

**PLEASE NOTE: There will be NO non-emergency Medical Out-of-Network Coverage**

**A Dental Health Coverage Plus option is available for the 2027 Plan Year**

**Vision Coverage will remain unchanged for the 2027 Plan Year**

| UHC MEDICAL PLAN                                                                                                                                                                                                                                                                                                                                                |                            |                                   | UHC Dental BASE PLAN                          |                                                  |                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------|-----------------------------------------------|--------------------------------------------------|------------------------------|
| Services                                                                                                                                                                                                                                                                                                                                                        | In Network                 | Out of Network                    | Services                                      | In Network                                       | Out of Network               |
| CALENDAR YEAR DEDUCTIBLE                                                                                                                                                                                                                                                                                                                                        |                            |                                   | CALENDAR YEAR DEDUCTIBLE                      |                                                  |                              |
| Individual                                                                                                                                                                                                                                                                                                                                                      | \$3,000                    | Not Covered                       | Individual                                    | \$0                                              | \$50                         |
| Family                                                                                                                                                                                                                                                                                                                                                          | \$6,000                    | Not Covered                       | Family                                        | \$0                                              | \$150                        |
| OUT OF POCKET EXPENSES                                                                                                                                                                                                                                                                                                                                          |                            |                                   | ANNUAL ALLOWABLE AMOUNT                       |                                                  |                              |
| Individual                                                                                                                                                                                                                                                                                                                                                      | \$4,800 (inc. deductible)  | Not Covered                       | Individual per person                         | \$1,000                                          | \$1,000                      |
| Family                                                                                                                                                                                                                                                                                                                                                          | \$14,400                   | Not Covered                       | DIAGNOSTIC SERVICES                           |                                                  |                              |
| Maximum Lifetime Benefit                                                                                                                                                                                                                                                                                                                                        | Unlimited Lifetime Maximum |                                   | Periodic Oral Eval.                           | 100%                                             | 100%                         |
| OFFICE VISITS AND PREVENTIVE CARE                                                                                                                                                                                                                                                                                                                               |                            |                                   | Radiographs                                   | 100%                                             | 100%                         |
| Office Visits                                                                                                                                                                                                                                                                                                                                                   | No co-pay after deductible | Not Covered                       | Lab and Other Diagnostic Tests                | 100%                                             | 100%                         |
| Wellness Visits                                                                                                                                                                                                                                                                                                                                                 | \$0 co-pay                 | Not Covered                       | PREVENTIVE SERVICES                           |                                                  |                              |
| Specialist                                                                                                                                                                                                                                                                                                                                                      | No co-pay after deductible | Not Covered                       | Prophylaxis (Preventive)                      | 100%                                             | 100%                         |
| Co-Insurance                                                                                                                                                                                                                                                                                                                                                    | 80% after deductible       | Not Covered                       | Fluoride Treatment (Preventive)               | 100%                                             | 100%                         |
| OUTPATIENT SERVICES                                                                                                                                                                                                                                                                                                                                             |                            |                                   | Sealants                                      | 100%                                             | 100%                         |
| Laboratory, X-Ray, and Diagnostics, Outpatient                                                                                                                                                                                                                                                                                                                  | 20% after deductible       | Not Covered                       | Space Maintainers                             | 100%                                             | 100%                         |
|                                                                                                                                                                                                                                                                                                                                                                 |                            |                                   | BASIC SERVICES                                |                                                  |                              |
| Laboratory and X-Ray – Major Diagnostics (CT Scan, PET Scan, MRI, Nuclear Medicine) Outpatient                                                                                                                                                                                                                                                                  | 20% after deductible       | Not Covered                       | Restorations                                  | 80%                                              | 80%                          |
|                                                                                                                                                                                                                                                                                                                                                                 |                            |                                   | General Services                              | 80%                                              | 80%                          |
|                                                                                                                                                                                                                                                                                                                                                                 |                            |                                   | Simple Extractions                            | 80%                                              | 80%                          |
| Outpatient Surgery                                                                                                                                                                                                                                                                                                                                              | 20% after deductible       | Not Covered                       | Oral Surgery (including surgical extractions) | 80%                                              | 80%                          |
| INPATIENT SERVICES                                                                                                                                                                                                                                                                                                                                              |                            |                                   | Periodontics                                  | 80%                                              | 80%                          |
| Hospital                                                                                                                                                                                                                                                                                                                                                        | 20% after deductible       | Not Covered                       | Endodontics                                   | 80%                                              | 80%                          |
| Professional Services                                                                                                                                                                                                                                                                                                                                           | 20% after deductible       | Not Covered                       | MAJOR SERVICES                                |                                                  |                              |
| EMERGENCY SERVICES                                                                                                                                                                                                                                                                                                                                              |                            |                                   | Inlays/Onlays/Crowns                          | 50%                                              | 50%                          |
| Emergency Room                                                                                                                                                                                                                                                                                                                                                  | 20% after deductible       | Covered (emergency services only) | Dentures/Removable                            | 50%                                              | 50%                          |
| Urgent Care                                                                                                                                                                                                                                                                                                                                                     | 20% after deductible       | Not Covered                       | Fixed Partials/Bridges                        | 50%                                              | 50%                          |
| Ambulance                                                                                                                                                                                                                                                                                                                                                       | 20% after deductible       | Covered (emergency services only) | UHC Dental Health Coverage Plus Plan          |                                                  |                              |
| MENTAL HEALTH SERVICES                                                                                                                                                                                                                                                                                                                                          |                            |                                   | ORTHODONTIC SERVICES – For ages 18 and under  |                                                  |                              |
| In-Patient                                                                                                                                                                                                                                                                                                                                                      | 20% after deductible       | Not Covered                       | Annual Deductible                             | \$0                                              | \$50 / \$150                 |
| Limit per Calendar Year                                                                                                                                                                                                                                                                                                                                         | No stay limitation         | Not Covered                       | Orthodontia                                   | 50%                                              | 50%                          |
| Limit per Lifetime                                                                                                                                                                                                                                                                                                                                              | No limitation              | Not Covered                       | Lifetime Ortho Max                            | \$2,500                                          | \$2,500                      |
| Outpatient Mental Health                                                                                                                                                                                                                                                                                                                                        | 20% after deductible       | Not Covered                       | Dental Implants                               | 50%                                              | 50%                          |
| Limit per Calendar Year                                                                                                                                                                                                                                                                                                                                         | No visit limitation        | Not Covered                       | UHC VISION PLAN                               |                                                  |                              |
| PRESCRIPTION DRUGS                                                                                                                                                                                                                                                                                                                                              |                            |                                   | Services                                      | Per Calendar Year In Network                     | Out of Network Reimbursement |
| Generic (31 day supply)                                                                                                                                                                                                                                                                                                                                         | 20% after deductible       | Not Covered                       | Exam                                          | \$10 co-pay                                      | \$40                         |
| Preferred (31 day supply)                                                                                                                                                                                                                                                                                                                                       | 20% after deductible       | Not Covered                       | Frame Benefit Private Provider                | \$120-\$150 (Retail Price)                       | \$45                         |
| Non-Preferred (31 day supply)                                                                                                                                                                                                                                                                                                                                   | 20% after deductible       | Not Covered                       | Frame Benefit                                 | Retail Provider-\$130                            | \$45                         |
| Specialty (31 day supply)                                                                                                                                                                                                                                                                                                                                       | 20% after deductible       | Not Covered                       | Contacts                                      | \$105 Allowance                                  | \$105                        |
| Mail Order Generic (90 day supply)                                                                                                                                                                                                                                                                                                                              | 20% after deductible       | Not Covered                       | LENSES (Standard)                             |                                                  |                              |
| Mail Order Preferred (90 day supply)                                                                                                                                                                                                                                                                                                                            | 20% after deductible       | Not Covered                       | Single Vision                                 | No co-pay                                        | \$40                         |
|                                                                                                                                                                                                                                                                                                                                                                 |                            |                                   | Lined Bifocal                                 | No co-pay                                        | \$60                         |
| Mail Order Non-Preferred (90 day supply)                                                                                                                                                                                                                                                                                                                        | 20% after deductible       | Not Covered                       | Lined Trifocals                               | No co-pay                                        | \$80                         |
|                                                                                                                                                                                                                                                                                                                                                                 |                            |                                   | Laser Vision Correction                       | Discount Available<br>Please call 1-888-563-4497 |                              |
| Please note that the Benefit Summary above provides a brief description of coverage. It is not a policy, certificate of insurance or coverage document. For complete details on coverage, exclusions, limitations, and the terms under which coverage may continue, please contact your customer service representative or review the Summary Plan Description. |                            |                                   |                                               |                                                  |                              |

**HOW THE WELLNESS CREDIT AFFECTS YOUR PAYROLL DEDUCTION  
(WELLNESS CREDITS DO NOT APPLY TO CHILDREN)**

**Choice HDHP BASE PLAN Healthcare Deductions  
Effective January 1, 2027 – December 31, 2027**

| <b>ACTIVE PARTICIPANTS</b>                    | <b>Weekly</b> | <b>Bi-Weekly</b> | <b>Monthly</b> | <b>Projected Amount Paid by the City</b> |
|-----------------------------------------------|---------------|------------------|----------------|------------------------------------------|
| Employee Only (compliant)                     | \$23.15       | \$46.31          | \$100.34       | \$693.33                                 |
| Employee Only (non-compliant)                 | \$26.62       | \$53.23          | \$115.34       | \$693.33                                 |
| Employee & Child(ren) – (compliant)           | \$69.05       | \$138.10         | \$299.21       | \$1,166.09                               |
| Employee & Child(ren) – (non-compliant)       | \$72.51       | \$145.02         | \$314.21       | \$1,166.09                               |
| Employee & Spouse - EE/SP (compliant)         | \$91.73       | \$183.46         | \$397.49       | \$1,264.84                               |
| Employee & Spouse – (one non-compliant)       | \$95.19       | \$190.38         | \$412.49       | \$1,264.84                               |
| Employee & Spouse – EE/SP (two non-compliant) | \$98.65       | \$197.30         | \$427.49       | \$1,264.84                               |
| Employee & Family – EE/SP (compliant)         | \$104.82      | \$209.63         | \$454.20       | \$1,843.67                               |
| Employee & Family – (one non-compliant)       | \$108.28      | \$216.55         | \$469.20       | \$1,843.67                               |
| Employee & Family – EE/SP (two non-compliant) | \$111.74      | \$223.48         | \$484.20       | \$1,843.67                               |

**HOW THE WELLNESS CREDIT AFFECTS YOUR PAYROLL DEDUCTION  
(WELLNESS CREDITS DO NOT APPLY TO CHILDREN)**

**Choice HDHP PLUS PLAN Healthcare Deductions  
Effective January 1, 2027 – December 31, 2027**

| <b>ACTIVE PARTICIPANTS</b>                    | <b>Weekly</b> | <b>Bi-Weekly</b> | <b>Monthly</b> | <b>Projected Amount Paid by the City</b> |
|-----------------------------------------------|---------------|------------------|----------------|------------------------------------------|
| Employee Only (compliant)                     | \$25.25       | \$50.50          | \$109.41       | \$693.33                                 |
| Employee Only (non-compliant)                 | \$28.71       | \$57.42          | \$124.41       | \$693.33                                 |
| Employee & Child(ren) – (compliant)           | \$74.21       | \$148.41         | \$321.56       | \$1,166.09                               |
| Employee & Child(ren) – (non-compliant)       | \$77.67       | \$155.33         | \$336.56       | \$1,166.09                               |
| Employee & Spouse - EE/SP (compliant)         | \$96.26       | \$192.52         | \$417.13       | \$1,264.84                               |
| Employee & Spouse – (one non-compliant)       | \$99.72       | \$199.45         | \$432.13       | \$1,264.84                               |
| Employee & Spouse – EE/SP (two non-compliant) | \$103.18      | \$206.37         | \$447.13       | \$1,264.84                               |
| Employee & Family – EE/SP (compliant)         | \$110.34      | \$220.68         | \$478.13       | \$1,843.67                               |
| Employee & Family – (one non-compliant)       | \$113.80      | \$227.60         | \$493.13       | \$1,843.67                               |
| Employee & Family – EE/SP (two non-compliant) | \$117.26      | \$234.52         | \$508.13       | \$1,843.67                               |

**Revised 9/23/2026**