

**CITY OF NEW ORLEANS**  
**2022 CHOICE PLAN ACTIVE SUMMARY SHEET**  
**PLEASE NOTE: There will be NO Medical Out-of-Network Coverage**  
**Dental Coverage has a Buy-Up Option for 2022 Plan Year**  
**Vision Coverage WILL NOT change for 2022 Plan Year**

<b>UHC MEDICAL PLAN</b>			<b>UHC Dental BASE PLAN</b>		
Services	In Network	Out of Network	Services	In Network	Out of Network
<b>CALENDAR YEAR DEDUCTIBLE</b>			<b>CALENDAR YEAR DEDUCTIBLE</b>		
Individual	\$750	Not Covered	Individual	\$0	\$50
Family	\$2,250	Not Covered	Family	\$0	\$150
<b>OUT OF POCKET EXPENSES</b>			<b>ANNUAL ALLOWABLE AMOUNT</b>		
Individual	\$4,500 (incl. deductible)	Not Covered	Individual	\$1,000 per person	\$1,000 per person
Family	\$13,500	Not Covered	<b>DIAGNOSTIC SERVICES</b>		
Maximum Lifetime Benefit	unlimited lifetime maximum		Periodic Oral Eval.	100%	100%
<b>OFFICE VISITS AND PREVENTATIVE CARE</b>			Radiographs	100%	100%
Office Visits	\$30 co-pay	Not Covered	Lab and Other Diagnostic Tests	100%	100%
Wellness Visits	\$0 co-pay	Not Covered	<b>PREVENTIVE SERVICES</b>		
Specialist	\$45co-pay	Not Covered	Prophylaxis (Preventive)	100%	100%
<b>OUTPATIENT SERVICES</b>			Fluoride Treatment (Preventive)	100%	100%
Laboratory, X-Ray, and Diagnostics, Outpatient	0%	Not Covered	Sealants	100%	100%
Laboratory and X-Ray – Major Diagnostics (CT Scan, PET Scan, MRI, Nuclear Medicine) Outpatient	20% after deductible	Not Covered	Space Maintainers	100%	100%
Outpatient Surgery	20% after deductible	Not Covered	<b>BASIC SERVICES</b>		
<b>INPATIENT SERVICES</b>			Restorations	80%	80%
Hospital	20% after deductible	Not Covered	General Services	80%	80%
Professional Services	20% after deductible	Not Covered	Simple Extractions	80%	80%
<b>EMERGENCY SERVICES</b>			Oral Surgery (incl. surgical extractions)	80%	80%
Emergency Room	\$350 co-pay	Covered (emergency services only)	Periodontics	80%	80%
Urgent Care	\$50 co-pay	Not Covered	Endodontics	80%	80%
Ambulance	20% after deductible	Covered (emergency services only)	<b>MAJOR SERVICES</b>		
<b>MENTAL HEALTH SERVICES</b>			Inlays/Onlays/Crowns	50%	50%
In-Patient	20% after deductible	Not Covered	Dentures/Removable	50%	50%
Limit per Calendar Year	No stay limitation	Not Covered	Fixed Partials/Bridges	50%	50%
Limit per Lifetime	No limitation	Not Covered	<b>UHC Dental BUY-UP PLAN</b>		
Outpatient Mental Health	\$30 per visit	Not Covered	<b>ORTHODONTIC SERVICES – Up to Age 19 Only</b>		
Limit per Calendar Year	No visit limitation	Not Covered	Annual Deductible	\$0	\$50 / \$150
<b>PRESCRIPTION DRUGS</b>			Orthodontia	50%	50%
Generic (31 day supply)	\$10 co pay	Not Covered	Lifetime Ortho Max	\$2,500	\$2,500
Preferred (31 day supply)	\$35 co pay	Not Covered	Dental Implants (any age)	50%	50%
Non-Preferred (31 day supply)	\$70 co pay	Not Covered	Implant Annual Max	\$1,000	\$1,000
Mail Order Generic (90 day supply)	\$30 co pay	Not Covered	<b>UHC VISION PLAN</b>		
Mail Order Preferred (90 day supply)	\$105 co pay	Not Covered	Services	In Network Per Calendar Year	Out of Network Reimbursement
Mail Order Non-Preferred (90 day supply)	\$210 co pay	Not Covered	Exam	\$10 co pay	\$40
<b>PRESCRIPTION DRUGS</b>			Frame Benefit Private Provider	\$120-\$150 (Retail Price)	\$45
Generic (31 day supply)	\$10 co pay	Not Covered	Frame Benefit	Retail Provider-\$130	\$45
Preferred (31 day supply)	\$35 co pay	Not Covered	Contacts	\$105 Allowance	\$105
Non-Preferred (31 day supply)	\$70 co pay	Not Covered	<b>LENSES (Standard)</b>		
Mail Order Generic (90 day supply)	\$30 co pay	Not Covered	Single Vision	No co pay	\$40
Mail Order Preferred (90 day supply)	\$105 co pay	Not Covered	Lined Bifocal	No co pay	\$60
Mail Order Non-Preferred (90 day supply)	\$210 co pay	Not Covered	Lined Trifocals	No co pay	\$80
			Laser Vision Correction	Discount Available 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 TO APPLY THE WELLNESS CREDIT TO YOUR WEEKLY / BI-WEEKLY PAYROLL  
(WELLNESS CREDITS DO NOT APPLY TO CHILDREN)**

**BASE PLAN Healthcare Deductions  
Effective January 1, 2022 – December 31, 2022**

<b>ACTIVE PARTICIPANTS</b>	<b>Weekly</b>	<b>Bi-Weekly</b>	<b>Monthly</b>	<b>Paid by the City</b>
Employee Only (compliant)	\$30.16	\$60.31	\$130.67	\$478.83
Employee Only (non-compliant)	\$33.62	\$67.23	\$145.67	\$478.83
Employee & Child(ren) – (compliant)	\$81.97	\$163.95	\$355.21	\$770.08
Employee & Child(ren) – (non-compliant)	\$85.43	\$170.87	\$370.21	\$770.08
Employee & Spouse - EE/SP (compliant)	\$101.78	\$203.55	\$441.03	\$835.57
Employee & Spouse – (one non-compliant)	\$105.24	\$210.47	\$456.03	\$835.57
Employee & Spouse – EE/SP (two non-compliant)	\$108.70	\$217.40	\$471.03	\$835.57
Employee & Family – EE/SP (compliant)	\$120.47	\$240.94	\$522.03	\$1,242.64
Employee & Family – (one non-compliant)	\$123.93	\$247.86	\$537.03	\$1,242.64
Employee & Family – EE/SP (two non-compliant)	\$127.39	\$254.78	\$552.03	\$1,242.64

**HOW TO APPLY THE WELLNESS CREDIT TO YOUR WEEKLY / BI-WEEKLY PAYROLL  
(WELLNESS CREDITS DO NOT APPLY TO CHILDREN)**

**BUY-UP PLAN Healthcare Deductions  
Effective January 1, 2022 – December 31, 2022**

<b>ACTIVE PARTICIPANTS</b>	<b>Weekly</b>	<b>Bi-Weekly</b>	<b>Monthly</b>	<b>Paid by the City</b>
Employee Only (compliant)	\$31.70	\$63.41	\$137.38	\$478.83
Employee Only (non-compliant)	\$35.17	\$70.33	\$152.38	\$478.83
Employee & Child(ren) – (compliant)	\$85.79	\$171.57	\$371.74	\$770.08
Employee & Child(ren) – (non-compliant)	\$89.25	\$178.49	\$386.74	\$770.08
Employee & Spouse - EE/SP (compliant)	\$105.13	\$210.26	\$455.56	\$835.57
Employee & Spouse – (one non-compliant)	\$108.59	\$217.18	\$470.56	\$835.57
Employee & Spouse – EE/SP (two non-compliant)	\$112.05	\$224.10	\$485.56	\$835.57
Employee & Family – EE/SP (compliant)	\$124.55	\$249.11	\$539.73	\$1,242.64
Employee & Family – (one non-compliant)	\$128.01	\$256.03	\$554.73	\$1,242.64
Employee & Family – EE/SP (two non-compliant)	\$131.48	\$262.95	\$569.73	\$1,242.64

Revised 10/01/2021