

Northwestern University Pre-65 Retiree Plan Comparison

Plan Year 2026

2026 Pre-65 Medical Plans				
Plan Features	PPO ^{1, 2}	HDHP Plus ^{2,3}	HDHP Essential ^{2,3}	HMO ¹
In-Network Providers				
Deductible (Individual/Family)	\$750/\$1,500	\$2,000/\$4,000	\$4,000/\$8,000	Not applicable
Coinsurance	20%	20%		
Out-of-Pocket Maximum (Individual/Family)	\$3,000/\$6,000	\$4,000/\$8,000	\$7,000/\$14,000	\$1,500/\$3,000
Office Visit	\$40 Primary Care Physician/\$55 specialist	20% Coinsurance after Deductible		\$25 PCP/\$35 specialist
ER	\$150 (waived if admitted) + 20% Coinsurance after Deductible			\$150 (waived if admitted)
Out-of-Network Providers				
Deductible (Individual/Family)	\$1,500/\$3,000	\$4,000/\$8,000	\$8,000/\$16,000	Not applicable
Coinsurance	40%	40%		
Out-of-Pocket Maximum (Individual/Family)	\$6,000/ \$12,000	\$8,000/\$16,000	\$14,000/\$28,000	
Office Visit	40% Coinsurance after Deductible			\$150 (waived if admitted)
ER	\$150 (waived if admitted) + 20% Coinsurance after Deductible	20% Coinsurance after Deductible		

¹ Copays apply toward out-of-pocket maximums.

² The in- and out-of-network deductibles and out-of-pocket maximums are tracked separately.

³ For participants who choose You + Spouse, You + Child(ren), or You + Spouse + Child(ren) coverage, family deductible and out-of-pocket rates may apply.

2026 Pre-65 Prescription Drug Coverage				
Plan Features	PPO ¹	HDHP Plus ²	HDHP Essential ²	HMO ¹
Out-of-Pocket Maximum (Individual/Family)	\$1,500/\$3,000	\$4,000/\$8,000	\$7,000/\$14,000	\$1,500/\$10,200
Prescription Drugs (Retail/Mail Order)	Copay:	Coinsurance after deductible:	Coinsurance after deductible:	Copay:
Generic	\$10 /\$20	20%/20%	20%/20%	\$10/\$20
Formulary	\$50/\$100	20%/20%	20%/20%	\$30/\$60
Non-Formulary	\$75/\$150	20%/20%	20%/20%	\$60/\$120
Specialty	\$100/\$200	20%/20%	20%/20%	\$90/\$180

¹ Out-of-pocket maximums for medical and Rx are tracked separately. Rx copays apply toward out-of-pocket maximums.

² Out-of-pocket maximums for medical and Rx are combined.

Applies to all Medical Plans

- [Generics preferred](#): Ancillary charges apply to brand-name if generic available, even when Dispense as Written box is checked.
- [CVS Retail 90 Network](#): Select long-term [medications](#) require a 90-day supply and can be filled at Walgreens, CVS, and CVS Mail Order only.
- [Specialty drugs](#) typically must be filled through CVS Specialty pharmacy, even if administered at your doctor's office or an infusion center.

PPO and HMO Only

- [PrudentRx](#): If your specialty medication is noted on the [PrudentRx Drug List](#), you **must** participate in the PrudentRx program. Under the program you will receive your medications free of charge (\$0).

Resources

- To verify if your medication is covered under the plan, you may contact CVS Caremark directly at 833-844-5348 or by reviewing the [search tools by medical plan on the website](#).
- Review the online [FAQs](#) to find answers to common questions about prescription drug questions.

Dental				
	Pre-65 Retiree PPO (Delta Dental)		Pre-65 Retiree DHMO (Guardian)	
Common Dental Event	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$50 individual/ \$150 family	\$50 individual/ \$150 family	\$0	Not Applicable
Preventive & Diagnostic	100%	100%	100%	
Minor Dental Services	80%	80%	Based on schedule of copays	
Major Dental Services	50%	50%		
Annual Calendar Maximum	\$3,000	\$3,000		

Vision		
Pre-65 Retiree PPO (BCBSIL/EyeMed)		
Common Vision Event	In-Network	Out-of-Network
Eye Exam	\$10	Up to \$40 Reimbursement
Frames	\$75 copay + (80% of charge)	\$75 copay + (80% of charge)
Contacts	\$200 Allowance	\$200 Allowance

2026 Retiree Rates

Pre-65 Retirees

Pre-65 Health Monthly Premiums				
Coverage	You Only	You + Spouse	You + Child(ren)	You + Spouse + Child(ren)
Pre-65 Retiree PPO (UHC)	\$1,009	\$2,209	\$1,876	\$3,320
Pre-65 Retiree HDHP Plus (UHC)	\$898	\$1,965	\$1,669	\$2,953
Pre-65 Retiree HDHP Essential (UHC)	\$804	\$1,760	\$1,495	\$2,646
Pre-65 Retiree HMO (UHC)	\$803	\$1,753	\$1,512	\$2,646
Pre-65 Dental Monthly Premiums				
Coverage	You Only	You + Spouse	You + Child(ren)	You + Spouse + Child(ren)
Pre-65 Retiree Dental PPO (Delta)	\$77	\$166	\$187	\$265
Pre-65 Retiree Dental HMO (Guardian)	\$14	\$27	\$28	\$42
Pre-65 Vision Monthly Premiums				
Coverage	You Only	You + Spouse	You + Child(ren)	You + Spouse + Child(ren)
Pre-65 Retiree Vision PPO (BCBSIL/EyeMed)	\$10	\$20	\$23	\$28