Northwestern University Pre-65 Retiree Plan Comparison 2027

2027 Medical Plans				
Plan Features	PPO [1, 2, 3, 5]	HSA Plus [2, 4, 5]	HSA Essential [2, 3, 5]	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/$55 specialist	20% Coinsurance after Deductible		$25 Primary Care/$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			
ER	$150 (waived if admitted) + 20% Coinsurance after Deductible	20% Coinsurance after Deductible		$150 (waived if admitted)
Health Savings Account Eligibility				
University Match	n/a	Employee Only $1,000 / Family $2,000		n/a

[1] *Copays apply toward out-of-pocket maximums.*

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

[3] *Each family member has an individual deductible within the overall family deductible. Once a family member meets their individual deductible, coinsurance begins for that person even if the full family deductible has not been met. The remaining family deductible must be met by any combination of the other family members before coinsurance begins for the remaining family members.*

[4] *For You + Spouse, You + Child(ren), or You + Spouse + Child(ren) coverage, the family deductible must be met before coinsurance coverage begins for any individual member.*

[5] *Each family member has an individual out-of-pocket maximum (OOPM) within the overall family OOPM. Once a member meets their individual OOPM, the plan pays 100% for that person even if the full family OOPM has not yet been met. The remaining family OOPM must be met by any combination of other family members before the plan pays 100% for the remaining family members.*

2027 Prescription Drug Coverage				
Plan Features	**PPO** [1, 2, 4]	**HSA Plus** [3]	**HSA Essential** [3]	**HMO** [1, 2, 4]
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.*

[2] *Rx copays apply toward out-of-pocket maximums.*

[3] *Out-of-pocket maximums for medical and Rx are combined.*

[4] *Family out-of-pocket maximum is $1,500 per individual until the family limit is reached.*

Applies to all Medical Plans

- Generics preferred: Ancillary charges apply to brand-name if generic is available, even when "Dispense as Written" box is checked.
- CVS Retail 90 Network: Select long-term medications require a 90-day supply and must be filled at Walgreens, CVS, and CVS Mail Order only.
- Specialty drugs: Must be filled through CVS Specialty pharmacy, even if administered at your doctor's office or an infusion center.
- While you may use third party assistance, such as manufacturer coupons, for the amount you pay, it is not applied towards satisfying your deductible or out-of-pocket maximums.

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). Medication covered under PrudentRx is not applied toward your annual deductible or annual out-of-pocket maximum. If you have any questions about the PrudentRx program and how to enroll, call 800-578-4403.

Pre-65 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		

Pre-65 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