Gallagher

Insurance | Risk Management | Consulting

# Medical Plan Comparisons:

# Blue Cross Blue Shield of IL & United Healthcare

# Northwestern University - Postdoctoral Benefit Program
## 1/1/2026 Carrier Migration
## HMO Medical Benefit Analysis

| Core Benefits (what member pays) | BCBS of Illinois - In Network | | | UHC Navigate HMO UHC of IL - In Network | | |
|---|---|---|---|---|---|---|
| **Maximum Out of Pocket (Medical):** | $1,500 Individual/$3,000 Family | | | $1,500 Individual /$3,000 Family | | |
| **Maximum Out of Pocket (RX):** | $1,500 Individual/$10,200 Family | | | **N/A** | | |
| **Deductible:** | | | | | | |
| Individual - | None | | | None | | |
| Family | None | | | None | | |
| Lifetime Maximum | Unlimited | | | Unlimited | | |
| Routine Physical Exams | No Copay | | | No Copay | | |
| Office Visit | $25 Copay | | | $25 Copay | | |
| Office Visit - persons under 19yo | $25 Copay | | | **No Copay** | | |
| Specialist Office Visit | $35 Copay | | | $35 Copay | | |
| Diagnostic Tests | No Copay | | | No Copay | | |
| Major Diagnostic & Imaging | No Copay | | | No Copay | | |
| **Hospitalization:** | | | | | | |
| Inpatient - | $500 Copay per admission | | | $500 Copay per admission | | |
| Outpatient Surgery - | $250 Copay per visit | | | **No copay** | | |
| Maternity - | $500 Copay per admission | | | Amount you pay is based on where the covered health care service is provided. | | |
| **Prescription Drugs:** | In-Network Retail (30 days) | In-Network Mail Order (90 days) | Out-of-Network Provider | In-Network Retail (31 day) | In-Network Mail Order (90 day) | Out-of-Network Provider |
| Generic | $10 Copay | $20 Copay | Not Covered | $10 | **$25** | Not Covered |
| Brand Name | $30 Copay | $60 Copay | Not Covered | **$40** | **$100** | Not Covered |
| Non Formulary | $60 Copay | $120 Copay | Not Covered | **$75** | **$187.50** | Not Covered |
| Specialty | $90 Copay | N/A | Not Covered | **$125** | $312.50 | Not Covered |
| Urgent Care Visits | $25 Copay | | | $25 Copay | | |
| Emergency Room Visits | $150 Copay (Copayment waived if admitted) | | | $150 Copay (Copayment waived if admitted) | | |
| Telehealth* | $25/$35 Per visit | | | $25/$35 Per visit | | |
| Virtual Care Services** | Not mentioned in plan docs | | | **No Copay** | | |
| **Mental Health:** | | | | | | |
| Outpatient - | $25 Copay | | | $25 Copay | | |
| Inpatient - | $500 Copay per admission | | | **No Copay** | | |

*Telehealth/Telemedicine Services means a health service delivered by a health professional licensed, certified or otherwise entitled to practice in Illinois and acting within the scope of the health professional's license, certification, or entitlement to a patient in a different physical location than the health professional using telecommunications or information technology.

**Virtual Care Services defined as medical care provided by a third party like TeleDoc, Doctor on Demand, Amwell.

# Northwestern University - Postdoctoral Benefit Program
## 1/1/2026 Carrier Migration
## PPO Medical Benefit Analysis

BlueCross BlueShield of Illinois

UnitedHealthcare

| Core Benefits (what member pays) | BCBS of Illinois PPO | | United Healthcare | | |
|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In- Designated Network**** | In-Network | Out-of-Network |
| **Maximum Out of Pocket:** | $3,000 Individual | $6,000 Individual | $3,000 Individual | $3,000 Individual | $6,000 Individual |
| | $8,000 Family | $16,000 Family | $8,000 Family | $8,000 Family | $16,000 Family |
| **Deductible:** | | | | | |
| Individual - | $500 | $1,000 | $500 | $500 | $1,000 |
| Family | $1,500 | $3,000 | $1,500 | $1,500 | $3,000 |
| Lifetime Maximum | Unlimited | | Unlimited | | |
| Routine Physical Exams | No Copay* | 20% after deductible | No Copay* | No Copay* | **40% after deductible** |
| Office Visit | $25 Copay* | 40% after deductible | $25 Copay* | $25 Copay* | 40% after deductible |
| Office Visit - persons under 19yo | $25 Copay* | 40% after deductible | **No Copay*** | **No Copay*** | 40% after deductible |
| Specialist Office Visit | $35 Copay* | 40% after deductible | **$25 Copay*** | $35 Copay* | 40% after deductible |
| Diagnostic Tests | 20% after deductible | 20% after deductible | **No Copay*** | | **40% after deductible** |
| Major Diagnostic & Imaging | 20% after deductible | 20% after deductible | 20% after deductible | | **40% after deductible** |
| **Hospitalization:** | | | | | |
| Inpatient - | 20% after deductible | 20% after deductible | 20% after deductible | | **40% after deductible** |
| Outpatient - | 20% after deductible | 20% after deductible | 20% after deductible | | **40% after deductible** |
| Childbirth/Delivery - | 20% after deductible | 20% after deductible | Amount you pay is based on where the covered health care service is provided; deductible applies. Annual Deductible will not apply for a newborn child whose length of stay in hospital is same as mother's length of stay. | | |
| **Prescription Drugs:** | | | | | |
| **RX Out-of-Pocket Maximum** | $1,500 Individual/ $5,450 Family | | **Combined with Medical Out-of-Pocket Maximum** | | |
| | In-Network Retail (30 | In-Network Mail Order (90 | Out of Network Retail (30 days) | In-Network Retail (30 days) | In-Network Mail Order (90 days) | Out of Network Retail (30 days) |
| Generic | $10 Copay* | $20 Copay* | $10 Copay* | $10 Copay* | $25 Copay* | $10 Copay* |
| Brand Name | $30 Copay* | $60 Copay* | $30 Copay* | **$40 Copay*** | **$100 Copay*** | **$40 Copay*** |
| Non Formulary | $60 Copay* | $120 Copay* | $60 Copay* | **$75 Copay*** | **$187.50 Copay*** | **$75 Copay*** |
| Specialty | N/A | $90 Copay* | $90 Copay* | **$125 Copay*** | **$312.50 Copay*** | **$125 Copay*** |
| Urgent Care Visits | 20% after deductible | | 20% after deductible | **20%*** | | **40% after deductible** |
| Emergency Room Visits | $150 Copay + 20%* (Copay waived if admitted) | | $150 Copay + 20%* (Copay waived if admitted) | $150 Copay + 20%* (Copay waived if admitted) | | $150 Copay + 20%* (Copay waived if admitted) |
| Telehealth (primary care/specialist)** | $25 per Visit* | | 20% of Maximum Allowance | $25/$25 per Visit* | $25/**$35** per Visit* | **40% after deductible** |
| Virtual Care Services*** | Not Covered | | Not Covered | **No copay*** | | **40% after deductible** |
| **Mental Health:** | | | | | |
| Outpatient Office Visits - | 20% after deductible | | 20% after deductible | **$25 Copay*** | | **40% after deductible** |
| Outpatient Intensive Treatment - | 20% after deductible | | 20% after deductible | **No Copay after deductible** | | **40% after deductible** |
| Inpatient - | 20% after deductible | | 20% after deductible | 20% after deductible | | **40% after deductible** |

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**** In-Designated Network - Discounts may be provided for Premium care physicians designated for providing effective and efficient quality care.