# 2026 Intergovernmental Personnel Benefit Cooperative Retiree Plan Options

| 2026 Plan Year | Premium | Premier | Choice | | Classic |
|---|---|---|---|---|---|
| *Medical Insurer* | *The Hartford* | *Blue Cross Blue Shield of Illinois* | *Blue Cross Blue Shield of Illinois* | | *Blue Cross Blue Shield of Illinois* |
| *Prescription Drug Coverage* | *Prime Therapeutics* | *Prime Therapeutics* | *Prime Therapeutics* | | *Prime Therapeutics* |
| **Medical Benefits** | | | | | |
| **Medical Deductible (In-Network)** | $0 | $0 | $0 | | $750 |
| **Maximum Out of Pocket Medical** | No Max Out of Pocket | $0 | $500 | | $3,500 |
| **Primary Care Visit** | $0 | $0 | $0 | | $15 |
| **Specialist Care Visit** | $0 | $0 | $0 | | $40 |
| **Inpatient Copay Per Day** | $0 Days 1-150 | $0 Per Stay | $100 Per Stay | | $250 Days 1-7<br>$0 Days 8+ |
| **Outpatient Copay** | $0 | $0 | $100 | | 20% |
| **Outpatient Hospital Services** | $0 | 0% | $100 | | 20% |
| **Skilled Nursing Copay (Days 1-20)** | $0 | $0 | $0 | | $0 |
| **Skilled Nursing Copay (Days 21-100)** | $0 | $0 | $100 | | $150 |
| **Ambulance** | $0 | $0 | $100 | | $200 |
| **Emergency Room** | $0 | $0 | $100 | | $120 |
| **Vision Benefits** | | | | | |
| **Diabetic Eye Exam** | Not Included | $0 | $0 | | $0 |
| **Routine Eye Exam** | Not Included | $0 | $0 | | Not Included |
| **Eyewear 1 per Year** | Not Included | Included | Not Included | | Not Included |
| **Max for Eyewear** | Not Included | $250 | Not Included | | Not Included |
| **Hearing Benefits** | | | | | |
| **Medicare Covered Exam** | Not Included | $0 | $0 | | $0 |
| **Routine Exam** | Not Included | $0 | $0 | | Not Included |
| **Hearing Aid Allowance - Every 3 Years** | Not Included | $3,000 | Not Included | | Not Included |
| **Dental Benefits** | | | | | |
| **Medicare Covered Exam** | Not Included | $30 | $20 | | $20 |
| **Basic Restorative (cavities, non-surgical extractions, dental pain relief)** | Not Included | 20% | Not Included | | Not Included |
| **Major Restorative (Surgical tooth extractions, root canals, includes crowns and dentures)** | Not Included | 50% | Not Included | | Not Included |
| **Annual Allowance Preventive** | Not Included | $1,500 | Not Included | | Not Included |
| **Prescription Drug Benefits** | | | | | |
| **Annual Deductible** | $0 | $0 | $50 (Tiers 3-5) | | $590 (Tiers 3-5) |
| **Pharmacies** | Preferred | Preferred | Preferred | Standard | Preferred |
| | | | | | |
| **Tier 1: Preferred Generics** | | | | | |
| ***30-Day Supply Retail or Mail*** | $0 | $0 | $0 | $7 | $10 |
| ***90-Day Supply Retail*** | $0 | $0 | $0 | $21 | $30 |
| ***90-Day Supply Mail*** | $0 | $0 | $0 | $21 | $30 |
| **Tier 2: Generics** | | | | | |
| ***30-Day Supply Retail or Mail*** | $5 | $5 | $6 | $13 | $15 |
| ***90-Day Supply Retail*** | $15 | $15 | $18 | $39 | $45 |
| ***90-Day Supply Mail*** | $10 | $10 | $18 | $39 | $45 |
| **Tier 3: Preferred Brand** | | | | | |
| ***30-Day Supply Retail or Mail*** | $20 | $20 | $26 | $33 | $47 |
| ***90-Day Supply Retail*** | $60 | $60 | $78 | $99 | $141 |
| ***90-Day Supply Mail*** | $40 | $40 | $78 | $99 | $141 |
| **Tier 4: Non-Preferred Drugs** | | | | | |
| ***30-Day Supply Retail or Mail*** | $35 | $35 | $56 | $63 | 25% |
| ***90-Day Supply Retail*** | $105 | $105 | $168 | $189 | 25% |
| ***90-Day Supply Mail*** | $70 | $70 | $168 | $189 | 25% |
| **Tier 5: Specialty** | | | | | |
| ***30-Day Supply Retail or Mail*** | $55 | $55 | 25% | 25% | 25% |
| ***90-Day Supply Retail*** | $165 | $165 | 25% | 25% | 25% |
| ***90-Day Supply Mail*** | $110 | $110 | 25% | 25% | 25% |
| ***Note: GLP-1 drugs for weight loss are NOT covered by these pharmacy benefit plans.*** | | | | | |
| **Monthly Medical + Prescription Drug Premiums** | | | | | |
| **Per Member Per Month** | **Pre 65 - $628.31<br>65+ - $548.75** | **$508.25** | **$412.25** | | **$181.25** |

**Benistar Customer Service: 1.800.236.4782**

Eligibility requirements

*Must be retired and Medicare eligible