

2026 Intergovernmental Personnel Benefit Cooperative Retiree Plan Options

2026 Plan Year	Premium	Premier	Choice	Classic
<i>Medical Insurer</i>	<i>The Hartford</i>	<i>Blue Cross Blue Shield of Illinois</i>	<i>Blue Cross Blue Shield of Illinois</i>	<i>Blue Cross Blue Shield of Illinois</i>
<i>Prescription Drug Coverage</i>	<i>Prime Therapeutics</i>	<i>Prime Therapeutics</i>	<i>Prime Therapeutics</i>	<i>Prime Therapeutics</i>
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 \$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 <u>weight loss</u> are NOT covered by these pharmacy benefit plans.				
Monthly Medical + Prescription Drug Premiums				
Per Member Per Month	under 65 - \$757.31 65-69 - \$547.89 70-74 - \$579.12 75-79 - \$598.95 80-84 - \$609.24 85+ - \$612.77	\$508.25	\$412.25	\$181.25

Benistar Customer Service: 1.800.236.4782

Eligibility requirements

*Must be retired and Medicare eligible