IPBC
Intergovernmental
Personnel Benefit
Cooperative

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 1-100	$0 Days 1-5	$100 Day 1		$250 Days 1-7
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)
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%
Monthly Medical + Prescription Drug Premiums					
Per Member Per Month	**$548.75**	**$508.25**	**$412.25**		**$181.25**

Benistar Customer Service: 1.800.236.4782

Eligibility requirements

*Must be aged 65+, retired and becoming Medicare eligible