

Mansfield Township Board of Education AmeriHealth / BeneCard RxAlliance Plan Benefits Comparison

	AmeriHealth PPO \$10		AmeriHealth PPO \$15		AmeriHealth EPO
Medical:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Referral Required	No		No		Yes
Individual Deductible	None	\$100	None	\$100	None
Family Deductible	None	\$250	None	\$250	None
Max. Coinsurance Single	\$400	\$2,000	\$400	\$2,000	
Max. Coinsurance Family	\$800	\$5,000	\$800	\$5,000	
Max. Out of Pocket Single	\$400	\$2,000	\$5,280	\$2,000	\$5,280
Max. Out of Pocket Family	\$800	\$5,000	\$10,560	\$5,000	\$10,560
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
PCP Office Copay	\$10	80% after deductible	\$15	70% after deductible	\$10
Specialist Office Copay	\$10	80% after deductible	\$15	70% after deductible	\$10
Inpatient Hospital Copay	100%	80% after deductible	100%	70% after deductible	100%
Outpatient Surgery Copay	100%	80% after deductible	100%	70% after deductible	100%
Emergency Room Copay	100% after \$25 copay		100% after \$50 copay		100% after \$35 copay
Routine Eye Exam Copay	\$10	Not Covered	\$15	Not Covered	\$10
Medical Monthly Premium Rates effective July 1, 2025:					
Single	\$1,302.00		\$1,243.00		\$1,182.00
Parent/Child(ren)	\$2,214.00		\$2,116.00		\$2,009.00
2-Party	\$2,607.00		\$2,488.00		\$2,362.00
Family	\$3,519.00		\$3,356.00		\$3,191.00
BeneCard / Rx Alliance Prescription:					
Retail Generic Copay	\$3		\$3		\$3
Retail Brand Copay	\$10		\$10		\$10
Mail Order Generic Copay	\$5		\$5		\$5
Mail Order Brand Copay	\$15		\$15		\$15
Prescription Drug Monthly Premium Rates effective July 1, 2025:					
Single	\$301.91		\$301.91		\$301.91
Parent/Child(ren)	\$528.29		\$528.29		\$528.29
2-Party	\$603.78		\$603.78		\$603.78
Family	\$830.17		\$830.17		\$830.17
Total Annual Premium: (Med/Rx)					
Single	\$19,247		\$18,539		\$17,807
Parent & Child	\$32,907		\$31,731		\$30,447
Member & Spouse/Partner	\$38,529		\$37,101		\$35,589
Family	\$52,190		\$50,234		\$48,254