

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, 2026:					
Single	\$1,493.00		\$1,426.00		\$1,356.00
Parent/Child(ren)	\$2,540.00		\$2,427.00		\$2,304.00
2-Party	\$2,990.00		\$2,854.00		\$2,709.00
Family	\$4,036.00		\$3,849.00		\$3,660.00
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, 2026:					
Single	\$372.86		\$372.86		\$372.86
Parent/Child(ren)	\$652.44		\$652.44		\$652.44
2-Party	\$745.67		\$745.67		\$745.67
Family	\$1,025.26		\$1,025.26		\$1,025.26
Total Annual Premium: (Med/Rx)					
Single	\$22,390		\$21,586		\$20,746
Parent & Child	\$38,309		\$36,953		\$35,477
Member & Spouse/Partner	\$44,828		\$43,196		\$41,456
Family	\$60,735		\$58,491		\$56,223