Pennsylvania Townships Health Insurance Cooperative Trust
Effective Date: 01-01-2026
Open Choice PPO Plan – Plan 3

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 10%	20%
Payment Limit (per calendar year)	$6,600 Individual $13,200 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the in-network and out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months age 22 and older	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; no deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	20%; no deductible
Breast cancer screenings	Covered 100%; deductible waived	20%; after deductible

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Women's Health	Covered 100%; deductible waived	20%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	20%; no deductible
Routine Eye Exams Limited to 1 exam every 24 consecutive months	Covered 100%; deductible waived	20%; after deductible
Routine Hearing Screening	Not Covered	Not Covered
Medications	Certain over-the-counter preventive medications covered 100% in network.	
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$35 office visit copay; deductible waived	20%; after deductible
Specialist Office Visits	$35 office visit copay; deductible waived	20%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$35 copay; deductible waived	20%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	20%; after deductible
Allergy Injections	Covered 10%; after deductible.	20%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 10%; after deductible	20%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 10%; after deductible.	20%; after deductible
Diagnostic Complex Imaging If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 10%; after deductible.	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$25 office visit copay; deductible waived	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room Copay waived if admitted	$100 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	$100 copay; deductible waived	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 10%; after deductible.	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 10%; after deductible.	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	Covered 10%; after deductible.	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	Covered 10%; after deductible.	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 10%; after deductible.	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 10%; after deductible. .	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health	$35 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 10%; after deductible.	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	Covered 10%; after deductible. .	20%; after deductible
Substance Abuse	$35 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 10%; after deductible	20%; after deductible
Limited to 90 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 10%; after deductible	20%; after deductible
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered 10%; after deductible	20%; after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		

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Spinal Manipulation Therapy Limited to 20 visits per year	$35 copay; deductible waived	20%; after deductible
Short-Term Rehabilitation	$35 copay; deductible waived	20%; after deductible
Limited to 30 visits per year for physical and occupational therapy combined. Speech therapy limited to 30 visits per year.		
Habilitative Physical Therapy	Covered 10%; after deductible	20%; after deductible
Habilitative Occupational Therapy	Covered 10%; after deductible	20%; after deductible
Habilitative Speech Therapy	Covered 10%; after deductible	20%; after deductible
Autism Behavioral Therapy	$35 copay; deductible waived	20%; after deductible
Autism Applied Behavior Analysis	Covered 10%; after deductible	20%; after deductible
Autism Physical Therapy	Covered 10%; after deductible	20%; after deductible
Autism Occupational Therapy	Covered 10%; after deductible	20%; after deductible
Autism Speech Therapy	Covered 10%; after deductible	20%; after deductible
Durable Medical Equipment	Covered 10%; after deductible	20%; after deductible
Prosthetics/Orthotics	Covered 10%; after deductible	20%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	Covered same as any other medical expense.	Covered same as any other medical expense.
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 10%; after deductible	20%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	Covered 10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
TMJ	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition and artificial insemination.		
Comprehensive Infertility Services Ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Covered same as any other medical expense.	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
Deductible (per calendar year)	$50 Individual $100 Family	$50 Individual $100 Family
Value Drugs Tier 1A		
Retail	$3 copay	20%; after deductible
Mail Order	$7.50 copay	Not Covered
Generic Drugs		
Retail	20%; after deductible	20%; after deductible
Mail Order	$15 copay	Not Covered
Preferred Brand-Name Drugs		
Retail	20%; after deductible	20%; after deductible
Mail Order	$15 copay	Not Covered
Specialty Drugs		
Preferred Specialty	20%; after deductible	Not Covered
Non-Preferred Specialty	$15 copay	Not Covered

Pharmacy Day Supply and Requirements

Retail 30-day supply or 100-unit doses, whichever is greater
Mail Order 90-day supply or 300-unit doses, whichever is greater
Specialty Up to a 30-day supply
All prescription fills must be through our preferred specialty pharmacy network.
Aetna Specialty Network Drug List

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Plan Includes: Diabetic supplies, blood glucose monitors, and contraceptive drugs and devices obtainable from a pharmacy.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions.
CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.