

**TORRANCE UNIFIED SCHOOL DISTRICT
MEDICAL PLAN BENEFIT SUMMARY – RETIREE PLAN 65
Effective 10-01-18**

PART A BENEFITS

Medicare Part A Hospital Insurance	Medicare Pays	TUSD Retiree Plan 65 Pays
Hospital Stays – Inpatient First 60 days per Benefit Period 61 st thru 90 th day per Benefit Period 91 st thru 150 th day – Reserve Days** Beyond 150 Days	All but the Deductible All but the Coinsurance All but the Coinsurance -0-	Deductible* Coinsurance Coinsurance -0-
Skilled Nursing Facility (SNF)*** First 20 days per Benefit Period 21 st thru 100 th day per Benefit Period Beyond 100 days	100% of approved amounts All but the Coinsurance -0-	-0- Coinsurance -0-
Home Health Care Home Care Services Durable Medical Equipment	100% of approved amounts 80% of approved amounts	-0- 20%
Hospice Care Pain and symptom relief and supportive services for the management of a terminal illness	All but limited costs for Outpatient drugs and Inpatient Respite Care	Balance
Blood - Inpatient From a Hospital or Skilled Nursing Facility during a covered stay. First 3 pints For additional pints	-0- 100%	100% -0-
Out of Country Emergency Services Medical Emergency Only	-0-	80% of Usual, Customary and Reasonable rates

* Medicare part A & B deductible amounts are available after January 1st of each year.

** The 60 reserve days may only be used once.

*** Neither Medicare nor TUSD Retiree Plan 65 will pay for nursing home care.

NOTE: TUSD Retiree Plan 65 does not consider as Eligible Expenses any charges or allowed amounts that are in excess of the charges or allowed amounts as determined by Medicare. If you access health services from a provider who does not accept assignment from Medicare, these providers may charge you more than the Medicare allowed amount and they may require that you pay the entire amount at the time of service and you will need to submit your claim yourself to Medicare and Medicare will reimburse you the Medicare allowed amount.

Psychiatric Hospital Care – In addition to covering care in a general Hospital, Medicare Part A helps to pay for up to 190 lifetime days of Inpatient care in a Medicare-participating psychiatric Hospital. Inpatient care in a psychiatric Hospital is subject to the same terms and conditions as inpatient care in a general Hospital.

To the extent three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

Benefit Period: Starts the day of admission to a Hospital or Skilled Nursing Facility and ends when Hospital Inpatient or Skilled Nursing Facility care has not been received for 60 consecutive days.

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PART B BENEFITS**

Medicare Part B Medical Insurance	Medicare Pays	TUSD Retiree Plan 65 Pays
Acupuncture	-0-	-0-
Ambulance Services If you need to go to the Hospital or Skilled Nursing Facility (SNF), ambulance services are covered only if transportation in any other vehicle would endanger your life.	80% For transportation to the closest facility that can provide the care you need Note: Air ambulance is paid only in the most severe situations. If you could have gone by land ambulance without serious danger to your life, Medicare pays only the land ambulance rate and you are responsible for the rest	20%±
Ambulatory Surgical Center	80%	20%±
Anesthesia – Outpatient	80%	20%±
Blood - Outpatient First 3 pints For additional pints NOTE: The 3 pints blood “deductible” can be met under Part A or Part B	-0- 80%	100% 20%±
Chiropractic Services – (limited)	80%	20%±
Clinical Laboratory Tests Medicare Covered Lab tests only All other Lab Tests	100% 80%	-0- 20%±
Diabetic Self-management Training	80%	20%±
Diabetic Supplies	80%	20%±
Diagnostic Tests Includes X-rays, MRI’s, CT Scans, EKG’s, Cardiac stress tests, etc.	80%	20%±
Doctor Services	80%	20%±
Durable Medical Equipment Includes items such as: oxygen, crutches, wheelchairs, walkers, Hospital beds, etc.	80%	20%±
Emergency Room Services	80%	20%±
Eye Exams – (Limited) Eye exams are covered only when related to Glaucoma, Macular Degeneration, or a yearly exam for patients with diabetes.	80%	20%±
Eyeglasses – (Limited) Coverage only applies after cataract surgery with an implanted intraocular lens. Only pays for standard frames	80%	20%±
Foot Exams and Treatment Does not cover routine foot care	80%	20%±
Hearing Exam Covered if ordered by a Physician for medical treatment	80%	20%±

PART B BENEFITS CONTINUED

All Plan benefits are subject to all of the provisions, exclusions & limitations explained in detail in your Plan Document. The above represents only a summary of the available benefits and is not a contract.

Eff: 10/01/18

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Home Health Services Part-time or intermittent skilled care and Home Health Aide services	100%	-0-
Hospital Services - Outpatient	80%	20%±
Kidney Dialysis Services	80%	20%±
Mental Health Care / Substance Abuse Rehab - Outpatient	50%	50%±
Occupational Therapy	80%	20%±
Physical Therapy	80%	20%±
Physician Services - Outpatient	80%	20%±
Prescription Drugs – Outpatient	-0-	Costs in excess of the NMHC Rx Card Copayments – see below for specific Copayments & details
*Preventive Services Bone Mass Measurements Cardiovascular Blood Screening Colorectal Cancer Screening: - Fecal Occult Blood Test (age 50+) - Flexible Sigmoidoscopy (age 50+) - Screening Colonoscopy - Barium Enema (age 50+) - Prostate Cancer Screening (age 50+) Diabetes Monitoring / Screening Glaucoma Tests Pap Smear & Pelvic Exam: - Pelvic / Breast Exam - Pap Smear Physical Exam Screening Mammogram, annually (age 40+) Vaccinations: Flu Shot & Pneumococcal Hepatitis B	80%± (once every 2 years) 80%± (once every 5 years) 100% (once every year) 80%± (once every 4 years) 80%± (once every 10 years) 80%± (once every 4 years) 80%± Digital rectal exam and PSA Blood Test (once every year) 80%± 80%± (Once every 2 years) 80%± 100%± -0- 80%± 100%± 80%±	20%± 20%± -0- 20%± 20%± 20%± 20%± 20%± 20%± (Once every 2 years) 20%± -0- 100% 20%± -0- 20%±
Prosthetic / Orthotic Items Including arm, leg, neck and back braces; artificial limbs; breast prostheses; prosthetic devices used to replace an internal body part or function;	80%	20%±
Speech & Language Pathology	80%	20%±
Surgical Services - Outpatient	80%	20%±
Transplant Services	80%	20%±
Travel – Outside the U.S.	-0-	80% of Usual, Customary and Reasonable rates

* Refer to Medicare for current benefit guidelines www.medicare.gov/coverage or 1-800-MEDICARE (1-800-633-4227)

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OUTPATIENT PRESCRIPTION DRUG SERVICES

Participating Pinnacle Rx Solutions
Pharmacy Email: Customerservice@prxsolutions.com

Type of Medication	30-Day Retail Option Co-pays*	90 Day Mail Service Option Co-pays*	90 Day Retail Option Copays*
Generic – Tier I	\$10	\$20	\$30
Preferred Brand – Tier II	\$30	\$60	\$90
Non-preferred Brand – Tier III	\$50	\$100	\$150

If a Covered Person requests brand when there is an FDA approved generic alternative and the MD has not indicated that a brand name drug is necessary, the Covered Person will be responsible for the applicable co-pay plus the cost difference between the brand-name drug and its generic equivalent.

* = these items do not apply to your Out of Pocket maximum

Pinnacle Rx Solutions

Outpatient Prescription Drug Services Retail Pharmacy 877-782-9658 www.prxsolutions.com
Mail Order Pharmacy: 888-479-2000 pinnacle.welldynrx.com
Specialty Pharmacy Program: 877-782-9658 www.prxsolutions.com

± These Part B expenses are subject to Medicare's Part B Deductible, which changes from year to year. This deductible applies each Calendar Year. The Plan will reimburse 20% of this Deductible in addition, the Plan will reimburse the 20% share on the balance of covered charges. This Plan will not reimburse Prescription Drug Card Copayments.

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This schedule is a summary only. Please refer to the covered Medical Expenses section for more complete information or to www.medicare.gov/coverage to obtain additional information about what is covered under Medicare.

IMPORTANT: Except for outpatient prescription drugs and out of country emergency care, expenses which are not covered by Medicare or which exceeds Medicare's approved amounts are not covered by this Plan.

Important Contact Information for Pinnacle Claims Management, Inc.

Customer Service: 1-844-899-2195
Website: www.pinnacletpa.com
Claims Address: PO Box, 2220 Newport Beach, CA 92658
E-Mail: customerservice@pinnacletpa.com