Torrance Unified School District Medical Plan
Summary of Benefits
Effective: October 1, 2026

Administered by Pinnacle Health Solutions

All Plan benefits are subject to all the provisions, exclusions & limitations explained in detail throughout this Plan Document. The following represents only a summary of the available benefits. Please refer to the other sections within this Plan Document for additional information on your Plan benefits.

A. GENERAL FEATURES	
Lifetime Maximum Benefit	Unlimited
Participating Provider Network (EPO)	**California:** Anthem Blue Cross Prudent Buyer Plan Network **Arizona:** Blue Cross Blue Shield of Arizona or **Outside California & Arizona:** First Health
Maternity Coverage	Participant , Spouse or Dependent Child
Plan Year Deductible: Individual and Family	None
Out of Pocket Maximum Individual Maximum Family Maximum	 $2,000 $4,000

Except as noted, a Covered Person will not be required to pay more than **$2,000 as an Individual** or **$4,000 as a Family** in any Plan Year toward his share of Eligible Expenses which are not paid by the Plan. Once a Covered Person has met their out-of-pocket maximum, Eligible Expenses will be paid at 100% of the Negotiated Fee or Usual and Customary rates for the remainder of the Plan Year.

The following will <u>not</u> be applied to the Out-of-Pocket Maximum:

- Non-covered Expense
- Non-compliance penalties for non-precertification
- Amounts paid at 100%
- Infertility Services – not billed by Hospital

	EPO PROVIDERS
Percentage Payable – The percentage that the Plan pays. Except as otherwise noted below	90% of Covered Expense after applicable co-payments
Covered Expense	Covered Expense is limited to the Negotiated Fee Rate.

This is an Exclusive Provider Option (EPO) plan, and as such coverage is only provided when services are obtained by Participating Providers. The exception to this provision is for an Emergency or for referrals by a Participating Provider to a Non-Participating Provider for laboratory, x-rays or diagnostic services. See each service as defined herein for benefits resulting from a referral.

Emergency If you have a true Emergency, as defined below, the following coverage is provided:

- **Emergency Room with Admission to Hospital or within 48 hrs of an accident – $250 deductible, paid at 90% of Covered Expense by the Plan**
- **Emergency Room – Sudden & Serious – $150 Co-pay per use, balance paid at 100% of Covered Expense by Plan**
- **Emergency Room – Physician Services Covered only in the case of an Emergency at 100% less a $25 Co-pay**
- **Ambulance services – benefits paid at 90% of Covered Expense by Plan**
- **Anesthesia services – benefits paid at 90% of Covered Expense by Plan**

Emergency – Notification Required. An accidental injury or the sudden onset of a medical condition, either of which is sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: Placing you or, with respect to a pregnancy, your unborn child, in serious jeopardy; Serious impairment of bodily functions; or Serious dysfunction of any bodily organ or part.

Sudden & Serious Illness	**Life-Threatening Condition**
A Sudden & Serious Illness is any condition that begins suddenly and is considered out of the ordinary. A Sudden & Serious Illness usually includes: • Temperature above 102° (oral) or 103° (rectal) • Chest pain with sudden onset • Profuse Hemorrhage • Severe abdominal pain of sudden onset • Acute respiratory distress • Obvious severe mental distress • Life-threatening situations • Visits to the Emergency room requiring Emergency Hospital admission	A Life-Threatening Condition is defined as a sudden and unexpected onset of a medical condition requiring medical or surgical care. Life-Threatening Conditions usually include: • Severe chest pain • Profuse hemorrhaging (bleeding) • Difficulty in breathing • Sudden onset of weakness or paralysis of a body part • Unconsciousness • Convulsions • Severe burns • Multiple injuries or trauma • Partial or complete severing of a limb • Ingestions of a poisonous substance

B. PAID HOSPITAL EXPENSES	**PLAN PAYS EPO PROVIDERS**	**EMPLOYEE PAYS**
Inpatient Care (Includes Room & Board, Ancillary Charges, Intensive Care) **Requires Pre-Certification Failure to obtain approval results in a reduction in payable benefits to 50%.**	- 90% of Covered Expense	- $250 deductible, 10% of Covered Expense
- Ambulatory Surgery Center **Requires Pre-Certification Failure to obtain approval results in a reduction in payable benefits to 50%.**	- 90% of Covered Expense	- 10% of Covered Expense
- Outpatient Surgery at Hospital	- 90% of Covered Expense	- 10% of Covered Expense
- All Other Outpatient Hospital Services	- 90% of Covered Expense	- 10% of Covered Expense
- Birthing Center / Midwife	- 90% of Covered Expense	- 10% of Covered Expense
- Preadmission Testing	- 90% of Covered Expense	- 10% of Covered Expense
C. COVERED EXPENSES	**PLAN PAYS EPO PROVIDERS**	**EMPLOYEE PAYS**
Acupuncture Services Limited to 26 visits per Plan Year combined with Chiropractic Care	- 100%, after a $30 Co-pay per visit	- $ 30 Co-pay per visit
Allergy Injections / Treatment Co-pay is only taken if an Office Visit is billed with Injection	- 100%, after a $25 Co-pay per visit	- $ 25 Co-pay per visit
*Allergy Testing	- 100% of Covered Expense	- $-0-
Ambulance	- 90% of Covered Expense	- 10% of Covered Expense
Anesthesia	- 90% of Covered Expense	- 10% of Covered Expense
Blood or Blood Products	- 90% of Covered Expense	- 10% of Covered Expense
Chemotherapy	- 90% of Covered Expense	- 10% of Covered Expense
Chiropractic type Care Limited to 26 visits per Plan Year combined with Acupuncture Care	- 100%, after a $30 Co-pay per visit	- $ 30 Co-pay per visit
- X-rays billed as part of Chiropractic Type Care	- 100% of Covered Expense	- $-0-
Contraceptive Management - Office Visit - *Contraceptive Injections *Contraceptive Medications & Devices (includes all FDA approved contraception devices)	- - 100%, after a $25 Co-pay per visit - 100% of Covered Expense - 100%	- $25 Co-pay per visit - $-0- - $-0-
Diabetic Nutritional Counseling	- 100%, after a $25 Co-pay per visit	- $ 25 Co-pay per visit

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

C. COVERED EXPENSES cont'd	PLAN PAYS EPO PROVIDERS	EMPLOYEE PAYS
Diagnostic X-Ray & Lab – office, clinic or free-standing facility – hospital, including professional fees	 - 100% of Covered Expense - 100% of Covered Expense	 - $-0- - $-0-
Dialysis Services	- 90% of Covered Expense	- 10% of Covered Expense
Durable Medical Equipment	- 90% of Covered Expense	- 10% of Covered Expense
Emergency Room – Outpatient due to Sudden & Serious – with Hospital Admission or within 48 hrs of an accident – Physician Services due to Emergency	 - 100% of Covered Expense - 90% of Covered Expense - 100%	 - $150 Co-pay - $250 deducible - $ 25 Co-pay
Family Planning - Tubal Ligation - Vasectomy	 - 100%, after a $150 Co-pay - 100%, after a $150 Co-pay	 - $150 Co-pay - $150 Co-pay
Hearing Exams & Hearing Aids	Not a Covered Expense	- 100% of Billed Charges
Home Health Care Limited to 100 visits per Plan Year	- 90% of Covered Expense	- 10% of Covered Expense
Home Infusion Therapy / Home Injectable Services	- 90% of Covered Expense	- 10% of Covered Expense
Hospice Care, Patient Care - Bereavement Counseling, per visit Limited to 8 visits for members of immediate family during the 6 months following the death of the Covered Person	- 90% of Covered Expense - 100%, after a $25 Co-pay per visit	- 10% of Covered Expense - $25 Co-pay per visit
Immunizations - *Preventive - *Non-Routine	 - 100% of Covered Expense - 100% of Covered Expense	 $-0- $-0-
Infertility Services - Maximum of $10,000 per Lifetime - Includes Physician services & medications - Surgical / Diagnostic procedures for diagnosis of infertility *Storage of Embryo or Cord Blood	 - 80% of Covered Expense - 80% of Covered Expense - 90% of Covered Expense Not a Covered Expense	 - 20% of Covered Expense - 20% of Covered Expense - 10% of Covered Expense -100% of Billed Charges
*Mammograms (Medically Necessary)	- 100% of Covered Expense	$-0-
Medical and Surgical Supplies	- 90% of Covered Expense	-10% of Covered Expense
Mental Health Care - Inpatient Care **Pre-certification required or payable benefits are reduced to 50%.** - Outpatient Care	 - 90% of Covered Expense - 100%, after a $25 Co-pay per visit	 - 10% of Covered Expense - $25 Co-pay per visit
*MRI, Cat Scan, Ultrasound & Nuclear Medicine (Inpatient or Outpatient)	-100% of Covered Expense	- $ -0-
Occupational Therapy Coverage is limited to services to restore physical function	-100%, after a $30 Co-pay per visit	- $30 Co-pay per visit
Orthotics Covered only when Medically Necessary & are custom made for the feet.	- 90% of Covered Expense	-10% of Covered Expense
Physical Therapy 26 visits, review for medical necessity on any additional visits	-100%, after $30 Co-pay per visit	$30 Co-pay per visit
Physician Services - Visit (Office/Home) - *Services in the office (lab,X-ray,injections,supplies,etc) - Telehealth/ Telemedicine - *In office Surgery Maximum of 1 co-pay per day if multiple services are billed in conjunction with the office visit - Hospital Visit – Inpatient - Emergency Room Visit * = these items do not apply to your Out of Pocket maximum	 - 100%, after a $25 Co-pay per visit - 100% of Covered Expense - 100% of Covered Expense - 100% of Covered Expense - 90% of Covered Expense - 100%, after a $25 Co-pay per visit	 - $25 Co-pay per visit - $ -0- - $25 Co-pay per visit - $ -0- - 10% of Covered Expense - $25 Co-pay per visit

MEDICAL PLAN BENEFIT SUMMARY (cont'd)

C. COVERED EXPENSES (cont'd)	PLAN PAYS EPO PROVIDERS	EMPLOYEE PAYS
Pregnancy & Maternity Care **Pre-certification required or payable benefits are reduced to 50%.** - Office Visit – initial visit & any diagnostic visits outside the Global Fee for the delivery - *All other visits associated with the Global Fee for the delivery - Normal Delivery, cesarean section and complications of pregnancy prior to birth or to the mother - Inpatient Physician Services & Hospital Services - Elective Abortion - Circumcision for Newborn Services for newborn healthy baby are payable as part of the Mothers benefits for first 31 days only Services for newborn sick baby are payable under the baby's benefits Baby MUST be enrolled within 31 days through the TUSD Benefits Department	- 100%, after $25 Co-pay - 100% of Covered Expense - 90% of Covered Expense - 90% of Covered Expense - 100%, after $150 Co-pay - 90% of Covered Expense	- $25 Co-pay per visit $ - 0 – - 10% of Covered Expense - 10% of Covered Expense - $150 Co-pay - 10% of Covered Expense
*Preventive Care: Adult - Age 18 & over Well Child Care - up to Age 18 - routine office visits *See Table entitled Preventive Services for further information*	- 100% of Covered Expense	- $-0-
Prosthetics	- 90% of Covered Expense	- 10% of Covered Expense
Radiation Therapy	- 90% of Covered Expense	- 10% of Covered Expense
Respiratory Therapy	- 90% of Covered Expense	- 10% of Covered Expense
Second Surgical Opinion	- 100%, after a $25 Co-pay per visit	- $25 Co-pay per visit
Sleep Disorders – Treatment & Testing	- 90% of Covered Expense	- 10% of Covered Expense
Speech Therapy *Covered only when used to restore or rehabilitate speech loss caused by Injury, Sickness or disability*	- 100%, after a $25 Co-pay per visit	- $25 Co-pay per visit
Skilled Nursing Limited to 100 days per Plan Year and **Pre-Certification is required.** Failure to obtain approval results in a reduction in payable benefits to 50%.	- 90% of Covered Expense	- 10% of Covered Expense
Substance Abuse - Inpatient Care **Pre-certification required or payable benefits are reduced to 50%.** - Outpatient Care	- 90% of Covered Expense - 100%, after a $25 Co-pay per visit	- 10% of Covered Expense - $25 Co-pay per visit
Surgeon, Assistant Surgeon	- 90% of Covered Expense	- 10% of Covered Expense
TMJ / Jaw Joint Treatment Limited to $3,000 in benefits per Plan Year	- 90% of Covered Expense	- 10% of Covered Expense
Transplants – Organ & Tissue Requires pre-certification Failure to obtain approval results in a reduction in payable benefits to 50%.	- 90% of Covered Expense	- 10% of Covered Expense
Urgent Care Facility (Participating Provider) – per visit (Co-pay is waived if admitted to the Hospital directly from Urgent Care) - Physician Visit billed separately from Urgent Care	- 100% of Covered Expense 100% of Covered Expense	- $25 Co-pay per visit - $25 Co-pay per visit

D. UTILIZATION MANAGEMENT - PRE-CERTIFICATION	Anthem Blue Cross (800) 274-7767
Inpatient Admissions ***Non-compliance penalties will not apply to the Out of Pocket Maximum***	Requires pre-admission review of at least 3 working days for non-Emergency Hospital admissions. Within 48 hours of admission for all other admissions. Requires prior certification or payable benefits are reduced to 50%.
Outpatient Surgery at Surgery Center; Inpatient Mental Health; Maternity Care, Substance Abuse	Requires prior certification or payable benefits are reduced to 50%.

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

OUTPATIENT PRESCRIPTION DRUG SERVICES

Participating Pinnacle RX Solutions / OrionRx www.prxsolutions.com Phone: 844-899-2195

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 100% of the applicable drug cost. The drug cost will not apply to the out of pocket maximum.

SPECIALTY MEDICATION

www.prxsolutions.com Phone: 844- 899-2195

Type of Medication	30-Day Mail Order Co-pays
Generic – Tier I	$10
Preferred Brand – Tier II	$30
Non-preferred Brand – Tier III	$50

PREVENTIVE SERVICES

Preventive Care includes:

COVERED PREVENTIVE SERVICES FOR ADULTS

(AGE 18 & OLDER)

Abdominal Aortic Aneurysm - One-time screening for men of specified ages who have ever smoked
Alcohol Misuse- Screening and counseling
Aspirin - Recommended use for the prevention of heart disease
Blood Pressure - Screening for all adults
Cholesterol - Screening for adults of certain ages or at higher risk
Colorectal Cancer - Screening for adults over age 50
Depression - Screening for adults
Diabetes (Type 2) - Screening for adults with high blood pressure
Diet - Counseling for adults at higher risk for high cholesterol or heart disease
HIV - Screening for all adults at higher risk
Immunizations & Vaccines - Doses, recommended ages and recommended populations vary
Hepatitis A; Hepatitis B; Herpes Zoster; Human Papillomavirus; Influenza; Measles; Mumps; Meningococcal; Pneumococcal; Tetanus; Diphtheria; Pertussis; Varicella; Rubella; Prevnar
Sexually-Transmitted Infection (STI) - Prevention counseling for adults at higher risk
Syphilis - Screening for all adults at higher risk
Tobacco Use - Screening only

ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN (AGE 18 & OLDER)

Birth Control (All forms of birth control and no age restriction)
BRCA Gene Counseling about genetic testing for women at higher risk
Breast Cancer Mammography Screenings every 1 to 2 years for women over 40
Breast Cancer Chemoprevention Counseling for women at higher risk, Tamoxifen and Raloxifene
Cervical Cancer Screening for sexually-active women
Chlamydia Infection Screening for younger women and other women at higher risk
Folic Acid Supplements for women who may become pregnant
Gonorrhea Screening for all women at higher risk
Osteoporosis Screening for women over age 60 depending on risk factors

PREVENTIVE SERVICES FOR COVERED PREGNANCIES

Anemia Screening on a routine basis for pregnant women
Bacteriuria -Urinary tract or other infection screening for pregnant women
Breast Feeding - Interventions to support and promote breast feeding
Hepatitis B - Screening for pregnant women at their first prenatal visit
Rh Blood Typing - Screening for all pregnant women
Tobacco Use - Screening, interventions and expanded counseling for pregnant tobacco users
Syphilis – Screening for all pregnant women or other women at increased risk
Iron Supplements -Children ages 6 to 12 months at risk for anemia
Lead Screening - Children at risk of exposure
Medical History -All children throughout development

COVERED PREVENTIVE SERVICES FOR CHILDREN (BIRTH TO AGE 18)

Alcohol & Drug Use Assessment - Adolescents
Autism Screening - 18 and 24 months
Behavioral Assessments - All children throughout development
Cervical Dysplasia Screening - Sexually active females
Congenital Hypothyroidism Screening All newborns
Developmental Screening - Children under age 3 and surveillance throughout childhood
Dyslipidemia Screening - Children at higher risk of lipid disorders
Fluoride Chemoprevention Supplements - Children without fluoride in their water source
Gonorrhea Preventive Eye Medication - All newborns
Hearing Screening - All newborns
Height, Weight & Body Mass Index - All children throughout development
Hematocrit or Hemoglobin Screening - All children
Hemoglobinopathies/Sick Cell Screening - All newborns
HIV Screening - Adolescents at higher risk
Immunizations & Vaccines
Diphtheria; Tetanus; Pertussis; Haemophilus Influenza (Type b); Hepatitis A; Hepatitis B; Human Papillomavirus: Inactivated Poliovirus; Influenza ; Measles; Mumps; Rubella; Meningococcal; Pneumococcal; Rotavirus; Varicella;
Iron Supplements - Children ages 6 to 12 months at risk for anemia
Lead Screening - Children at risk of exposure
Medical History - All children throughout development
Oral Health Risk Assessment - Young children
Phenylketonuria (PKU) Genetic Screening - All newborns
Sexually Transmitted Infection (STI)
Prevention Counseling - Adolescents at higher risk
Tuberculin Testing - Children at higher risk of tuberculosis
Vision Screening - All children