THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Diocese of Stockton, PPO Medical Plan

Blue Shield of California for In California and BlueCard Program Network for Outside of California

Benefits described below are effective July 1, 2026 through June 30, 2027

Plan is non-grandfathered

Plan Year Medical Deductible **The deductible applies to all services unless noted**	**Preferred Providers** **$500** – Individual **$1,000** – Family	**Non-Preferred Providers** **$1,500** – Individual **$3,000** – Family

Family maximum is consolidated between all eligible participants with no more than the individual amount applied to each individual. Preferred and Non-Preferred providers are not consolidated together. **Deductible Credit for the wellness only applies to In Network or Preferred Provider Services.**

Plan Year Out of Pocket Maximum	**Preferred Providers** **$2,500** – Individual **$7,500** – Family	**Non-Preferred Providers** **$10,000** – Individual **$20,000** – Family

Family maximum is consolidated between all eligible participants with no more than the individual per person being applied. Preferred and Non-Preferred Providers are not combined together. The Preferred out of pocket amount includes copays, deductible, coinsurance amounts and pharmacy copays/coinsurance. The Non-Preferred includes the 50% coinsurance. The out of pocket limits do not include non-covered services or amounts over the UCR for Non-Preferred providers.

LIFETIME BENEFIT MAXIMUM **Unlimited**

PROFESSIONAL SERVICES	Preferred Providers	Non-Preferred Providers
Professional (Physician) Benefits		
Physician and Specialist Office Visits	$25 Copay (deductible waived)	50%
Inpatient Hospital Visits	20%	50%
Allergy: Injection, Serum and Testing	20%	50%
Pregnancy-Delivery Charge	20%	50%
Surgery, Injections, Supplies done in a Physician's Office	20%	50%
Urgent Care	$25 Copay (deductible waived)	50%
Counseling (Mental Health and Substance Abuse)	$25 Copay (deductible waived)	50%
Testing (Mental Health)	20%	50%

Benefit Descriptions, continued	Preferred Providers	Non-Preferred Providers
Preventive Health Benefits		
Preventive Exam (in accordance with USPSTF requirements for adults and children)	$0 (deductible waived)	Not Covered
Immunizations (in accordance with USPSTF requirements for adults and children)	$0 (deductible waived)	Not Covered
Breast-Feeding equipment and Pre-Natal Care/women of all ages (in accordance with USPSTF requirements)	$0 (deductible waived)	Not Covered
Family Planning	Not Covered	Not Covered
Mammogram (One per 1-2 Plan Years for women age 40+)	$0 (deductible waived)	Not Covered
Colonoscopy (Age 50+ allowed once per 5-10 years)	$0 (deductible waived)	Not Covered
Outpatient Services (not done in a hospital setting)		
CT scans, MRIs, MRAs, PET scans, and Cardiac Diagnostic	20%	50%
Procedures Utilizing Nuclear Medicine	20%	50%
Laboratory and Pathology	20%	50%
X-ray, EKG, Diagnostic Medicine Services	20%	50%
Outpatient services (done in a hospital setting)		
CT scans, MRIs, MRAs, PET scans, and Cardiac Diagnostic	20%	50% (Plan maximum $600 allowed per day)
Procedures Utilizing Nuclear Medicine	20%	50% (Plan maximum $600 allowed per day)
Laboratory and Pathology	20%	50% (Plan maximum $600 allowed per day)
X-ray, EKG, Diagnostic Medicine Services	20%	50% (Plan maximum $600 allowed per day)
Hospital Services		
Outpatient Surgery	20%	50% (Plan maximum $600 allowed per day)
Emergency Room/Facility Charge (copay waived if admitted)	$400 Copay (deductible waived)	$200 Copay (deductible waived)
Emergency Room/Physician Charge	20%	???
Inpatient Room and Board (including mental health and substance abuse)	20% and $250 Copay	20% and $250 Copay (when emergency admission) 50% (Plan maximum $600 allowed per day when not an emergency admission)

Benefit Descriptions, continued	Preferred Providers	Non-Preferred Providers
Additional Covered Services		
Day Treatment (mental health/substance abuse)	20% (Copay is per episode which is admit to discharge/leaving program)	50% (Plan maximum $600 allowed per day)
Residential Treatment (mental health/substance abuse)	20% and $250 Copay (copay is per admission)	50% (Plan maximum $600 allowed per day)
Ambulance Services (emergency or authorized transport)	20%	20%
Durable Medical Equipment (rental up to purchase price)	20%	50%
Hearing Devices	20%	50%
Orthotic Equipment and Devices (includes custom molded foot orthotic)	20%	50%
Oxygen and Supplies	20%	50%
Bariatric Services (gastric bypass/sleeve when medically necessary for morbid obesity)	20%	50%
Prosthetic Equipment and Devices	20%	50%
Home Health Services		
Home Care Agency Services (100 visits per plan year)	20%	Not Covered
Home Infusion/Home IV Therapy	20%	Not Covered
Infusion Nursing Visits	20%	Not Covered
Hospice (for terminal illness and includes respite, home and general care)	$0 for Respite Care 20% all other Hospice	Not Covered
Rehabilitation Services		
Chiropractic (12 visits per Plan Year)	$25 Copay	50%
Acupuncture (20 visits per Plan Year)	$25 Copay	$25 Copay
Cardiac Rehabilitation	20%	50% (Plan maximum $600 allowed per day when done in a hospital location)
Occupational Therapy (MD's treatment plan required)	$25 copay	50% (Plan maximum $600 allowed per day when done in a hospital location)
Physical Therapy (MD's treatment plan required)	$25 copay	50% (Plan maximum $600 allowed per day when done in a hospital location)
Pulmonary/Respiratory Therapy	$25 copay	50% (Plan maximum $600 allowed per day when done in a hospital location)
Speech Therapy (MD's treatment plan required)	$25 copay	50% (Plan maximum $600 allowed per day when done in a hospital location)
Vision Therapy/Orthoptics	20%	50%

ADDITIONAL INFORMATION

Prescription Benefits are administered by: **LucyRx (877) 860-8846**

- o Generic Copay $10
- o Brand Name (formulary) Copay $25
- o Brand Name (non-formulary) Copay $40
- o Mail Order/Generic Copay $20
- o Mail Order/Brand Name (formulary) Copay $50
- o Mail Order/Brand Name (formulary) Copay $80
- Specialty Drugs (retail only) 20% up to $150 per script - There is a $150 deductible per member each Plan year for Brand/Specialty RX.

***Through* Walgreens Specialty after first retail fill.** **(866) 202-4014**

Delta Navigator: **RightwayHealthcare.com (833) 950-4397**

Delta Navigator by Rightway provides Health Guides to assist with finding high quality in-network Doctors and Specialists, answer medical billing questions, disputing medical claims, making medical appointments (including Telemedicine), Nurseline, and answer healthcare and benefit questions. This is a free benefit, to get started download the Rightway app and activate your account or call 833-950-4397

Employee Assistance Program: **Guidance Resources (888) 327-9573**

Dental Claims administered by: **Delta Health Systems (888) 212-1231 (PPO Plan)**
Utilizing Cigna Dental Network

Vision Claims administered by: **Vision Service Plan (800) 877-7195**

Medical: Non-Covered Services, this list is not all inclusive, please refer to the summary plan document for details on any service limitation before service(s) are incurred.

Biofeedback	Custodial Care	Learning Disabilities	Impregnation
Refractive Eye Procedures	Routine Foot Care	Sexual Dysfunction	Smoking Cessation
Cosmetic Services/procedures	Family Counseling		

Non-PPO providers allowance is based on UCR (Usual Customary and Reasonable by geographic area and is subject to change periodically)

Utilization Review is required for the items listed below and is handled by Blue Shield of California (800) 393-6130

- All inpatient facility services (acute care, surgical, mental health and substance abuse)
- Skilled Nursing facility
- Home health
- Home infusion therapy
- Transplants
- Outpatient surgery (for specific procedures only, contact Blue Shield of California to confirm if proposed surgery requires pre-auth)
- Case Management
- Air Ambulance (non-emergency use)
- Durable Medical Equipment
- Bariatric services