Whoa & Co, Inc. High Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Whoa & Co, Inc.: Medical Plan

Coverage Period: 07/01/2026 – 06/30/2027
Coverage for: Individual, Family | **Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact CAS customer service at 855-373-8232. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.casbenefits.com or call 855-373-8232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network Providers: $500 Individual / $1,500 Family Out-of-Network Providers: $10,000 Individual / $30,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	There is no additional deductible amount you must meet before this plan begins to pay for specific services.
What is the out-of-pocket limit for this plan?	In Network Providers: $2,500 Individual / $7,500 Family Out-of-Network Providers: $20,000 Individual / $60,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.accesscas.com or call 855-373-8232 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, (office visit charge, labs, x-rays, injections & allergy services) deductible waived All other Services: 30% coinsurance, after deductible	40% coinsurance, after deductible	Copay applies to the physician office visit charge, labs, x-rays and injections only. Includes telemedicine other than Teladoc. You have no costs for consultations through Teladoc.
	Specialist visit	$30 copay/visit, deductible waived All other Services: 30% coinsurance, after deductible	40% coinsurance, after deductible	Copay applies to the physician office visit charge, labs, x-rays and injections only. Includes telemedicine other than Teladoc. You have no costs for consultations through Teladoc.
	Preventive care/screening/ immunization	Covered at 100%	40% coinsurance, after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay/visit, deductible waived	40% coinsurance, after deductible	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required.
If you need drugs to treat your illness or condition Your Prescription Drug Benefit is administered by US-Rx Care. For prescription drug questions please call 1-877-200-5533 or visit www.us-rxcare.com.	Tier 1 – Preferred Generics and Some Brands	Retail & Mail Order: $10 copay (30 day) $20 copay (60 day) $30 copay (90 day)	Not Covered	Preventive drugs: No charge Deductible does not apply. Covers up to a 90 day supply (retail and mail order prescription). The 90-day supply for Retail / Mail Order prescription only applies to Tiers 1, 2, & 3.The copay applies per prescription. There is no charge or deductible for preventive drugs. Dispense as Written (DAW) provision applies. If you purchase brand medication over an available generic, you will pay the difference in
	Tier 2 – Preferred Brands and Some Generics	Retail & Mail Order: $20 copay (30 day) $40 copay (60 day) $60 copay (90 day)	Not Covered	
	Tier 3 – Non-Preferred Brands and Generics	Retail & Mail Order: $40 copay (30 day) $80 copay (60 day) $120 copay (90 day)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider (You will pay the most)	
				cost between the generic and the brand name medication.
	Tier 4 – Specialty	Retail & Mail Order: $350 copay (30 day)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance, after deductible	40% coinsurance, after deductible	
If you need immediate medical attention	Emergency room care	$250 copay/visit, then 10% coinsurance, after deductible		
	Emergency medical transportation	20% coinsurance, after deductible		Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.
	Urgent care	Hospital Based: 10% coinsurance, after deductible All other Locations: $60 copay/visit, deductible waived	40% coinsurance, after deductible	What You Will Pay for related services (for example, blood work, x-rays, and imaging) is listed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, after deductible	$500 copay/admission, then 40% coinsurance, after deductible	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance, after deductible	40% coinsurance, after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copay/visit, deductible waived Other Outpatient: 10% coinsurance, after deductible	40% coinsurance, after deductible	Includes telemedicine.
	Inpatient services	10% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required.
If you are pregnant	Office Visits	Initial Visit: $30 copay/visit, deductible waived All Other Visits: 10% coinsurance, after deductible	40% coinsurance, after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% coinsurance, after deductible	$500 copay/admission, then 40% coinsurance, after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/ delivery professional services	10% coinsurance, after deductible	$500 copay/admission, then 40% coinsurance, after deductible	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	10% coinsurance, after deductible	40% coinsurance, after deductible (plan pays a maximum of $55 per visit)	Limited to 100 days per Calendar Year. Preauthorization is required.
	Rehabilitation/Habilitation services	10% coinsurance, after deductible	40% coinsurance, after deductible	Physical & occupational therapy limited to a combined maximum of 60 visits per year. Speech/hearing therapy limited to 30 visits per year. Chiropractic care limited to 30 visits per year. Preauthorization is required for inpatient services.
	Skilled nursing care	10% coinsurance, after deductible	40% coinsurance, after deductible (plan pays a maximum of $200 per day)	Limited to 100 days per Calendar Year. Preauthorization is required.
	Durable medical equipment	10% coinsurance, after deductible	40% coinsurance, after deductible	Preauthorization is required for DME over $500. Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	10% coinsurance, after deductible	40% coinsurance, after deductible (plan pays a maximum of $55 per visit)	Bereavement counseling is covered if received within 6 months of death. Inpatient and outpatient limited to 185 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance, after deductible	Coverage limited as required by PPACA.
	Children's glasses	Not covered		None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No charge	40% coinsurance, after deductible	Coverage limited to oral health risk assessment as required by PPACA.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult and Child)
- Hearing aids
- Infertility treatment **(except diagnosis or treatment of underlying medical condition)**
- Long term care
- Non-emergency care when traveling outside the US
- Routine eye care (Adult and Child)
- Routine foot care (except for metabolic or
- peripheral vascular disease)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-855-373-8232

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-373-8232

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Primary care physician coinsurance	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**110%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,770**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,260**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) copayment	**$250**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The plan would be responsible for the other costs of these EXAMPLE covered services.