Employer Name: Whoa & Co, Inc.
Group Number: 22501350
Effective Date: 7/1/2026
Plan Administrator: Coastal Administrative Services
Claims Address:
PO Box 46511,
Cincinnati, OH 45246
Payor ID:
31441

MEDICAL BENEFITS SCHEDULE – High Plan

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Claims must be received by the Claims Administrator within **365 days** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second opinion.		
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**	
CALENDAR YEAR BENEFIT AMOUNT	**UNLIMITED**	
DEDUCTIBLE, PER CALENDAR YEAR		
Family Deductible is embedded. In-network and Non-network Deductibles accumulate separately.	$500 per Plan Participant $1,500 per Family Unit	$10,000 per Plan Participant $30,000 per Family Unit
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Family Out-of-Pocket Maximum is embedded. In-network and Non-network Out-of-Pocket maximums accumulate separately.	$2,500 per Plan Participant $7,500 per Family Unit	$20,000 per Plan Participant $60,000 per Family Unit

The maximum out-of-pocket amount includes Deductible, Coinsurance and Copayments applied toward covered medical and prescription benefits as shown above.

The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100%, even when the maximum out-of-pocket amount has been met:

- Any charges Incurred due to failure to preauthorize
- Charges in excess of the Maximum Allowable Charge
- Expenses Incurred for non-covered services

Covered Expenses are limited to the Maximum Allowable Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.

The percentages shown in the following Schedule reflect the amount the Plan pays for Eligible Expenses after any required Deductible has been satisfied. A "copay" is an amount the Plan Participant must pay. Copays are usually paid to the provider at the time of service.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Abortion Services	90% after deductible	60% after deductible
Ambulance		
Air Ambulance	This benefit is payable at the lesser of the contracted rate OR a percentage of Medicare. This benefit is paid at 80% after the deductible.	
Land Ambulance	80% after deductible	
Ambulatory Surgical or Outpatient Surgical Facility	90% after deductible	60% after deductible
Applied Behavioral Analysis (ABA) Therapy	90% after deductible	60% after deductible
Cardiac Rehabilitation	90% after deductible	60% after deductible
Chemotherapy	90% after deductible	60% after deductible
Chiropractic Care *Limited to 30 visits per Calendar Year.*	90% after deductible	60% after deductible
Diabetic Equipment and Supplies	90% after deductible	60% after deductible
Diagnostic Testing		
Laboratory Testing	$30 copay/visit, then 100% deductible waived	60% after deductible
Imaging – X-Ray, MRI, MRA, CT/PET	90% after deductible	60% after deductible
Dialysis Services	90% after deductible	60% after deductible
Durable Medical Equipment (DME)	90% after deductible	60% after deductible
Emergency Room Services	$250 copay/visit, then 90% after deductible	
Home Health Care *Limited to 100 days per Calendar Year.*	90% after deductible	60% after deductible (plan pays a maximum of $55 per visit)

Home Infusion Therapy	90% after deductible	60% after deductible
Hospice Care *Limited to 185 days per lifetime.*	90% after deductible	60% after deductible
Hospital Services		
Facility Fee	90% after deductible	$500 copay/visit, then 60% after deductible
Physician Fees	90% after deductible	60% after deductible
Infertility		
Medical Fertility Treatment *Limited to diagnosis and testing only.*	90% after deductible	60% after deductible
Maternity Care		
Office Visits	Initial Visit: $30 copay/visit, then 100% deductible waived All Other Visits: 90% after deductible	60% after deductible
Professional and Facility Services	90% after deductible	$500 copay/visit, then 60% after deductible
Breast Pump *Limited to one (1) breast pump purchase every 3 Calendar Years.* *Breast Pump supplies covered per pregnancy.*	100% deductible waived	60% after deductible
Nutritional Counseling	90% after deductible	60% after deductible
Occupational Therapy *Limited to 60 visits per Calendar Year.* *Combined with Physical and Occupational Therapy.*	90% after deductible	60% after deductible
Physical Therapy *Limited to 60 visits per Calendar Year.* *Combined with Physical and Occupational Therapy.*	90% after deductible	60% after deductible
Physician Services		
Office Visit *Copay applies to labs, x-rays, injections & allergy services only.*	$30 copay/visit, then 100% deductible waived All other Services: 70% after deductible	60% after deductible
Specialist Office Visit *Copay applies to labs, x-rays, injections & allergy services only.*	$30 copay/visit, then 100% deductible waived All other Services: 70% after deductible	60% after deductible
Outpatient Surgery	90% after deductible	60% after deductible

Inpatient Surgery	90% after deductible	60% after deductible
Professional Services	90% after deductible	60% after deductible
Preventive Care	No cost to Plan Participant	60% after deductible

Routine Well Care services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) or as otherwise required by law, *unless otherwise specifically stated in this Medical Benefits Schedule*, and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

Routine Well Care services will include, but will not be limited to, the following routine services: Office visits, routine physical exams, prostate screening, female sterilization procedures, patient education and counseling, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child examinations.

Women's Preventive Services, will include, but will not be limited to, the following routine services: Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune- deficiency virus (HIV), counseling and screening for interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. Additional information can be located using the following website: https://www.healthcare.gov/preventive-care-women

Covered Expenses are limited to the Maximum Allowable Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.

DESCRIPTION	NETWORK PROVIDER	NON-NETWORK PROVIDER
Prosthetics, Orthotics, Supplies and Surgical Dressings	90% after deductible	60% after deductible
Radiation Therapy	90% after deductible	60% after deductible
Skilled Nursing Care *Limited to 100 visits per Calendar Year.*	90% after deductible	60% after deductible (plan pays a maximum of $200 per day)
Speech Therapy *Limited to 30 visits per Calendar Year.*	90% after deductible	60% after deductible
Sterilization Services		
Female Services *Covered Under Preventative Benefit*	100% deductible waived	60% after deductible
Male Services *Vasectomies*	90% after deductible	60% after deductible
Telehealth	$30 copay/visit, then 100% deductible waived	60% after deductible

Teladoc	$0 copay/visit, then 100% deductible waived	Not Applicable
Transplant Services *Travel is covered if members live 75 miles or over from transplant facility.* *Limited to $10,000 for travel costs per transplant.*	Facility: $500 copay/visit, then 60% after deductible Professional Fees: 60% after deductible	Facility: $500 copay/visit, then 60% after deductible Professional Fees: 60% after deductible
Treatment of Mental or Nervous Disorders or Substance Abuse		
Inpatient Services	90% after deductible	60% after deductible
Outpatient Services	90% after deductible	60% after deductible
Office Visits	$30 copay/visit, then 100% deductible waived	60% after deductible
Urgent Care	Hospital Based: 90% after deductible All other Locations: $60 copay/visit, then 100% deductible waived	60% after deductible
Wigs and Scalp Prothesis *Limited to medical necessity.* *Limited to 1 wig per Calendar Year with a $500 max per wig.*	90% after deductible	60% after deductible
All Remaining Eligible Expenses	90% after deductible	60% after deductible

PREAUTHORIZATION

These services require Preauthorization:

Inpatient / Residential Admissions:
- Medical & Surgical
- Behavioral Health
- Substance Use Disorder
- Long Term Acute Care (LTAC)
- Inpatient Rehabilitation
- Skilled Nursing Facility (SNF)
- Hospice

Elective surgical procedures performed:
- With anticipated inpatient stay
- In hospital outpatient/ambulatory settings
- In Ambulatory Surgery Center
- In the physician's office

Outpatient treatment programs:
- Partial Hospitalization programs (PHP)
- Intensive Outpatient programs (IOP)

Outpatient therapy Services:
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)
- Applied Behavioral Analysis (ABA)

Home-based treatment (home health including home health nursing and therapies, home IV infusion, hospice)

Durable Medical Equipment (DME) Consider dollar threshold (over $500*), or provide list of specific DME requirements.
*Dollar limit to be inclusive of equipment and integral supplies at time of purchase.
Ancillary Testing (including high tech radiology services) Consider dollar threshold (such as over $500), or provide list of
specific ancillary service requirements (MRI, CT, PET, Sleep Studies, etc.)
Other Services (services with complex medical necessity guidelines and/or experimental and investigational procedures or services)

- Radiation Therapy
- Chemotherapy
- Dialysis
- Genetic Testing
- Biologics, Immunotherapy, Gene Therapy, and Cellular Therapy
- Transplant Evaluation
- Injectable medications
- Interventional pain management (back/knee/trigger point/cortisone injections, etc.)

All services requiring Preauthorization are to be authorized in advance, except for emergencies, by contacting Innovative Care Management (ICM) at 800-862-3338. The Plan Participant or their Authorized Representative is required to call the phone number for Preauthorization located on the back of their identification card for the services specified above at least 10-15 days prior to the services being rendered. The Plan Participant or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Preauthorization determinations and service prepricing. Additional information is available in the Medical Management Services section of this Plan.

PRESCRIPTION DRUG BENEFITS SCHEDULE – High Plan

Not all Prescription Drugs are covered.

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Pharmacy Option - 31-90 day Supply		
Generic Drugs	30 day- $10 copay/prescription 60 day-$20 copay/prescription 90 day- $30 copay/prescription	Not Covered
Formulary Brand Drugs	30 day- $20 copay/prescription 60 day-$40 copay/prescription 90 day- $60 copay/prescription	Not Covered
Non-Formulary Brand Drugs	30 day- $40 copay/prescription 60 day-$80 copay/prescription 90 day- $120 copay/prescription	Not Covered
Specialty	$350 copay/prescription (30 day)	Not Covered
Mail Order Option - 90 Day Supply		
Generic Drugs	30 day- $10 copay/prescription 60 day-$20 copay/prescription 90 day- $30 copay/prescription	Not Covered
Formulary Brand Drugs	30 day- $20 copay/prescription 60 day-$40 copay/prescription 90 day- $60 copay/prescription	Not Covered
Non-Formulary Brand Drugs	30 day- $40 copay/prescription 60 day-$80 copay/prescription 90 day- $120 copay/prescription	Not Covered
Specialty	$350 copay/prescription (30 day)	Not Covered
Refer to the Prescription Drug Benefits for details on the Prescription Drug Program.		

It is agreed by Whoa & Co, Inc. that the provisions outlined in the above benefit schedule(s) are acceptable and will be the basis for the administration of claims until Summary Plan Document is executed in full.

Date Signed June 24, 2026

Whoa & Co, Inc.

Virginia Garver — Controller

Signature — Title

Virginia Garver

Print Name