GUIDED ALIGN

Guided Care. Serious Protection.

PLAN SUMMARY

SUMMARY

Guided Align provides protection for surgeries, hospitalizations, and serious illnesses. After the Annual HSA Gateway is met, the deductible and coinsurance are waived when members use Care Coordination. Designed to maintain HSA compatibility, the plan includes an Annual HSA Gateway that members satisfy before coverage applies. With no pre-existing condition limitations and access to Care Coordination support, Guided Align helps members make informed healthcare decisions with greater confidence.

Deductible	Out-of-Pocket Limit	HSA Gateway	Policy Maximum
$5,000 per event	$15,000 per year	$1,700 Individual / $3,400 Family (2026)	$2,000,000 per year

PROTECTION

Medical Event	Coverage Details
Surgery	$0 after the Annual HSA Gateway is met, with Care Coordination
Hospitilization	$0 after the Annual HSA Gateway is met, with Care Coordination
Illness/ Injury	$0 after the Annual HSA Gateway is met, with Care Coordination
Maternity *Member + Spouse or Family tier required*	$0 after the Annual HSA Gateway is met, with Care Coordination Limits: Vaginal delivery up to $25,000; C-section up to $50,000
Emergency Services	Once the Annual HSA Gateway has been satisfied, the $5,000 Medical Event Deductible and 20% coinsurance are waived for eligible Emergency Services. Advance approval is not required for an emergency, but the member must contact Care Coordination as soon as reasonably practical after stabilization so that ongoing and post-stabilization care can be coordinated.

HSA GATEWAY

HSA GATEWAY

This plan is designed to complement companion HSA-qualified coverage and may be paired with an HSA-compatible preventive health plan. To maintain HSA compliance, members satisfy an Annual HSA Gateway before plan benefits apply. The 2026 HSA Gateway is $1,700 for Individual and $3,400 for Family coverage, and adjusts each calendar year. Enrollment in Guided Align alone does not establish or guarantee HSA eligibility.

Family Coverage: Members enrolled in a family coverage tier share one Annual HSA Gateway. Qualifying expenses incurred by any covered family member accumulate toward the family gateway. Once the full family gateway is satisfied, the Care Coordination waiver becomes available to every covered family member for the remainder of the Policy Year.

HSA GATEWAY

Annual Reset: The Annual HSA Gateway resets at each annual policy renewal. Expenses incurred during the prior Policy Year do not carry over. For treatment that continues across renewal, expenses incurred after the renewal date are subject to the new gateway before Guided Align benefits resume.

Example	Amount
Eligible Covered Expenses	$10,000
Insured responsibility (HSA gateway)	$1,700
Medical Event Deductible	Waived
Coinsurance	Waived
Guided Align Benefit	$10,000 - $1,700 = **$8,300**

NO NETWORK

CARE COORDINATION FIRST

You are not limited to a specific provider network. For the best experience and the lowest overall costs, contact Care Coordination before receiving non-emergency services.The Care Coordination team helps you navigate the healthcare system by identifying quality providers, coordinating care, and negotiating pricing on your behalf. By using Care Coordination, members can make more informed healthcare decisions, reduce out-of-pocket costs, and minimize exposure to balance billing.Whether you're scheduling a procedure, seeking treatment options, or managing a serious medical condition, Care Coordination is there to support you every step of the way.

IMPORTANT INFORMATION

The Guided Align plan is designed to help protect against the financial impact of covered surgeries, hospitalizations, serious illnesses, injuries, and other eligible medical events.Common exclusions include preventive and routine care, cosmetic procedures, fertility treatments, experimental treatments, mental health treatment, and services that are not medically necessary. Refer to the policy document for a complete list of exclusions and limitations.Provider charges that exceed plan reimbursement amounts may remain the responsibility of the member.This brochure is intended only as a summary of benefits. Refer to the policy document for complete coverage details.

This coverage is a Limited Medical Expense Policy and is not comprehensive health insurance. It is not ACA-compliant, is not a Qualified Health Plan, and does not provide all benefits required under the Affordable Care Act. Coverage is issued by Greystone Benefits, Inc. under the authority of the Modoc Nation as a tribally regulated insurance product. This coverage is not regulated by state insurance departments and is not protected by state insurance guaranty funds.

GUIDED ALIGN

GROUP LIMITED MEDICAL INSURANCE POLICY
FOR AN EMPLOYER-SPONSORED ERISA PLAN

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IMPORTANT INFORMATION

Guided Align (Group) is a fully insured group limited medical insurance product issued by Greystone Benefits, Inc. to the employer identified in the Group Policy Schedule. The employer may use this Group Policy to fund benefits under an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA).

This Group Limited Medical Insurance Policy ("Group Policy" or "Policy") is a contract between Greystone Benefits, Inc. ("Insurer," "We," "Our," "Us," or "Ours") and the Group Policyholder. Covered Persons are entitled to benefits in accordance with the Group Policy but are not parties to the insurance contract. The Group Policy describes insured benefits, eligibility conditions applicable to the insurance coverage, claims procedures, limitations, exclusions, and other Policy provisions. The Employer, as Plan Sponsor and Plan Administrator unless otherwise stated, remains responsible for ERISA duties that are not expressly delegated in writing.

This Group Policy must be read together with the Group Policy Schedule, Certificate of Coverage, Summary of Benefits and Coverage, applicable endorsements or riders, enrollment materials, and the Employer's ERISA plan document or wrap document and Summary Plan Description. Those documents may contain employer-specific eligibility, contribution, continuation, and administrative provisions. Defined terms are capitalized and explained in the Definitions section.

Please Note: This Policy provides limited medical coverage and should not be described as comprehensive major medical coverage. Any representation that the coverage provides minimum essential coverage, minimum value, or compliance with a particular Affordable Care Act requirement must be made only in written materials approved by the Insurer. The Employer and its legal and benefits advisors are responsible for determining how this coverage may lawfully be offered within the Employer's overall benefit program.

Funding Status: Benefits under this Group Policy are fully insured. Greystone Benefits, Inc. assumes financial responsibility for payment of Covered Benefits, subject to all Group Policy terms, conditions, limitations, and exclusions. Planstin Administration, Inc. performs third-party administrative services and assumes no financial risk.

HSA Coordination Notice: This Policy is designed to be paired with Companion HSA-Qualified Coverage. Enrollment in this Policy does not, by itself, establish or guarantee a Covered Person's eligibility to contribute to a Health Savings Account. HSA eligibility depends on all coverage and individual circumstances applicable to the Covered Person.

I. GROUP POLICY AND PLAN ADMINISTRATION INFORMATION

Insurance Product	Guided Align Group Limited Medical
Policy Type	Fully Insured Group Limited Medical Insurance Policy
Group Policyholder / Employer / Plan Sponsor	The employer identified in the Group Policy Schedule
ERISA Plan Name / Plan Number / Sponsor EIN	As identified in the Group Policy Schedule or the Employer's ERISA plan document
Plan Administrator / Named Fiduciary / Agent for Service	The Employer unless another person or entity is identified in the Group Policy Schedule or governing plan document. Legal process may also be served on the Plan Administrator.
Insurer / Benefits Claims Administrator	Greystone Benefits, Inc.
Third-Party Administrator	Planstin Administration, Inc. 1506 S Silicon Way, Suite 2B St. George, UT 84770 888-920-7526
Funding	Fully insured through premiums paid to Greystone Benefits, Inc.
Group Policy Effective Date / Plan Year	As shown in the Group Policy Schedule
Policy Delivery and Governing Framework	The Group Policy is issued under the authority of the Modoc Nation. The Employer's employee welfare benefit plan is governed by ERISA and other applicable federal laws.
Administrative Roles	Greystone Benefits, Inc. is responsible for insured benefits and benefit-claim determinations. Planstin Administration, Inc. performs delegated administrative and claims-processing services. The Employer retains Plan Sponsor, Plan Administrator, fiduciary, disclosure, eligibility, contribution, COBRA, filing, and other responsibilities not expressly delegated in writing.

Certain terms used in this Group Policy have specific meanings and are defined in the Definitions section. Employer-specific information is stated in the Group Policy Schedule and the Employer's ERISA plan documents.

II. ELIGIBILITY

Employee Eligibility	Employees who satisfy the eligibility requirements stated in the Group Policy Schedule and the Employer's ERISA plan document. Eligibility will not terminate solely because a Covered Person attains age 65, becomes eligible for Medicare, or enrolls in Medicare. An actively employed eligible employee, and the eligible spouse of an actively employed employee, will be offered coverage in accordance with applicable federal law and on the same terms and conditions applicable to similarly situated employees and spouses under age 65.
Dependent Eligibility	Eligible spouses and dependent children who satisfy the Employer's eligibility rules. An eligible child may remain covered until attainment of age 26, subject to the terms of the Plan and applicable law.
Group Eligibility	Available to an eligible employer group with two or more employees, including at least one common-law employee, subject to the Insurer's participation, contribution, and underwriting requirements.
Enrollment and Special Enrollment	Initial, open, late, and special enrollment rights are governed by the Group Policy Schedule, the Employer's Plan, and applicable federal law, including HIPAA special enrollment requirements when applicable.
Age 65 and Medicare Eligibility	Eligibility will not terminate solely because a Covered Person attains age 65, becomes eligible for Medicare, or enrolls in Medicare. Medicare coordination will be administered under applicable Medicare Secondary Payer rules, and Medicare will not be treated as primary when federal law requires the Employer's Plan to pay primary.
Renewability	The Group Policy is renewable subject to continued group eligibility, timely premium payment, the Group Policy Schedule, and the terms of this Policy.

III. COVERAGE

Insuring Agreement

Subject to payment of required premium and all terms of this Group Policy, the Insurer agrees to insure eligible Covered Persons and pay Covered Benefits directly to providers or Covered Persons for Covered Services incurred while coverage is in force.

Covered Services

Covered Services are subject to Policy limitations, medical necessity, maternity limitations, and all other applicable terms, conditions, limitations, and exclusions.

Care Navigation and Non-Coordinated Services

Covered Persons are encouraged to use Care Navigation before obtaining non-emergency medical care. No benefits are payable under this Policy until the applicable Annual HSA Gateway has been satisfied. After the Annual HSA Gateway is satisfied, for Covered Services coordinated through Care Navigation and approved in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf, the applicable Medical Event Deductible and Coinsurance shall be waived, and Covered Services shall be payable at 100% of the Allowed Amount, subject to all terms, conditions, limitations, exclusions, and Policy Maximums under this Policy.

Use of Care Navigation may assist Covered Persons in reducing overall healthcare costs and minimizing exposure to non-covered charges. Care Navigation does not guarantee payment for services that are not otherwise Covered Services under this Policy.

Claims for Covered Services obtained without Care Navigation may remain eligible for reimbursement after the applicable Annual HSA Gateway has been satisfied, subject to the $5,000 Medical Event Deductible, 20% Coinsurance, and all other Policy terms, conditions, limitations, and exclusions.

For non-coordinated services, Greystone Benefits, Inc., as Insurer, may determine the Covered Expense or Allowed Amount using a Reference-Based Pricing methodology, including a percentage or multiple of amounts payable under Medicare or other industry-recognized reimbursement benchmarks, in accordance with this Policy and consistent with the type of service provided. Planstin Administration, Inc. may process such claims under delegated administrative authority.

Balance Billing and Member Responsibility

Except to the extent prohibited by applicable federal or other controlling law, Covered Persons may remain responsible for charges billed by providers in excess of the Allowed Amount or other amounts payable under this Policy, including permissible balance billing amounts. Except as otherwise required by applicable law, such amounts do not apply toward the Annual HSA Gateway, Medical Event Deductible, or out-of-pocket maximum under this Policy. For non-coordinated services, Covered Persons remain responsible for applicable deductible, coinsurance, permissible balance billing amounts, and all amounts otherwise excluded under this Policy, except to the extent prohibited by applicable law.

Covered Services include:

Inpatient Services

- Hospital room and board
- Intensive Care Unit (ICU)/Critical Care Unit (CCU)
- Inpatient physician services
- Specialist consultations
- Surgery
- Anesthesia
- Diagnostic imaging (MRI, CT, PET)
- Diagnostic laboratory services
- Inpatient-administered medications
- Transplants, when Medically Necessary and subject to all Policy terms, conditions, limitations, exclusions, and benefit maximums
- Rehabilitation services (as limited herein)

Outpatient Services

- Outpatient surgery
- Physician office visits
- Specialist consultations
- Diagnostic imaging (MRI, CT, PET), up to $25,000 per year
- Diagnostic laboratory services
- Outpatient-administered medications incidental to treatment
- Rehabilitation services (as limited herein)

All Covered Services are subject to Medical Necessity, the Policy Annual Maximum, applicable benefit maximums, and all Policy terms, conditions, limitations, and exclusions.

Emergency Services

- Advance Care Navigation approval is not required for Emergency Services. No benefits are payable under this Policy until the applicable Annual HSA Gateway has been satisfied.
- The Covered Person must engage Care Navigation as soon as reasonably practicable following stabilization.
- After the applicable Annual HSA Gateway has been satisfied, the Medical Event Deductible and Coinsurance shall be waived for eligible Emergency Services and approved post-stabilization care when the Covered Person complies with the applicable Care Navigation requirements under this Policy.

International and Worldwide Travel Coverage

Coverage under this Policy applies to Covered Services incurred by a Covered Person while temporarily traveling outside the United States, subject to all Policy terms, conditions, limitations, exclusions, cost-sharing requirements, prior-approval requirements, and benefit maximums.

- Emergency Services received outside the United States are eligible for coverage without prior approval when required for the immediate evaluation or treatment of an Emergency Medical Condition resulting from an Accident or Illness.
- Following stabilization, the Covered Person must contact Care Navigation as soon as reasonably possible. Continued or follow-up care outside the United States is subject to the advance-approval requirements below.
- Any non-emergency, elective, scheduled, planned, or member-directed medical care outside the United States must be approved in writing in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf and coordinated through Care Navigation to be eligible for coverage.
- Greystone Benefits, Inc. may approve Covered Services outside the United States when, based on information coordinated through Care Navigation, it determines that the proposed treatment is Medically Necessary and may provide improved access, favorable clinical value, lower overall cost, or access to treatment or technology not reasonably available within the United States. In deciding whether and on what terms to approve care, Greystone Benefits, Inc. may consider the proposed provider and facility, treatment plan, supporting clinical evidence, anticipated outcomes and benefits, risks, cost, the Covered Person's individual circumstances, and arrangements for follow-up care.
- A treatment is not automatically excluded solely because it is not routinely available within the United States or does not have a particular United States regulatory approval. These circumstances do not require Greystone Benefits, Inc. to approve the treatment. Greystone Benefits, Inc. retains discretion to evaluate the available evidence, provider and facility qualifications, expected benefit, risks, cost, and follow-up care.
- Travel, transportation, lodging, meals, translation services, companion expenses, repatriation, evacuation, and other non-medical expenses are not Covered Expenses unless expressly approved in writing by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf. Greystone Benefits, Inc. may, in its discretion, approve some or all such expenses when they support an approved course of treatment and are expected to reduce the total cost of care. This is a discretionary approval and not a guaranteed benefit.

- International claims must include itemized billing records, relevant medical records, proof of payment when applicable, and an English-language translation reasonably acceptable to the Claims Administrator. Covered Expenses may be converted to United States dollars using a commercially reasonable exchange rate selected by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf.

Maternity

- Vaginal Delivery: up to $25,000.
- C-section delivery: up to $50,000.
- Complications of pregnancy are treated as general medical expenses and are subject to the Policy Annual Maximum.
- Maternity benefits are available only for Covered Persons enrolled under a Member + Spouse or Member Family coverage tier on the Policy Effective Date or before the pregnancy began, as reasonably determined from available medical records, and who remain continuously enrolled through the date of delivery.
- Maternity benefits are subject to all other applicable Policy terms, conditions, limitations, exclusions, and benefit maximums.

Rehabilitation Services

Physical rehabilitation services may be eligible for coverage when Medically Necessary and provided as part of treatment for a covered Accident or Illness, subject to all Policy terms, conditions, limitations, exclusions, applicable cost-sharing requirements, Care Navigation requirements, and the Policy Annual Maximum.

Covered physical rehabilitation services may include rehabilitative care intended to restore physical function that has been lost or impaired due to a covered Accident, Illness, surgery, hospitalization, or other covered medical event, when ordered by a licensed healthcare provider as part of the Covered Person's treatment plan.

Rehabilitation services are not covered when related to an excluded condition, excluded service, or non-covered medical event. Mental health rehabilitation, behavioral health rehabilitation, substance abuse rehabilitation, eating disorder treatment programs, residential treatment programs, maintenance therapy, custodial care, wellness programs, athletic training, educational services, and services that are not Medically Necessary are excluded under this Policy.

IV. MAXIMUM BENEFIT

The Policy Annual Maximum is **$2,000,000 per Covered Person per Policy Year**, subject to all Policy terms, conditions, limitations, exclusions, and applicable benefit maximums.

The Policy Annual Maximum applies to all Covered Services combined, unless a specific benefit maximum or sublimit applies.

V. EXCLUSIONS

This Policy does not cover the below services:

1. Preventive, wellness, routine care, routine physicals, unless expressly included by endorsement;
2. Services obtained outside Care Navigation except as otherwise payable under the terms, conditions, limitations, reimbursement provisions, and cost-sharing requirements of this Policy;
3. Cosmetic or elective procedures that are not Medically Necessary;
4. Experimental or Investigational treatments, except when expressly approved in writing under the International and Worldwide Travel Coverage provision after review of the available evidence and circumstances by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf;
5. Unapproved, member-directed international treatment, including travel undertaken primarily or partly to obtain medical treatment, surgery, procedures, medications, or other healthcare services, when the proposed services were not approved in writing in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf and coordinated through Care Navigation;
6. Travel, transportation, lodging, meals, translation services, companion expenses, repatriation, evacuation, and other non-medical international expenses unless expressly approved in writing by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf;
7. Fertility treatments;
8. Custodial care;
9. Services not deemed Medically Necessary;
10. Injuries resulting from intentional self-harm or participation in illegal activities;
11. Mental health;
12. Services covered by workers' compensation or similar laws;
13. Accident that occurs while a Covered Person is on active duty service in the military, naval, or air force of any country;
14. Routine dental care;
15. Injury or Illness sustained during war or acts of war, whether declared or not; and/or
16. Treatment for substance abuse, unless specifically covered by endorsement.
17. Regular prescription drug coverage, including retail prescriptions, maintenance medications, specialty pharmacy medications, and self-administered outpatient drugs;
18. Mental health rehabilitation, behavioral health rehabilitation, substance abuse rehabilitation, eating disorder treatment programs, residential treatment programs, maintenance therapy, custodial care, wellness programs, athletic training, educational services, and services that are not Medically Necessary.

VI. COST-SHARING STRUCTURE

- Annual HSA Gateway: No benefits are payable under this Policy until the applicable Annual HSA Gateway has been satisfied with Gateway-Eligible Expenses. For individual coverage, the Annual HSA Gateway is the Applicable Federal HSA Minimum for self-only HSA-qualified high deductible health plan coverage. For Member + Child(ren), Member + Spouse, and Member Family coverage, the Annual HSA Gateway is the Applicable Federal HSA Minimum for family HSA-qualified high deductible health plan coverage and is accumulated on a single aggregate basis across all Covered Persons enrolled under the family coverage tier.
- Gateway Period: The Annual HSA Gateway will be administered using the same annual coverage period as the deductible under the Companion HSA-Qualified Coverage. The applicable annual period will be identified in the Group Policy Schedule.
- Coverage Tier Changes: If a Covered Person changes coverage tiers during the applicable annual coverage period, the Annual HSA Gateway and previously accumulated Gateway-Eligible Expenses will be administered in accordance with the Companion HSA-Qualified Coverage, applicable federal requirements, and the Claims Administrator's written procedures. Benefits will not become payable unless the applicable Annual HSA Gateway for the coverage tier then in effect has been satisfied.

- Gateway-Eligible Expenses and Automatic Accumulation: Gateway-Eligible Expenses are medical expenses incurred during the applicable annual coverage period that are applied toward the deductible of the Companion HSA-Qualified Coverage and substantiated to the satisfaction of the Claims Administrator. When the Companion HSA-Qualified Coverage is administered by Planstin Administration, Inc., qualifying expenses reflected in Planstin's claims records will be accumulated automatically toward the Annual HSA Gateway based on the adjudicated Covered Person responsibility shown in those records; separate proof of payment is not required for automatic accumulation.
- Member Submission of Additional Expenses: A Covered Person may submit additional qualifying expenses not reflected in Planstin's claims records for review and possible credit toward the Annual HSA Gateway. For those expenses, the Claims Administrator may require an Explanation of Benefits, itemized provider statement, proof of payment, or other documentation reasonably necessary to verify the expense and the Covered Person's responsibility. Expenses submitted outside Planstin's claims records will be credited only after the Claims Administrator determines that they are Gateway-Eligible Expenses and are adequately substantiated.
- Gateway Accumulation and Concurrent Credit: A Covered Claim may satisfy the Annual HSA Gateway. When it does, the Covered Person is responsible only for the remaining Annual HSA Gateway amount, and otherwise payable Covered Expenses above that amount will be adjudicated under the applicable coordinated or non-coordinated benefit provisions. Gateway-Eligible Expenses that are also Covered Expenses under this Policy apply concurrently toward the $5,000 Medical Event Deductible for the same Covered Medical Event. The Covered Person is not required to satisfy the Annual HSA Gateway and Medical Event Deductible consecutively for the same expenses.
- No Retroactive Payment of Pre-Gateway Claims: Covered Expenses incurred before the Annual HSA Gateway is satisfied are not retroactively payable solely because the Annual HSA Gateway is satisfied at a later date. This limitation does not prevent payment of otherwise eligible Covered Expenses above the remaining Annual HSA Gateway amount within a Claim that causes the Annual HSA Gateway to be satisfied.
- Medical Event Deductible and Coinsurance: Covered Services obtained without Care Navigation are subject to a $5,000 Medical Event Deductible for each Covered Medical Event and 20% Coinsurance after satisfaction of that deductible, subject to all Policy terms, conditions, limitations, exclusions, and benefit maximums. When a non-coordinated Covered Claim satisfies the remaining Annual HSA Gateway, the amount applied to the Annual HSA Gateway also applies dollar-for-dollar toward the Medical Event Deductible for that same Covered Medical Event. The Covered Person will not be required to pay the remaining Annual HSA Gateway in addition to the $5,000 Medical Event Deductible. After the Annual HSA Gateway and Medical Event Deductible are satisfied, 20% Coinsurance applies to otherwise payable Covered Expenses.
- Coordinated Care Navigation Services: After the applicable Annual HSA Gateway has been satisfied, for Covered Services coordinated through Care Navigation and approved in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf, the $5,000 Medical Event Deductible and Coinsurance shall be waived, and Covered Services shall be payable at 100% of the Allowed Amount, subject to all terms, conditions, limitations, exclusions, and Policy Maximums under this Policy. If a Covered Claim causes the Annual HSA Gateway to be satisfied, the Covered Person is responsible only for the remaining amount of the Annual HSA Gateway, and eligible Covered Expenses above that amount are payable under this coordinated-care provision.
- Family Gateway Activation: Once the aggregate Family Annual HSA Gateway is satisfied, the Care Navigation Waiver is available to each Covered Person enrolled under that family coverage tier for the remainder of the Policy Year, subject to all other Policy requirements.
- Out-of-Pocket Maximum: For individual coverage, the annual out-of-pocket maximum is $15,000 per Policy Year. For Member + Child(ren), Member + Spouse, and Member Family coverage, the annual out-of-pocket maximum is $15,000 in the aggregate across all Covered Persons enrolled under that coverage tier. Eligible member-paid cost-sharing amounts incurred by any Covered Person enrolled under the applicable coverage tier accumulate collectively toward that out-of-pocket maximum.

Amounts that count toward the annual out-of-pocket maximum are: (a) member-paid Annual HSA Gateway amounts, but only to the extent they relate to Covered Expenses under this Policy; (b) member-paid Medical Event Deductible amounts; and (c) member-paid Coinsurance amounts.

Deductible or Coinsurance amounts waived through Care Navigation, amounts paid by the Policy, permissible balance billing amounts, non-covered services, excluded services, charges above the Allowed Amount, and Gateway-Eligible Expenses that are not Covered Expenses under this Policy do not apply toward the annual out-of-pocket maximum. Once $15,000 in qualifying cost sharing has accumulated for the applicable coverage tier, the Medical Event Deductible and Coinsurance shall be waived for otherwise payable Covered Expenses incurred by any Covered Person enrolled under that coverage tier for the remainder of the Policy Year, subject to all Policy exclusions, limitations, Allowed Amount provisions, and benefit maximums.

- Cost-Sharing Reductions or Waivers: Greystone Benefits, Inc. reserves the right, in its discretion, to reduce or waive applicable deductibles, coinsurance, or other Covered Person cost-sharing obligations in connection with approved Care Navigation arrangements, negotiated provider agreements, approved medical events, or other circumstances determined appropriate by Greystone Benefits, Inc. No discretionary reduction or waiver may cause benefits to become payable before the applicable Annual HSA Gateway has been satisfied.
- Care Navigation Waiver: The Medical Event Deductible and Coinsurance waiver is available only after the Annual HSA Gateway is satisfied and only for Covered Services arranged through Care Navigation and approved by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf in accordance with this Policy. The waiver does not expand Covered Services, remove exclusions, increase benefit maximums, or waive any other Policy requirement.

VII. PREMIUMS, CONTRIBUTIONS, AND RATES

Premium rates, employer contribution requirements, participant contributions, enrollment tiers, tobacco surcharges, rating methodology, and any participation requirements are stated in the Group Policy Schedule, an approved rate exhibit, or enrollment materials incorporated into the Group Policy. The Employer is responsible for collecting participant contributions and remitting required premiums. Any change applies prospectively and will be communicated in accordance with the Group Policy and applicable law.

VIII. CLAIMS PROCEDURE

Care Navigation and Pre-Service Requests

Covered Persons must use Care Navigation before obtaining non-emergency medical care to qualify for the Care Navigation Waiver. No benefits are payable until the applicable Annual HSA Gateway has been satisfied. After the Annual HSA Gateway is satisfied, for Covered Services coordinated through Care Navigation and approved in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf, the applicable Medical Event Deductible and Coinsurance shall be waived, and Covered Services shall be payable at 100% of the Allowed Amount, subject to all terms, conditions, limitations, exclusions, and Policy Maximums under this Policy.

Care Navigation does not guarantee payment for services that are not otherwise Covered Services. Claims for services obtained without Care Navigation may remain eligible after the Annual HSA Gateway is satisfied, subject to the $5,000 Medical Event Deductible, 20% Coinsurance, and all other Policy provisions.

A request for required prior approval or other authorization that must be obtained before services are received, including a request facilitated through Care Navigation, is treated as a pre-service claim. Advance approval through Care Navigation is not required for Emergency Services; the Covered Person must engage Care Navigation as soon as reasonably practicable following stabilization.

Filing a Claim

Claims and supporting documentation may be submitted by a Covered Person, an authorized representative, or a provider to Greystone Benefits, Inc., care of Planstin Administration, Inc., 1506 S Silicon Way, Suite 2B, St. George, UT 84770, telephone 888-920-7526, using any electronic or other submission method made available by the Claims Administrator.

Gateway-Eligible Expenses reflected in Planstin's claims records may be credited based on adjudicated Covered Person responsibility without separate proof of payment. For expenses not reflected in Planstin's claims records, the Claims Administrator may require an Explanation of Benefits, itemized provider statement, proof of payment, or other documentation reasonably necessary to verify the expense, the Covered Person's responsibility, and the amount eligible for Annual HSA Gateway credit.

Documentation submitted solely for Annual HSA Gateway credit must be submitted within the same timeframe applicable to post-service Claims unless the Claims Administrator establishes a longer period in its written procedures.

Notice of a post-service claim should be submitted within ninety (90) days after the Covered Service is received. Failure to submit within ninety (90) days will not invalidate the claim when it was not reasonably possible to submit the claim within that period and the claim is submitted as soon as reasonably possible. Except in the case of legal incapacity or other circumstances required by applicable law, a claim should be submitted no later than twelve (12) months after the date of service.

The Claims Administrator may request itemized bills, medical records, proof of payment, authorizations, or other information reasonably necessary to decide the claim. A Covered Person may designate an authorized representative in accordance with the Claims Administrator's reasonable procedures.

Claim Categories and Initial Benefit Determinations

- **Urgent Care Claims:** A claim involving urgent care will be decided as soon as possible, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt. If additional information is required, notice will be provided as soon as possible and no later than twenty-four (24) hours after receipt, and the claimant will have at least forty-eight (48) hours to provide the information.
- **Pre-Service Claims:** A pre-service claim will be decided within a reasonable period appropriate to the medical circumstances, but no later than fifteen (15) days after receipt. The period may be extended once for up to fifteen (15) additional days for matters beyond the Claims Administrator's control, with advance notice. When information is requested from the claimant, the claimant will be allowed at least forty-five (45) days to provide it.
- **Concurrent Care Decisions:** If Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf has approved an ongoing course of treatment, any reduction or termination before the approved period or number of treatments ends will be communicated sufficiently in advance to allow an appeal before the reduction or termination takes effect. An urgent request to extend concurrent care will be decided as soon as possible and generally within twenty-four (24) hours when the request is received at least twenty-four (24) hours before the approved course ends.
- **Post-Service Claims:** A post-service claim will be decided within a reasonable period, but no later than thirty (30) days after receipt. The period may be extended once for up to fifteen (15) additional days for matters beyond the Claims Administrator's control, with advance notice. When additional information is requested from the claimant, the claimant will be allowed at least forty-five (45) days to provide it.

Notice of an Adverse Benefit Determination

If a claim is denied in whole or in part, the claimant will receive written or electronic notice that includes the specific reason for the decision; the applicable Policy or Plan provisions; any additional information needed to perfect the claim and why it is needed; a description of the Claims Administrator's review procedures and

applicable time limits; information sufficient to identify the claim; any applicable denial code and its meaning; a description of any medical-necessity, experimental-treatment, or similar standard used; and a statement of the claimant's rights to appeal, request relevant documents without charge, seek any applicable external review, and bring a civil action under ERISA section 502(a) after completing required review procedures.

Appeal of an Adverse Benefit Determination

A claimant has one hundred eighty (180) days after receiving an adverse benefit determination to request an appeal. The appeal may include written comments, documents, records, evidence, and testimony relating to the claim. Upon request and without charge, the claimant will receive reasonable access to and copies of documents, records, and other information relevant to the claim.

Greystone Benefits, Inc., acting as Claims Administrator, will ensure that the appeal is reviewed without deference to the initial decision by a person who did not make the initial decision and is not that person's subordinate. When the decision involves medical judgment, the reviewer will consult an appropriately trained and experienced healthcare professional who was not consulted on the initial decision and is not subordinate to that professional. Claims and appeals will be administered in a manner designed to preserve the independence and impartiality of the persons involved.

Before a final adverse benefit determination on appeal is issued, the claimant will receive, without charge and sufficiently in advance to allow a reasonable response, any new or additional evidence considered, relied upon, or generated in connection with the appeal and any new or additional rationale on which the final decision may be based.

Appeal Decision Timeframes

- **Urgent Care Appeals:** As soon as possible, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt. An urgent appeal may be submitted orally or in writing.
- **Pre-Service Appeals:** No later than thirty (30) days after receipt.
- **Post-Service Appeals:** No later than sixty (60) days after receipt.

External Review and Legal Remedies

When an external review process is required by applicable federal law, the final adverse benefit determination will explain the right to request external review and how to do so. If the Plan fails to follow applicable claims and appeals requirements, the claimant may be treated as having exhausted the internal process to the extent provided by law. Nothing in this Policy limits a claimant's right to pursue remedies available under ERISA section 502(a) or other applicable law after completing, or being deemed to have completed, required administrative review procedures.

IX. COORDINATION OF BENEFITS

Any other medical or health coverage available to the Covered Person shall be primary to this Policy, and this Policy shall provide benefits only as secondary coverage, except where applicable law requires otherwise.

X. SUBROGATION

To the extent of any payment made under this Policy, the Insurer shall be subrogated to all rights of recovery of the Covered Person against any third party. The Covered Person agrees to cooperate fully with the Insurer in enforcing such rights.

XI. CONTINUATION, TERMINATION, AND RENEWAL

Continuation Coverage

When the Employer's group health plan is subject to COBRA, eligible Covered Persons may have the right to elect temporary continuation coverage following a qualifying event. COBRA eligibility, notices, election procedures, premiums, duration, and termination are administered by the Employer or its designated COBRA administrator and are described in the Employer's Summary Plan Description and COBRA notices. Continuation may also be available under USERRA, FMLA, or other applicable federal law. This Policy does not expand continuation rights beyond applicable law or the Employer's Plan.

Termination of a Covered Person's Coverage

A Covered Person's coverage may terminate on the date specified in the Group Policy Schedule, Certificate of Coverage, or Employer's Plan when:

1. The Covered Person no longer satisfies the Plan's eligibility requirements;
2. Required participant contributions or premiums are not paid when due, subject to any applicable grace period;
3. The Covered Person requests termination in accordance with the Plan's election rules;
4. The Group Policy terminates;
5. The Covered Person commits fraud or makes an intentional material misrepresentation, subject to the rescission rules below; or
6. Termination is otherwise permitted by the Policy, the Employer's Plan, and applicable law.

Termination of the Group Policy

The Group Policy may terminate for nonpayment of premium; failure of the Group Policyholder to satisfy participation, contribution, eligibility, or administrative requirements stated in the Group Policy Schedule; fraud or intentional material misrepresentation by the Group Policyholder; withdrawal or discontinuance of the product on a class basis; mutual written agreement; or as otherwise permitted by the Group Policy and applicable law. The Group Policyholder is responsible for providing participants and beneficiaries any notices required by ERISA or other applicable law.

Rescission

Coverage will not be rescinded retroactively except in the case of fraud or an intentional material misrepresentation of fact, and then only to the extent permitted by applicable law. Any rescission will be treated as an adverse benefit determination and will include advance notice and appeal rights as required by law.

Renewal

The Group Policy is guaranteed renewable subject to continued group eligibility, timely payment of premium, the terms of the Group Policy Schedule, and the Insurer’s right to modify premiums or Policy terms prospectively on a class basis at renewal as permitted by applicable law. Renewal of the Group Policy does not guarantee that any individual will remain eligible under the Employer’s Plan.

The Annual HSA Gateway will be administered using the same annual coverage period as the deductible under the Companion HSA-Qualified Coverage, as identified in the Group Policy Schedule, and will reset at the beginning of that annual period. Gateway-Eligible Expenses incurred before the beginning of a new annual coverage period do not apply to the new period. For an approved coordinated course of treatment that continues into a new annual coverage period, the new Annual HSA Gateway applies to services incurred after the start of that period. Existing Care Navigation approval may remain valid subject to confirmation by Care Navigation and the Claims Administrator, but no benefits are payable for services incurred in the new annual coverage period until the new Annual HSA Gateway is satisfied. Once the new Annual HSA Gateway is satisfied, the Care Navigation Waiver resumes for otherwise eligible services during the remainder of that annual coverage period.

XII. GENERAL PROVISIONS

Entire Contract
The entire insurance contract consists of this Group Policy, the Group Policy Schedule, the Group Policyholder's application, approved enrollment records, endorsements, riders, amendments, and any documents expressly incorporated by reference. The Employer's separate ERISA plan document and Summary Plan Description govern the Employer's establishment and administration of the employee welfare benefit plan but do not enlarge the Insurer's obligations beyond this insurance contract unless the Insurer agrees in writing.

Order of Precedence
If provisions conflict, an endorsement or amendment controls over the Group Policy; the Group Policy Schedule controls for employer-specific information; and the Group Policy controls over enrollment materials or summaries. The Summary of Benefits and Coverage summarizes benefits but does not replace or amend the Group Policy.

Amendments and Plan Changes
No amendment to the Group Policy is valid unless made in writing and approved by an authorized officer of the Insurer. The Employer may amend or terminate its ERISA plan in accordance with the Employer's plan documents. The Employer is responsible for furnishing any Summary of Material Modifications or other participant notice required by ERISA or applicable law.

Assignment
The Insurer may pay benefits directly to a provider or other person furnishing Covered Services. A purported assignment of a claim or right under the Policy does not expand benefits, waive defenses, or prevent the Insurer or Claims Administrator from communicating with and paying the Covered Person, except as required by applicable law or accepted in writing by the Insurer.

Clerical Error and Misstatement
A clerical error, delay, or omission will not create coverage that would not otherwise exist or terminate coverage that should otherwise remain in effect. Eligibility and premium may be corrected prospectively or retroactively as permitted by applicable law. Any age or eligibility misstatement may be corrected based on the true facts and applicable rate or benefit provisions.

Records and Cooperation
The Group Policyholder and Covered Persons must provide information reasonably required to administer eligibility, premiums, claims, coordination of benefits, subrogation, and legal compliance. Medical and personal information will be handled in accordance with applicable privacy and security requirements.

Governing Law
This Group Policy is issued by Greystone Benefits, Inc. under the authority of the Modoc Nation. An employer-sponsored employee welfare benefit plan using this Policy is governed by ERISA and other applicable federal laws. To the extent of a conflict, controlling federal law applies to the Employer's Plan and its participants, and applicable Modoc Nation law governs the insurance contract to the extent not preempted or superseded by controlling law.

Claims and Dispute Resolution
Benefit disputes must first be processed under the Claims Procedure section. After required administrative remedies are exhausted or deemed exhausted, the parties may voluntarily attempt negotiation or mediation. Mediation is not mandatory and does not limit any right to external review or to bring a civil action under ERISA section 502(a) or other applicable law.

Conformity with Law
Any Policy provision that conflicts with controlling applicable law is amended to conform to the minimum requirements of that law, without invalidating the remainder of the Policy.

XIII. ERISA PLAN PROVISIONS

Relationship to the Employer's Plan
This Group Policy is the insurance contract that funds the benefits described here. It is not, by itself, the Employer's complete written plan document or Summary Plan Description. The Group Policy must be read together with the Group Policy Schedule, Certificate of Coverage, Summary of Benefits and Coverage, the Employer's ERISA plan document or wrap document, and required participant notices.

Plan Sponsor, Plan Administrator, and Named Fiduciary
The Employer identified in the Group Policy Schedule is the Plan Sponsor and, unless the Group Policy Schedule states otherwise, the Plan Administrator and named fiduciary for the Employer's Plan. The Employer retains all fiduciary and administrative responsibilities not expressly delegated in writing.

Delegation of Benefit-Claim Authority
To the extent delegated by the Plan Sponsor, Greystone Benefits, Inc. is the benefits Claims Administrator and has authority to interpret the insurance terms, determine eligibility for insured benefits, decide claims and appeals, and apply medical-necessity, experimental-treatment, reimbursement, Allowed Amount, and other Policy standards. Planstin Administration, Inc. performs ministerial and administrative services on behalf of Greystone Benefits, Inc. and does not assume financial risk. Care Navigation coordinates care, identifies providers and facilities, arranges treatment, and facilitates approval requests. Neither Planstin Administration, Inc. nor Care Navigation independently determines entitlement to insured benefits unless Greystone Benefits, Inc. expressly authorizes the entity to act as its delegate for a specified benefit-determination function.

Employer Disclosure and Administration Responsibilities
The Employer is responsible for maintaining its ERISA plan document; furnishing the Summary Plan Description, Summary of Benefits and Coverage, Summary of Material Modifications, COBRA notices, and other required disclosures; maintaining required records; making any required Form 5500 or other filings; administering payroll deductions and participant contributions; and performing all other Plan Sponsor or Plan Administrator duties not expressly delegated.

No Employment Contract or Vested Right
This Policy does not create a contract of employment. Except for a claim for Covered Services incurred while coverage is in force, no person has a vested right to continued coverage or unchanged benefits. The Employer may amend or terminate its Plan and the Insurer may amend or terminate the Group Policy as provided in the governing documents and applicable law.

Participant Rights Preserved
Nothing in this Policy is intended to waive, restrict, or misstate any right or protection available to a participant or beneficiary under ERISA or other controlling federal law. The Employer's Summary Plan Description must include the applicable consolidated statement of ERISA rights and the employer-specific information required by law.

XIV. DEFINITIONS

For purposes of this Policy, the following terms shall have the meanings set forth below:

1. **"Accident"** means a sudden, unforeseen, and unintended event, independent of Illness or any other cause, that results in bodily injury.
2. **"Annual HSA Gateway"** means the amount of Gateway-Eligible Expenses that must be incurred during the applicable annual coverage period before any benefits are payable under this Policy. The applicable annual coverage period is the same period used for the deductible under the Companion HSA-Qualified Coverage and is identified in the Group Policy Schedule. For individual coverage, the amount is the Applicable Federal HSA Minimum for self-only HSA-qualified high deductible health plan coverage. For Member + Child(ren), Member + Spouse, and Member Family coverage, the amount is the Applicable Federal HSA Minimum for family HSA-qualified high deductible health

plan coverage and is accumulated on a single aggregate basis across all Covered Persons enrolled under the family coverage tier.

3. **"Applicable Federal HSA Minimum"** means the minimum annual deductible prescribed under Internal Revenue Code Section 223 for HSA-qualified high deductible health plan coverage in effect for the applicable Policy Year and coverage tier.
4. **"Care Navigation"** means the Plan's designated service provider or program that assists Covered Persons with coordinating care, identifying providers or facilities, arranging approved domestic or international treatment, and facilitating requests for prior approval. Care Navigation does not independently determine entitlement to insured benefits unless expressly authorized by Greystone Benefits, Inc. to act as its delegate. Benefit approvals and coverage determinations are made by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf.
5. **"Claim"** means a request for benefits submitted to the Insurer for a covered Accident or Illness.
6. **"Coinsurance"** means the percentage of Covered Expenses payable by the Covered Person after satisfaction of the Medical Event Deductible for non-coordinated Covered Services. Coinsurance is waived for Covered Services coordinated through Care Navigation and approved in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf only after the Annual HSA Gateway has been satisfied, subject to all terms, conditions, limitations, exclusions, and Policy Maximums under this Policy.
7. **"Companion HSA-Qualified Coverage"** means the HSA-qualified high deductible health plan or other HSA-qualified coverage identified by the Employer and approved by the Insurer for coordination with this Group Policy. The Companion HSA-Qualified Coverage must cover the same Covered Person and must correspond to the applicable self-only or family coverage category under Internal Revenue Code Section 223. Companion HSA-Qualified Coverage is not required to be administered by Planstin Administration, Inc.; however, expenses not contained in Planstin's claims records must be reported and substantiated in accordance with the Claims Administrator's procedures.
8. **"Covered Expense(s)"** means the amount eligible for reimbursement under this Policy for Medically Necessary Covered Services, as determined by Greystone Benefits, Inc. Covered Expenses may include negotiated rates obtained through Care Navigation or amounts determined through a Reference-Based Pricing methodology, including a percentage or multiple of amounts payable under Medicare or other industry-recognized reimbursement benchmarks. Except to the extent prohibited by applicable federal or other controlling law, Covered Persons may be responsible for permissible amounts billed by providers in excess of Covered Expenses. A Covered Expense is deemed to have occurred on the date such treatment, service, or supply was rendered or obtained.
9. **"Covered Medical Event"** means a separate medical condition, Illness, Accident, injury, or course of treatment to which one Medical Event Deductible applies, as determined under the terms of this Policy. Related services arising from the same diagnosis, Accident, Illness, injury, or continuous course of treatment will be treated as one Covered Medical Event unless Greystone Benefits, Inc., acting as Claims Administrator, determines that a separate and unrelated condition or course of treatment has begun. A recurrence or continuation of the same condition remains part of the same Covered Medical Event when it is clinically related to the prior course of treatment. In making this determination, Greystone Benefits, Inc. may consider whether the services arise from the same diagnosis or underlying condition, whether there has been a continuous or related course of treatment, whether later treatment is clinically related to the earlier condition, and whether a separate and unrelated diagnosis or course of treatment has begun.
10. **"Covered Person"** means a Participant or eligible dependent who is enrolled and eligible for insured benefits under the Employer's Plan and this Group Policy.
11. **"Deductible" or "Medical Event Deductible"** means the $5,000 amount of Covered Expenses that must be incurred by the Covered Person for each Covered Medical Event before benefits become payable for non-coordinated Covered Services. Covered Expenses applied to the Annual HSA Gateway and the Medical Event Deductible for the same Covered Medical Event are credited concurrently. After the Annual HSA Gateway is satisfied, the Medical Event Deductible is waived for Covered Services coordinated through Care Navigation and approved in advance by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf.

12. **“Effective Date”** means the date on which coverage for the Group Policy or a Covered Person begins, as shown in the Group Policy Schedule, Certificate of Coverage, or enrollment records, as applicable.
13. **“Gateway-Eligible Expenses”** means medical expenses incurred during the applicable annual coverage period that are applied toward the deductible of the Companion HSA-Qualified Coverage and substantiated to the satisfaction of the Claims Administrator. Gateway-Eligible Expenses are not required to be Covered Expenses under this Policy. When the Companion HSA-Qualified Coverage is administered by Planstin Administration, Inc., the adjudicated Covered Person responsibility reflected in Planstin’s claims records is credited automatically without separate proof of payment. Additional expenses not reflected in those records may be credited after submission and review of an Explanation of Benefits, itemized provider statement, proof of payment, or other documentation reasonably requested by the Claims Administrator.
14. **“Illness”** means a sickness, disease, or medical condition that requires examination, diagnosis, care, or treatment by a healthcare provider, whether first manifested before or after the Covered Person’s Effective Date, subject to all other terms, conditions, limitations, and exclusions of this Policy.
15. **“Medically Necessary”** means services or supplies required to diagnose or treat an Accident or Illness that are:
    (a) consistent with generally accepted standards of medical practice;
    (b) clinically appropriate in type, frequency, extent, site, and duration; and
    (c) not primarily for the convenience of the patient or provider. For proposed international treatment, Greystone Benefits, Inc. may consider available clinical evidence, provider and facility qualifications, expected benefit and outcome, risks, cost, the Covered Person's circumstances, and follow-up care. Lack of routine availability or a particular regulatory approval within the United States is not, by itself, conclusive.
16. **“Policy Annual Maximum”** means the maximum amount payable under this Policy for Covered Services incurred during a Policy Year.
17. **“Tobacco Surcharge”** means an additional premium amount applicable when any Covered Person or household member qualifies as a Nicotine, Tobacco, and Smoking Products User.
18. "**Nicotine, Tobacco, and Smoking Products User**" means a Covered Person or household member who has used tobacco, nicotine, smoking, vaping, inhaled, smokeless, or similar products at any time during the twenty-four (24) months immediately preceding enrollment or renewal.
19. **“Allowed Amount”** means the amount approved or determined by Greystone Benefits, Inc., or an expressly authorized delegate acting on its behalf, for a Covered Service, including amounts established through Care Navigation, negotiated provider arrangements, Reference-Based Pricing, or another reimbursement methodology recognized under this Policy.
20. **“Claims Administrator”** means Greystone Benefits, Inc. with respect to benefit determinations and appeals under this Policy, acting through Planstin Administration, Inc. for ministerial processing as delegated.
21. **“Employer” or “Group Policyholder”** means the employer identified in the Group Policy Schedule to which this Group Policy is issued.
22. **“Experimental or Investigational”** means a treatment, service, supply, drug, device, or procedure that Greystone Benefits, Inc., or an expressly authorized delegate acting on its behalf, determines is not established as safe and effective for the Covered Person's condition based on the available evidence and generally accepted standards of medical practice. For proposed international treatment, Greystone Benefits, Inc. may consider the evidence, provider and facility qualifications, expected benefit, risks, cost, individual circumstances, and follow-up care; lack of a particular United States regulatory approval alone is not determinative.
23. **“Group Policy Schedule”** means the document issued with this Group Policy that identifies the Group Policyholder and employer-specific information, including effective dates, Plan Year, the annual coverage period applicable to the Annual HSA Gateway, policy number, contribution or participation requirements, premiums or rate exhibits, and other terms expressly assigned to the Schedule.
24. **“Participant”** means an eligible employee who is enrolled for coverage under the Employer's Plan and this Group Policy.

25. **“Plan”** means the employee welfare benefit plan established and maintained by the Employer and funded, in whole or in part, through this Group Policy. References to the Plan mean the Employer's employee welfare benefit plan and do not, by themselves, confer authority on the Employer to make insured benefit determinations under this Policy. Insured benefit determinations under this Policy are made by Greystone Benefits, Inc. or an expressly authorized delegate acting on its behalf.
26. **“Plan Administrator”** means the Employer unless another person or entity is identified in the Group Policy Schedule or the Employer's governing plan document.
27. **“Plan Sponsor”** means the Employer identified in the Group Policy Schedule.

This Group Policy is issued by Greystone Benefits, Inc. to the Group Policyholder and becomes effective on the date shown in the Group Policy Schedule following acceptance of the Group Policyholder's application and receipt of required premium. Coverage for each Covered Person begins and ends as stated in the Group Policy Schedule, Certificate of Coverage, enrollment records, and the Employer's Plan.