

PREVENTIVE COPAY

Accessible care at an affordable price.



PREVENTIVE
CARE INCLUDED

PLAN SUMMARY

Your health plan includes copays for doctor visits, a prescription program, coverage for preventive care, a telehealth membership, and no plan limit on pre-existing conditions. Your plan also includes complimentary care coordination services to help you find lower-cost providers and potentially reduce costs by up to 50%. Contact the Care Coordination team at coordination@planstin.com.

Note: If you receive a bill for a preventive service covered by your plan, contact Member Services **888-920-7526**.



NO NETWORK

FAIR-PRICED HEALTHCARE

Instead of using a contracted network, the plan pays for claims based on fair rates for your area. Visit planstin.com/help-center/what-is-fair-priced-healthcare.



AFFORDABLE
COPAYS

COPAYS & LIMITS

Service	Copay	Max Payout	Plan Year Limit
Lab Work	\$10	\$100/Lab	15 Labs
Primary Care Visit	\$20	\$150/Visit	No Limit
Specialist or Urgent Care Visit	\$50	\$300/Visit	No Limit
Diagnostic X-ray	\$50	\$250/Visit	5 X-rays
CAT-scan, MRI, Ultrasound	\$200	\$1,000/Visit	2 Tests

Please see your plan's summary of benefits and coverage (SBC) for more details.



VIRTUAL CARE

TELEHEALTH

A Primestin Care membership is included with this health plan. Membership provides unlimited access to a physician 24/7/365, with no copay for general visits.



PRESCRIPTIONS

PRESCRIPTIONS

Prescription coverage, home delivery (required for recurring orders), and significant discounts on brand name and specialty medications. Visit planstin.myrxvalet.com to get started.

Prescription Type	Retail (First Fill)	Mail Order (All Refills)	Max Paid/Mo
Tier 1: Generic	\$10	\$20	\$1000/Rx
Tier 2: Preferred Brand	\$25	\$50	\$1000/Rx
Tier 3: Non-Preferred Brand	\$50	\$100	\$1000/Rx

GUIDED ETHOS

Guided Care. Serious Protection.

PLAN SUMMARY



COORDINATED
CARE: \$0

Guided Ethos is a limited medical expense insurance policy designed to help protect Members from significant covered medical expenses, subject to the terms of the applicable Policy. Guided Ethos helps members navigate major medical events with confidence, helping protect against the financial impact of surgeries, hospitalizations, and serious illnesses—with no pre-existing condition limitations. Through Care Coordination, members receive support before non-emergency treatment, helping them identify quality providers, explore care options, and potentially reduce out-of-pocket costs.

Deductible	Out-of-Pocket Limit	Policy Maximum
\$5,000 per event	\$15,000 per year	\$2,000,000 per year



PROTECTION

Medical Event	With Care Coordination	Without Care Coordination
Surgery	\$0	\$5,000 deductible + 20% coinsurance
Hospitalization	\$0	\$5,000 deductible + 20% coinsurance
Illness / Injury	\$0	\$5,000 deductible + 20% coinsurance
Maternity <i>Member + Spouse or Family tier required</i>	\$0	\$5,000 deductible + 20% coinsurance
	Limits: Vaginal delivery up to \$25,000; C-section up to \$50,000.	
Emergency Services	No prior approval needed. Deductible + coinsurance apply. Once stabilized, contact Care Coordination to assist with ongoing treatment planning, provider arrangements, and cost management.	

CARE COORDINATION FIRST



NO NETWORK

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.

GUIDED ETHOS

Guided Care. Serious Protection.

IMPORTANT INFORMATION

The Guided Ethos 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 ETHOS
GROUP LIMITED MEDICAL POLICY

SAMPLE

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IMPORTANT INFORMATION

Guided Ethos (Group) is a limited medical benefit program providing limited medical coverage. The program is issued by Greystone Benefits, Inc. and regulated under the authority of the Modoc Nation. It is administered as a tribally regulated insurance entity and is not subject to state insurance laws or consumer protections.

This Limited Medical Expense Policy (“Policy”) describes all of the benefits available between Greystone Benefits, Inc. (“Insurer,” “We,” “Our,” “Us,” or “Ours”) and the Covered Person (“you,” “your,” or “yours”) under the Plan, including eligibility requirements for coverage, the benefits provided, the conditions that must be met to qualify for Plan benefits, and other special Plan provisions. Although every effort has been made to make the description in this Policy as accurate as possible, this Policy does not include every relevant detail of the Plan. No representations are made regarding any additional or other coverage, nor are additional or other coverages available to a member unless specifically stated in this Policy. No benefits are available to you which are not specifically identified in this Policy.

It is important that you read this Policy in its entirety, so that you can understand the details of the Plan. Many sections of the Policy are related to other sections of the document. You may not have all of the information you need by reading just one section, so it is important that you review all sections that apply to a specific topic. We have made every effort to present the information as clearly and simply as possible. However, sometimes We must use words and phrases that are legal in nature. We have included a glossary at the end of this Policy to help clarify those terms, and terms from the glossary are capitalized throughout this Policy. Whenever the benefits in this Policy materially change, you will be notified of the modifications of your benefits. Keep this Policy and all notices together so you have ready access to the most current information about the Plan.

Please Note: This Policy provides limited medical coverage to individuals and families. It does NOT constitute comprehensive health insurance coverage and does NOT satisfy a person’s individual obligation to secure minimum essential coverage under the Affordable Care Act (“ACA”). For more information about the ACA, please refer to www.HealthCare.gov.

Funding Status: Greystone Benefits, Inc., assumes full financial responsibility for payment of covered claims under this program.

I. PLAN ADMINISTRATION INFORMATION

Plan Name	Guided Ethos Group Limited Medical
Common Name	“Policy”
Type of Plan	Limited Medical Expense Policy
Covered Person(s)	Individual and Family
Insurer/Plan Sponsor	Greystone Benefits, Inc.
Third-Party Administrator	Planstin Administration, Inc.
Policy Effective Date	
Plan Year	12 months from Policy Effective Date
Roles of Insurer and Third-Party Administrator	Greystone Benefits, Inc., as the Insurer, is solely responsible for payment of Covered Services under this Policy, subject to all Policy terms, conditions, limitations, and exclusions. All benefits are funded through premiums paid to the Insurer. Planstin serves as a third-party administrator and has been hired to process claims. As a third-party administrator, Planstin assumes no financial risk. Planstin Administration, Inc. 1506 S Silicon Way Suite 2B St. George, UT 84770 888-920-7526
Jurisdiction of Delivery	Modoc Nation
Plan Number	

Certain terms used in this Policy have specific meanings and are defined in the Definitions Glossary. Understanding the meanings of all the defined terms will help You better understand the coverage provided under this Policy.

II. ELIGIBILITY

Coverage Eligibility	Eligible employees ages 18-64 and eligible dependents ages 0-64
Group Eligibility	Offered to groups of two or more employees
Renewability	Guaranteed renewable, subject to the terms of this Policy
Age 65+ Continuation	Covered Persons age 65 or older may continue coverage only if they enrolled before age 65 and maintain continuous coverage under this Policy.

III. COVERAGE

Insuring Agreement

The Insurer agrees to pay Covered Benefits directly to providers or Covered Persons for Covered Services incurred, subject to the terms of the Policy.

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 strongly encouraged to utilize Care Navigation services prior to obtaining non-emergency medical care in order to identify high-quality, cost-effective providers and treatment arrangements approved by the Plan.

For Covered Services coordinated through Care Navigation and approved in advance by the Plan, the applicable 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.

Covered Services obtained without use of Care Navigation may still be eligible for reimbursement under this Policy, subject to all applicable deductibles, coinsurance, limitations, exclusions, and Policy provisions.

For non-coordinated services, the Plan may reimburse providers using a Reference-Based Pricing methodology, including a percentage or multiple of amounts payable under Medicare or other industry-recognized reimbursement benchmarks, as determined by the Plan in its sole discretion and consistent with the type of service provided.

Balance Billing and Member Responsibility

Covered Persons may remain responsible for charges billed by providers in excess of amounts payable under the Plan, including balance billing amounts. Such amounts may not apply toward any deductible or out-of-pocket maximum under this Policy.

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

- Emergency Services are covered subject to applicable deductibles, coinsurance, and Policy provisions without prior approval.
- Following stabilization, Covered Persons are strongly encouraged to engage Care Navigation whenever reasonably possible in order to assist with ongoing treatment planning, provider arrangements, and potential reduction of Covered Person financial responsibility.
- The Plan 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 the Plan.

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 at the time of conception or on the Policy Effective Date 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;
5. Fertility treatments;
6. Custodial care;
7. Services not deemed Medically Necessary;
8. Injuries resulting from intentional self-harm or participation in illegal activities;
9. Mental health;
10. Services covered by workers' compensation or similar laws;
11. Accident that occurs while a Covered Person is on active duty service in the military, naval, or air force of any country;
12. Routine dental care;
13. Injury or Illness sustained during war or acts of war, whether declared or not; and/or
14. Treatment for substance abuse, unless specifically covered by endorsement.
15. Regular prescription drug coverage, including retail prescriptions, maintenance medications, specialty pharmacy medications, and self-administered outpatient drugs;
16. 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

- **Coordinated Care Navigation Services:** For Covered Services coordinated through Care Navigation and approved in advance by the Plan, the applicable 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.
- **Non-Coordinated Services Deductible:** Covered Services obtained without use of Care Navigation are subject to a \$5,000 deductible per event. Each separate medical condition, illness, injury, or course of treatment is subject to a separate deductible. The deductible is not an annual aggregate deductible and applies separately to each covered medical event.
- **Non-Coordinated Services Coinsurance:** After satisfaction of the applicable deductible, Covered Persons are responsible for 20% coinsurance for non-coordinated Covered Services, subject to all Policy terms, conditions, limitations, exclusions, and benefit maximums.
- **Out-of-Pocket Maximum:** The annual out-of-pocket maximum is \$15,000 per Plan Year, subject to the terms, conditions, limitations, and exclusions of this Policy.

Only Covered Person cost-sharing amounts actually paid by the Covered Person for Covered Expenses shall apply toward the annual out-of-pocket maximum.

For a medical event to be eligible for accumulation toward the out-of-pocket maximum, Covered Expenses for that medical event must exceed the applicable \$5,000 deductible. Once the deductible threshold for an eligible medical event has been exceeded, member-paid deductible amounts and member-paid coinsurance amounts for that medical event may be credited toward the annual out-of-pocket maximum.

Amounts paid by the Policy, amounts waived through Care Navigation or Care Coordination programs, expenses incurred for medical events that do not exceed the applicable deductible, balance billing amounts, non-covered services, excluded services, and charges in excess of amounts payable under this Policy do not apply toward the annual out-of-pocket maximum.

- **Cost-Sharing Reductions or Waivers:** The Plan 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 the Plan.

VII. RATE CONDITIONS

Age Rating Bands	18–29, 30–49, 50–64, and 65+
Age Rate Adjustments	Age rates are adjusted annually and may not coincide with the Covered Person's enrollment date.
Household Rating	Rates are based on the age of the Covered Employee.
Enrollment Tiers	Member, Member + Child(ren), Member + Spouse, and Member Family
Tobacco Surcharge	A tobacco surcharge of \$100 per household applies.

VIII. CLAIMS PROCEDURE

Care Navigation

Covered Persons are strongly encouraged to use Care Navigation prior to obtaining non-emergency medical care. For Covered Services coordinated through Care Navigation and approved in advance by the Plan, the applicable 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 under this Policy. Claims for services obtained without use of Care Navigation may still be eligible for reimbursement under this Policy, subject to all applicable deductibles, coinsurance, limitations, exclusions, and Policy provisions.

Notice of a Claim

Written notice of claim must be provided to Us within ninety (90) days after the occurrence of a Covered Service.

Proof of Loss

Proof of loss must be submitted to Us within ninety (90) days and shall include itemized bills and supporting medical documentation. If it cannot be provided within that time, then it should be sent as soon as reasonably possible. In no event, except in the case of legal capacity, should proof of loss be submitted later than six (6) months after the time proof is otherwise required.

Payment of Claims

The Insurer shall pay claims within thirty (30) days after receipt of satisfactory Proof of Loss.

Appeals

A Covered Person may request review of an adverse benefit determination by submitting a written appeal to the Plan within one hundred eighty (180) days following receipt of the adverse benefit determination notice.

The appeal should include any additional information, documentation, or explanation the Covered Person wishes the Plan to consider.

The Plan will review the appeal and provide a written determination within a reasonable period of time following receipt of the appeal and supporting documentation.

The Plan reserves the right to request additional information reasonably necessary to evaluate the appeal.

All appeal determinations shall be made in accordance with the terms, conditions, limitations, exclusions, and provisions of this Policy.

IX. COORDINATION OF BENEFITS

Any Medicare benefits or other coverage available to the Covered Person shall be primary to this Policy. This Policy shall coordinate benefits to prevent duplication of payment and shall provide benefits only as secondary coverage, subject to all Policy terms, conditions, limitations, exclusions, and benefit maximums.

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. TERMINATION AND RENEWAL

Termination

Coverage may be terminated for:

1. Non-payment of premium;
2. Fraud or material misrepresentation; and/or
3. As otherwise permitted by law.

Renewal

This Policy is guaranteed renewable, subject to the Insurer's right to adjust premiums on a class basis. Covered Persons age 65 or older may continue coverage only if they enrolled before age 65 and maintain continuous coverage under this Policy.

XII. GENERAL PROVISIONS

Entire Contract

This Policy, including endorsements and the application, constitutes the entire contract.

Amendments

No amendment shall be valid unless approved by an authorized officer of the Insurer.

Assignment

We may pay benefits directly to any hospital, health care facility, or person rendering covered services, unless the Covered Person requests in writing no later than the time s/he submits written Proof of Loss.

Governing Law

This program is issued by Greystone Benefits, Inc. and regulated under the authority of the Modoc Nation. It is administered as a tribally regulated insurance entity and is not subject to state insurance laws or consumer protections regulations.

Dispute Resolution

Any dispute arising under this Policy shall be resolved through negotiation. If such dispute cannot be resolved within thirty (30) days, then it will be subject to mediation. Each party will equally share the cost of the mediator.

Conformity with Law

Any provision of this Policy that conflicts with applicable law shall be amended to conform to such law.

XIII. 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. **“Allowed Amount”** means the amount approved by the Plan for a Covered Service, including amounts established through Care Navigation, negotiated provider arrangements, Reference-Based Pricing, or other reimbursement methodology recognized under this Policy.
3. **“Care Navigation”** means the Plan’s service provider that Covered Persons contact to coordinate care.
4. **“Claim”** means a request for benefits submitted to the Insurer for a covered Accident or Illness.
5. **“Coinsurance”** means the percentage of Covered Expenses payable by the Covered Person after satisfaction of the Deductible for non-coordinated Covered Services. Coinsurance is waived for Covered Services coordinated through Care Navigation and approved in advance by the Plan, subject to all terms, conditions, limitations, exclusions, and Policy Maximums under this Policy.
6. **“Covered Expense(s)”** means the amount eligible for reimbursement under this Policy for Medically Necessary Covered Services, as determined by the Insurer. 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. Covered Persons may be responsible for 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.
7. **“Covered Person”** means an individual who is enrolled and eligible for benefits under this Policy.
8. **“Deductible”** means the amount of Covered Expenses that must be incurred and paid by the Covered Person before benefits become payable for non-coordinated Covered Services. The Deductible is waived for Covered Services coordinated through Care Navigation and approved in advance by the Plan, subject to all terms, conditions, limitations, exclusions, and Policy Maximums under this Policy.
9. **“Effective Date”** means the date on which coverage for a Covered Person begins.
10. **“Illness”** means a sickness, disease, or medical condition first manifested after the Effective Date of coverage, and which requires examination, diagnosis, care, or treatment by a healthcare provider.
11. **“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.
12. **“Policy Annual Maximum”** means the maximum amount payable under this Policy for Covered Services incurred during a Policy Year.
13. **“Tobacco Surcharge”** means an additional premium amount applicable when any Covered Person or household member qualifies as a Nicotine, Tobacco, and Smoking Products User.

14. **"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.

This Policy is issued by Greystone Benefits, Inc. and becomes effective upon approval of enrollment, receipt of applicable premium, and issuance of coverage by the Insurer.

SAMPLE