Introduction to Health Plan of Nevada, Inc. ("HPN") Point-of-Service ("POS") Plan

The HPN POS Plan is a unique healthcare plan that offers Members flexibility and freedom of choice to use either Tier I HMO benefits, Tier II Plan Provider benefits or Tier III Non-Plan Provider benefits when healthcare benefits are needed.*

Tier I HMO Benefits apply when a Member obtains or arranges Covered Services through an HPN Plan Provider from HPN's Basic Provider network and the care has been Prior Authorized by HPN, if required. No claim forms are required for Tier I HMO benefits when Covered Services are received from HPN Plan Providers. Tier I HMO benefits provide a higher level of coverage with less out-of-pocket expenses to the Member.

Tier II Plan Provider Benefits apply when a Member obtains Covered Services from a Plan Provider from HPN's Expanded Provider network. Certain Covered Services require Prior Authorization from HPN's Managed Care Program in order for the Member to receive maximum benefits. The Member's out-of-pocket expenses will be higher than they would under the Tier I HMO benefits because the Member will be responsible for a Calendar Year Deductible, Coinsurance amounts and, in some plans, higher Copayments. Claim forms are not required when using Plan Providers. Please contact HPN for a complete list of Basic and Expanded Providers.

Tier III Non-Plan Provider Benefits apply when a Member obtains Covered Services from a Tier III Non-Plan Provider. Certain Covered Services require Prior Authorization from HPN's Managed Care Program in order for the Member to receive maximum benefits. All Benefits are subject to a Calendar Year Deductible and Coinsurance amount up to the Member's Calendar Year Coinsurance Maximum as set forth in the Attachment A, Benefit Schedule. Claim forms must be submitted for services received from Tier III Non-Plan Providers.

Emergency Services: The Tier I HMO level of benefits will apply to Emergency Services provided at any duly licensed facility. Upon admission to a Tier III Non-Plan Provider Hospital and stabilization of the emergency condition and safe for transfer as determined by the attending Physician, the Plan may require transfer to an Tier I HMO contracted facility in order to pay benefits at the Tier I HMO benefit level. Benefits for post-stabilization and follow-up care received at a Tier II Plan Provider or Tier III Non-Plan Provider Hospital facility are subject to the applicable benefit tier.

IMPORTANT INFORMATION

Benefits for certain Covered Services are only payable under the Tier I HMO benefit level.

Benefits for all Tier I HMO Covered Services not provided by the Member's Primary Care Provider (PCP) require Prior Authorization from the PCP and the Plan in the form of a written Referral authorization. Failure to comply with this requirement will result in the Member being responsible for the costs incurred for these medical services.

Certain Tier II Plan Provider and Tier III Non-Plan Provider non-Emergency Covered Services require review and Prior Authorization from HPN's Managed Care Program in order for the Member to receive maximum benefits. Failure to comply with the Prior Authorization requirements will result in a reduction of benefits.

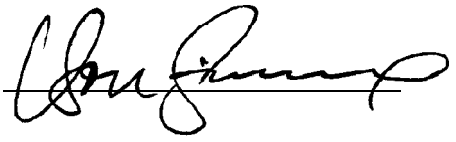
NOTE: You are responsible for expenses which exceed the EME payments to the Tier III Non-Plan Provider and amounts that exceed the applicable maximum benefit payments and penalties for not complying with HPN's Managed Care Program. Claim forms must be submitted for services received from Tier III Non-Plan Providers. Please refer to the Attachment A, Benefit Schedule for specific maximum benefit amounts.

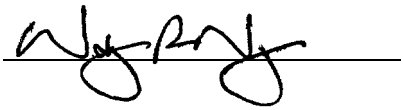
HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

HPN POS Rider to the Evidence of Coverage

This Rider is a supplement to your Evidence of Coverage (EOC) issued by HPN. Subject to the applicable terms, conditions, limitations and exclusions stated in the EOC and this Rider, the following benefits are included in your healthcare coverage. Nothing in this Rider will change the terms of the EOC except as otherwise stated herein. This Rider shall terminate upon termination of the Plan and under the same terms and conditions specified therein, and Members shall no longer be entitled to any of the benefits set forth in this Rider. Nothing contained in this Rider shall vary, waive, alter, or extend any of the terms, conditions or limitations of the EOC, except as specifically stated in this Rider.

All benefits for Emergency Services will be administered under the provisions of the HPN EOC. Benefits for services received in an emergency room which are Medically Necessary but not of an emergency nature are limited. Please refer to the Attachment A Benefit Schedule for further information.

President 

Secretary 

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SECTION 1. Obtaining Covered Services under the Tier II Plan Provider and Tier III Non-Plan Provider benefit levels

This section tells you under what conditions benefits for Covered Services are available under the Tier II and Tier III benefit levels and your obligations as a Member. You should also carefully review the Exclusions and Limitations described in the HPN EOC prior to obtaining healthcare services.

1.1 Provider Selection

Subject to all conditions, Exclusions, and Limitations of the HPN EOC and this Rider, if the Member uses the services of a Provider who is a licensed Practitioner in the state in which he is practicing and who is operating within the scope of his license, then such services shall be treated as though they had been performed by a Physician.

1.2 Tier II and Tier III Services Requiring Prior Authorization

Covered Services requiring Prior Authorization and review through HPN's Managed Care Program include, but are not limited to:

a) All elective Inpatient admissions and extensions of stay beyond the original certified length of stay to a Hospital or Skilled Nursing Facility;

b) All outpatient surgery provided in any setting, including technical and professional services;

c) All outpatient tests, including technical and professional services, including, for example, but not limited to the following: angiograms; echocardiograms; EEGs; EMGs; and nerve conduction studies; Holter monitors (heart monitor-24 hours); myelograms; non-invasive vascular studies; psychological testing; pulmonary function tests; CAT scans, MRI scans, nuclear scans; sleep apnea studies; and treadmill stress tests (cardiac exercise tests); Positron Emission Tomography (PET Scan); and

d) All outpatient courses of treatment, including, for example, but not limited to, the following: allergy testing/treatment (e.g. skin, RAST); angioplasty; anti-cancer drug therapy; dialysis; Home Health Care; physiotherapy or Manual Manipulation; radiation therapy; and rehabilitation (physical, speech, occupational).

1.3 Failure to Comply

Failure of the Member to comply with the requirements of HPN's Managed Care Program will result in a reduction of benefits. Benefits for Covered Services obtained under the Tier II or Tier III benefit levels which are not certified by HPN's Managed Care Program will be reduced to 50% of the benefits which would have been payable if the services had been certified.

1.4 Appeals Rights

All decisions of HPN's Managed Care Program may be appealed by the Member through the Appeals Procedures or, if time is of the essence, directly to the Medical Director. Please refer to the HPN EOC for additional information on the Appeals Procedure.

SECTION 2. Preexisting Condition Limitation

HPN does not apply a Preexisting Condition Limitation to its Point-of-Service (POS) Plans.

SECTION 3. Claims Provisions

This section tells you how and when to file a claim for benefits under this Plan when you receive services from a Tier III Non-Plan Provider.

3.1 Notice and Proof of Claim

Written notice of each claim for benefits should be given to the Plan within thirty (30) days of the date any healthcare services are received. Failure to furnish notice within thirty (30) days will not invalidate or reduce any claim if it is shown that notice was provided to the Plan within twelve (12) months of the date of service. The Plan, upon receipt of such notice, will furnish to the Member forms for filing the proof of claim. The Plan agrees to:

a) provide claim forms to the Group for submitting claims to the Plan;

b) receive claims and claims documentation;

c) correspond with the Members and Providers of services if additional information is deemed by the Plan to be necessary to complete the processing of claims;

d) coordinate benefits payable under the Plan with other benefit plans, if any;

e) determine the amount of benefits payable under the Plan; and

f) pay the amount of benefits determined to be payable under the Plan and pay all claims that are clearly for eligible Members for Covered Services that were appropriately authorized within thirty (30) days. Claims may be pended and appropriately delayed if there are issues regarding proper authorization, eligibility or Coordination of Benefits.

3.2 Late Claims Exclusion

No payment shall be made under the Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by the Plan within twelve (12) months after the date Covered Services are provided.

SECTION 4. Glossary

4.1 "Coinsurance" means the percentage of the charges billed or the percentage of Eligible Medical Expenses, whichever is less, that a Member must pay a Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the Provider who bills for the Covered Services. (See Attachment A, Benefit Schedule.)

4.2 "Deductible" means the portion of the covered expenses billed by Providers each Calendar Year that a Member must pay, either in the aggregate or for a particular service, before the Plan will make any benefit payments for Covered Services under the Tier II Plan Provider and Tier III Non-Plan Provider benefit levels.

4.3 "Tier II Plan Provider Benefits" means those benefits for services received from an HPN Plan Provider from HPN's expanded list of Providers, after satisfaction of a Calendar Year Deductible and subject to the Member's Coinsurance amounts, and/or Copayments, in some instances. Certain Covered Services require Prior Authorization from HPN's Managed Care Program in order for the Member to receive maximum benefits.

4.4 "Tier III Non-Plan Provider Benefits" means those benefits for services received from a Tier III Non-Plan Provider after satisfaction of the applicable Calendar Year Deductible and subject to the Member's Coinsurance amount. Certain Covered Services require Prior Authorization from HPN's Managed Care Program in order for the Member to receive maximum benefits. Member may be required to submit claim forms and itemized bills for services rendered.