19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

NUMBER: 485 005 DIVISION: N

J. ROBERT WOOLEY, AS ACTING COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA

COPY

VERSUS

GULF SOUTH HEALTH PLANS, INC.

FILED:_____ _____
DEPUTY CLERK

EX PARTE MOTION
(1) TO AMEND THE CUT OFF DATE FOR THE FILING OF CLAIMS,

(2) FOR APPROVAL OF THE FORM OF THE NOTICE OF THE CUT OFF DATE FOR THE FILING OF CLAIMS AND FOR FILING OBJECTIONS TO THE GENERAL HEALTH SYSTEM PROPOSAL AND THE HEARING TO CONSIDER THE GENERAL HEALTH SYSTEM PROPOSAL,
AND
(3) FOR APPROVAL OF THE NOTICE PROCESS FOR THE WIND UP OF THE AFFAIRS OF GULF SOUTH HEALTH PLANS, INC., A LOUISIANA HEALTH MAINTENANCE ORGANIZATION

NOW INTO COURT, through undersigned counsel, comes the Commissioner of Insurance for the State of Louisiana (the "Commissioner"), who represents that an order was entered in this matter on June 19, 2001 setting a cut off date for all claims as to Gulf South Health Plans, Inc. ("Gulf South") by Gulf South subscribers, enrollees, providers and other creditors on or before August 20, 2001 (sixty [60] days from the date of the signing of the order). The Commissioner desires and is entitled to an order amending the cut off date and extending the period for notice for the reasons shown in the attached memorandum, which is attached hereto and incorporated herein. Further, the Commissioner desires and is entitled to an order approving the form of the notice to be sent to Gulf South subscribers and enrollees, Gulf South providers, and Gulf South creditors, all as more fully explained in the memorandum attached hereto and incorporated herein. Copies of the three notice forms recommended by the Commissioner are attached hereto and incorporated herein and marked **Exhibit A** (Notice to Providers, Notice to Members, Enrollees, and Subscribers, and Notice to Creditors). Additionally, the Commissioner desires and is entitled to an order approving the notice process, which process is more fully explained in the memorandum attached hereto and incorporated herein, and is more fully explained in attached **Exhibit B**

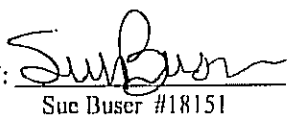
WHEREFORE, mover prays for an order accordingly.

Respectfully Submitted.

J. ROBERT WOOLEY
Acting Commissioner of Insurance for the State of Louisiana
Claire L. Lemoine
Senior Attorney
Bar Roll #20497

RICHARD P. IEYOUB
ATTORNEY GENERAL
STATE OF LOUISIANA
Cassandra Simms #12091
Arlene Knighten #7754
Jackie Harris #26043

Buser & Associates, APLC

BY: 
Sue Buser #18151
10225 Florida Boulevard
Eighth Floor
Baton Rouge, LA 70815
Telephone: (225) 275-9111

19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

NUMBER: DIVISION:

J. ROBERT WOOLEY, AS ACTING COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA
VERSUS
GULF SOUTH HEALTH PLANS, INC.

FILED:_____ _____
DEPUTY CLERK

ORDER

Considering the ex parte motion (1) to amend the cut off date for filing of claims, (2) for approval of the form of the notice of the cut off date for the filing of claims and for filing objections to the General Health System Proposal and the hearing to consider the General Health System Proposal, and (3) for approval of the notice process for the wind up of the affairs of Gulf South Health Plans, Inc., ("Gulf South") filed herein, and the Court finding that mover is entitled to the relief requested and granted herein,

IT IS ORDERED, ADJUDGED AND DECREED that September 25, 2001 is established as the cut off date by which claims of enrollees, subscribers, members, providers, and creditors of Gulf South must be submitted and received by Gulf South (the "Claims Bar Date").

IT IS ORDERED, ADJUDGED AND DECREED that the form of the three notices proposed for notice of the Claims Bar Date, notice of the date for filing objections to the General Health System proposal, and notice of the date of the hearing to consider the General Health System proposal -- the Notice To Providers, the Notice to Members, Enrollees, and Subscribers, and the Notice to Creditors and Others -- copies of which are attached to the motion filed herein, be and same are approved.

IT IS ORDERED, ADJUDGED AND DECREED that the notice process for the wind up of the affairs of Gulf South, a copy of which is attached to the motion filed herein, be and same is approved.

Baton Rouge, Louisiana, this ___ day of _____, 2001.

_____
JUDGE

CONSENTED TO AND AGREED TO BY:

GENERAL HEALTH SYSTEM

By: _____
Its authorized representative

GULF SOUTH HEALTH PLANS, INC.

By: _____
Its authorized representative

19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

NUMBER: DIVISION:

J. ROBERT WOOLEY, AS ACTING COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA

VERSUS

GULF SOUTH HEALTH PLANS, INC.

FILED:_____ _____
DEPUTY CLERK

MEMORANDUM IN SUPPORT OF THE EX PARTE MOTION (1) TO AMEND THE CUT OFF DATE FOR THE FILING OF CLAIMS, (2) FOR APPROVAL OF THE FORM OF THE NOTICE OF THE CUT OFF DATE FOR THE FILING OF CLAIMS AND FOR FILING OBJECTIONS TO THE GENERAL HEALTH SYSTEM PROPOSAL AND THE HEARING TO CONSIDER THE GENERAL HEALTH SYSTEM PROPOSAL, AND (3) FOR APPROVAL OF THE NOTICE PROCESS FOR THE WIND UP OF THE AFFAIRS OF GULF SOUTH HEALTH PLANS, INC., A LOUISIANA HEALTH MAINTENANCE ORGANIZATION CONSENT ORDER FOR THE WIND UP OF THE AFFAIRS OF A HEALTH MAINTENANCE ORGANIZATION

MAY IT PLEASE THE COURT:

On June 19, 2001, this Court entered an order for the wind up of the affairs of Gulf South Health Plans, Inc. ("Gulf South"). On that date, the Court also entered an order granting preliminary approval of the proposal of General Health System to fund the wind up plan. The order for the wind up of the affairs of Gulf South (the "Wind Up Order") established a cut off date by which the claims of enrollees, members, subscribers, providers and other creditors of Gulf South were to be submitted and received by Gulf South, which date was established as sixty (60) days from the date of the signing of the order or August 20, 2001 (the "Claims Bar Date"). Gulf South has advised the Commissioner that additional time was needed in order to devise the form of the notice, to develop the procedures for implementing mailing of the notice, to obtain an outside vendor to perform the mailing, to determine how and to whom the notices are to be sent. Since a great number of Gulf South members were enrolled in a federal Medicare program through Gulf South, discussions were underway with the Federal Health Care Financing Administration ("HCFA") as to the federal requirements and/or guidelines for notice of filing claims. HCFA has advised the Commissioner that notice to all Gulf South members enrolled between the period of October 1, 2000 and May 31, 2001 is an acceptable period for the notice. The Commissioner concurs in HCFA's recommendation as to the notice period. Gulf South advises the Commissioner that as many as 125,000 notices may

be required to be sent.

For all these reasons, the Commissioner requests that the Claims Bar Date be extended to September 25, 2001 in order to afford Gulf South enrollees, members, subscribers, providers and creditors with ample time to file claims. Further, the Commissioner requests that the Court approve the form of the three proposed notices, copies of which are attached hereto and incorporated herein, with one notice to go to providers, one to go to members, enrollees, and subscribers, and one to go to creditors and others. Gulf South has further recommended a process for the mailing of the notices, a copy of which is attached hereto and incorporated herein. The Commissioner requests that the Court approve the process proposed.

Respectfully Submitted,

J. ROBERT WOOLEY
Acting Commissioner of Insurance for the State of Louisiana
Claire I. Lemoine
Senior Attorney
Bar Roll #20497

RICHARD P. IEYOUB
ATTORNEY GENERAL
STATE OF LOUISIANA
Cassandra Simms #12091
Arlene Knighten #7754
Jackie Harris #26043

Buser & Associates, APLC

BY: _____
Sue Buser #18151
10225 Florida Boulevard
Eighth Floor
Baton Rouge, LA 70815
Telephone: (225) 275-9111

EXHIBIT A

NOTICE TO MEMBERS, ENROLLEES, AND SUBSCRIBERS

NOTICE TO PROVIDERS

NOTICE TO CREDITORS AND OTHERS

NOTICE TO PROVIDERS

WIND UP OF GULF SOUTH HEALTH PLANS, INC.

DOCKET NUMBER 485,005 - DIVISION N
19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

THIS NOTICE CONTAINS IMPORTANT INFORMATION WHICH AFFECTS YOUR LEGAL RIGHTS

The 19th Judicial District Court for the Parish of East Baton Rouge, State of Louisiana, has entered an order for the wind up of the affairs of Gulf South Health Plans, Inc. ("Gulf South") under the supervision of the Court and the administrative regulation of the Commissioner of Insurance for the State of Louisiana (the "Commissioner"). The Court also entered an order granting preliminary approval of the proposal of General Health System, the parent company of Gulf South, for the funding of the wind up plan submitted by the Commissioner and approved by the Court.

NOTICE OF HEARING

A hearing will be held in the above referenced case for all interested parties who timely file objections or oppositions to appear and show cause why preliminary approval by the Court of the proposal of General Health System for funding the wind up plan for Gulf South should not be made final. Any opposition or objections to the General Health proposal must be in writing and filed with the Clerk of Court in the above captioned matter not later than **5:00 p.m. on OCTOBER 1, 2001**, with copies being delivered to the Chambers of the Judge and served on counsel for the Commissioner and General Health System and on Gulf South. The Court will then consider at the hearing any timely filed opposition or objection.

DATE OF HEARING:	**NOVEMBER 5, 2001 at 9:30 a.m.**
PLACE OF HEARING:	**19th JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE, DIVISION N**

STAY AND ABATEMENT OF LEGAL PROCEEDINGS

Pursuant to the order of the 19th Judicial District Court, all suits and seizures against Gulf South, its parent company (only to the extent it is sought to be held liable for the obligations of Gulf South), the Commissioner of Insurance, and the enrollees and subscribers of Gulf South are stayed. The order prohibits the commencement or maintenance of any action or proceeding, including those in the nature of an attachment, garnishment, or execution, against Gulf South. Attorneys are requested to advise appropriate courts of this Notice and the Court's order.

NOTICE OF RIGHT TO FILE CLAIM

Any provider may file a claim on his own behalf for any monies claimed due from Gulf South. All claims must be filed electronically or in writing and received by Gulf South at the address shown below on or before **SEPTEMBER 25, 2001. CLAIMS RECEIVED BY GULF SOUTH AFTER SEPTEMBER 25, 2001 WILL NOT BE PROCESSED FOR PAYMENT OR REIMBURSEMENT.**

Providers participating with Gulf South may only bill members, enrollees, and subscribers for the portion of their claim that is the member, enrollee, or subscriber's 'responsibility. This includes deductibles, co-insurance and/or co-payments. Any other demands for payment of the lawful obligations of Gulf South Health Plans, Inc. from enrollees, subscribers, or members are prohibited by state law and the order of the court. Failure to comply with the prohibition on billing enrollees, subscribers, or members for the lawful obligations of Gulf South Health Plans, Inc. will be reported to the court for further court action.

LEGAL NOTICE

This notice constitutes legal notice from Gulf South for the submission of all claims. This notice also constitutes notice of the hearing on the General Health System proposal for funding the wind up plan and notice of the date and manner in which an opposition or objection to that proposal must be made, all as set forth above.

CLAIMS MUST BE SUBMITTED ELECTRONICALLY OR IN WRITING TO:

GULF SOUTH HEALTH PLANS, INC.
ATTENTION: CLAIMS
P. O. Box 14449
Baton Rouge, LA 70898
OR FAXED TO: (225) 237-1813

If you have any questions concerning this notice, please contact Gulf South at (225) 237-1700 or see information about this matter on line at **www.gulfsouth.com.**

THE DEADLINE FOR FILING AND RECEIPT OF YOUR CLAIM IS SEPTEMBER 25, 2001.

FURTHER INFORMATION

If you want further information about Gulf South Health Plans, Inc. and/or this legal proceeding, you may wish to contact your own legal counsel or

GULF SOUTH HEALTH PLANS, INC.
P. O. Box 14449
Baton Rouge, LA 70898
(225) 237-1700
Fax (225) 237-1813
www.gulfsouth.com

Documents available at **www.gulfsouth.com** and at the Clerk of Court, 19th Judicial District:

- Notices to Members, Enrollees, Subscribers, Providers, Creditors and Others
- Court's Wind Up Order
- Wind Up Plan
- General Health System Proposal to Fund Wind Up Plan
- Court's Order Granting Preliminary Approval of Proposal to Fund Wind Up Plan and Setting Hearing Date and Deadlines

NOTICE TO MEMBERS, ENROLLEES AND SUBSCRIBERS

WIND UP OF GULF SOUTH HEALTH PLANS, INC.

DOCKET NUMBER 485,005 - DIVISION N
19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

THIS NOTICE CONTAINS IMPORTANT INFORMATION WHICH AFFECTS YOUR LEGAL RIGHTS

The 19th Judicial District Court for the Parish of East Baton Rouge, State of Louisiana, has entered an order for the wind up of the affairs of Gulf South Health Plans, Inc. ("Gulf South") under the supervision of the Court and the administrative regulation of the Commissioner of Insurance for the State of Louisiana (the "Commissioner"). The Court also entered an order granting preliminary approval of the proposal of General Health System, the parent company of Gulf South, for the funding of the wind up plan submitted by the Commissioner and approved by the Court.

NOTICE OF RIGHT TO FILE CLAIM

Check to see if your providers are listed in the Gulf South Directory. If you cannot locate your directory, you may contact us directly at (225) 237-1700 or your provider to find out if your provider was a participating provider.

If services were provided to you by a provider not listed in the Gulf South directory (a non-participating provider), make sure that all claims are submitted in writing by your provider and received by Gulf South at the address shown below no later than **SEPTEMBER 25, 2001.** If your provider is not submitting a claim on your behalf for covered out-of-network services, you must file a claim in writing and it must be received by Gulf South at the address shown below on or before **SEPTEMBER 25, 2001**. You will not be reimbursed for any out-of-network medical care that is not claimed by **SEPTEMBER 25, 2001**. You may be responsible for these charges if you have not filed a claim in writing that is received by Gulf South at the address shown below on or before **SEPTEMBER 25, 2001**. If you have paid for services provided by a participating provider and believe you are due reimbursement from Gulf South, you must file a claim in writing and it must be received by Gulf South at the address shown below on or before **SEPTEMBER 25, 2001. CLAIMS RECEIVED BY GULF SOUTH AFTER SEPTEMBER 25, 2001 WILL NOT BE PROCESSED FOR PAYMENT OR REIMBURSEMENT.**

NOTICE OF YOUR RIGHT NOT TO BE BILLED FOR SERVICES OWED BY GULF SOUTH HEALTH PLANS, INC.

If you receive bills from providers listed in the Gulf South Directory (participating providers) for any amounts over your deductible, coinsurance, or copayment amounts, contact Gulf South Health Plans, Inc. immediately at (225) 237-1700. You are only responsible for your deductible, coinsurance and/or copayment amounts. Demands for any other payments are prohibited by state law and the order of the court, and should be reported immediately to Gulf South.

LEGAL NOTICE

This notice constitutes legal notice from Gulf South for the submission of all claims. This notice also constitutes notice of the hearing on the General Health System proposal for funding the wind up plan and notice of the date and manner in which an opposition or objection to that proposal must be made **all as set forth above.**

NOTICE TO SUBSCRIBERS

Mailing of this notice to the subscriber on the Gulf South certificate of coverage will serve as notice to each member, enrollee, or other person covered under the certificate of coverage.

CLAIMS MUST BE SUBMITTED IN WRITING TO:

GULF SOUTH HEALTH PLANS, INC.
ATTENTION: CLAIMS
P. O. Box 14449
Baton Rouge, LA 70898
OR FAXED TO: (225) 237-1813

If you have any questions concerning this notice, please contact Gulf South at (225) 237-1700 or see information about this matter on line at **www.gulfsouth.com.**

THE DEADLINE FOR FILING AND RECEIPT OF CLAIMS IS SEPTEMBER 25, 2001.

NOTICE OF HEARING

A hearing will be held in the above referenced case for all interested parties who timely file objections or oppositions to appear and show cause why preliminary approval by the Court of the proposal of General Health System for funding the wind up plan for Gulf South should not be made final. Any opposition or objections to the General Health proposal must be in writing and filed with the Clerk of Court in the above captioned matter not later than **5:00 p.m. on OCTOBER 1, 2001**, with copies being delivered to the Chambers of the Judge and served on counsel for the Commissioner and General Health System and on Gulf South. The Court will then consider at the hearing any timely filed opposition or objection.

DATE OF HEARING: **NOVEMBER 5, 2001 at 9:30 a.m.**

PLACE OF HEARING: **19th JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE, DIVISION N**

STAY AND ABATEMENT OF LEGAL PROCEEDINGS

Pursuant to the order of the 19th Judicial District Court, all suits and seizures against Gulf South, its parent company (only to the extent it is sought to be held liable for the obligations of Gulf South), the Commissioner, and the enrollees and subscribers of Gulf South are stayed. The order prohibits the commencement or maintenance of any action or proceeding, including those in the nature of an attachment, garnishment, or execution, against Gulf South. Attorneys are requested to advise appropriate courts of this Notice and the Court's order.

FURTHER INFORMATION

If you want further information about Gulf South Health Plans, Inc. and/or this legal proceeding, you may wish to contact your own legal counsel or

GULF SOUTH HEALTH PLANS, INC.
P. O. Box 14449
Baton Rouge, LA 70898
(225) 237-1700
Fax (225) 237-1813
www.gulfsouth.com

Documents available at **www.gulfsouth.com** and at the Clerk of Court, 19th Judicial District:

- Notices to Members, Enrollees, Subscribers, Providers, Creditors and Others
- Court's Wind Up Order
- Wind Up Plan
- General Health System Proposal to Fund Wind Up Plan
- Court's Order Granting Preliminary Approval of Proposal to Fund Wind Up Plan and Setting Hearing Date and Deadlines

NOTICE TO CREDITORS AND OTHERS

WIND UP OF GULF SOUTH HEALTH PLANS, INC.

DOCKET NUMBER 485,005 - DIVISION N
19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

THIS NOTICE CONTAINS IMPORTANT INFORMATION WHICH AFFECTS YOUR LEGAL RIGHTS

The 19th Judicial District Court for the Parish of East Baton Rouge, State of Louisiana, has entered an order for the wind up of the affairs of Gulf South Health Plans, Inc. ("Gulf South") under the supervision of the Court and the administrative regulation of the Commissioner of Insurance for the State of Louisiana (the "Commissioner"). The Court also entered an order granting preliminary approval of the proposal of General Health System, the parent company of Gulf South, for the funding of the wind up plan submitted by the Commissioner and approved by the Court.

NOTICE OF HEARING

A hearing will be held in the above referenced case for all interested parties who timely file objections or oppositions to appear and show cause why preliminary approval by the Court of the proposal of General Health System for funding the wind up plan for Gulf South should not be made final. Any opposition or objections to the General Health System proposal must be in writing and filed with the Clerk of Court in the above captioned matter not later than **5:00 p.m. on OCTOBER 1, 2001**, with copies being delivered to the Chambers of the Judge and served on counsel for the Commissioner and General Health and on Gulf South. The Court will then consider at the hearing any timely filed opposition or objection.

DATE OF HEARING: **NOVEMBER 5, 2001 at 9:30 a.m.**

PLACE OF HEARING: **19th JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE, DIVISION N**

STAY AND ABATEMENT OF LEGAL PROCEEDINGS

Pursuant to the order of the 19th Judicial District Court, all suits and seizures against Gulf South, its parent company (only to the extent it is sought to be held liable for the obligations of Gulf South), the Commissioner of Insurance, and the enrollees and subscribers of Gulf South are stayed. The order prohibits the commencement or maintenance of any action or proceeding, including those in the nature of an attachment, garnishment, or execution, against Gulf South. Attorneys are requested to advise appropriate courts of this Notice and the Court's order.

NOTICE OF RIGHT TO FILE CLAIM

Any creditor or other person or entity may file a claim on his own behalf for any monies claimed due from Gulf South. All claims must be filed in writing and received by Gulf South at the address shown below on or before **SEPTEMBER 25, 2001**.

If a claimant fails to file a claim by **SEPTEMBER 25, 2001**, the claim will be considered untimely filed and no recovery will be available for the claim.

Creditors of Gulf South must submit all bills or other claims, together with all supporting documentation, to Gulf South in writing and same must be received by Gulf South at the address shown below by **SEPTEMBER 25, 2001. CLAIMS RECEIVED BY GULF SOUTH AFTER SEPTEMBER 25, 2001 WILL NOT BE PROCESSED FOR PAYMENT OR REIMBURSEMENT.**

LEGAL NOTICE

This notice constitutes legal notice from Gulf South for the submission of all claims. This notice also constitutes notice of the hearing on the General Health System proposal for funding the wind up plan and notice of the date and manner in which an opposition or objection to that proposal must be made, all as set forth above.

CREDITOR AND OTHER CLAIMS MUST BE SUBMITTED IN WRITING TO:

GULF SOUTH HEALTH PLANS, INC.
ATTENTION:CLAIMS
P. O. Box 14449
Baton Rouge, LA 70898
OR FAXED TO: (225) 237-1813

If you have any questions concerning this notice, please contact Gulf South at (225) 237-1700 or see information about this matter on line at **www.gulfsouth.com.**

THE DEADLINE FOR FILING AND RECEIPT OF YOUR CLAIM IS SEPTEMBER 25, 2001.

FURTHER INFORMATION

If you want further information about Gulf South Health Plans, Inc. and/or this legal proceeding, you may wish to contact your own legal counsel or

GULF SOUTH HEALTH PLANS, INC.
P. O. Box 14449
Baton Rouge, LA 70898
(225) 237-1700
Fax (225) 237-1813
www.gulfsouth.com

Documents available at **www.gulfsouth.com** and at the Clerk of Court, 19th Judicial District:

- Notices to Members, Enrollees, Subscribers, Providers, Creditors and Others
- Court's Wind Up Order
- Wind Up Plan
- General Health System Proposal to Fund Wind Up Plan
- Court's Order Granting Preliminary Approval of Proposal to Fund Wind Up Plan and Setting Hearing Date and Deadlines

EXHIBIT B

NOTICE PROCESS FOR THE WIND UP OF THE
AFFAIRS OF GULF SOUTH HEALTH PLANS, INC.,
A LOUISIANA HEALTH MAINTENANCE ORGANIZATION

NOTICE PROCESS FOR THE WIND UP OF THE AFFAIRS OF GULF SOUTH HEALTH PLANS, INC.

The following is the process proposed by Gulf South Health Plans, Inc. ("GSHP") to send the Notice Of The Cut Off Date For The Filing Of Claims And For Filing Objections To The General Health System Proposal And The Hearing To Consider The General Health System Proposal ("Notice"). It is anticipated that all Notices will be mailed on or before July 25, 2001. GSHP will contract with a mail service vendor. Notices and mailing lists will be given to the mail service vendor in an electronic format acceptable to the vendor. The mail service vendor will be required to mail the Notices and provide GSHP with a printed listing of the names, addresses and date of mailing by noting and signing each page of a written list and signing an affidavit verifying the lists for each Notice or a certificate of mailing from the U. S. Post Office. The addresses used will be the last address known to GSHP for Subscribers, Providers and Creditor/Vendors as defined below. GSHP will retain unopened Notices that are returned as undeliverable or not accepted for verification as necessary.

GSHP will notify anyone requesting a copy of a Notice that the Notices are available on the GSHP web site. If anyone requests that a Notice be sent to them via fax or mail GSHP will respond within five business days of the request. GSHP will maintain a log of requests for Notices. The log will include the date the request is received, the Notice requested, name of the person and entity (if applicable) making the request, address or fax number and date mailed or faxed.

Notices to Members, Enrollees and Subscribers

Gulf South Health Plans, Inc. will obtain reports from its claims payment system to obtain mailing information for Subscribers. This report will include Subscribers who were contracted with GSHP at any time between October 1, 2000 and May 15, 2001, inclusive. A Subscriber means:

1) an individual policy holder who meets all eligibility requirements of Part II (Attachment A), and whose Enrollment Form has been accepted by GSHP in accordance with the enrollment requirement of the Policy; or
2) a person covered through a group policy who meets all eligibility requirements of Part II (Attachment B), and whose Enrollment Form has been accepted by GSHP in accordance with the enrollment requirement of the Policy; or
3) the Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in Gulf South Health Plans/Option 65 and whose enrollment had been confirmed by HCFA; or
4) an Employee or Retiree of the East Baton Rouge Parish School System as defined in Attachment C for whom premium payment has been made.

The Subscriber is responsible for notification to any members or enrollees included in their contract.

Notices to Providers

Gulf South Health Plans, Inc. will obtain reports from its claims payment system to obtain mailing information for Participating Providers. This report will include any health care professional, health care facility or other provider that was contracted directly or indirectly with GSHP to provide health care services to members at any time between October 1, 2000 and May 15, 2001, inclusive.

Notice to Creditor/Vendors

Gulf South Health Plans, Inc. will obtain a report from the General Health System Finance Department to obtain mailing information for Creditor/Vendors. A Creditor/Vendor means any person or entity that provided a service or product to GSHP and is identified in the accounts payable system of General Health System at any time between October 1, 2000 and June 30, 2001, inclusive.

Public Notice

A Public Notice will be placed in newspapers in the major metropolitan areas of New Orleans, Baton Rouge, Shreveport, Monroe, Alexandria, Lafayette, and Lake Charles.

NOTICE OF PROCESS FOR THE WIND UP OF THE AFFAIRS OF GULF SOUTH HEALTH PLANS, INC.

ATTACHMENT A

OOO. *Undisclosed Medical Condition* means a serious, chronic or lingering medical condition a Member had, within the ten (10) years prior to the Effective Date of Coverage, that was not disclosed in the Medical History portion of the Membership Enrollment Form. Conditions not disclosed during the enrollment process will not be covered until twelve (12) months from the date of discovery by Health Plan or three (3) years from the Effective Date of Coverage, whichever occurs first. If intentional Material Misrepresentation or fraud is proven, membership will be terminated.

PPP. *Urgent Care Center* means a non-Hospital based facility which provides health related services that are required to prevent serious deterioration of a Covered Member's health and that are required as a result of an unforeseen sickness, injury or onset of threatening symptoms.

QQQ. *Usual, Customary and Reasonable (UCR) Charge* means the amount charged or the amount Health Plan determines to be the prevailing charge, whichever is less, for a particular health service in the geographical area in which it is performed.

PART II. ELIGIBILITY AND ENROLLMENT.

A. **Who is Eligible for Coverage.**

1. **Subscriber.** To be eligible to enroll as a Subscriber, a person must reside in the Service Area and be:

   a. a US citizen or legal resident for five (5) or more years.
   b. age 0 - 64, not covered by any other health care program, not eligible for Medicare or Medicaid and make application for enrollment, submit all forms and remit the first month's premium to and be accepted by Health Plan. Special conditions are applicable to children under the age of eighteen (18) applying for coverage.

2. **Eligible Family Members.** To be eligible to enroll as a Family Member, a person must be listed on the Enrollment Form completed by the Subscriber, meet all established eligibility criteria, including those relating specifically to Dependents, reside in the Service Area and be:

   a. The Subscriber's present lawful spouse who resides in the same household and is under age 65.
   b. Any unmarried (never married) child, including stepchild, legally adopted child, placement of child by agency for adoption, as well as natural child, of either Subscriber or Subscriber's spouse, to age twenty-one (21), who lives in the Service Area and resides in the household of the Subscriber or Subscriber's spouse (except full-time student), who is chiefly dependent upon the Subscriber for support, and is eligible to be claimed as a Dependent according to the United States Internal Revenue Code and regulations. A Family Member shall also include any child for whom Subscriber or Subscriber's spouse is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Enrollment Form and provided the above criteria are satisfied. A foster child or a child who has been placed in the Subscriber's household is not an eligible Family Member for the purposes of this Policy. A child who is the subject of a Qualified Medical Child Support Order is an eligible Family Member without regard to limitations requiring custody or the ability to claim as a Dependent for income tax purposes.
   c. Any unmarried (never married) child as defined in subsection (b) above, beyond the age of twenty-one (21) to the age of twenty-four (24) who is enrolled and attending classes as a full-time student (full-time student as defined by the college or university, but usually twelve [12] or more credit hours) in an accredited college or university, or a vocational technical, or trade school or institute, or secondary school. Coverage will continue during the summer months provided the Dependent met enrollment requirements during the spring semester. Residency in the Service Area is not required; however, coverage outside the Service Area is limited to Emergency Services only (HMO plans). Upon request of Health Plan, Subscriber agrees to provide proof of full-time student status. **However, the Subscriber must notify Health Plan when a Dependent is no longer a full-time student. If a Dependent is no longer a full-time student, and proper notification is not provided, Health Plan shall have the right to retroactively terminate coverage on the date full-time student status ceased, and to recover from Subscriber any amounts paid for services provided following such date.**

d. Any unmarried (never married) child who upon his or her twenty-first (21st) birthday, or his or her twenty-fourth (24th) birthday if a full-time student, is incapable of self-sustaining employment due to mental retardation or physical handicap that commenced **prior to that child attaining the Limiting Age**, shall continue to be considered a Dependent provided he or she is principally dependent on Subscriber for support. Proof of incapacity and dependency must be submitted to Health Plan within thirty-one (31) days of the date the child reaches the Limiting Age, and subsequently as may be required by Health Plan. Health Plan's determination of eligibility shall be conclusive. In addition, such unmarried child must be a Family Member enrolled hereunder prior to reaching the Limiting Age.

e. Newborn children of Subscriber or Subscriber's spouse or Newly Born adopted child must be enrolled within thirty-one (31) days of birth, and applicable premiums paid from the date of birth.

B. Rules of Eligibility.

1. Premiums due must be paid in full by Subscriber and enrolled Family Member(s).
2. Any Dependent Member other than a natural Newborn child, or Newly Born adopted child, of the Subscriber or Subscriber's spouse must not be confined to a Hospital or other medical facility or confined at home.
3. Eligibility requirements must continue to be met by all Members.
4. No person is eligible to re-enroll hereunder who has had coverage terminated under Part IV (A) (1-7).
5. Limiting Age must not have been met or exceeded, Member must not be eligible for Medicare or Medicaid or obtained age sixty-five (65)..

C. **Enrollment.**

1. **Initial Enrollment.** During the Initial Enrollment Period, a prospective Member shall be entitled to apply for coverage for himself or herself and for any eligible Family Members who must be listed on the Enrollment Form provided by Health Plan.

   No coverage is in force until approved by Health Plan, Subscriber is notified in writing by Health Plan and an Effective Date of Coverage has been assigned. Once approved, benefits may be changed by the Subscriber only on the Policy's Renewal (anniversary) Date.

2. **Newly Eligible Family Members.** Any person attaining eligibility to become a Family Member (e.g., spouse) may be enrolled by the Subscriber by completing a Health Form, including the Medical History portion, along with a completed Member Status Change Form and submitting it to Health Plan within thirty-one (31) days of the Family Member attaining eligibility. The Family Member's coverage shall be effective the first of the month following approval by Health Plan. For a Newborn, or Newly Born adopted child, a Member Status Change Form must be submitted to Health Plan no later that thirty-one (31) days after birth, and applicable premiums paid, for the Newborn or Newly Born adopted child to be covered from date of birth.

3. **Pre-existing Condition.** All Members are subject to Pre-Existing Condition limitations as defined by Part I, (ZZ) and (OOO) above unless provisions of Portability apply and are provided to Health Plan at the time of enrollment for coverage.

4. **Portability.** If Pre-Existing Conditions apply, credit for prior coverage may be used to satisfy the time requirement stated before the condition will be covered in accordance with State and Federal Law.

C. **Delivery of Documents.** Health Plan will provide an Individual Health Maintenance Policy to the Primary Subscriber and Identification Cards to each Member upon approval.

D. **Notice of Ineligibility.** It shall be the Subscriber's responsibility to notify Health Plan of any changes which will affect his or her eligibility or that of Family Members for services or benefits under this Policy.

PART III. EFFECTIVE DATE OF COVERAGE.

Subject to payment of applicable premiums by the Subscriber, Health Plan's receipt of an application from, or on behalf of each prospective Member, and the provisions of this Policy (except as may be otherwise provided in the Individual Enrollment Agreement), coverage under this Policy shall become effective on the earliest of the following dates:

NOTICE OF PROCESS FOR THE WIND UP OF THE AFFAIRS OF GULF SOUTH HEALTH PLANS, INC.

ATTACHMENT B

MMM. ***Professional Services***, ex l as limited or excluded herein, means M. .ically Necessary services, performed by Physicians and health professionals, generally recognized as appropriate care.

NNN. ***Referral*** is an authorization requested by a Member's Primary Care Physician (PCP) or Referral Physician to allow the Member to be seen by another Referral Physician or specialist.

OOO.***Second Surgical Opinion*** is an opinion from a surgeon outside of the original surgeon's practicing group regarding the appropriateness of a recommended surgical procedure.

PPP.***Service Area*** means those parishes in Louisiana in which the Louisiana Commissioner of Insurance has authorized Health Plan to operate.

QQQ.***Skilled Nursing Facility*** means an institution which is licensed by the state in which it is located to provide skilled nursing services and has been approved as a participating Skilled Nursing Facility under the Medicare program.

RRR. ***Subrogation*** is a legal right of Health Plan to recover medical expenses paid on behalf of a Member as the result of negligence of a third party against the Member.

SSS. ***Subscriber*** means a person who meets all applicable eligibility requirements of Part II, and whose Enrollment Form has been accepted by Health Plan in accordance with the enrollment requirements of this Policy.

TTT. ***Substance Abuse*** means the abuse of or the psychological and/or physical addiction or dependence to alcohol or other chemical substance.

UUU. ***Undisclosed Medical Condition*** means a serious, chronic or lingering medical condition a Member had, within the ten (10) years prior to the Effective Date of Coverage, that was not disclosed in the Medical History portion of the Membership Enrollment Form. Conditions not disclosed during the enrollment process will not be covered until twelve (12) months from the date of discovery by Health Plan or three (3) years from the Effective Date of Coverage, whichever occurs first. If intentional Material Misrepresentation or fraud is proven, membership will be terminated.

VVV.***Urgent Care Center*** means a non-Hospital based facility which provides health related services that are required to prevent serious deterioration of a Covered Member's health and that are required as a result of an unforeseen sickness, injury or onset of threatening symptoms.

WWW.***Usual, Customary and Reasonable (UCR) Charge*** means the amount charged or the amount Health Plan determines to be the prevailing charge, whichever is less, for a particular health service in the geographical area in which it is performed.

PART II. ELIGIBILITY AND ENROLLMENT.

A. Who is Eligible for Coverage.

1. **Subscriber.** To be eligible to enroll as a Subscriber, a person must reside in the Service Area and be:

   a. An Eligible Employee of the Group, which is an individual working a minimum of thirty (30) hours per week, forty-eight (48) weeks per year and classified as a full-time Employee of the Group, who is entitled on his or her own behalf to participate in the medical and Hospital benefits arranged by Group, including satisfaction of any probationary or waiting period or other eligibility requirements established by Group; and or
   b. Entitled to coverage under a trust agreement or employment contract.

2. **Eligible Family Members.** To be eligible to enroll as a Family Member, a person must be listed on the Enrollment Form completed by the Subscriber, meet all eligibility criteria established by the Group including those relating specifically to Dependents, reside in the Service Area and be:

   a. The Subscriber's present lawful spouse.

b. Any unmarried (never married) child, including stepchild, legally adopted child, placement of child by agency for adoption, as well as natural child, of either Subscriber or Subscriber's spouse, to age twenty-one (21), who lives in the Service Area and resides in the household of the Subscriber or Subscriber's spouse (except full-time student), who is chiefly dependent upon the Subscriber for support, and is eligible to be claimed as a Dependent according to the United States Internal Revenue Code and regulations. A Family Member shall also include any child for whom Subscriber or Subscriber's spouse is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Enrollment Form and provided the above criteria are satisfied. A foster child or a child who has been placed in the Subscriber's household is not an eligible Family Member for the purposes of this Policy. A child who is the subject of a Qualified Medical Child Support Order is an eligible Family Member without regard to limitations requiring custody or the ability to claim as a Dependent for income tax purposes.

c. Any unmarried (never married) child as defined in subsection (b) above, beyond the age of twenty-one (21) to the age of twenty-four (24) who is enrolled and attending classes as a full-time student (full-time student as defined by the college or university, but usually twelve [12] or more credit hours) in an accredited college or university, or a vocational technical, or trade school or institute, or secondary school. Coverage will continue during the summer months provided the child met enrollment requirements during the spring semester. Residency in the Service Area is not required, however, coverage outside the Service Area is limited to Emergency Services only (HMO plans). Upon request of Health Plan, Subscriber agrees to provide proof of full-time student status. **However, the Subscriber must notify Health Plan when a Dependent is no longer a full-time student. If a Dependent is no longer a full-time student, and proper notification is not provided, Health Plan shall have the right to retroactively terminate coverage on the date full-time student status ceased, and to recover from Subscriber any amounts paid for services provided following such date.**

d. Any unmarried (never married) child who upon his or her twenty-first (21st) birthday, or his or her twenty-fourth (24th) birthday if a full-time student, is incapable of self-sustaining employment due to mental retardation or physical handicap that commenced **prior to that child attaining the Limiting Age**, shall continue to be considered a Dependent provided he or she is principally dependent on Subscriber for support. Proof of incapacity and dependency must be submitted to Health Plan within thirty-one (31) days of the date the child reaches the Limiting Age, and subsequently as may be required by Health Plan. Health Plan's determination of eligibility shall be conclusive.

e. Newborn children of Subscriber or Subscriber's spouse or Newly Born adopted childmust be enrolled within thirty-one (31) days of birth, and applicable premiums paid from the date of birth.

B. **Enrollment.**

IMPORTANT NOTICE REGARDING "SPECIAL ENROLLMENT PERIODS"

If a person declines enrollment for himself/herself or for his/her Dependents (including spouse) because of other health insurance coverage, that person may in the future be able to enroll himself/herself or his/her Dependents in this plan, provided that person requests enrollment within thirty-one (31) days after his other other coverage ends. In addition, if that person has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he/she may be able to enroll himself/herself and his/her Dependents, provided he/she requests enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

1. **Initial Enrollment.** During the initial Group Open Enrollment Period, each Eligible Employee of the Group shall be entitled to apply for coverage for himself or herself and for the Employee's eligible Family Members who must be listed on the Enrollment Form provided by Health Plan.

2. **Newly Eligible Employee.** Each new Employee of the Group entering employment subsequent to the Group's initial enrollment Effective Date shall be permitted to apply for coverage for himself or herself and eligible Family Members, within thirty-one (31) days of becoming eligible, subject to the enrollment regulations in effect with the Group.

3. **Newly Eligible Family Members.** Any person attaining eligibility to become a Family Member (e.g., spouse) may be enrolled by the Subscriber by completing a Member Status Change Form and submitting it

to the Health Plan within thirty-one (31) days of the Family Member's attaining eligibility. The Family Member's coverage shall be effective as of the date he or she attained eligibility, **provided application is made within the required thirty-one (31) days.**

4. **Group Enrollment Period.** A Group Enrollment Period shall be held according to the Group Enrollment Agreement between Group and Health Plan.

5. **Limitation.** Persons initially or newly eligible for enrollment who do not enroll within thirty-one (31) days of becoming eligible may not enroll until the subsequent Group Enrollment Period, unless otherwise qualifying for enrollment under Part II (B) of this Policy - Special Enrollment Periods.

6. **Pre-Existing Condition.** The Group may have Pre-Existing Condition limitations which apply to Part II,(B)(1),(2) and (3) above.

7. **Portability.** If Pre-Existing Conditions apply, credit for prior coverage may be used to satisfy the time requirement stated before the condition will be covered in accordance with State and Federal Law.

C. **Extension of Eligibility.**

1. Approved Leave of Absence under provisions of the Family and Medical Leave Act (FMLA) will extend eligibility and hence coverage, provided full premium due continues to be paid. Group is required to notify Health Plan when eligibility is extended under this provision.
2. Upon death or divorce of the Subscriber, the surviving Family Members who have not reached their Limiting Age, if currently covered under this Policy for at least ninety (90) days and not eligible for medical coverage by another plan, shall have the right to:
   a. Remain on the current plan for up to twelve (12) months provided all other eligibility conditions are met and continue to be met.
   b. Apply for coverage under the provisions of COBRA, or Louisiana Continuation Plan, provided all other eligibility conditions are met.
   c. Obtain Conversion coverage as defined in Part XII (A), (B) without regard to Pre-Existing Conditions.
3. Upon the attainment of the Limiting Age twenty-one (21), or twenty-four (24) if a full-time student, a Covered Dependent child shall have the right to:
   a. Apply for coverage under the provisions of COBRA, or Louisiana Continuation Plan, provided all other eligibility conditions are met.
   b. Obtain Conversion coverage as defined in Part XII (A), (B) without regard to Pre-Existing Conditions.

D. **Delivery of Documents.** Health Plan will provide a Group Health Maintenance Policy to each Subscriber upon enrollment.

E. **Notice of Ineligibility.** It shall be the Subscriber's responsibility to notify Health Plan of any changes which will affect his or her eligibility or that of Family Members for services or benefits under this Policy.

F. **Rules of Eligibility.** No eligible person will be refused enrollment or re-enrollment by Health Plan because of his or her health status, age except as provided in Part II(A), requirements for health services, or the existence, on the Effective Date of coverage under this Policy, of a Pre-Existing physical or mental condition. However, no person is eligible to re-enroll hereunder who has had coverage terminated under Part IV (A)(1) through (7). In addition, no Member's coverage shall be terminated by Health Plan due to health status or health care needs.

PART III. EFFECTIVE DATE OF COVERAGE.

Subject to payment of applicable premiums by the Group for the Subscriber, Health Plan's receipt of an application form, or on behalf of each prospective Member, and the provisions of this Policy (except as may be otherwise provided in the Group Enrollment Agreement), coverage under this Policy shall become effective on the earliest of the following dates:

1. When a person makes written application for membership on or prior to the date he or she satisfies the eligibility requirements of Part II, coverage shall be effective as of the date which Health Plan determines, if all eligibility requirements, including completion of Enrollment Form, are satisfied.

NOTICE OF PROCESS FOR THE WIND UP OF THE AFFAIRS OF GULF SOUTH HEALTH PLANS, INC.

ATTACHMENT C

PART I. DEFINITIONS.

A. "Case Manager" means a Primary Care Physician who is contractually obligated to coordinate all of a Member's medical care and who approves or makes medically necessary referrals for any non-Primary Care Physician services to another Participating Provider or a non-Participating Provider.

B. "Coinsurance" means the applicable percentage of the Usual Customary and Reasonable charge which is due and payable by the Member.

C. "Copayment" means the amount of payment indicated in the Schedule of Benefits and Exclusions (Attachment A) which is due and payable by the Member.

D. "Covered Services" means services, benefits and supplies which are covered under the terms of this Certificate.

E. "Deductible" means the amount payable by the Member before the applicable Coinsurance benefits are payable.

F. "Emergency Services" means those Medically Necessary services provided in connection with an "Emergency." An Emergency is defined as a sudden or unexpected onset of a condition requiring medical or surgical care which the Member secures immediately after the onset of such condition (or as soon thereafter as the care can be made available but which in any case not later than twenty-four (24) hours after the onset) and in the absence of such care the Member could reasonably be expected to suffer serious physical impairment or death. Heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock and other acute conditions as Gulf South shall determine, are Emergencies.

G. "Employee" means a person who meets all applicable eligibility requirements of Part II, and whose Enrollment Form has been accepted by Gulf South in accordance with the enrollment requirements of this Certificate.

H. "Family Members" means those members of the Employee's or Retiree's family who meet the eligibility requirements of this certificate set forth in Part II and who have been enrolled by the Employee or Retiree. For purposes of this Certificate, Family Members may also be referred to as "Dependents".

I. "Group Enrollment Agreement" means the agreement between Gulf South and the School Board whereby Gulf South coverage for Employees and Retirees and their Family Members is elected.

J. "Group Enrollment Period" means those periods of time established by the School Board and Gulf South during which eligible Employees and Dependents of active and retired Employees who are not currently enrolled with Gulf South or other medical coverage offered by the School Board may do so, subject to Evidence of Insurability and Pre-Existing condition limitations.

K. "Gulf South" means Gulf South Health Plans, Inc., a Louisiana corporation licensed by the Louisiana Department of Insurance.

L. "Home Health Agency" means an organization licensed by the state in which it operates and has been approved as a participating Home Health Agency under the Medicare program.

M. "Hospital" means a legally operated facility defined as an acute-care hospital and an institution licensed by the state in which it is located and accredited by the Joint Commission on Accreditation of Hospitals (JCAH), and qualified under the Medicare program.

N. "Hospital Services" (except as limited or excluded herein) means those acute-care services furnished and billed by a Hospital or Skilled Nursing Facility and set forth in Attachment A.

O. "Maximum Out-of-Pocket" means the maximum expenses for which a Family Member or family will be liable for applicable Non-Network services.

P. "Medical Director" means a Physician designated by Gulf South to monitor and review the provision of Covered Services to Members.

The Precertification Penalty is referred to as the Certification Penalty.

BB. "Primary Care Physician" means a Participating Physician who acts as Case Manager and who provides primary care services to Members (e.g. general or family practitioner, internist, pediatrician, or such other physician specialty as may be designated by Gulf South) and is responsible for referrals of Members to Referral Physicians, other Participating Providers and, if necessary, to Non-Participating Providers. Each Member shall select or have selected on his or her behalf a Primary Care Physician.

CC. "Professional Services" (except as limited or excluded herein) means Medically Necessary services, performed by Physicians and health professionals, generally recognized as appropriate care.

DD. "Retiree" (effective July 1, 1993) means an employee who was a covered employee, as defined in G. of this Certificate, immediately prior to the date of retirement and who, upon retirement;

1. immediately received benefits from an approved state or state governmental agency defined benefit plan; or

2. was not eligible for participation in such a plan or had legally opted to not participate in such a plan and

   a. was employed prior to September 16, 1979, has ten years of continuous state service and has reached the age of 65; or
   b. was employed after September 16, 1979, has ten years of continuous state service and has reached the age of 70; or
   c. was employed after July 8, 1992, has ten years of continuous state service, had a credit for a least forty quarters in the Social Security system at the time of employment and has reached the age of 65; or

3. immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility hereunder to the State Employees Group Benefits Program.

EE. "School Board" means the East Baton Rouge Parish School Board.

FF. "Service Area" means those areas set forth in Attachment B of the Group Health Certificate.

GG "Skilled Nursing Facility" means an institution which is licensed by the state in which it is located to provide skilled nursing services and has been approved as a participating Skilled Nursing Facility under the Medicare program.

HH. "Usual, Customary and Reasonable (UCR) Charge" means the amount charged or the amount Gulf South determines to be the prevailing charge, whichever is less, for a particular health service in the geographical area in which it is performed.

PART II. ELIGIBILITY AND ENROLLMENT.

A. An Employee or Retiree and his or her eligible dependents who reside in the Service Area are eligible to enroll in the Point-of-Service Plan.

In the event the husband and wife are both eligible for coverage under the Plan as Employees, all eligible dependent Children will be enrolled Dependents of either the husband or wife. IN NO EVENT MAY A PERSON BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

1. The term Employee as used herein shall mean a full-time Employee of the School Board, who normally works thirty (30) hours or m a week or one whose full-time occupation n ally requires fewer than thirty (30) hours per week. In no event shall any person appointed on a temporary basis be considered an Employee.

2. The term Retiree as used herein shall mean an Employee who was a covered Employee, as defined by the terms of this contract, immediately prior to the date of retirement.

3. The term Covered Person as used herein shall mean an active or retired employee, or his eligible Dependent, or any other individual eligible for coverage under the provisions of continued coverage, for whom the necessary application forms have been completed and for whom the required contribution is being made.

4. The term Dependent as used herein shall mean any of the following persons who are enrolled for coverage as Dependents, provided that they are not also covered as an Employee or Retiree:

   a. The covered Employee's or Retiree's legal spouse;

   b. Any unmarried (never married) children from the date of birth to 21 years of age, dependent upon the Employee or Retiree for support;

   c. Any unmarried (never married) children 19 years of age but under age 24 (eligibility ceases as of Dependent's 24th birthday), who are enrolled and attending classes as full-time students and who depend upon the Employee/Retiree for support. The term full-time student shall mean students who are enrolled at an accredited college or university, or at a vocational, technical, vocational-technical, trade school, institute, or secondary school, for the number of hours or courses which is considered to be full-time attendance by the institution the student is attending.

      It shall be the responsibility of the Member to furnish proof acceptable to the School Board and Gulf South documenting the full-time student status of a dependent child each semester, or as required by the School Board or Gulf South.

      In addition, any unmarried (never married) Dependent who upon attaining age 21, or age 24 if a full-time student, is incapable of self-sustaining employment due to mental retardation or physical handicap that commenced prior to that child attaining the limiting age, shall continue to be considered a Dependent provided he or she is principally dependent on you for support. Proof of incapacity and dependency must be submitted to the School Board within thirty (30) days of the date the child reaches the limiting age. The School Board has the right to require proof of continuation of such incapacity at any time.

      Newly hired Employees <u>may</u> cover a handicapped child older than age 24 if the School Board and Gulf South are notified at time of hiring that the child is handicapped and meets criteria.

5. The term Children as used herein shall mean:

   a. Any natural or legally adopted Children of the Employee or Retiree and/or the Employee's/Retiree's legal spouse dependent upon the Employee/Retiree for support;

   b. Any children in the process of being adopted by the covered Employee/Retiree through an agency or private adoption who are living in the household of the Employee/Retiree and who are or will be included as dependents on the Employee's/Retiree's federal income tax return for the current or next tax year (if filing is required); and

   c. Such other Children for whom the Employee/Retiree has legal custody, who live in the household of the Employee/Retiree, and who are, or will be included as dependents on the Employee's/Retiree's federal income tax return for the current or next tax year (if filing is required); and

d. Grandchildren [illegible] whom the Employee/Retiree does not have legal custody, who are dependent upon the Employee/[illegible]ree for support, and one of whose parents is a covered dependent as defined in this section. If the Employee/Retiree seeking to cover a grandchild is a paternal grandparent, the School Board shall require the biological father, i.e., the covered son of the plan member, execute an acknowledgement of paternity in accordance with Louisiana law (effective July 1, 1991).

If the dependent parent becomes ineligible for coverage under the terms of this Certificate, the grandchild becomes ineligible, unless the Employee/Retiree has legal custody of the grandchild.

6. The term Date Acquired as used herein shall mean the date a Dependent of a covered Employee or Retiree is acquired in the following instances and on the following dates only:

a. Legal Spouse - date of marriage;

b. Children:

(1.) Natural or legally adopted Children - the date of birth or the date of judgment granting adoption;

(2.) Children in the process of being adopted through an agency or private adoption - the earlier of;
(a.) the date the child comes to live with and becomes dependent on the covered Employee or Retiree for support, or

(b.) the date the adoption contract or agreement was executed;

(3.) Other children living in the household of the covered Employee or Retiree who are, or will be included as dependents on the Employee's or Retiree's federal income tax return - the date of the order granting legal custody;

(4.) Grandchildren meeting the eligibility requirements as stated previously (PART II, A, 5), the earlier of;

(a.) the date of the court order granting legal custody, or

(b.) the first date the grandchild comes to live with and becomes dependent on the covered Employee or Retiree for support.

7. Effective Date of Coverage.

a. Employees

An Employee will become eligible for coverage on the first day of the month immediately following the completion of one calendar month of employment as a full-time Employee, provided the Employee meets all eligibility requirements and is actively at work. If the Employee is not actively at work on the date coverage would be effective or on the date the amount of insurance would change due to a change in employee classification, the Employee will become effective on the date he/she returns to active employment.

If coverage is not elected within thirty (30) days of becoming eligible for coverage,, the Employee will be considered an Overdue Applicant and will be subject to Part XI (P). Refer to 8. Overdue Applicants, in this section for effective dates of coverage.

b. Retirees

A Retiree is eligible on the first day of the month following the date of retirement, provided the Employee meets all eligibility requirements and the Employee and employer have agreed to make and are making the required contribution.

Retirees are no' gible to apply for coverage as Late Applica

c. Dependents

The Employee or Retiree must be insured in order for Dependents to be covered.

If a Dependent, other than a newborn, is confined at home, in a nursing home, hospital or elsewhere, by reason of disease, illness, accident or injury on the date he or she would otherwise become effective under this Plan, the effective date of that Dependent's coverage shall be deferred until the date confinement terminates or disability ends, whichever is later.

If dependent coverage is elected within thirty (30) days of the date the Employee became eligible for coverage, coverage shall be effective on the same date as the covered Employee. If application for dependent coverage is received more than thirty (30) days after the date the covered Employee was eligible to elect coverage, the dependent will be considered an Overdue Applicant and will be subject to Part XI (P).

For newly eligible dependents, if application is received within thirty (30) days of the Date Acquired, the dependent will become effective as of the Date Acquired. If application for dependent coverage is received more than thirty (30) days after the Date Acquired, the dependent will be considered an Overdue Applicant and will be subject to Part XI (P).

8. Overdue Applications

The terms of the following paragraphs shall apply to all eligible Employees and Dependents of active and retired Employees for whom application for coverage was not made within the time limitations listed in the preceding section, Effective Date of Coverage.

Gulf South will require that all Overdue Applicants complete an "Evidence of Insurability" form and sign an "Acknowledgement of Pre-Existing Condition" form.

The effective date of coverage shall be a) the first of the month following the date of receipt by the School Board of all required forms, if such forms are received prior to the fifteenth of the month, or b) the first of the second month following the date of receipt by the School Board of all required forms, if such forms are received on or after the fifteenth of the month.

Medical expenses incurred during the first 24 months that coverage is in force under this contract will not be considered as covered medical expenses if they are in connection with a disease, illness, accident or injury that manifested itself or was diagnosed, treated, or for which drugs were prescribed during the 12-month period immediately prior to the effective date of such coverage.

9. Reenrollment, Previous Employment (Rehired Employees)

An application for coverage by an Employee of a participating employer whose employment is terminated while covered or eligible for coverage under this plan, and who is reemployed by the same or another participating employer within 12 months of the effective date of termination, shall be considered a reenrollment, previous employment application. A reenrollment, previous employment applicant will be eligible for only that classification of coverage in force on the effective date of termination, subject to all modifications of eligible expenses, benefits, and/or premiums which became effective in the interim. Application must be made within thirty (30) days of the date of rehire.

B. Enrollment

1. Newly Eligible Employee. Each new Employee of the School Board entering employment subsequent to the School Board's initial enrollment effective date shall be permitted to apply without proof of insurability for coverage for him or herself and eligible Family Members, within thirty (30) days of employment subject to the enrollment regulations in effect with the School Board.

2. Newly Eligible Family mbers. Any person attaining eligibility to b me a Family Member may be enrolled by the Employee by completing a Member Status Change Form and submitting it to the School Board within thirty (30) days of the Family Member's attaining eligibility. No proof of insurability shall be required.

3. Point of Service Election. At each School Board Enrollment, eligible Employees of the School Board who live in Gulf South's Service Area shall be entitled to apply for coverage as an Employee in the Point-of-Service Plan. Also, the Employee's Family Members, for whom application has been made, will be enrolled in the Point-of-Service Plan.

   Those Employees who do not reside in Gulf South's Service Area may elect to participate either in the Out-of-Area Plan or in the Point-of-Service Plan for the entire year. The Employee's Family Members, for whom application has been made, will also be enrolled in the Plan chosen by the Employee.

   Those newly hired Employees who become eligible for coverage during a Plan year may enroll in the Point-of-Service Plan or in the Out-of-Area Plan according to the rules stated above.

C. Delivery of Documents. Gulf South will provide a Group Health Plan Certificate to each Employee upon enrollment.

D. Notice of Ineligibility. It shall be the Employee's responsibility to notify Gulf South of any changes which will affect his or her eligibility or that of Family Members for services or benefits under this Certificate.

E. Rules of Eligibility. No eligible person will be refused enrollment or re-enrollment by Gulf South because of his or her health status, age (except as provided in Part II(A), requirements for health services, or the existence, on the effective date of coverage under this Certificate, of a pre-existing physical or mental condition, including pregnancy. However, no person is eligible to re-enroll hereunder who has had coverage terminated under Part III (A)(1) and (2). In addition, no Member's coverage shall be terminated by Gulf South due to health status or health care needs. Pre-existing conditions established by Gulf South will apply with respect to Overdue Applicants as described by Part II (A)(8) and (B)(4) under this Certificate.

PART III. TERMINATION OF COVERAGE.

A. Termination of Employee or Retiree Coverage. Coverage under this Certificate will terminate on the earliest of the following dates:

1. If the Group Enrollment Agreement is terminated, Employee's coverage under this Certificate shall also terminate on the effective date of the termination of the Group Enrollment Agreement.

2. On the contribution due date if the group or agency fails to pay the required contibution for the covered Employee, except when resulting from clerical or other inadvertent error on the part of the group or agency.

3. On the contribution due date if the covered person fails to make any contibution which is required for the continuation of his coverage.

4. On the last day of the month of the covered Employee's death.

B. Termination of Dependent Coverage. Coverage under this Certificate will terminate on the earliest of the following dates:

1. On the date the covered Employee ceases to be covered with respect to himself under this Certificate.

2. When the covered Employee's Dependent, other than a legal spouse, becomes eligible for coverage as an Employee under this contract.

3. On the last day of the month in which the Dependent, as defined in this Certificate, ceases to be an eligible Dependent of the covered Employee.

19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

NUMBER: DIVISION:

J. ROBERT WOOLEY, AS ACTING COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA
VERSUS
GULF SOUTH HEALTH PLANS, INC.

FILED:_____ _____
DEPUTY CLERK

ORDER

Considering the ex parte motion (1) to amend the cut off date for filing of claims, (2) for approval of the form of the notice of the cut off date for the filing of claims and for filing objections to the General Health System Proposal and the hearing to consider the General Health System Proposal, and (3) for approval of the notice process for the wind up of the affairs of Gulf South Health Plans, Inc., ("Gulf South") filed herein, and the Court finding that mover is entitled to the relief requested and granted herein,

IT IS ORDERED, ADJUDGED AND DECREED that September 25, 2001 is established as the cut off date by which claims of enrollees, subscribers, members, providers, and creditors of Gulf South must be submitted and received by Gulf South (the "Claims Bar Date").

IT IS ORDERED, ADJUDGED AND DECREED that the form of the three notices proposed for notice of the Claims Bar Date, notice of the date for filing objections to the General Health System proposal, and notice of the date of the hearing to consider the General Health System proposal -- the Notice To Providers, the Notice to Members, Enrollees, and Subscribers, and the Notice to Creditors and Others -- copies of which are attached to the motion filed herein, be and same are approved.

IT IS ORDERED, ADJUDGED AND DECREED that the notice process for the wind up of the affairs of Gulf South, a copy of which is attached to the motion filed herein, be and same is approved.

Baton Rouge, Louisiana, this ___ day of _____, 2001.

_____
JUDGE

CONSENTED TO AND AGREED TO BY:

GENERAL HEALTH SYSTEM

By: _____
Its authorized representative
David S. Rubin

GULF SOUTH HEALTH PLANS, INC.

By: _____
Its authorized representative