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## 2021 IMPORTANT NOTICES

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1. Medicare Part D Notice
2. Women's Health and Cancer Rights Act
3. HIPAA Special Enrollments Rights
4. HIPAA Notice of Privacy Policy and Practices
5. COBRA General Notice
6. Medicaid and the Children's Health Insurance Program (CHIP)

# Required Notices

## Important Notice from Chouest Group Health About Your Prescription Drug Coverage and Medicare under the Blue Cross Blue Shield of Louisiana Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Chouest Group Health and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Chouest Group Health has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Louisiana plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Chouest Group Health coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Chouest Group Health coverage, be aware that you and your dependents will not be able to get this coverage back.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Chouest Group Health and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed at the end of these notices for further information.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Chouest Group Health changes. You also may request a copy of this notice at any time.

## For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- » Visit [www.medicare.gov](http://www.medicare.gov)
- » Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- » Call 1-800-MEDICARE (1-800-633-4227).  
TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

*Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).*

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Date:	January 1, 2021
Name of Entity/Sender:	Chouest Group Health
Contact—Position/Office:	Human Resources
Address:	16201 East Main Street Houma, LA 70363
Phone Number:	985-601-4203

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## Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- » Reconstruction of the breast on which a mastectomy has been performed
- » Surgery and reconstruction of the other breast to produce a symmetrical appearance
- » Prostheses
- » Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at 985-601-4203.

## HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 985-601-4203.

## HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- » Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- » Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- » Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- » Failing to return from an FMLA leave of absence; and
- » Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 985-601-4203.

**Effective Date:** January 1, 2021

**NOTICE OF PRIVACY PRACTICES FOR  
CHOUEST GROUP HEALTH PLAN PARTICIPANTS AND  
THEIR COVERED SPOUSES AND DEPENDENTS**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

As used in this notice, the term "Plan" refers to the Chouest Group Health Plan, the term "Company" refers to Galliano Marine Service, LLC (and those of its affiliates, if any, who have employees covered by the Plan), the term "Participant" refers to an individual who is or was a Participant in the Plan and thereby entitled to health benefits under the Plan and the term "Potential Participant" refers to an individual who may at sometime become a Participant but who is not yet a Participant. If you have any questions about this notice, please contact the Contact Person of the Plan. The Plan's Contact Person can be reached as follows:

Gina Cheramie  
Benefits Director  
Galliano Marine Service, LLC  
16201 East Main Street  
Cut Off, LA 70345  
(985) 601-4203

**WHY WE ARE PROVIDING THIS NOTICE.**

The Company sponsors the Plan for the benefit of certain of its employees, certain of their family members and their designated domestic partners. As a necessary part of the operation and administration of the Plan, the Company's employees and entities such as claims administrators, COBRA vendors and case management companies (and their employees, agents and representatives) (the "Business Associates") may have access to individually identifiable health information of Participants and Potential Participants which is protected under applicable federal law (such information is sometimes referred to as "PHI"). Federal law (i.e., the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) requires that access to PHI be limited and that individuals and entities having access to PHI be restricted in their use and disclosure of PHI. The purpose of this notice is to provide you with information regarding your PHI privacy rights and certain special protections for genetic information.

**WHO WILL FOLLOW THIS NOTICE**

The privacy practices described in this notice will be followed by the Plan and its fiduciaries (i.e., the people who operate the plan, such as the Company's Benefits and Compensation Committee), the Plan's Business Associates and, to the extent they are involved in the operation and administration of the Plan or its sponsorship, by the Company, its employees and agents.

**GENERAL RULES REGARDING HEALTH INFORMATION:**

Information about you and your health is personal. The Plan is committed to protecting health information about you which is obtained in connection with the operation and administration of the Plan. This notice will tell you about the ways in which the Plan may use and disclose health information about you to someone other than yourself (or your

legal representative). It also describes your rights regarding and certain obligations the Plan has regarding the use and disclosure of health information.

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- follow the terms of the Plan's privacy practices notice that is currently in effect.

## **HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.**

The following categories describe different ways that the Plan uses and may disclose PHI. For each category of uses or disclosures this notice will explain what it means and, in some cases, try to give some examples. Not every use or disclosure in a category will be listed. In addition, many of the uses and disclosures may be performed on the Plan's behalf by Business Associates, the Company and its employees or agents. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories and in most cases the amount of health information used or disclosed will be limited to the minimum necessary amount (determined under a standard defined in HIPAA).

- **For Treatment.** The Plan may receive, use and disclose health information about you to provide you with or help you to obtain health treatment (i.e., providing, coordinating or managing your health care) or services. For example, the Plan may request and receive from a doctor who is treating you, information about the health condition for which you are seeking treatment in order to determine if the treatment you are seeking (for instance, cosmetic surgery) is not covered by the Plan. As another example, the Plan may request a doctor who is recommending that you obtain treatment from a specialist for health information regarding your condition to determine if the specialist referral is for ordinary and necessary medical treatment that is covered by the Plan.
- **For Payment.** The Plan may receive, use and disclose health information about you so that the bills for health treatment and services you have received may be paid by a Plan. For example, the Plan may need to have information about a surgery which you have received provided to the Plan to determine if the charges for such surgery exceed the reasonable and customary charges for such surgery to determine what portion of such charges should be paid by the Plan. The Plan might also need to receive information about a health condition which you have in order to preauthorize a given health procedure for that condition where such approval is required in advance of your obtaining that procedure in order to qualify for any payment by the Plan for the procedure or for payment by the Plan at a more favorable reimbursement rate for procedure. Similarly, the Plan may receive use and disclose health information to fiduciaries of the Plan in order to provide them with information necessary to process an appeal that you file with respect to a claim for Plan benefits which has been modified or denied. Other payment activities of the Plan with respect to which the Plan may use and disclose health information about you include claims management, risk adjustment, reinsurance, collection and other "behind the scenes" Plan functions.
- **For Health Care Operations.** The Plan may receive, use and disclose health information about you for purposes of the Plan's operations such as underwriting (except as prohibited with respect to the use and disclosure of genetic information), premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, for legal or auditing functions or for general management and administrative activities. For instance, the Plan may request from any insurer currently funding or providing medical benefits under the Plan information relating to your and other Plan Participants' health procedures and treatments over a prior period in order to provide other insurers with information to

make knowledgeable bids to insure benefits under the Plan for future periods. Also, the Plan might use information about your Plan claims to review the effectiveness of wellness programs or cost containment measures.

- **Plan Sponsor Information Request.** The Plan may disclose to the Company at the request of the Company summary health information (i.e., information that summarizes the claims history, claims expenses or type of claims experienced by Participants under the Plan) for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or modifying, amending or terminating the Plan. For example, the Company may request summary health information about Plan Participants' claims over a given period to determine ways in which the Plan design may be changed in the future to reduce the costs of providing the Plan. The Plan may also disclose to the Company information on whether a person is participating in the Plan or is enrolled in or has disenrolled from a health insurance or health maintenance organization offered by the Plan. The Company can only be provided other health information regarding Plan Participants for use by persons identified in the Plan documents, such as the employees in the Company's Benefits Department, and for the purpose or purposes described in the Plan document, such as specific plan administration activities, and only if the Plan documents restrict use and disclosure of such information by the Company and establish adequate separation between the Plan and the Company with respect to the use and disclosure of PHI. In addition, the Plan must provide that it will disclose PHI to the Company only upon receipt of a certification from the Company that the Plan documents have been amended to incorporate these restrictive provisions and that the Company agrees to comply with such restrictions. A summary of such restrictive provisions may also be obtained at any time, without charge, from the Plan's Contact Person.
- **Disclosure to You.** The Plan may disclose your medical information to you.
- **Individuals Involved in Your Care or Payment for Your Care.** Unless you advise the Plan otherwise by completing the attached Disclosure Objection Form and returning a copy of such completed form to the Plan's Contact Person, the Plan will be entitled to disclose protected health information that is relevant to your health care treatment under the Plan or payment for such treatment as follows: if you are married, to your spouse; if you have a domestic partner which you have designated as such under the Company's domestic partner benefit policy, to your domestic partner; and if you are covered by the Plan as a child (regardless of whether you have obtained the age of legal majority), to either of your parents (which may include a stepparent). The Plan will have the right to make such disclosures for as long as you are covered by the Plan (including coverage following reenrollment should you for any reason discontinue your Plan coverage and thereafter reenroll in the Plan) or have claims pending with the Plan following the termination of your coverage. However, you may file a Disclosure Objection Form at any time if you want the Plan to cease making family member or domestic partner disclosures as described above. Your Disclosure Objection Form should be returned to the Plan's Contact Person at the address noted on the first page of this notice.
- **Disclosures to Business Associates.** The Plan may disclose your medical information to a Business Associate and the Business Associate will be required to appropriately safeguard your medical information and use or disclose it only for permitted purposes.
- **To Notify of a Data Breach.** In the unlikely event that there is an unauthorized acquisition, access, use, or disclosure of your medical information that compromises the security or privacy of this information, the Plan is generally required to provide you written notice concerning this data breach no later than 60 days from the date the breach was discovered. For this purpose, security or privacy is generally considered compromised when the unauthorized acquisition, access, use, or disclosure of the medical information poses a significant risk of financial, reputational or other harm to you.

- **Marketing.** The Plan may use or disclose your medical information for purposes of marketing products or services if the particular marketing activity either occurs face-to-face with you or involves giving you an inexpensive item that promotes the Plan.
- **Limited Data Set.** The Plan may use or disclose your medical information for purposes of health care operations, research, or public health activities if the information is stripped of direct identifiers and the recipient agrees to keep the information confidential.
- **Pursuant to Your Authorization.** Other uses and disclosures of health information not covered by this notice or the laws that apply to the Plan will be made only with your written permission. If you provide the Plan permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures already made with your permission, and that the Plan is required to retain its records regarding your protected health information which the Plan has obtained.
- **As Required By Law.** The Plan may disclose PHI about a Participant when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose PHI about a Participant when necessary to prevent a serious health and safety threat.
- **Specialized Governmental Functions.** The Plan may disclose PHI about a Participant as required by military command authorities (including appropriate foreign military authority in the case of foreign military personnel). The Plan may also release PHI about a Participant in connection with: national security and intelligence activities and protective services for governmental officials.
- **Workers' Compensation.** The Plan may disclose PHI about a Participant for workers' compensation or similar programs.
- **Lawsuits and Disputes.** Subject to a number of protective requirements and restrictions, the Plan may disclose PHI about a Participant in response to (i) a court or administrative order and (ii) a subpoena, discovery request, or other lawful process by someone else involved in the dispute.
- **Law Enforcement.** The Plan may disclose PHI about a Participant if asked to do so by a law enforcement official for law enforcement purposes or in response to certain court orders or in the course of judicial or administrative proceedings.
- **Inmates.** If a Participant is an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose PHI about the Participant to the correctional institution or law enforcement officials to: provide the Participant with health care; protect the Participant's health and safety or the health and safety of others; or protect the safety and security of the correctional institution.
- **Public Health Activities.** The Plan may disclose PHI about a Participant to persons who may be at risk of contacting or spreading a disease or condition, to public health authorities to prevent or control disease or to report child abuse or neglect and to the Federal Food and Drug Administration with respect to adverse events or product defects.
- **Victims of Abuse, Neglect or Domestic Violence.** The Plan may disclose PHI about a Participant to governmental authorities authorized by law to receive reports of abuse, neglect or domestic violence as required by law or if the Participant agrees or the Plan believes the disclosure is necessary to prevent serious harm.

- **Decedents.** The Plan may disclose PHI about a Participant to a coroner or medical examiner to identify a deceased or determine the cause of death and to funeral directors to carry out their duties.
- **Organ, Eye or Tissue Donations.** The Plan may disclose PHI about a Participant to organ procurement organizations or other entities to facilitate organ, eye or tissue donations and transplantations.
- **Research Purposes.** The Plan may disclose PHI about a Participant subject to special rules and restrictions under HIPAA to facilitate medical research.
- **Health Oversight Activities.** The Plan may disclose PHI about a Participant for activities authorized by law for oversight of the health care system, government benefit programs and compliance with regulatory programs or civil rights laws.
- **Department of Health and Human Services.** The Plan may disclose PHI about a Participant to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rules.
- **Incidental Uses and Disclosures.** Uses and disclosures that occur incidentally with a use or disclosure described above in this notice may occur, as long as the Plan has implemented and followed reasonable safeguards to limit such uses and disclosures.

**Special Protections For Genetic Information.** In accordance with the Genetic Information Nondiscrimination Act of 2008, the Plan is not permitted to use or disclose your genetic information for underwriting purposes, which generally includes (1) determining your eligibility for benefits under the Plan, (2) computing the premium amounts for Plan coverage, (3) applying any pre-existing condition exclusion under the Plan, and (4) other activities related to the creation, renewal, or replacement of health benefits. In general, and subject to certain exceptions, your genetic information includes genetic tests of you and your family members (up to the fourth degree of kinship), family medical histories, and genetic counseling and education.

## **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding health information the Plan has about you:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of all health information that the Plan has about you. Usually, this includes health and billing records, but according to the HIPAA privacy rules does not include psychotherapy notes. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Plan's Contact Person. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may file a complaint with the Plan's Contact Person or the Secretary of Health and Human Services.

If the Plan maintains an electronic health record containing your medical information, you have the right to request that a copy of this medical information be sent in an electronic format to you or to a clearly designated third party. An "electronic health record" is an electronic record of health-related information that is created, gathered, managed, and consulted by authorized health care clinicians and staff. The Plan may charge a reasonable fee for sending the electronic copy of your medical information.

- **Right to Amend.** If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan's Contact Person. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that: was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the health information kept by or for the Plan; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures made by the Plan of health information about you for reasons other than treatment, payment or health care operations or pursuant to your authorization. To request this list or accounting of disclosures, you must submit your request in writing to the Plan’s Contact Person. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. If the Plan agrees, it will comply with your request unless the information is needed to provide you emergency treatment or required by law until you or the Plan cancels the limitation. To request restrictions, you must make your request in writing to the Plan’s Contact Person. In your request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit its use, disclosure or both; and (3) to whom you want the limits to apply.

The Plan is generally not required to agree to your request for restrictions. However, except as otherwise required by law, a covered entity (such as the Plan or a health care provider) must agree to certain requested restrictions if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment) and relates solely to a health care item or service for which the health care provider has been paid out of pocket in full. For example, this means that a doctor or other health care provider generally must agree to your request to not send medical information to the Plan in certain circumstances if the medical information concerns an item or service for which you have paid the provider out of pocket in full.

- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Plan’s Contact Person. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Copy of This Notice.** You may ask us to give you a copy of this notice at any time. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain an electronic copy of this notice at the following website: [www.chouest.com](http://www.chouest.com).

## CHANGES TO THIS NOTICE

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for health information the Plan already has about you as well as any information it receives in the future. The Plan will post a copy of the current notice in the Company’s Benefits Office and at the website set forth in the above paragraph. The effective date of notice will be written on the notice’s first page.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Plan's Contact Person or with the Secretary of the Department of Health and Human Services. A complaint filed with the Plan's Contact Person must be submitted in writing and must comply with the Plan's privacy right complaint procedures. A copy of such procedures can be obtained from the Plan's Contact Person without charge upon written request.

**You will not be penalized for filing a complaint.**

You may contact Department of Health and Human Services by telephone at 1-800-368-1019, by electronic mail at [ocrprivacy@hhs.gov](mailto:ocrprivacy@hhs.gov), or by regular mail addressed to:

Director, Office of Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201

## **HEALTH PROVIDERS AND YOUR HEALTH INFORMATION.**

Health providers (such as doctors, medical clinics, health maintenance organizations, hospitals, etc.) may also use and disclose health information about you. You also have rights regarding the health information which they obtain and have about you. You should consult the notices of privacy practices which you receive from health care providers for information regarding how and under what circumstances they may use and release your health information and what rights you have with respect to their practices regarding your health information.

## **MISCELLANEOUS**

The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you, subject to limits imposed by law.

US 1595087v.2

## **\*\* Continuation Coverage Rights Under COBRA\*\***

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### **What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

### When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:**

#### Notice Procedures:

Any notice that you provide must be in *written*. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department, or firm listed below, at the following address:

Gina Cherie  
Benefits Director  
16201 East Main Street  
Cut Off, LA 70345  
985-601-4203

### How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### ***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

**You must make sure that the Plan Administrator or its designee is notified in writing**

### ***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period<sup>1</sup> to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

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<sup>1</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

## **If you have questions**

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

## **Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **Plan contact information**

Gina Chermic  
Benefits Director  
16201 East Main Street  
Cut Off, LA 70345  
985-601-4203

# Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –**

## ALABAMA – Medicaid

WEBSITE <http://myalhipp.com/>  
PHONE 1-855-692-5447

## ALASKA – Medicaid

WEBSITE The AK Health Insurance Premium Payment Program  
<http://myakhipp.com/>  
PHONE 1-866-251-4861  
EMAIL [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
MEDICAID ELIGIBILITY <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

## ARKANSAS – Medicaid

WEBSITE <http://myarhipp.com/>  
PHONE 1-855-MyARHIPP (855-692-7447)

## COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

WEBSITE Health First Colorado Website:  
<https://www.healthfirstcolorado.com/>  
PHONE Health First Colorado Member Contact Center:  
1-800-221-3943/ State Relay 711  
CHP+ WEBSITE <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>  
CHP+ PHONE 1-800-359-1991/ State Relay 711

## FLORIDA – Medicaid

WEBSITE <http://flmedicaidtprecovery.com/hipp/>  
PHONE 1-877-357-3268

## GEORGIA – Medicaid

WEBSITE <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>  
PHONE 678-564-1162 ext 2131

## INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64  
WEBSITE <http://www.in.gov/fssa/hip/>  
PHONE 1-877-438-4479  
All other Medicaid  
WEBSITE <http://www.indianamedicaid.com>  
PHONE 1-800-403-0864

## IOWA – Medicaid

WEBSITE <http://dhs.iowa.gov/Hawki>  
PHONE 1-800-257-8563

## KANSAS – Medicaid

WEBSITE <http://www.kdheks.gov/hcf/>  
PHONE 1-785-296-3512

## KENTUCKY – Medicaid

WEBSITE <https://chfs.ky.gov>  
PHONE 1-800-635-2570

## LOUISIANA – Medicaid

WEBSITE <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>  
PHONE 1-888-695-2447

## MAINE – Medicaid

WEBSITE <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>  
PHONE 1-800-442-6003  
TTY: Maine relay 711

## MASSACHUSETTS – Medicaid and CHIP

WEBSITE <http://www.mass.gov/eohhs/gov/departments/masshealth/>  
PHONE 1-800-862-4840

## MINNESOTA – Medicaid

WEBSITE <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>  
PHONE 1-800-657-3739

## MISSOURI – Medicaid

WEBSITE <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>  
PHONE 573-751-2005

## MONTANA – Medicaid

WEBSITE <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>  
PHONE 1-800-694-3084

## NEBRASKA – Medicaid

WEBSITE <http://www.ACCESSNebraska.ne.gov>  
PHONE (855) 632-7633  
Lincoln: (402) 473-7000  
Omaha: (402) 595-1178

## NEVADA – Medicaid

MEDICAID WEBSITE <https://dhcfp.nv.gov>  
MEDICAID PHONE 1-800-992-0900

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**NEW HAMPSHIRE – Medicaid**

WEBSITE <https://www.dhhs.nh.gov/oii/hipp.htm>  
PHONE 603-271-5218  
TOLL FREE FOR 1-800-852-3345, ext 5218  
HIPPI PROGRAM

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**NEW JERSEY – Medicaid and CHIP**

MEDICAID WEBSITE <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>  
MEDIACAI D PHONE 609-631-2392  
CHIP WEBSITE <http://www.njfamilycare.org/index.html>  
CHIP PHONE 1-800-701-0710

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**NEW YORK – Medicaid**

WEBSITE [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)  
PHONE 1-800-541-2831

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**NORTH CAROLINA – Medicaid**

WEBSITE <https://medicaid.ncdhhs.gov/>  
PHONE 919-855-4100

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**NORTH DAKOTA – Medicaid**

WEBSITE <http://www.nd.gov/dhs/services/medicalsev/medicaid/>  
PHONE 1-844-854-4825

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**OKLAHOMA – Medicaid and CHIP**

WEBSITE <http://www.insureoklahoma.org>  
PHONE 1-888-365-3742

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**OREGON – Medicaid**

WEBSITE <http://healthcare.oregon.gov/Pages/index.aspx>  
<http://www.oregonhealthcare.gov/index-es.html>  
PHONE 1-800-699-9075

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**PENNSYLVANIA – Medicaid**

WEBSITE <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthipprogram/index.htm>  
PHONE 1-800-692-7462

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**RHODE ISLAND – Medicaid and CHIP**

WEBSITE <http://www.eohhs.ri.gov/>  
PHONE 855-697-4347  
DIRECT RITE 401-462-0311  
SHARE LINE

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**SOUTH CAROLINA – Medicaid**

WEBSITE <https://www.scdhhs.gov>  
PHONE 1-888-549-0820

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**SOUTH DAKOTA - Medicaid**

WEBSITE <http://dss.sd.gov>  
PHONE 1-888-828-0059

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**TEXAS – Medicaid**

WEBSITE <http://gethipptexas.com/>  
PHONE 1-800-440-0493

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**UTAH – Medicaid and CHIP**

MEDICAID WEBSITE <https://medicaid.utah.gov/>  
CHIP WEBSITE <http://health.utah.gov/chip>  
PHONE 1-877-543-7669

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**VERMONT– Medicaid**

WEBSITE <http://www.greenmountaincare.org/>  
PHONE 1-800-250-8427

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**VIRGINIA – Medicaid and CHIP**

MEDICAID WEBSITE [http://www.coverva.org/programs\\_premium\\_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
MEDIACAI D PHONE 1-800-432-5924  
CHIP WEBSITE [http://www.coverva.org/programs\\_premium\\_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)  
CHIP PHONE 1-855-242-8282

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**WASHINGTON – Medicaid**

WEBSITE <https://www.hca.wa.gov/>  
PHONE 1-800-562-3022 ext. 15473

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**WEST VIRGINIA – Medicaid**

WEBSITE <http://mywvhipp.com/>  
PHONE Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)

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**WISCONSIN – Medicaid and CHIP**

WEBSITE <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>  
PHONE 1-800-362-3002

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**WYOMING – Medicaid**

WEBSITE <https://wyequalitycare.acs-inc.com/>  
PHONE 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**

Employee Benefits Security Administration  
**[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)**  
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**

Centers for Medicare & Medicaid Services  
**[www.cms.hhs.gov](http://www.cms.hhs.gov)**  
1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.