

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER

HEALTH PLAN NOTICES

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 - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
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IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan’s prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, “Important Notice From **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER About Your Prescription Drug Coverage and Medicare.”**

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Creditable

INSTRUCTIONS FOR ACCOUNT TEAMS AND PLAN SPONSOR

This notice applies to both ERISA and non-ERISA plans that provide prescription drug coverage, and should be provided to each person enrolled in the plan or who is seeking enrollment in the plan, who is also “Medicare-eligible,” which in this context means actually enrolled in or covered by Medicare Parts A or B. Because you may not be able to identify all these individuals, many sponsors simply issue this notice to all covered employees, retirees, COBRA beneficiaries, etc.

Under federal rules, this notice is supposed to be provided at a variety of times, but a sponsor is only required to give the notice once in any 12-month period, unless the creditable or non-creditable nature of the health plan’s prescription drug coverage changes during that 12-month period, or unless an individual requests the notice again.

The attached notice is a generalized Medicare Part D notice. A personalized notice of creditable (or non-creditable) coverage may be supplied upon the request of an individual. Your Lockton Account Team can help you prepare a personalized notice, if one is requested.

Literally, the notice should be supplied prior to each October 15 (the start of Medicare Part D’s annual enrollment period), but many sponsors include the notice in an open enrollment packet, and rely upon the “once every 12 months” rule to avoid giving the notice again, prior to each October 15. However, this only works for employees hired before the October 15th date if the Medicare Part D coverage notice is separately provided upon hire (whether included within the initial benefit eligibility packet or otherwise).

This notice may be mailed or hand-delivered. Posting the notice is not adequate. Notice may be provided electronically to individuals who have adequate means to access electronic information, but they must first consent to receiving the notice electronically. Your Lockton Account Service Team can supply you with additional information about electronic disclosure requirements.

If this notice were given separately, it would have to be hand-delivered or mailed to the participant’s home (however, mailing to the home is not adequate if the plan knows a person enrolled in Medicare Parts A or B resides elsewhere. In that case, the plan should mail a separate notice to such individual). These same rules, then, apply to how this packet should be delivered.

Text highlighted in yellow indicates information that should be verified or inserted.

WARNING: The notice may be combined with other plan-related materials, including initial or open enrollment materials, but in order to do that, you must place a conspicuous warning on the cover of the packet, informing the recipient that the packet contains a Medicare Part D notice. A sample text box appears below, for cutting and pasting.

**IMPORTANT NOTICE FROM MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE
REGIONAL MEDICAL CENTER ABOUT
YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** has determined that the prescription drug coverage offered by the **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan 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. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this

higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** Plan 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 below.

If you do decide to join a Medicare drug plan and drop your **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

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

Contact the person listed below for further information, or call **307-633-7700**. **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 **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** changes. You also may request a copy.

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.
- 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, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage 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 whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2024
Name of Entity/Sender: MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA
CHEYENNE REGIONAL MEDICAL CENTER
Contact—Position/Office: Cheyenne Regional Benefits Team
Address: 214 E 23rd St
Cheyenne, WY 82001
Phone Number: 307-633-7700
benefits@crmcwy.org

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

**HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY
AND PROCEDURES**

INSTRUCTIONS FOR ACCOUNT TEAMS AND PLAN SPONSOR

This HIPAA Privacy Notice applies to both ERISA and non-ERISA health plans subject to the HIPAA privacy rules (e.g., self-insured plans, and insured plans that have gone “hands on” enrollees’ “protected health information.” A plan’s HIPAA Privacy Notice requires some customization, so be careful to use this model merely as a guide.

A plan should supply its HIPAA privacy notice, if required, to individuals upon their enrollment, and upon request. This notice must be re-issued within 60 days after a material change to its contents. Every three years a plan is required to provide a *reminder* to enrollees, that a copy of the privacy notice is available upon request. Rather than keep track of such 3-year windows, many plan sponsors simply include the privacy notice in open enrollment packets or other benefit communication materials.

The privacy policy must be individually delivered to the participant. Posting on a website or making the notice available to the participant (such as by posting or making copies available at the workplace) will not substitute for the required actual delivery. But special or separate mailings are *not* required; delivery to the enrolled participant is deemed to be delivery to all of his or her dependents. If a dependent asks for a separate notice, however, the plan must supply it.

The plan may include the privacy notice with other written materials that are mailed to the participant or include the notice with an SPD or with enrollment materials. The policy may be e-mailed if the participant has agreed to receive an electronic notice. Your Lockton Account Service Team can supply you with additional information about electronic disclosure requirements.

If a health plan maintains a website that contains information about the plan’s customer services or benefits, the plan must post its notice of privacy practices on the website and must make the notice available electronically through the website. This is typically more an issue for insurance carriers than for employer plan sponsors.

Text highlighted in **yellow** indicates information that should be verified or inserted.

**This is a sample, model HIPAA Privacy Notice document.
A plan's (or plans') HIPAA Privacy Notice requires some customization so be careful to use this model merely as a guide, reflecting the type and nature of information required to be reflected in a privacy notice.**

**MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL
CENTER**

**IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES**

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.

This notice is provided to you on behalf of:

**MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL
CENTER HEALTH & WELFARE BENEFIT PLANS ***

*** This notice pertains only to healthcare coverage provided under the plan.**

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
 - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment

team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
 - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER**) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
 - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
 - **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
 - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
 - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
 - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
 - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
 - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
 - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is

required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan’s Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan’s privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan’s Privacy Official, the person responsible for ensuring compliance with this notice, is:

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL
CENTER
Cheyenne Regional Benefits Team
307-633-7700
benefits@crmcwy.org

Effective Date

The effective date of this notice is: January 1, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

INSTRUCTIONS FOR ACCOUNT TEAMS AND PLAN SPONSOR

This Notice applies to both ERISA and non-ERISA plans. This Notice (or one substantially similar to it) must be provided to employees at or before the time the employees are offered an opportunity to enroll in the plan. Electronic notice is permitted, subject to compliance with the DOL's regulations for providing electronic notices. Your Lockton Account Service Team can supply you with additional information about electronic disclosure requirements.

Text highlighted in yellow indicates information that should be verified or inserted.

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER EMPLOYEE HEALTH CARE PLAN

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 toward 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 (e.g., 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 eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility 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 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 toward 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:

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER
Cheyenne Regional Benefits Team
307-633-7700
benefits@crmcwy.org

** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.*

GENERAL COBRA NOTICE

INSTRUCTIONS FOR ACCOUNT TEAMS AND PLAN SPONSOR

This notice applies to ERISA and non-ERISA plans, but not self-funded church plans. If you intend to utilize this model, take care to conform it to the particulars of the relevant plan or plans.

Plans must provide a General COBRA Notice to participants and, if married, to their covered spouses, upon their enrollment in the plan. After that, the enrolled member need not be supplied a General COBRA Notice on a regular basis, but many sponsors include the Notice in open enrollment packets or benefits brochures, to supplement or reiterate the Notice the enrollee received upon enrollment.

The Notice must be provided within 90 days after coverage under the plan begins. If an employee moves to a different plan at open enrollment, you must issue a new General COBRA Notice (but you are not required to do so if the employee merely moves from option to option within a single plan). If an employee is enrolled and then adds a spouse, the spouse must receive the General COBRA Notice within 90 days after enrollment. Generally, delivery of the Notice to the employee and spouse satisfies the obligation to supply a Notice to other enrolled family members...unless the plan is aware that the other family members live apart from the employee. In those cases, a separate General COBRA Notice should be mailed to such other family members.

Remember to provide a General COBRA Notice to health FSA and HRA participants and beneficiaries. Those programs are also subject to COBRA.

The best delivery mechanism for the General COBRA Notice upon an employee or spouse's enrollment is first class (or better) mail addressed to the employee and, if the spouse is covered, to the covered spouse. Electronic notice is permitted, subject to compliance with the DOL's regulations for providing electronic notices. Your Lockton Account Service Team can supply you with additional information about electronic disclosure requirements. Regardless of the method of delivery used, the plan should be able to prove that the required notices were sent.

Thus, if you intend to meet the General COBRA Notice obligation by including it in a packet of notices, such as this packet, supplied at initial enrollment, the packet should be mailed to the employee's home, properly addressed as described above. However, if enrollees in the health plan receive a General COBRA Notice in the mail, *independently of this packet of notices*—in other words, if this packet of notices includes a General COBRA Notice simply as a reminder—then it may not be necessary to mail this packet to the employee's home, depending on what other notices are included in the packet, and any special delivery requirements that may apply to such other notices.

Text highlighted in yellow indicates information that should be verified or inserted.

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans) ** Continuation Coverage Rights Under COBRA **

Introduction

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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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.

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 period¹ 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>.

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

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

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. (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.

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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER

Cheyenne Regional Benefits Team

214 E 23rd St

Cheyenne, WY 82001

307-633-7700

benefits@crmcy.org

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

INSTRUCTIONS FOR ACCOUNT TEAMS AND PLAN SPONSOR

Federal rules require a health plan to supply a Women's Cancer Rights Act Notice upon an individual's initial enrollment in the health plan, and annually thereafter, prior to the beginning of each plan year. Plan sponsors will typically include this Notice in an enrollee's initial enrollment packet, and his or her annual enrollment packet. Sponsors sometimes also include the Notice, for informational purposes, in a benefits brochure or pamphlet.

The Notice below may be used to satisfy both the initial notice requirement (upon the individual's initial enrollment in the plan) and the annual notice requirement.

The Notice must be delivered by a method reasonably calculated to ensure actual receipt of the material, including by first-class mail, hand-delivery, or electronically. Your Lockton Account Service Team can supply you with additional information about electronic disclosure requirements. Regardless of the method of delivery used, the plan should be able to prove that the required notices were sent.

Text highlighted in yellow indicates information that should be verified or inserted.

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER

Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Basic PPO	Platinum	Tier 1	Tier 2	Out of Network
Individual Deductible	\$3,000	\$5,000	\$5,000	\$7,500
Family Deductible	\$6,000	\$9,000	\$9,000	\$11,000
Coinsurance	0%	10%	30%	50%
Plus PPO	Platinum	Tier 1	Tier 2	Out of Network
Individual Deductible	\$500	\$1,500	\$1,500	\$2,500
Family Deductible	\$1,000	\$2,500	\$2,500	\$5,000
Coinsurance	0%	10%	20%	40%

CDHP	Platinum	Tier 1	Tier 2	Out of Network
Individual Deductible	\$3,500	\$6,500	\$6,500	Not Covered
Family Deductible	\$7,000	\$11,500	\$13,000	Not Covered
Coinsurance	0%	20%	30%	Not Covered

If you would like more information on WHCRA benefits, please refer to your [Summary Plan Description](#) or contact your Plan Administrator at:

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL
 CENTER
 Cheyenne Regional Benefits Team
 307-633-7700
benefits@crmcwy.org

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

*EEOC regulations under the Americans with Disabilities Act (ADA) require employers that offer wellness programs **that include medical examinations or disability-related inquiries** (such as typical health risk assessments, including biometric examinations) and collect employee health information to **provide a notice to employees** informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. The EEOC has published a sample notice to help employers comply with the ADA.*

The sample notice may be modified to suit an employer's particular circumstances, but should clearly address (1) the health information the wellness program will acquire from employees, (2) who will obtain the information, (3) what the information will be used for, and (4) how the recipient of the information will assure confidentiality of the information. If wellness program details are described in another document, then the employer might consider including this notice while referencing that other document.

The EEOC also published a list of FAQs for employers, regarding how to use the notice. The FAQs follow the notice.

IMPORTANT NOTE: If spouses can receive an incentive for completing a medical examination or disability related inquiry, then a separate authorization must be obtained from the spouse prior to his or her participation. A sample authorization can be found on the Lockton intranet or through your Lockton account team.

MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER Wellness Program is a voluntary wellness program available to **All active fulltime employees**. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the **2024 Benefits Guide**.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the **Cheyenne Regional Benefits Team** at **307-663-7700** or **benefits@crmcwy.org**.

The information from **the Biometric Screening** and **the Health Risk Assessment** will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as **education, coaching, or additional testing, or free or reduced diabetes testing supplies**. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and **MEMORIAL HOSPITAL OF LARAMIE COUNTY DBA CHEYENNE REGIONAL MEDICAL CENTER** may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.

Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) **qualified medical healthcare professionals** in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **Cheyenne Regional Benefits Team** at **307-663-7700** or **benefits@crmcwy.org**.

INSTRUCTIONS FOR ACCOUNT TEAMS

ADA WELLNESS NOTICE: EEOC FAQs AND LOCKTON COMMENTS

1. If wellness program participants already get a notice under the Health Insurance Portability and Accountability Act (HIPAA), do they need to get a separate ADA notice?

Employers that already provide a notice that informs employees *what information will be collected, who will receive it, how it will be used, and how it will be kept confidential*, may not have to provide a separate notice under the ADA. However, if an existing notice does not provide all of this information, or if it is not easily understood by employees, then employers must provide a separate ADA notice that sets forth this information in a manner that is reasonably likely to be understood by employees.

Lockton Comment: Employers who have prepared employee notices under the ACA/HIPAA wellness program rules, apprising employees about the availability of alternative methods to earn incentives, etc., might prefer to modify *those* notices to include the information required by the EEOC, so that only a single notice needs to be provided. Please note also that if the employer is providing an incentive for a *spouse's* participation in a health risk assessment, including biometrics, the employer requires a separate authorization from the spouse, pursuant to EEOC regulations issued under the Genetic Information Nondiscrimination Act. The EEOC has not yet issued a model GINA notice. Lockton's sample notice has been released and is available at: http://www.locktononline.com/ss/benefits/na/compliance/HRAP%20Tools%20By%20Topic/GINA%20Spouse%20Model%20Authorization_Lockton_Final.docx. An authorization from the employee is required if the employer is collecting genetic information (including family medical history) from the employee. See Q&A 7, below.

2. Who must provide the notice?

An employer may have its wellness program provider give the notice, but the employer is still responsible for ensuring that employees receive it.

3. Does the notice have to include the exact words in the EEOC sample notice?

No. As long as the notice tells employees, in language they can understand, *what information will be collected, how it will be used, who will receive it, and how it will be kept confidential*, the notice is sufficient. Employers do not have to use the precise wording in the EEOC sample notice. The EEOC notice is written in a way that enables employers to tailor their notices to the specific features of their wellness programs.

4. When should employees get the notice?

The requirement to provide the notice takes effect as of the first day of the plan year that begins on or after January 1, 2017 for the health plan an employer uses to calculate any incentives it offers as part of the wellness program. For more information about which plan to use in calculating wellness program incentives, refer to EEOC's [questions and answers on the ADA rule](#) and the [Genetic Information Nondiscrimination Act \(GINA\) rule](#). Once the notice requirement becomes effective, the EEOC's rule does not require that employees get the notice at a particular time (e.g., within 10 days prior to collecting health information). *But they must receive it before providing any health information, and with enough time to decide whether to participate in the program. Waiting until after an employee has completed an HRA or medical examination to provide the notice is illegal.*

Lockton Comment: Employers who have prepared employee notices under the ACA/HIPAA wellness program typically supply those notices in wellness program materials that are distributed to employees well before the kick-off of the program (or, for newly-hired employees, as part of benefit enrollment materials). Including the EEOC's required notice as part of those materials should assure adequate delivery to the employees, assuming the other materials are timely provided.

5. Is an employee's signed authorization required?

No. The ADA rule only requires a notice, not signed authorization, though other laws may require authorization. The Genetic Information Nondiscrimination Act (GINA) requires prior, written, knowing, and voluntary authorization when a wellness program collects genetic information, including family medical history. (See Q&A 7 below.)

Lockton Comment: This is most likely to happen when the employer offers an incentive for a spouse to participate in a health risk assessment.

6. In what format should the notice be provided?

The notice can be given in any format that will be effective in reaching employees being offered an opportunity to participate in the wellness program. For example, it may be provided in *hard copy* or as *part of an email sent to all employees with a subject line that clearly identifies what information is being communicated* (e.g., "Notice Concerning Employee Wellness Program"). Avoid providing the notice along with a lot of information unrelated to the wellness program as this may cause employees to ignore or misunderstand the contents of the notice. If an employee files a charge with EEOC and claims that he or she was unaware of a particular medical examination conducted as part of a wellness program, EEOC will examine the contents of the notice and all of the surrounding circumstances to determine whether the employee understood what information was being collected, how it was being used, who would receive it, and how it would be kept confidential.

Employees with disabilities may need to have the notice made available in an alternative format. For example, if you distribute the notice in hard copy, you may need to provide a large print version to employees with vision impairments, or may have to read the notice to a blind employee or an employee with a learning disability. A deaf employee may want a sign language interpreter to communicate information in the notice, whether the notice is in hard copy or available electronically. *Notices distributed electronically should be formatted so that employees who use screen reading programs can read them.*

7. What notice must employers provide for spouses participating in an employer's wellness program?

As was the case prior to the issuance of the EEOC 2016 regulations, GINA requires that an employer that offers health or genetic services and requests current or past health status information of an employee's spouse obtain prior, knowing, written, and voluntary authorization from the spouse before the spouse completes a health risk assessment. Like the ADA notice, the GINA authorization has to be written so that it is reasonably likely to be understood by the person providing the information. It also has to describe the genetic information being obtained, how it will be used, and any restrictions on its disclosure.