INFORMATION FOR ASSOCIATES/DEPENDENTS

ABOUT THE ASSOCIATES' MEDICAL PLAN AND THE DENTAL PLAN AUTHORIZATION FORM

WHAT IS HIPAA AND HOW DOES IT AFFECT ME?

Congress has passed a law called HIPAA (Health Insurance Portability Accountability Act) which restricts who can access certain health information. The information covered by this Law is called Protected Health Information (PHI).

There are times, however, when you may want others to have your health information.

These are the main instances in which HIPAA may affect you:

- If you want your Personnel Manager or Personnel Training Coordinator to call the Benefits Department for information about your medical coverage, you will have to give them authorization to speak on your behalf by completing and returning an Authorization Form. If you are present when the Personnel Representative makes the call, you do not have to complete an Authorization.
- If you have received an 'Explanation of Benefits" after 4/14/2003 with the Designation of Personal Representatives Statement printed on it and have not objected, we will assume that you want us to speak to your spouse about your benefits, If you are a dependent and have not objected, we will assume that you want us to speak to your acting parents about your benefits.

If you disagree, please call Customer Service at (866) 823-3790.

- If you want a friend or other family member to have access to your Protected Health Information, you will have to complete and return an Authorization Form granting them permission to have this access.
- You do not need to authorize the Associates' Medical Plan or the Dental Plan to release information to health care providers, such as hospitals and doctors, for routine purposes of treatment, payment, or healthcare administration.

If you want further details on HIPAA, consult the HIPAA Section at the back of the Associate Guide or visit the HIPAA website on Pipeline/WIRE

In addition you need to know:

- No one but you can complete your Authorization Form.
- Personnel Managers and Personnel Training Coordinators cannot complete an Authorization Form for any Associate, other than themselves.

TERMS YOU NEED TO KNOW

- Authorization (also called a Release): Gives written permission to release Protected Health Information for non-routine purposes beyond treatment, payment, and health care administration.
- Participant: includes Associates and covered dependents who are enrolled in the Wal-Mart Associates' Medical Plan or the Dental Plan.
- Protected Health Information (PHI): Generally any health-related information that could identify a particular individual's personal information.

ADDITIONAL INFORMATION

- Authorizations remain in effect for one (1) year from the date of your signature.
- If you do not receive a response within 45 days, you may assume the request has been granted.

You may return your completed Authorization Form by MAIL, FAX, or by SCAN-SENDING it through EMAIL. You do not need to return this page.

MAIL TO:

Wal-Mart Benefits Department
Attn: HIPAA Compliance Team
508 SW 8th St.
Mail Stop: 3500
Bentonville, AR 72716-3500

FAX to the Attention of the Compliance Team at (479) 204-0990
SCANSEND to Privacy@wal-mart.com

Associates may also complete the Authorization Form online
Pipeline: Benefits/HIPAA Online Auth.
WIRE: Life_Resources/More >>/HIPAA/Group Health/HIPAA Online Authorization
Dependents of Associates must complete paper forms.

ASSOCIATES' MEDICAL PLAN AND THE DENTAL PLAN-AUTHORIZATION

Participant Release of Protected Health Information

PARTICIPANT INFORMATION

Name of Associate Carrying Medical Coverage_____
Associate's Date of Birth_____
State where Associate lives_____
Participant (This is the Person whose Protected Health Information will be released)_____
Participant's Date of Birth _____Telephone Number_____
Participant's Address_____

AUTHORIZATION (This is who will receive the participant's Protected Health Information) I authorize the Associates' Medical Plan, the Dental Plan, and its business associates to release Protected Health Information to the people, group, or organization listed below:

Full Name _____Date of Birth_____
(person, group, organization other than self) (person)

Address_____
(person, group, or organization address needed for verification purposes)

I authorize the Plan to release: (only mark one)

☐ All my Protected Health Information or ☐ All my Protected Health Information except:

If you have marked except, list the information (treatment for the dates of service, diagnosis (es)/condition(s), and/or treatment by the following provider(s) name/address) that you do not want released: (Attach additional pages if necessary.)

REASON FOR REQUEST:

You may check the box below that states "At participant's request" or you may specify below the reasons you are authorizing the Plan to share your Protected Health Information.

☐ At the participant's request ☐ Other reasons (specify)_____

SIGNATURE

I understand that:

- This authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this authorization at any time by completing a Cancellation of Authorization Form.
- My written cancellation will not affect the ability of the Associates' Medial Plan and the Dental Plan to use or disclose my PHI to the extent that it has already acted on reliance on this authorization.
- I hereby authorize the use or disclosure of the PHI described in this authorization. I understand that if the person or entity that receives my PHI is not required to comply with the federal privacy regulations, the information would no longer be protected by those regulations.

I understand that payment of my claims, my ability to enroll in the Associates' Medical Plan and the Dental Plan or be eligible for benefits is not conditioned on my signing this authorization.

_____ _____
Participant's Signature (This is the Person whose Protected Health Information will be released) Date

If you are authorizing the release of your own information, you are furnished and it is not necessary to complete the below. If you have completed this form as a legally recognized representative of the participant it is necessary to complete the following:

Name of Representative (please print your name)_____
State your relationship to the participant (that allows you to act on their behalf)_____
Sign this form on behalf of the participant Representative's Signature_____Date _____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Associates' Medical Plan and the Dental Plan will obtain a valid, signed authorization from a Plan participant prior to using or releasing the participant's Protected Health Information, unless the Plan participant's authorization is not legally required by law.

Return Form to: **Wal-Mart Benefits Department**
Attn: HIPAA Compliance Team
508 SW 8th St.
Mail Stop: 3500
Bentonville, AR 72716-3500