Annual Executive Physical Program

Summary Plan Description

A benefit offered under the
Associates' Health and Welfare Plan

Effective **January 1, 2025**

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Introduction

The Annual Executive Physical Program (AEPP), offered under the Associates' Health and Welfare Plan (the Plan), provides company-paid benefits for Walmart executives who are "eligible corporate officers." Eligible corporate officers are officers of Walmart or an affiliate participating in the Plan in the role of vice president and above. This document serves as the Summary Plan Description (SPD) for the AEPP.

If you are an eligible participant, the AEPP provides you the opportunity to receive an annual company physical, including specified diagnostic and laboratory tests, free of charge at the following AEPP providers: Mayo Clinic in Jacksonville, Florida; Mayo Clinic in Scottsdale, Arizona; Mayo Clinic in Rochester, Minnesota; Mercy in Rogers, Arkansas; Cooper Clinic in Dallas, Texas; and EHE International, with several locations to choose from. All covered services are for preventive purposes, and not for the treatment, cure, or testing of a known illness or disability, physical injury, complaint, or specific symptom of a bodily malfunction.

The AEPP is an employer-sponsored health and welfare employee benefit plan governed under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The terms and conditions of the AEPP are set forth in this SPD, in the Associates' Health and Welfare Plan Wrap Document, and in the other welfare program documents incorporated into the Wrap Document. The Wrap Document, together with this SPD and the other incorporated documents, constitutes the written instrument under which the AEPP is established and maintained.

UMR is the third-party administrator of the AEPP.

Walmart reserves the right to amend or terminate the AEPP at any time.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get a list of covered services	Refer to **Addendum: Services by AEPP Provider** section of the **2025 Walmart AEPP Summary Plan Description**	Email the AEPP team at **aeppbox@walmart.com**

Eligibility and enrollment

If you are an eligible corporate officer, you are eligible to participate in the AEPP, regardless of whether you are enrolled in other benefits offered under the Plan. Spouses, domestic partners, and dependents are not eligible to participate in the AEPP.

If you are an eligible corporate officer, you are automatically enrolled in the AEPP as of your date of hire or date of promotion, with no waiting period. Covered benefits under the AEPP are fully funded by Walmart and provided at no cost to you while you are employed. If you elect to continue coverage after you terminate employment, you will be required to pay a premium. See the **COBRA continuation coverage** section.

Covered benefits

Each AEPP provider has identified a set of specific preventive services that it provides to eligible corporate officers under the AEPP. There are some common preventive services covered under the AEPP regardless of which AEPP provider you choose, but some covered preventive services vary by AEPP provider. The AEPP covers a service performed by an AEPP provider only if that service is specifically identified in the set of services that AEPP provider has agreed to provide to eligible corporate officers under the AEPP. The AEPP does not cover services performed by an AEPP provider if that service has not been identified as a specific service in the set of services which that AEPP provider has agreed to provide to eligible corporate officers. This means that services performed by one AEPP provider may be covered while those same services performed by another AEPP provider may not be covered. The AEPP will cover each service in a single AEPP provider's set of services once per calendar year. The AEPP will not cover any service already performed at a different AEPP provider.

A complete list of covered services, by AEPP provider, is attached in the **Addendum**. Contact the Benefits AEPP team by email at **aeppbox@walmart.com** for a paper copy of the lists of services covered under the AEPP.

If the AEPP provider you choose performs any services not included in the list of preventive services provided by that provider to eligible corporate executives under the AEPP, you are responsible for paying for those services; they are not covered by the AEPP. The AEPP provider will submit claims for these additional services to the Plan, if you have medical coverage under the Plan, or to other health insurance coverage that you may have. Claims for services not covered under the AEPP are processed under normal rules applicable to your health coverage. See the applicable summary plan description (the *Associate Benefits Book* if you have coverage under the Plan) for additional details.

OBTAINING BENEFITS

To receive the maximum benefit offered through AEPP, please follow these steps:

1. Review the complete list of services provided by each AEPP provider.
2. Contact your AEPP provider of choice to schedule your appointment.
3. Your AEPP provider must file a claim for payment as described in the **Claims and appeals** section below. If the AEPP provider you choose performs services that are not included in the list of preventive services provided by that AEPP provider to eligible corporate executives under the AEPP, you are responsible for paying the full cost for any services that are not covered by the AEPP or under your medical plan.
4. If you have questions, email the Benefits AEPP team at **aeppbox@walmart.com**.

Claims and appeals

FILING A CLAIM FOR BENEFITS

All claims under the AEPP are filed electronically by your AEPP provider through UMR. Claims for services not covered under the AEPP are submitted to the Plan or other medical coverage that you have.

Your AEPP provider must file an initial claim for benefits within 12 months from the date of service.

INITIAL CLAIMS DETERMINATION

Your claim is treated as a post-service claim and determined within a reasonable amount of time, but in no event longer than 30 days after receipt of the claim. If UMR determines that an extension is necessary due to matters beyond its control, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which UMR expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. UMR will then make a determination within 15 days from the date it receives your information, or, if earlier, the deadline to submit the information.

If your claim is partially or fully denied, UMR will send a denial notice with the following information:

- The specific reasons for the denial
- Reference to provisions of the AEPP on which the denial was based
- Information regarding time limits for appeal
- A description of any additional information necessary to consider your claim and why such information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request)
- Notice regarding your right to bring legal action following a denial on appeal
- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable (upon written request, the AEPP will provide you with the diagnosis and treatment codes, and their corresponding meanings, associated with any denied claim or appeal)
- The denial code and its meaning
- A description of the AEPP's standard for denying the claim, and
- Information regarding available internal and voluntary appeals, including how to initiate an appeal.

APPEALING A DENIED CLAIM

You may request an appeal of the decision. In order for your appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 180 days of the date of the initial denial, and
- Contain any additional information/documentation you would like considered.

Send your written request for review to:

Mail Stop 3610—Benefits Total Rewards Team
Attn: Internal Appeals
508 SW 8th St.
Bentonville, Arkansas 72716-3610

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. You will be provided with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the AEPP will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the AEPP will provide you with the identification of any medical expert whose advice was obtained on behalf of the AEPP in connection with your appeal.

You will be notified of the appeal determination within a reasonable period of time, but no later than 60 days from the date your request is received.

If your claim is denied on appeal, you will receive a denial notice that includes:

- The specific reasons for the denial
- Reference to provisions of the AEPP on which the denial was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- An explanation of this rule (or a statement that it is available upon request), if your denial is based on a medical necessity or similar limitation
- A description of any voluntary review procedures available
- Notice regarding your right to bring legal action following a denial on appeal
- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable (upon written request, the AEPP will provide you with the diagnosis and treatment codes, and their corresponding meanings, associated with any denied claim or appeal)
- The denial code and its meaning
- A description of the AEPP's standard for denying the claim, and

- Information regarding available internal and voluntary appeals, including how to initiate an appeal.

VOLUNTARY REVIEW

You may request a voluntary review of the decision on your appeal if your appeal was denied for administrative reasons, such as exceeding the number of allowed visits or tests, and not for a medical judgment reason. You must file your request within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are applied to this voluntary level of review.

You must send a written request for a voluntary appeal for administrative denial to:

Mail Stop 3610—Benefits Total Rewards Team
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

DEADLINE TO BRING LEGAL ACTION

You must file any lawsuit for benefits within 180 days after the final decision on appeal (whether by the AEPP or after voluntary review). You may not file suit after that 180-day period expires. You are not required to request a voluntary review of the decision on appeal before filing a lawsuit. If you request a voluntary review of the decision on appeal, where applicable, the time taken by these reviews will not be counted against the 180 days you have to file a lawsuit.

QUESTIONS REGARDING ELIGIBILITY

If it is determined that you are not eligible for the AEPP and you have not yet obtained benefits, you can appeal this decision within 365 days from the date of that determination in writing to the following address:

Mail Stop 3610—Benefits Total Rewards Team
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610
COBRA participants should send the appeal in writing to the following address:

WageWorks (COBRA Appeals)
P.O. Box 14390
Lexington, Kentucky 40512-4390

Your appeal will be handled within 60 days from the date it is received (30 days for COBRA appeals). This 60-day period (or 30-day period for COBRA appeals) may be extended if it is determined that an extension is necessary beyond the AEPP's control. You will be notified prior to the end of the 60-day period (or 30-day period for COBRA appeals) if an extension or additional information is required. Eligibility appeals will be eligible for voluntary review.

When AEPP benefits end

Your AEPP benefits end upon the earlier of:

- Your termination of employment for any reason
- The date that you are no longer eligible for the benefit (i.e., no longer classified as an eligible corporate officer)
- Any misrepresentation or fraudulent submission of a claim for benefits or eligibility, or
- When the benefit is no longer offered by Walmart.

You may maintain your AEPP benefit coverage while you are on a company-approved leave of absence. Coverage generally is maintained on the same terms and conditions as if you had continued to work during the leave. Decisions about leaves of absence are made by the company, not the AEPP.

COBRA continuation coverage

If your coverage under the AEPP ends, you may be able to continue your AEPP coverage under the Plan's continuation coverage provisions, which comply with the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). This coverage is referred to as "COBRA coverage" or "COBRA continuation coverage." An event that makes you eligible for COBRA coverage is called a "qualifying event."

You must have had AEPP coverage under the Plan on the day prior to your qualifying event date to be eligible for COBRA coverage.

IF YOU ARE ON A LEAVE OF ABSENCE

Generally, if you were covered by the AEPP during your leave but you do not return to work when your leave ends, you will be offered COBRA, which will run from the date following your employment termination date.

COBRA QUALIFYING EVENTS

You are eligible for COBRA if your AEPP coverage ends because your employment with the company ends for any reason or your position changes for any reason, making you ineligible for AEPP coverage.

NOTIFICATION

In general, Walmart will notify WageWorks (a HealthEquity company), the Plan's third-party administrator for COBRA, if you become eligible for COBRA continuation coverage.

Walmart will generally make this notification to the COBRA administrator within 30 days after the qualifying event.

Within 14 days after the COBRA administrator receives notification that a qualifying event has occurred, the COBRA administrator, on behalf of the Plan, will send a COBRA election notice to you at your last known address. The election notice will describe your right to continue AEPP coverage under COBRA. (If you do not receive this notification, please contact People Services.) To receive COBRA continuation coverage, you must elect coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. To enroll, you must complete and mail your COBRA election notice to the address on the election notice or go online at **mybenefits.wageworks.com**. If you elect COBRA, notify the COBRA administrator of any change of address. Refer to **Paying for COBRA coverage** below for information on making COBRA payments. If you need assistance, call **800-570-1863**. COBRA is provided subject to your eligibility for coverage under the law and the terms of the Plan. To the extent permitted by law, the Plan will retroactively terminate your COBRA coverage if you are later determined to be ineligible.

PAYING FOR COBRA COVERAGE

You are responsible for the premium that was previously paid by Walmart, plus a 2% administrative fee. The letter sent to you following notice of a qualifying event will include the monthly premium cost for COBRA coverage.

Initial COBRA premium: Your first premium payment is due 45 days after you elect COBRA and must cover the period from the time your coverage was lost because of a qualifying event up to the end of the month in which your election is made.(For example, assume your employment terminates on Sept. 30, and you lose coverage on Sept. 30. You elect COBRA on Nov. 15. Your initial premium payment should equal the premiums for October and November and is due on or before Dec. 30, which is the 45th day after the date of your COBRA election. Ongoing premiums are due the first day of each month, with a 30-day grace period. So your December payment must be received no later than Dec. 31, the end of the 30-day grace period for the December coverage period.)

If your initial premium payment is not made in the allowed time frame, you will not be eligible for COBRA coverage.

Continuing premiums: Monthly premiums are due on the first day of each month following the due date of the initial premium. If you make your payment on or before the first day of each month, your COBRA coverage under the Plan will continue for that month. To eliminate any possible delay in the updating of your eligibility information, it is recommended that you pay your premiums 7-10 days in advance of the due date.

You will be allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment on the first day of the month or later, your coverage will be suspended, and any claims incurred will not be paid until coverage is paid through the current month. If you do not pay this premium, you will be responsible for claims incurred. If the 30th day falls on a weekend or holiday, you will have until the first business day following to have your payment postmarked or paid.

As a courtesy, the COBRA administrator will send you a COBRA premium payment invoice, unless you make your payments by Automatic Clearing House (ACH) debit, in which case you will not receive an invoice. Premiums are due regardless of your receipt of a payment invoice. To avoid interruption or cancellation of coverage, it is recommended that you pay your premiums 7-10 days in advance of the due date. Using the ACH debit through the COBRA administrator can cause eligibility delays since these drafts are taken on the first business day of the month. If you pay by mail, attach your payment to the invoice and mail to:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

To pay online, log on to **mybenefits.wageworks.com**, or to pay by phone, call **800-570-1863**.

If your COBRA coverage is canceled due to nonpayment of premiums, your COBRA coverage will end on the last day for which you paid your full COBRA premium on time, and it will not be reinstated.

COBRA coverage is month-to-month. If you decide you don't want to continue your coverage, you can cancel it in any of the following ways.

- Stop paying your premiums. This will automatically cancel your COBRA coverage.
- Enter a support request in the WageWorks online message center.
- Send a letter to WageWorks at the address below asking them to cancel your COBRA coverage.

  WageWorks
  P.O. Box 14390
  Lexington, Kentucky 40512-4390

If you choose to cancel coverage, it cannot be reinstated. Coverage will be automatically canceled if your payment isn't postmarked on or before the deadline date of the month your premium is due.

HOW LONG COBRA COVERAGE MAY LAST

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event making you eligible for COBRA coverage is termination of employment or a change in position that makes you ineligible for coverage under the Plan, COBRA generally lasts for 18 months. This 18-month period can be extended due to disability.

IF YOU ARE DISABLED

If you are determined by the Social Security Administration to be disabled and you notify the COBRA administrator in a timely manner, you may be entitled to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability extension applies only if all of the following conditions are met:

- The Social Security Administration determines that you are disabled
- The disability exists at any time within the first 60 calendar days of COBRA coverage and lasts at least until the end of the 18-month period of COBRA coverage, and
- You (or your authorized representative) notify the COBRA administrator of the Social Security Administration's disability determination by submitting a copy of the Social Security Administration disability determination Notice of Award letter to the COBRA administrator within your initial 18-month COBRA period.

In the absence of an official Notice of Award from Social Security, the Plan may accept other correspondence from the Social Security Administration if that correspondence explicitly includes all information the Plan needs in order to grant the extension and is submitted to the COBRA administrator within the time frames listed above.

If you qualify for the disability extension, a new invoice will be mailed to you before the end of the initial 18-month COBRA coverage period, unless you make your payments by Automated Clearing House (ACH) debit, in which case you will not receive an invoice. Contact the COBRA administrator for details about paying premiums during a disability extension.

The COBRA premium for the 19th through the 29th month of COBRA coverage generally is the amount Walmart was paying before the qualifying event, plus a 50% administrative fee, or 150% of the full premium amount.

WHEN COBRA COVERAGE ENDS

COBRA coverage usually ends after the 18-month or 29-month COBRA coverage period. COBRA coverage may be terminated before the end of the maximum period if:

- Walmart ceases to provide AEPP coverage
- After the initial 45-day payment period, you do not make a COBRA payment within 30 calendar days of the due date (if the 30th day falls on a weekend or non-postal delivery day, you will have until the next business day in order to have your payment postmarked or paid)
- During a disability extension period, you are determined by the Social Security Administration to no longer be disabled (COBRA coverage terminates as of the later of (a) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that you are no longer disabled, or (b) the end of the coverage period that applies without regard to the disability extension), or
- You submit a fraudulent claim to the Plan.

Instead of enrolling in COBRA continuation coverage there may be other coverage options for you through the Health Insurance Marketplace or Medicaid. You may also be eligible for a 30-day "special enrollment period" in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). You may also have the same special enrollment right at the end of your COBRA coverage if you take COBRA coverage for the maximum amount of time available to you. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Important information about your AEPP benefits

THE PLAN'S RIGHT TO REQUEST MEDICAL RECORDS

The Plan has the right to request medical records for any associate or covered individual.

THE PLAN'S RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for benefits that are not covered by the AEPP, for a participant who is not covered by the AEPP, when other insurance is primary, or other similar circumstances, the Plan has the right to

recover the overpayment. The Plan will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from you. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

THE PLAN'S RIGHT TO AUDIT

The Plan has the right to audit your claims, including claims of medical providers. The Plan may reduce or deny benefits for otherwise covered services for all current or future claims with the provider made on your behalf or on behalf of a participant in any other health and welfare plan administered by UMR based on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current or future claims you file.

THE PLAN'S RIGHT TO SALARY/WAGE DEDUCTION

To the extent that the Plan may recover from you all or part of benefits previously paid, you will be deemed, by virtue of your enrollment in the AEPP, to have agreed that Walmart may deduct such amounts from your wage or salary and pay the same to the Plan until recovery is complete.

THE PLAN'S SUBROGATION AND REIMBURSEMENT RIGHTS

If you are injured or otherwise harmed due to the conduct of another party and the Plan pays benefits as a result of such injury or harm, the Plan Administrator has the right to recover payments it makes on your behalf from you or any party responsible for compensating you for your illnesses or injuries. The legal term for this right of recovery is "subrogation." The Plan shall have a first-priority lien against any amounts you recover from another responsible party or insurer for the full amount of the benefits that are paid to or for you as a result of the third-party injury or harm, and the Plan shall have a right to offset such benefit amounts against future benefits due under the Plan.

The Plan has the right to do any of the following to enforce its lien and right of reimbursement and recovery:

- Reduce or deny benefits otherwise payable by the Plan, and
- Recover or subrogate 100% of the benefits paid or to be paid by the Plan on your behalf, to the extent of any and all of the following payments:
  - Any judgment, settlement, or payment made or to be made because of an accident or malpractice (except for malpractice that results in paraplegia/quadriplegia, severe burns that result in a whole-body impairment rating of at least 50%, as determined by an Independent Review Organization in accordance with American Medical Association guidelines for the evaluation of permanent impairment, total and permanent physical or mental disability, or death), regardless of how such judgment, settlement, or payment is characterized, including payments by any other insurance, whether providing third-party coverage or first-party coverage
  - Any auto or recreational vehicle insurance coverage or benefits, including but not limited to uninsured/underinsured motorist coverage
  - Business medical and/or liability insurance coverage or payments, and
  - Attorney fees.

The Plan's lien exists at the time the Plan pays any benefits to you or for your benefit. If you file a petition for bankruptcy, you agree that the Plan's lien existed prior to the creation of the bankruptcy estate.

Also note that:

- The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation
- The Plan has the right to recover interest on the amount paid by the Plan because of the accident
- The Plan has the right to 100% reimbursement in a lump sum
- The Plan is not subject to any state laws or equitable doctrine, including but not limited to the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of your attorney's fees, expenses, or costs
- The Plan is not responsible for your attorney's fees, expenses, or costs
- The right of reduction, reimbursement, and subrogation is based on the Plan language in effect at the time of judgment, payment, or settlement
- The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of your estate, and
- The Plan's first-priority right to reduction, reimbursement, or subrogation shall not be reduced due to your own negligence.

The Plan will not pursue reduction, reimbursement, or subrogation where the injury or illness that is the basis of your recovery from any party results in:

- Paraplegia or quadriplegia
- Severe burns that result in a whole-body impairment rating of at least 50%, as determined by an Independent Review Organization in accordance with American Medical Association guidelines for the evaluation of permanent impairment
- Total and permanent physical or mental disability, or
- Death.

The Plan Administrator has the authority, in its sole discretion, to determine to limit or not to pursue the Plan's rights to reduction, reimbursement, or subrogation. For more information, contact the Plan Administrator.

Whether you have a "total and permanent physical or mental disability" will be determined based on criteria developed and applied by the Plan Administrator in its sole discretion. One way of demonstrating total and permanent physical or mental disability is to show that you have qualified for Social Security disability income benefits, or have met the requirements to qualify for Social Security disability income benefits. The Plan Administrator will consider claims for physical and mental disability, even if you do not qualify for Social Security disability income benefits, under criteria developed by the Plan Administrator.

Even in circumstances where the Plan is not prohibited from seeking reduction, reimbursement, or subrogation, the Plan's right to reduction, reimbursement, or subrogation will be limited to no more than 50% of the total amount recovered by you or on your behalf from any party (which shall not be reduced for your attorney's fees or costs). The Plan requires you and your representatives to notify the Plan if you are involved in an incident that gives rise to such right of reduction, reimbursement, or subrogation. You and your representatives are required to cooperate with the Plan and execute any documents that the Plan Administrator deems necessary to protect the Plan's rights of reduction, reimbursement, or subrogation. You and your representatives must not do anything to hinder, delay, impede, or jeopardize the Plan's right of reduction, reimbursement, or subrogation. Failure to comply will entitle the Plan to withhold benefits due to you under the Plan. This is in addition to any and all other rights that the Plan has pursuant to its rights of reduction, reimbursement, and subrogation.

The Plan's rights to reduction, reimbursement, and subrogation apply regardless of any allocation or designation of the applicable settlement or award (e.g., pain and suffering or medical benefits) and regardless of the specific claims or causes of action being settled or adjudicated. The Plan's rights apply regardless of whether you have been made whole or fully compensated for your injuries and without regard to any state law or equitable doctrine, such as the make whole doctrine, that would limit the Plan's right of recovery based on whether you have been made whole, it being intended that the Plan's right of recovery is a right to first dollar recovery.

Additionally, the Plan has the right to file suit on your behalf for the condition related to the medical expenses to recover benefits paid, or to be paid, by the Plan on your behalf.

The Plan may also enforce its rights of reduction, reimbursement, and subrogation against any fund, tortfeasor, responsible party, or available insurance coverages, including underinsured, no-fault, or uninsured motorist coverages to the fullest extent allowed by law.

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, a covered person or their designated representative must, at the Plan's request and at its discretion:

- Take actions necessary to enable the Plan to exercise its rights of recovery
- Give information, or
- Provide the Plan with any requested information related to the claim involved, including information with respect to other insurance, judgments, payments, or settlements.

The Plan's decision to seek reduction, reimbursement, or subrogation is a determination of benefits under the Plan and may be appealed in accordance with procedures described in the **Claims and appeals** chapter of the *Associate Benefits Book*.

Plan information

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare, including Executive Physical Plan

Type of Administration: The Plan allocates discretionary authority among individuals, committees (or their delegates) concerning the administration, interpretation, and application of the Plan. The Plan also provides that discretionary

authority of claims for benefits and appeals is allocated to, among others, the third-party administrator. The AEPP is self-funded.

Plan Sponsor:

Walmart, Inc
702 SW 8th Street
Bentonville, Arkansas 72716-0295

Plan Sponsor's EIN: 71-0415188

Plan Administrator / Named Fiduciary:

Mail Stop 3610—Plan Administrator
Administrative Committee
Associates' Health and Welfare Plan
508 SW 8th Street
Mail Stop 3610
Bentonville, Arkansas 72716-3610
479-621-2058

Third-party Administrator:

UMR
P.O. Box 30541
Salt Lake City, UT 84130-0541

Agent for Service of Legal Process:

Corporate Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19081

Plan Trustee:

J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

Legal process may also be served on the Plan Administrator or Trustee.

FUNDING FOR THE PLAN

Walmart Inc. funds plan benefits out of its general assets. Former associates who have elected COBRA coverage are required to pay for that coverage. All assets of the Plan, including COBRA continuation payments and any dividends or earnings of the Plan, shall be available to pay any benefit provided under the Plan or expenses of the Plan, including insurance premiums.

PLAN AMENDMENT OR TERMINATION

Walmart reserves the right within its sole discretion to amend or terminate any benefit or provision under the AEPP, at any time and for any reason, as it relates to any current, past, or future participant under the AEPP.

Neither the AEPP nor the benefits described in this document can be orally amended. All oral statements and representations shall be without force or effect, even if such statements and representations are made by the Plan Administrator or by a management associate of the company. Only written statements by the Plan Administrator shall bind the Plan.

Your rights under ERISA

As a participant in the AEPP, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all AEPP and Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant a copy of this report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to continue health care coverage if there is a loss of coverage under the AEPP as a result of a qualifying event. You may have to pay for that coverage. Review this SPD and the documents governing the AEPP on the rules governing your COBRA continuation coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty

to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, can fire you or otherwise discriminate against you in any way in order to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why, to obtain copies of documents related to the decision (without charge), and to appeal any denial—all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the Plan and do not receive them within 30 days, you can file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. Generally, you must complete the appeals process before filing a law suit against the Plan. However, you should consult with your own legal counsel in determining when it is appropriate to file a law suit against the Plan.
- If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if the court determines your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have questions about the AEPP, you can email the AEPP Team at **aeppbox@walmart.com**. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at **866-444-3272** or by logging on to the internet at **dol.gov/ebsa**.

HIPAA notice of privacy practices

Effective date of this notice: August 1, 2019.

THIS NOTICE APPLIES TO THE WALMART ANNUAL EXECUTIVE PHYSICAL PROGRAM, REFERRED TO IN THIS NOTICE AS THE "PLAN"

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. You have certain rights under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA governs when and how your medical health information held by the Walmart Annual Executive Physical Program may be used and disclosed and how you can get access to this information.

THE PLAN'S COMMITMENT TO YOUR PRIVACY

This HIPAA Notice of Privacy Practices applies only to the Walmart Annual Executive Physical Program (Plan) maintained by Walmart. References to "we" and "us" throughout this notice mean the Plan.

The Plan is dedicated to maintaining the privacy of your health information for as long as the Plan holds your health information or for 50 years after your death. In operating the Plan, we create records regarding you and the benefits we provide to you. This notice will tell you about the ways in which we may use and disclose health information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to:

- Maintain the privacy of your health information, also known as Protected Health Information (PHI);
- Provide you with this notice;
- Comply with this notice; and
- Notify you if there is a breach of your unsecured PHI.

The Plan reserves the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this notice, the new notice will be distributed to you. You may obtain a paper copy of the current notice by contacting the Plan using the contact information listed at

the end of this notice. The most current notice is also available on One.Walmart.com.

HOW THE ANNUAL EXECUTIVE PHYSICAL PROGRAM MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your Protected Health Information (PHI) for certain purposes without your permission or authorization. The following gives examples of each of these circumstances:

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses, and other professionals who are involved in your care.

2. **For Payment.** We may use or disclose your PHI to provide payment for the treatment you receive under the Plan. For example, we may contact your health care provider to certify that you have received treatment (and for what range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or other insurance companies.

3. **For Health Care Operations.** We may use or disclose your PHI for our health care operations. For example, our claims administrators in some states or the Plan may use your PHI to conduct cost-management and planning activities. Any information which we use or disclose for underwriting purposes will not include any of your PHI which is genetic information.

4. **To the Plan's Sponsor.** The Plan may use or disclose your PHI to Walmart, the Plan Sponsor. The Plan's Sponsor will only use your PHI as necessary to administer the Plan. The law only permits the Plan to disclose your PHI to Walmart, in its role as the Plan's Sponsor, if Walmart certifies, among other things, that it will only use or disclose your PHI as permitted by the Plan, will restrict access to your PHI to those Walmart employees whose job it is to administer the Plan, and will not use PHI for any employment-related actions.

5. **For Health-Related Programs and Services.** The Plan may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.

6. **To Individuals Involved in Your Care or Payment for Your Care.** The Plan may disclose your PHI to a third party involved in your health care including a family member, close friend, or a person you identified to the Plan as involved in your health care, provided that you agree to this disclosure. If you are not present or available to agree or disagree to disclose your PHI to a third person requesting the PHI, then the Plan may use professional judgment to determine if the disclosure of PHI is in your best interests. If it is determined that a disclosure of PHI is then in your best interest, the Plan may disclose the minimum amount of PHI necessary to meet the need. Additionally, you have the right to request that the Plan limit any disclosure of PHI to specific individuals involved in your health care.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATION

The law allows us to disclose your PHI in the following circumstances without your permission or authorization:

1. **When Required by Law.** The Plan will use and disclose your PHI when we are required to do so by federal, state, or local law.

2. **For Public Health Risks.** The Plan may disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders, and dependent adults.

3. **For Health Oversight Activities.** The Plan may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits, and licensure.

4. **For Lawsuits and Disputes.** The Plan may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we receive satisfactory assurances from the party seeking the information that reasonable efforts have been made to inform you of the request and given you the opportunity to raise an objection to the court or obtain an order protecting the information the party has requested.

5. **To Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official in certain

circumstances, including but not limited to the following:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe might have resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena, or similar legal process
- To identify/locate a suspect, material witness, fugitive, or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime or the description, identity or location of the person who committed the crime), and
- In cases where a law enforcement agency has requested PHI for purposes of identifying or locating an individual, HIPAA permits that if certain specific situations are met, the Plan must disclose to the law enforcement agency limited information such as name, address, Social Security number, ABO blood type, type of injury, date and time of treatment or death, and distinguishing physical characteristics.

6. **To Avert a Serious Threat to Health or Safety.** The Plan may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **For Military Functions.** The Plan may use or disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required to assure the proper execution of a military mission if the appropriate military authority has published the required information in the Federal Register.

8. **For National Security.** The Plan may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

9. **Inmates**. The Plan may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: for the institution to provide health care services to you; for the safety and security of the institution; and/or to protect your health and safety or the health and safety of other individuals.

10. **To Workers' Compensation Programs.** The Plan may release your health information for workers' compensation and similar programs.

11. **For Services Related to Death.** The Plan may disclose your PHI upon your death to a coroner, funeral director, or to tissue or organ donation services, as necessary to permit them to perform their functions.

12. **Research.** HIPAA permits the Plan to disclose PHI for government-approved research purposes. It is the policy of the Plan not to disclose PHI for research purposes, and will not disclose your PHI for such purposes unless the PHI is required to be disclosed under law.

13. **Psychotherapy Notes.** An authorization is always required to use or disclose psychotherapy notes to a third person unless the use or disclosure is permitted under HIPAA regulations. Permissible uses or disclosures include: use for treatment, payment or health care operations; use by the originator of the notes for treatment; use by the Plan to defend itself in a lawsuit that you initiate; when required by the Secretary of the Department of Health and Human Services; when such disclosure is required by law; for health oversight activities as permitted under the regulations; disclosure to a person who can reasonably prevent serious harm to an individual or the public; and disclosure to a medical examiner or coroner for the purpose of identifying a deceased person, determining cause of death, or such other purposes permitted by law. While the regulations permit covered entities to use and disclose psychotherapy notes for purposes of training health professionals or students, the Plan does not engage in such training exercises and cannot disclose the information for these purposes.

14. **Victims of Abuse, Neglect, or Domestic Violence.** The Plan may disclose your PHI if there is reasonable belief that you are a victim of abuse, neglect, or domestic violence. Such disclosure is permitted under HIPAA only if required by law or with your permission or to the extent the disclosure is expressly authorized by statute and only if, in the Plan's best judgment, the disclosure is necessary to prevent serious harm to you or other potential victims.

15. **Health Oversight Activities and Joint Investigations.** The Plan must disclose PHI requested of health oversight agencies for purposes of legally authorized audits, investigations including joint investigations, inspections, licensure, disciplinary actions, or other oversight activities of authorized entities.
16. **Disaster Relief Efforts.** The Plan may use or disclose your PHI to notify a family member or other individual involved in your care of your location, general condition, or death, or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notification.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

The Plan will obtain your written authorization for any other uses or disclosures of your PHI, including for most uses and disclosures of psychotherapy notes, except in situations noted above, uses and disclosures of PHI for marketing purposes, and uses or disclosures that are a sale of PHI. The Plan will not condition eligibility to participate in the Plan or payment of benefits under the Plan upon your authorization, except where allowed by law. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization, except for where we have taken action in reliance on your authorization before we received your written revocation.

STRICTER STATE PRIVACY LAWS

Under the HIPAA Privacy Regulations, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain:

1. **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about your health and related issues in a particular manner or at a certain location if you feel that your life may be endangered if communications are sent to your home. For example, you may ask that we contact you at work rather than home. In order to request a type of confidential communication, you must make a written request to the address at the end of this section specifying the requested method of contact or the location where you wish to be contacted. For us to consider granting your request for a confidential communication, your written request must clearly state that your life could be endangered by the disclosure of all or part of this information.

2. **Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. We generally are not required to agree to your request except in limited circumstances; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosure of your PHI, you must make your request in writing to the address at the end of this section. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit the Annual Executive Physical Program's use, disclosure, or both; and (c) to whom you want the limits to apply.

3. **Right to Inspect and Copy.** Except for limited circumstances, you have the right to inspect and copy the PHI that may be used to make decisions about you. Usually, this includes medical and billing records. To inspect or copy your PHI, you must submit your request in writing to the address listed at the end of this section. The Plan must directly provide to you, and/or the individual you designate, access to the electronic PHI in the electronic form and format you request, if it is readily producible, or, if not, then in a readable electronic format as agreed to between you and the Plan. The Plan may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances, in which case you may submit a request to the Plan at the address at the end of this section that the denial be reviewed.

4. **Right to Request Amendment.** You have the right to request that we amend your PHI if you believe it is incorrect or incomplete. To request an amendment, you must submit a written request to the address listed at the end of this section. You must provide a reason that supports your request for amendment. We may deny your request if you ask us to amend PHI that is: (a) accurate and complete; (b) not part of the PHI kept by or for the Plan; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by

the Plan, unless the individual or entity that created the PHI is not available to amend it. Even if we deny your request for amendment, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request, it will become part of your medical record and we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

5. **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain disclosures we have made of your PHI, for most purposes other than treatment, payment, health care operations, and other exceptions pursuant to law or pursuant to your authorization. To request an accounting of disclosures, you must submit a written request to the address at the end of this section. You must specify the time period, which may not be longer than the six-year period prior to your request. We will notify you of the cost involved in complying with your request and you may choose to withdraw or modify your request at that time.

6. **Paper Notice.** You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

If you believe your privacy rights have been violated, you may file a complaint with the Annual Executive Physical Program or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit it in writing to the address listed at the end of this section. Neither Walmart nor the Plan will retaliate against you for filing a complaint. You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Annual Executive Physical Program or with the U.S. Department of Health and Human Services.

If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

Walmart People Services
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail Stop 3610
Bentonville, Arkansas 72716-3610

Email your questions to: **AHWPrivacy@walmart.com**
Telephone: **800-421-1362**

Addendum: Services by AEPP provider

MERCY

- Preventive exam
- Blood pressure
- Blood tests: CMP, thyroid panel, CBC, PSA (men, age appropriate), A1C
- Cholesterol abnormalities screening (lipid panel)
- Urinalysis
- EKG
- Colorectal cancer screening (FOBT/FIT annually or sigmoidoscopy every 5 years or colonoscopy every 10 years)
- Diabetic screening adults with HTN
- Diabetic screening pregnant women
- Abnormal aortic screening men >65 current or former smoker
- Breast cancer screening women 40+
- Cervical cancer screening every 3 years
- MDCT for coronary calcium (1x/at-risk)
- Skin cancer screening
- Behavioral health screening
- Chest X-ray (baseline)
- Pulmonary function test (baseline)
- Hearing test (baseline)
- Flu
- Tdap
- Travel immunizations as needed
- Smoking cessation counseling
- Other counseling as needed (nutrition, exercise, etc.)
- Breast diagnostic ultrasound

MAYO

- Preventive exam—new patient
- Preventive exam—established patient
- Report visit day 2
- Urinalysis (mid-stream)
- Venipuncture
- Lipid panel/Coronary risk profile
- CBC w/5-part differential
- Thyroid function cascade
- HIV (one-time screening)
- Vitamin D

- Prostate specific antigen (PSA: beginning age 40)
- Hepatitis C antibodies (one-time screening age 18-79)
- Vitamin B12 (baseline age 50)
- Electrocardiogram, resting (baseline; then at a minimum of every 3 years)
- Exercise treadmill test, electrocardiogram
- Audiogram (baseline age 60)
- Colonoscopy, base procedure (age 45; Q5-10, or clinical judgment)
- Facility fee
- U/S aorta/renal (males age 65)
- Cervical pap smear cytology
- Pap smear collection
- Digital mammogram bilateral (beginning age 40)
- Bone density (baseline women age 55; unless high risk or low energy fracture)
- Exercise physiology office visit for new executives under 40
- CT coronary calcium scan (baseline women age 55; men age 40)
- Assay urine osmolality
- Lipoprotein (a) (new patients)
- Tomosynthesis, computer aided direction
- Hemoglobin A1C
- Cologuard (age 45; every 5-10 years or clinical judgment; with physician approval)
- Breast ultrasound as needed
- Comprehensive metabolic panel
- Hepatitis B one-time screening
- V02 max test (new patients under 40)
- HBC total AB, serum
- HBC antibody, serum

EHE

- Preventive exam
- Blood pressure
- Lipids screen
- CVD counseling
- Exercise/fitness evaluation and counseling
- Stress management evaluation and counseling
- Sleep evaluation and counseling
- Obesity/nutrition
- Alcohol/substance
- Depression/mood
- Domestic violence
- Tobacco counseling
- Risk reduction intervention/counseling
- Flu vaccine
- Complete blood count
- Hearing and vision
- Complete metabolic profile
- Urinalysis
- Body map (movement screen)
- Advance directive
- HsCRP (C-reactive protein)
- FIT
- Electrocardiogram
- Breast cancer risk assessment
- Aortic aneurysm screen
- Blood typing (ABO)
- 3-minute step test
- Coronary calcium CT scan (CCT)
- Peripheral vascular disease screening (PVD)
- Chlamydia test
- Hemoglobin A1c
- Gonorrhea test
- Hepatitis A antibody test
- Hepatitis B screening (Ab/Ag)
- Hepatitis C screening
- HIV test
- Lung CT scan (lung cancer screening)
- Screening mammogram every 1-2 years
- Bone density screening (DEXA)
- Pap smear/HPV screening
- Prostate cancer screening
- Syphilis test
- TSH (thyroid) test
- Screening colonoscopy
- HPV vaccine
- Hepatitis A antibody test
- Hepatitis B antibody test
- Hepatitis B screening
- Hepatitis C screening
- Meningitis vaccine
- MMR vaccine
- PCV20/PCV21 vaccine
- Shingles vaccine

- TD/Tdap vaccine
- Varicella vaccine
- COVID 19 vaccine
- RSV vaccine
- Flu vaccine
- Comprehensive pre-travel consultation
- International certificate of vaccination
- Japanese encephalitis vaccine
- Rabies vaccine
- Typhoid vaccine
- Yellow fever vaccine
- Malaria prophylaxis
- Traveler’s diarrhea (prescription)
- Attitude sickness prophylaxis
- Breast screening ultrasound
- ASCVD heart disease risk assessment / PREVENT
- QuantiFERON test
- Lipoprotein (a)
- Iron Studies
- Vitamin B12 test
- Vitamin D test
- Urine albumin/creatinine ratio test
- Magnesium test
- Uric acid
- Testosterone
- Insulin
- Celiac disease screening

COOPER CLINIC

- Medical exam and counseling
- Chem 18
- Lipid panel
- Complete blood count (CBC)
- Omega 3 index
- Ferritin
- Testosterone
- Hemoglobin A1C
- Thyroid stimulating hormone (TSH)
- Hepatitis panel
- Total prostate specific antigen (TPSA)
- High sensitivity C-reactive protein (hs-CRP)
- Urinalysis
- Homocysteine
- Vitamin B12
- Human immunodeficiency virus (HIV)
- Vitamin D
- Cardiovascular screening—treadmill or stationary cycle stress test
- Dual source CT scan
- Dermatology—skin cancer screening
- Nutrition coaching
- Pap smear (females)
- Human papillomavirus (HPV) (females)
- 3D mammogram (females)
- Glomerular filtration fate (GFR)
- Breast unilateral diagnostic ultrasound
- Breast bilateral diagnostic ultrasound
- Breast screening ultrasound
- Apolipoprotein B
- Lipoprotein (a)

Annual Executive Physical Program | Summary Plan Description

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