Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Walmart

Group policy number: GP-0895530
Group control number: CN-0486824

Amendment effective date: January 1, 2025

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Maine. The benefits below will apply instead of those in your booklet-certificate.

Children's early intervention services

Covered services include children's early intervention services for dependents from birth to 36 months with an identified development disability or delay, as described in the Federal Individual with Education Act, Part C, United States Code, Section 1411, et seq. These services may be provided by:

- Licensed occupational therapists
- Physical therapists
- Speech-language pathologists, or
- Clinical social workers
- Other providers as designated within the Disabilities Act

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training, including training and education services provided through ambulatory diabetes facilities authorized by the State's Diabetes Control Project within the Bureau of Health

Hearing aids

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The maximum benefit payable is limited to $3,000 per hearing aid for each hearing-impaired ear every 36 months.

The following are not **covered services**:

- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription** drugs
  - Psychological counseling
  - Dietary counseling

The following are not **covered services**:

- Funeral arrangements
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, and postnatal visits. After your child is born, **covered services**. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 1 home visit after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

Routine newborn care services are part of the mother's benefit. The mother and newborn will be considered as one person when calculating the **deductible**, **coinsurance** and any applicable **copayments**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include parenteral and enteral formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

Covered services also include amino based elemental infant formula for any of the following documented conditions in children 2 and under:

- Symptomatic allergic colitis and proctitis
- Laboratory or biopsy proven allergic or eosinphillic gastroenteritis
- History of anaphylaxis
- Gastresophageal reflux disease
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a **provider**
- Cystic fibrosis
- Malabsorption of cow-milk based or soy-milk based infant formula

The submitted documentation for the above mentioned conditions must show:

- The formula is medically necessary as defined by Maine law
- The formula is 50% or more the primary nutrition source

Other commercial infant formulas, including cow and soy milks, have been tried, failed or are contraindicated.

The following are not **covered services**:

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items

Routine Cancer Screenings

Mammograms under the Routine Cancer Screening benefit also include an additional radiologic procedure recommended by a **provider** when the results of an initial radiologic procedure are not definitive.

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Benefits equal to the limits provided by Medicare law

You may receive a prosthetic device as part of another **covered service** and therefore it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Telehealth

Covered services include **telehealth** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telehealth provider** acting within the scope of their license.

For those plans that use a network of **providers, covered services** for **telehealth** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.aetna.com/ to review our **telehealth provider** listing and Contact us to get more information about your options, including specific cost sharing amounts

The following are not **covered services**:

- **Telehealth** kiosks

Protection from surprise bills

In cases where you try to stay in the network or unknowingly go out-of-network for your **covered services**, you may get a bill you didn't expect. The plan may have approved coverage but you went outside the network without even knowing it.

When you're a patient in a **hospital**, the **hospital** may be in the network but some services you receive can be from doctors and labs who are not in the network. You can tell the **hospital** staff to only use network services during your stay, but that's not always possible. When you don't know or have no choice, you will pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider, We will calculate any coinsurance amount based on the median network rate for that service. Contact us if you receive any surprise bills.

It is not a surprise bill when you knowingly choose to go outside the network. In this case, you will have to pay for it.

"Surprise bill" means a bill for health care services, including, but not limited to, emergency services, received by an enrollee for covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. "Surprise bill" does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours or 2 business days, whichever is less, after receipt. If approved, you may receive the non-preferred drug benefit level and the exception will apply for the entire time you are taking the prescription. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your **provider** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your provider of our decision.

Continuity of prescription drugs

If you are undergoing a course of treatment with a previously authorized **prescription** drug from another carrier and your coverage is replaced by this coverage, we will honor the prior carrier's authorization. We will continue to provide coverage in the same manner until we review the authorization with your prescriber.

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth (newborn is automatically covered for the first 31 days)
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Note for dependent children: Unless you have not given consent for notification, if a parent asks us, we will give them:

- An explanation of the payment or denial of any claim filed for you
- An explanation of proposed changes in the terms and conditions of the plan
- Reasonable notice that the plan may lapse
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Also, any parent that can give the information necessary to process a claim must be allowed to authorize a claim. You must provide an address where the parent can be notified.

Why would we end your coverage?

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

Reinstatement due to cognitive impairment or functional incapacity

You may tell us if you would like a representative appointed or changed for notifications. If we discontinue coverage for failure to pay your premium, you or your representative, will receive the notification for termination 10 days before the termination date. You or your representative may submit a request for reinstatement within 90 days of the notice, showing that your failure to pay was due to native impairment or functional incapacity.

We may request medical documentation, at your expense, documenting the diminished capacity.

How you can extend coverage if your coverage ends because you are laid-off or you sustain an injury or disease compensable under Workers' Compensation

If you are totally disabled when coverage ends, coverage for you and your dependents may be extended if your coverage ended because:

- You are temporarily laid-off
- You are permanently laid-off and are eligible for premium assistance pursuant to federal law; or
- You sustain an injury or disease that you claim to be compensable under Workers' Compensation law.

You are eligible to extend your coverage under this provision if:

- You had group health coverage continuously under this plan for the last 6 consecutive months

Your dependents are eligible to extend coverage under this provision if:

- They had group coverage continuously under this plan for the last 3 consecutive months, unless they were not eligible for coverage until after the beginning of that 3 month period

You may extend coverage until the earliest of:

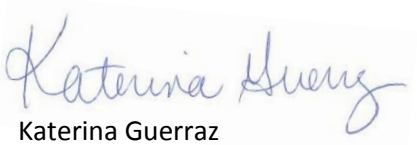
- When you become covered by another health benefits plan
- 12 months from the date of last employment
- The date the Workers' Compensation Board determines that the injury or disease that entitles you to continue coverage under this provision is not compensable under applicable Workers' Compensation law
- You fail to pay any required extension premium

We will extend your coverage only if you pay extension premiums. You must pay your first extension premium within 31 days after your coverage ends. Your extension premium may be up to 102% of the premium charged to a member who whose coverage has not ended.

Provider

A provider under your plan is defined as a **physician**, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Amendment: Maine Medical ET
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