

# Aetna Life Insurance Company

## Extraterritorial booklet-certificate amendment

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**Policyholder:** Walmart  
**Group policy number:** GP-895530-AR  
**Group control number:** CN-486824

**Amendment effective date:** January 1, 2021

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 Oregon. The benefits below will apply instead of those in your booklet-certificate.

### **Obtaining Coverage for Dependents** (GR-9N 029-010 02 OR)

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules outlined in the *Coverage for Domestic Partner* section below; and
- Your dependent children.

**Aetna** will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

### **Coverage for Domestic Partner** (GR-9N 29-010 01)

To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under Oregon law for entering into a domestic partnership; and
- jointly execute and register a Declaration of Domestic Partnership with the county clerk.

### **Coverage for Domestic Partner** (GR-9N 29-010 01)

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.

- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver’s license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.

## Prosthetic and Orthotic Devices (GR-9N-11-110-02 OR)

**Covered expenses** include charges made for internal and external prosthetic and orthotic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic and orthotic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

**Covered expenses** also include replacement of a prosthetic and orthotic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes those in the most recent Medicare Fee Schedule.

The plan will not cover expenses and charges for, or expenses related to:

- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

### Bilateral cochlear implants

**Eligible health services** include bilateral cochlear implants for the treatment of hearing loss and include the following related services and supplies:

- Programming and reprogramming of cochlear implants
- Repair and replacement parts including:
  - Repair or parts not covered by warranty
  - Repair or parts necessary for the device to be functional

Bilateral cochlear implants and related services		
Bilateral cochlear implants	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

## Hearing aids, hearing assistive technology systems, and exams

**Eligible health services** include hearing aids, hearing assistive technology systems, and exams as described below.

Hearing aid means:

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

Hearing assistive technology systems means:

- Devices used to improve your ability with hearing loss in situations such as:
  - Being located a distance from a speaker,
  - In an environment with competing background noise
  - In a room with poor acoustics or reverberation.

Hearing aid services are:

- Audiometric hearing exam 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, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who 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
- Bone conduction sound processors
- Any other related services necessary to access, select and adjust or fit a hearing aid

<b>Hearing aids, hearing assistive technology systems, and exams</b>		
Hearing aid exams	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Hearing aids	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Hearing assistive technology systems	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

## Chemotherapy

**Covered expenses** include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

## Radiation Therapy Benefits

**Covered expenses** include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

## Outpatient Infusion Therapy Benefits

**Covered expenses** include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

*Not* included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

### **Important Reminder**

Refer to the *Schedule of Benefits* for details on any applicable **deductible, coinsurance** and maximum benefit limits.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

## Smoking Cessation

Covered expenses for a covered person who is 15 years of age or older include physician services, prescription drugs and over-the-counter medications prescribed by a physician for a tobacco use cessation program.

A tobacco use cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco use cessation. A tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

<b><i>Tobacco Cessation</i></b>		
<b><i>Physician Services</i></b>	Cost sharing is based upon the type of physician providing the service.	Cost sharing is based upon the type of physician providing the service.
Prescription Drugs and Over-the-Counter Medications	100% per prescription, medication or refill, after Calendar Year <b>deductible</b>	80% per prescription, medication or refill, after Calendar Year <b>deductible</b>

The following exclusion has been removed:

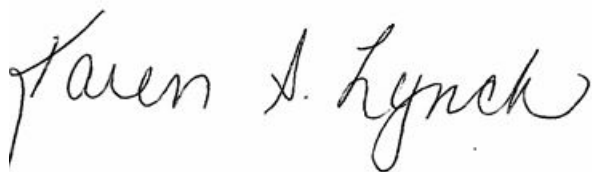
Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

### **Smoking Cessation**

Tobacco Cessation. For a covered person who is 15 years of age or older, the prescription drug plan covers prescription drugs and over-the-counter medications prescribed by a physician that are recommended by a physician and follow the United States Public Health Services guidelines for tobacco use cessation.

### **Substance Abuse**

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to food.



Karen S. Lynch  
 President  
 Aetna Life Insurance Company  
 (A Stock Company)

Amendment: Oregon Medical ET  
 Issue Date: October 1, 2020