AMENDMENT #3 **CEBT (EPO Plan)**
Employer Identification Number: 74-2141123

BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

On page 1-19, the Physical, Speech, Occupational and Aquatic Therapy benefit is amended to read as follows:

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Physical, Speech, Occupational and Aquatic Therapy EPO Plan 3 EPO Plan 4 EPO Plan 5 EPO Plan 6	 $40 copay per visit/100% $45 copay per visit/100% $50 copay per visit/100% $55 copay per visit/100%	Therapy services are limited to a combined maximum of 20 visits per *sickness* or *injury*. Additional visits may be available if approved by the *plan*. Specific to speech therapy: • the 20 visit maximum is not applied to speech therapy for autistic children • coverage will be allowed for covered *dependent* children up to age five, without regard to diagnosis (prior authorization is not required) *Prior authorization* is required (except as specifically stated otherwise for speech therapy for *dependent* children up to age five). Please refer to pages 1-1 and 1-2 for information.	

On page 1-23, the EPO Network Information section is amended to read as follows:

EPO NETWORK INFORMATION

EPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the *plan's* incentives to use *EPO* providers. These contracts establish a fair market value for health care services, which in most cases will reduce *your* costs.

The *trust* has contracted one or more *EPO's* to provide services to this *plan* in the areas it has *members*. Each *EPO* network consists of physicians, *hospitals* and other medical care providers. The *EPO* that is applicable to *you* is shown on *your* ID card. A provider may enter into an agreement to provide only certain covered health services, but not all covered health services, or to be an *EPO* network provider for only some products. In this case, the provider will be an *EPO* network provider for the covered health services and products included in the participation agreement, and a non-*EPO* network provider for other covered health services and products. The participation status of providers may change from time to time.

Any *plan* limits on access to specialist or emergency care, use of primary care physicians, or pre-authorization of benefits are shown on the Schedule of Benefits.

On page 1-31, the X-ray and Laboratory Tests benefit is amended to read as follows:

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A *qualified practitioner* must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered *injury* or oral surgery.

On page 1-35, item 2 of the Other Covered Expenses section is deleted from the *plan* in its entirety.

On page 1-35, item 5 of the Other Covered Expenses section is amended to read as follows:

5. Rental of durable medical equipment or purchase of such equipment when approved by the *plan* (e.g. wheelchair, *hospital* bed). The equipment must be needed for therapeutic treatment and not be mainly hygienic, custodial or educational in nature. It must be able to withstand repeated use. It must be primarily and normally used to serve a medical purpose. It must not be generally useful to a person except for the treatment of an *injury* or *sickness*. Repair expenses are covered for purchased equipment. Maintenance expenses are not covered. Convenience items, as determined by the *plan*, are not covered. Unless approved by the *plan* benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.

On page 1-36, item 16a is amended to read as follows:

a. bone marrow or stem cell transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) for certain conditions;

On page 1-41, item 36 of the Other Covered Expenses section is amended to read as follows:

36. Nutritional counseling/therapy, payable as any other *sickness* or *injury*. Nutritional counseling/therapy is only allowed for the following conditions:
    a. HIV/AIDS
    b. cancer
    c. premature infant
    d. diabetes
    e. eating disorders
    f. hyperlipidemia
    g. hypertension

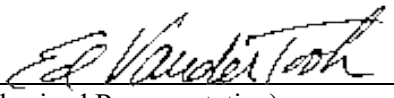
    The *plan* will cover a maximum of four visits per *lifetime* per condition (nutritional counseling as recommended by the United States Preventive Services Task Force (USPSTF) are not subject to this maximum). To be a *covered expense*, the nutritional counseling must be prescribed by a *qualified practitioner* and received from a licensed dietician or nutritionist under the supervision of a *qualified practitioner.*

On page 1-44, item 3 of the Reproduction section is amended to read as follows:

3. **Genetic testing or counseling**, unless used to treat the *sickness* or *injury* of a *covered person* or used in the treatment of a high risk pregnancy;

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of January 1, 2022.

Colorado Employer Benefit Trust



(Authorized Representative)

November 17, 2021

(Date)