AMENDMENT #3 **CEBT (PPO and High Deductible Plan)**
Employer Identification Number: 74-2141123

BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

On page 1-28, 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		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.	
PPO Plan 2	*PPO*: $30 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		
PPO Plan 3	*PPO*: $35 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		
PPO Plan 4	*PPO*: $40 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		
PPO Plan 5	*PPO*: $45 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		
PPO Plan 6	*PPO*: $50 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		
PPO Plan 7	*PPO*: $55 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Physical, Speech, Occupational and Aquatic Therapy – continued			
PPO Plan 8	*PPO*: $55 copay per visit/100% Non-*PPO*: Subject to the deductible and coinsurance		
QHDHP 2800, 3500, HDHP 2, HDHP 3, HDHP 4, HDHP 5	Subject to the deductible and coinsurance		

On page 1-36, the PPO Network Information section is amended to read as follows:

PPO NETWORK INFORMATION

PPO network means an organization that has contracted with various providers to provide health care services to *covered persons* at a *negotiated rate*. Providers who participate in a *PPO* network have agreed to accept the *negotiated rate* as payment in full, including any portion of the fees that the *covered person* must pay due to the deductible, coinsurance, copay or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the *negotiated rates* in the network contract. A provider who does not participate in a *PPO* network may bill *covered persons* for additional fees over and above what the *plan* pays.

Knowing which *PPO* network a provider belongs will help *you* to determine how much *you* will need to pay for certain services. To obtain the highest level of benefits under this *plan*, *covered persons* should receive services from *PPO* providers. However, this *plan* does not limit a *covered person's* right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a *covered expense* under this *plan*, or is subject to a limitation or exclusion.

The *trust* has contracted one or more *PPO* networks to provide services to this *plan* in the areas it has *employees*. Each *PPO* network consists of physicians, *hospitals* and other medical care providers. The *PPO* 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 a *PPO* network provider for only some products. In this case, the provider will be a *PPO* network provider for the covered health services and products included in the participation agreement, and a non-*PPO* 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 1-45, 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 1-49, item 2 of the Other Covered Expenses section is deleted from the *plan* in its entirety.

On page 1-49, 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 1-50, item 17a 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 1-55, item 34 of the Other Covered Expenses section is amended to read as follows:

34. 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

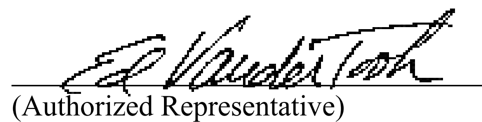
    The *plan* will cover a maximum of four visits per *lifetime* per condition (nutritional counseling as recommended by the United States Preventive Services Task Force (USPSTF) are not subject to this maximum). To be a *covered expense*, the nutritional counseling must be prescribed by a *qualified practitioner*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

On page 1-59, 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)