AMENDMENT TO THE

GBA INSURANCE TRUST MEDICAL PLAN (Plan)

The Georgia Bankers Association Insurance Trust, Inc. sponsors the Plan for the benefit of the eligible employees and family members of participating employers. In accordance with federal law, effective as of March 18, 2020 and continuing until the end of the declared public emergency due to COVID-19, the Plan is amended to provide as follows:

The following items and services shall be covered without cost sharing, provided that such items and services are determined by the covered member's attending healthcare provider to be medically appropriate for the covered member, in accordance with accepted standards of current medical practice. The Plan's prior authorization or other medical management requirements shall not apply.

(1) **Testing for diagnosis or confirmation of COVID-19.** In vitro diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19, as defined in FFCRA 6001(a), including serological testing for COVID-19 (an "In Vitro Diagnostic Product").

(2) **Related services, but only if testing is administered or ordered.** Items and services furnished to a covered member during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an In Vitro Diagnostic Product, but only to the extent the items and services relate to the furnishing or administration of the Product or to the evaluation of the covered member for purposes of determining the need for such Product.

(3) **Additional tests in the same visit to determine whether COVID-19 testing is needed.** Other tests (e.g., influenza tests, blood tests, etc.) performed during such visit to determine the need of a Covered Member for COVID-19 diagnostic testing, provided the visit results in an order for, or administration of, an In Vitro Diagnostic Product.

These items and services are provided without cost sharing when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice. The Plan's prior authorization or other medical management requirements will not apply. These rules also apply to high deductible health plans, even if the deductible has not been met.