



TRUIST FINANCIAL CORPORATION  
EMPLOYEE BENEFIT PLAN

Truist Financial Corporation Health Plan  
Summary Plan Description for Medical, Dental and Vision Benefits

Effective as of  
January 1, 2021

## FOREWORD

The Employee Retirement Income Security Act ("ERISA") is a federal law that sets the standards for many types of employee benefit plans. One of the requirements under ERISA is that the Plan Sponsor provides participants with a Summary Plan Description ("SPD") which is a non-technical summary of plan provisions.

This Summary Plan Description ("SPD") summarizes the Truist Financial Corporation Health Plan (the "Plan"). The Plan is designed to provide you and your covered dependents coverage for medical, dental and vision care expenses. Benefits under the Plan are described in the Program Documents listed in Appendix A.<sup>1</sup> This document, together with Program Documents listed under Appendix A and the plan document for the Truist Financial Corporation Employee Benefit Plan, is the governing Plan Document and SPD for the Plan as of January 1, 2021.

Self-funded benefits described in this SPD are provided under an administrative services only ("ASO") agreement between the Plan and the Third-party Administrator. Fully-insured benefits described in the SPD are provided under a group insurance policy issued by an Insurance Company. The Third-party Administrators and Insurance Companies (collectively, the "Benefits Service Managers")<sup>2</sup> have been designated and named the claims fiduciary for benefits provided under the Plan. The Benefits Service Managers have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions under the Plan, to the extent permitted by applicable state law. Benefits under the Plan are described in the Program Documents.

We encourage you to read the SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed under "Facts About the Plan" for each benefit program.

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<sup>1</sup> Appendix A may be amended by the Plan Sponsor and/or Plan Administrator at any time without formal amendment to the Plan.

<sup>2</sup> The Benefits Service Managers are listed in Appendix A.

## FACTS ABOUT THE PLAN

<b>Plan Name</b>	Truist Financial Corporation Health Care Plan. The Plan is a component plan of the Truist Financial Corporation Employee Benefit Plan (Plan Number 508).
<b>Plan Sponsor Address and Telephone Number</b>	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 715-2455, option 1 <a href="mailto:benefits@truist.com">benefits@truist.com</a>
<b>Employer Identification Number</b>	56-0939887
<b>Effective Date</b>	This is a summary of the Truist Financial Corporation Health Care Plan effective January 1, 2021
<b>Plan Administrator</b>	Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, Charlotte NC 28202
<b>Name and Address of Agent for Legal Service</b>	Chairman, Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, Charlotte NC 28202
<b>Plan Number</b>	508
<b>Type of Plan</b>	Self-Funded Welfare Plan providing medical, dental and vision benefits. Benefits provided through Kaiser Permanente and Cigna DHMO are fully insured.
<b>Plan Year/Benefit Period</b>	January 1 through December 31

## ELIGIBILITY

An eligible employee is any regular (not temporary or contingent) employee scheduled to work at least 20 hours per week. Benefits will be provided only if coverage is in effect for a participant or dependent at the time the charges are incurred.

Employee means (1) a common law employee of Truist Financial Corporation ("Truist") or any other Truist affiliate that becomes a participating employer in the Plan<sup>3</sup> (collectively, "Employer"). Employee shall not include a person who is classified by an Employer as an independent contractor or a person who is not treated by an Employer as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding. If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by an Employer, a governmental body, or the judiciary as an employee, such person, for purposes of the Plan, shall be deemed to be an employee from the actual (and not effective) date of such classification by Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable. Additionally, the term employee excludes any person who, as to the United States, is a non-resident alien with no U.S. source income from an Employer.

### Becoming a Participant

Eligible employees become participants on the first day of the month following employment, provided they elect to be covered under the Plan. An eligible employee may choose to be covered under the medical portion, the dental portion, the vision portion or any combination.

If an eligible employee does not elect to participate in the Plan, he or she may choose to become a participant by making an appropriate election during the Plan's annual enrollment period. Other entry dates may be available under certain specific circumstances. Please see "Changes in Coverage" for more information.

An employee who is not currently an eligible employee may become a participant on any such future date that he or she meets the eligibility requirements.

### Dependents

As a participant in this Plan, you may cover your dependents defined as follows:

- 1) Your legal Spouse;
- 2) Your Domestic Partner; and
- 3) Your Children under age 26.

For purposes of this Plan, "Spouse" means the person with whom the Employee has entered into a valid marriage in accordance with the law of the jurisdiction in which the marriage between the employee and such person is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the Employee is domiciled. For purposes of eligibility under this Plan, a person who is the Employee's Spouse is no longer considered a Dependent on the date a decree of divorce, legal separation, or

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<sup>3</sup> Participating employers are listed in Appendix D.

annulment between the employee and his or her Spouse is entered by a court.

For purposes of this Plan, "Domestic Partner" is any person who, with the employee, meets the following requirements:

- 1) Both persons are at least 18 years of age;
- 2) Both persons must share a common primary residence;
- 3) Neither person should be related by blood such that it would prevent them from being married in the state in which they reside;
- 4) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved or adjusted a nullity;
- 5) Both persons must be legally capable of consenting to a domestic partnership; and
- 6) Both persons have lived together at least one year (or the person is registered as your domestic partner in a state where registration is available).

For purposes of this Plan, "Child" or "Children" includes natural child, stepchild, adopted child, foster child, or any child who meets the definition of Qualifying Child in section 152(f) of the Internal Revenue Code

You may continue to cover any disabled children who are dependent on you even though they are no longer under age 26. If you want to continue to cover your disabled child, it will be necessary to submit proof of incapacity within 31 days after the date the child would have otherwise ceased to be an eligible dependent. An eligible employee can add a disabled child to the Plan. Proof of incapacity may be required from time to time.

If a child is eligible for coverage by more than one employee, only one employee may cover the child. In addition, an employee cannot cover another employee as a dependent. If you have questions regarding your dependents' coverage, contact Benefits Administration.

### **Dependent Eligibility**

Your dependents become eligible for coverage on the latest of the date you become eligible for coverage and:

- 1) The date a person becomes your legal dependent (for example, you get married or have a child); or
- 2) The date an adopted child is placed in your home for adoption, even though the adoption may not yet be final. If the adopted child is a newborn, the child will be covered from the moment of birth if the adoption petition has been filed, subject to coverage rules as defined below.

Coverage for a dependent will begin on the date the dependent becomes an eligible dependent, provided you make an election in Workday within 31 days of the eligibility date. **If you wait more than 31 days to apply for coverage for your dependent(s), you may not add the dependent(s) to your coverage until the Plan's next annual enrollment period.**

### **FUNDING**

The cost of the Plan is generally shared by you and your Employer. By sharing the cost of the Plan, we can provide the best possible coverage for you and your dependents at a reasonable cost. Fully-insured

benefits are provided under an insurance contract entered into between Truist and the Insurance Company identified in appendix A.

Self-Insured benefits are paid from the general assets of the Plan Sponsor. Claims processing and other delegated functions for the Benefit Plan are administered by the Third Party Administrator Identified in Appendix A.

### **ON-SITE HEALTH CLINICS**

In certain locations, Truist makes available an on-site health clinic for employees. The clinics are available, with applicable cost-sharing, to all benefits eligible employees even those who do not elect other medical coverage through the Plan. Employees who are not eligible for benefits may still be able to access the on-site clinic at their own cost.

### **EMPLOYEE ASSISTANCE PROGRAM**

All employees, even those who do not meet the requirements for benefits and those that elect no coverage in the health care plan, have access to an Employee Assistance Program (EAP) offered through ComPsych. Additional information about the EAP can be found at [benefits.truist.com](https://benefits.truist.com).

### **LIFEFORCE**

The Truist LifeForce Program encourages healthy lifestyles by evaluating an employee's current health and fitness level, and setting goals for achieving a desired level of fitness for each employee. A significant reduction in premiums for medical plans may be realized by successfully participating in the LifeForce Program. The LifeForce program is a voluntary, outcomes-based wellness program that is subject to federal guidelines. Specific information regarding the program's requirements and the data collected by the program can be found at [benefits.truist.com](https://benefits.truist.com). Please contact HR Central at 800-716-2455 or visit [benefits.truist.com](https://benefits.truist.com) for more information regarding this program.

### **CHANGES IN COVERAGE**

Prior to January 1 of each year, there will be an enrollment period for employees who wish to add or drop coverage for themselves or their dependents, or change Plan options. Benefit changes made during the enrollment period will be binding for the Plan year unless a status change is experienced. Status changes include:

- 1) Birth, Adoption, Placement for Foster Care, Legal Guardianship
- 2) Marriage, Divorce, Legal Separation
- 3) Gain or Loss of Spouse's coverage due to change in employment
- 4) Gain or Loss of coverage under Medicare or Medicaid
- 5) Loss of coverage due to loss of eligibility for Medicaid or CHIP<sup>4</sup>
- 6) Eligibility for premium assistance under Medicaid or CHIP<sup>5</sup>

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<sup>4</sup> For this change, you are allowed a 60-day period to initiate the change.

<sup>5</sup> For this change reasons only, you are allowed a 60-day period to initiate the change.

- 7) Death of Spouse or Child
- 8) COBRA coverage expires or COBRA subsidy expires
- 9) Start or End of Unpaid Leave of Absence
- 10) Start or End of Military Leave
- 11) Spouse moves into or out of the USA
- 12) Significant change in health care cost of Spouse's coverage
- 13) Loss of Eligibility under a parent's coverage

Voluntarily dropping coverage is not a status change that will allow you to change your coverage under the Plan. In addition, a child changing student status is not a status change that will allow you to change your coverage under the Plan.

It is the employee's responsibility to request changes in coverage after a status change within 31 days of the status change date. Employees can request changes by logging on to Workday or through [www.benefits.truist.com](http://www.benefits.truist.com).

## **TERMINATION OF COVERAGE**

### **Employees**

Your eligibility to participate in the Plan will terminate on the earliest of the following dates:

- 1) The 15th of the month in which you terminate if your last day worked is on or before the 15th. If you terminate after the 15th of the month, your coverage will end on the last day of the month in which you terminate employment;
- 2) The date the Plan is amended to terminate the coverage of a class of employees of which you are a member;
- 3) The date any required premium contribution is not made;
- 4) The date the Plan is terminated; or
- 5) The 15th of the month in which your scheduled hours drop below 20 hours per week if that change occurs on or before the 15th. If your scheduled hours drop below 20 hours per week after the 15th of the month, your coverage will end on the last day of the month.

If you meet the requirements to retire from Truist, your coverage will end on the last day of the month in which you retire. An employee qualifies for retirement from Truist if the employee has (1) reached age 55 and has 10 or more years of service, or (2) reached age 65 and has 5 or more years of service.

If you are absent due to an authorized leave of absence, participation may continue during your leave period. Continued coverage under the above conditions shall terminate upon failure to make any required premium contribution. Contact Truist Benefits Administration for details regarding these important benefits.

### **Dependents**

Coverage for dependents ends on the earliest of the following dates:

- 1) The date your coverage ends;
- 2) The date you stop participating in the Plan;
- 3) The end of the month a dependent child ceases to be a dependent child (e.g., reaching the age limit);

- 4) The date the Plan is amended to terminate dependent coverage;
- 5) The date you fail to provide required information on your disabled dependent children or qualifying child;
- 6) The date you and your Spouse become divorced; or
- 7) The date you and your Domestic Partner end your partnership.

### **LEAVE OF ABSENCE**

While on leave of absence (with or without pay), your coverage will be continued. However, during that time, you will be required to make any necessary premium contributions for coverage. Once leave has ended, if you have not returned to active employment with your Employer (or been granted additional leave), coverage will terminate. Continuation of Benefits will be offered as described under the "Continuation of Benefits (COBRA)" section, beginning on the earlier of the date on which (1) your approved leave ends, or (2) you inform your Employer that you do not intend to return to work.

### **NO ASSIGNMENT OF BENEFITS**

Notwithstanding anything to the contrary in this SPD, the Program Documents, and/or or any other document, no participant or his or her Spouse and /or dependent may at any time assign his or her right under the Plan or any of the benefits available under the Plan to any party, including, but not limited to, a provider of healthcare services/items, his/her right to benefits under this Plan, nor may he/she assign any administrative, statutory, or legal rights or causes of action he/she may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be null and void and unenforceable under all circumstances. Under no circumstances shall any payments or communications made to any party be interpreted or considered as a waiver of this anti-assignment provision.

### **CONTINUATION OF BENEFITS (COBRA)**

The 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA) requires Truist to offer continuation of medical, dental or vision care coverage to employees and their eligible dependents when certain events occur. As an employee of Truist covered by the Plan, you and your eligible dependents have the right to choose this continuation coverage if you lose your medical coverage because of a qualifying event. Refer to the "Summary of Qualifying Events" chart.

Continuation periods are available for the following events:

18 months – employee, Spouse, Domestic Partner, eligible dependent:

- 1) Termination (other than for gross misconduct) (continuation of coverage may be extended for an additional 11 months if disabled at any time during the first 60 days of continuation coverage)
- 2) Reduction in scheduled hours to less than 20 per week

36 months – Spouse/Domestic Partner of an employee:

- 1) Death of employee



- 2) Divorce or legal separation
- 3) End of the Domestic Partnership
- 4) Employee becomes eligible for Medicare

36 months – employee's eligible dependent child:

- 1) Death of employee
- 2) Parent's divorce or legal separation
- 3) Parent becomes eligible for Medicare
- 4) Dependent child ceases to qualify as a "dependent child" under the Plan's definition

You will be notified by Truist if you become eligible for this continuation coverage because of termination or reduction in hours. Your Spouse or Domestic Partner and eligible dependent children will be notified of their eligibility for this continuation coverage if you die while an Employee. **It is your responsibility to contact Benefits Administration within 31 days of the date of the qualifying event if you are divorced.** Truist's notification will include an election form, more information about the cost of coverage, payment methods and the period of coverage.

If, during the 18-month continuation period, you should die, divorce or become legally separated, or if a child ceases to qualify for dependent coverage as defined by the Plan, the period for the affected dependent may be extended beyond the 18 months, but in no event beyond a total continuation period of 36 months.

If you or your covered dependent becomes eligible for Medicare after the date of the COBRA election, coverage will cease.

If you had Medicare coverage prior to COBRA coverage, Medicare will be the primary payer. If you enroll in COBRA coverage and later enroll in Medicare, your COBRA eligibility will end. If you are eligible for Medicare but choose not to enroll, you may elect COBRA coverage.

If you or your covered dependent first becomes covered under another group health plan after the date of the COBRA election, coverage will end.

If you elect this coverage, it will be the same program provided to active employees. You will have to pay the total cost (i.e., with no Employer subsidy) of the continuation coverage plus a 2% administration fee.

Continuation of coverage also may be provided to the extent specified by law in the unlikely event Truist files for bankruptcy.

Continuation of COBRA coverage will stop before the end of the time period indicated if:

- 1) You or your dependent first becomes covered under another group health plan after the date of the COBRA election;
- 2) You or your dependent becomes eligible for Medicare after the date of the COBRA election;
- 3) You do not pay the required premium within the grace period;
- 4) Truist ceases to provide group coverage to any employee; or
- 5) The continuing participant ceases to be disabled according to Social Security Administration after the 11-month disability extension has begun.

## Summary of Qualifying Events

Qualifying Event	Who Is Eligible	Maximum Extension	Who Must Notify Plan Administrator	Time Period for Notification <sup>6</sup>
Termination of employment (other than for gross misconduct)	Employee/Spouse/ Domestic Partner/ Eligible Dependents	18 months <sup>7</sup>	Employer	30 days
Reduction in hours which renders Employee ineligible	Employee/Spouse/ Domestic Partner / Eligible Dependents	18 months	Employer	30 days
Death of Employee	Spouse / Domestic Partner / Eligible Dependents	36 months	Employer	30 days
Employee becomes eligible for and selects Medicare	Spouse/ Domestic Partner / Eligible Dependents	36 months	Employer	30 days
Divorce or legal separation	Spouse/ Domestic Partner / Eligible Dependents	36 months	Spouse /Dependents	60 days
Dependent no longer meets eligibility requirements	Dependent	36 months	Dependent	60 days

## SUBROGATION AND RIGHT OF RECOVERY PROVISION

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for damages or compensation due to a person covered under the Plan ("Covered Person") as a result of a Covered Person's injuries, illness, or condition, including the liability insurer of such Responsible Party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether you are fully compensated for your damages. The Plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated. Neither the make-whole doctrine nor the common fund doctrine apply to the Plan.

The Plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any damages collected from a Responsible Party whether by action at law, settlement or compromise, by a Covered Person or his/her legal representative as a result of a Covered Person's injuries or

<sup>6</sup> If the member is disabled at the time or within the first 60 days of termination, coverage may be extended an additional 11 months at 150% of the full premium.

<sup>7</sup> Maximum period which runs from the date of the qualifying event.

illness, to the full extent of benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from all Responsible Parties. Further, the Plan will automatically have a first priority equitable lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from any Responsible Party as a result of the Covered Person's injuries, illness, or condition. The amount of the lien is equal to the amount of prior and future benefits paid by the Plan. The Plan also has a right to impose a constructive trust on the process awarded, transferred or paid by or on behalf of a third party to you, your dependents and any other person or entity holding the proceeds, including a legal representative or trust.

The Plan Administrator, or its delegate, has the sole authority and discretion to decide whether to pursue any right of recovery in favor of the Plan.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within thirty (30) days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claim Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice

the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

### **Recovery of Overpayment**

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's claims administrators. Under this process, the claims administrator reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. This right does not affect any other right of recovery the plan may have with respect to overpayments.

## **HOW THE PLAN IS ADMINISTERED**

### **Plan Operations**

Because benefits are provided through provided both through insurance contracts and on a self-funded basis, the Plan is administered by the Plan Sponsor and, as applicable for each benefit, the Insurance Companies and the Third-party Administrators.

### **Plan Administration**

The Plan Sponsor has named the Employee Benefits Plan Committee (Committee) as the Plan Administrator of the Plan. The Committee shall be the Plan Administrator, and the Chairman of the Committee shall be the agent for service of legal process on the plan.

As the Plan Administrator, the Committee is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs and, as required, filing an annual report about the Plan with the government).

The Committee shall consist of a Chairman, designated in the Committee's charter and not less than three

(3) individuals appointed by the Chairman. The Chairman may appoint a secretary who will not be a Committee member. Any member of the Committee may resign, and his successor, if any, shall be appointed by the Chairman.

### **Determining Eligibility to Participate**

The Committee is responsible for determining whether a particular individual is eligible to participate in the Plan.

### **Power and Authority of the Insurance Companies and Third-party Administrators**

Claims for insured benefits are sent to the applicable Insurance Company and claims for self-funded benefits are sent to the applicable Third-party Administrator (collectively, the "Benefits Service Managers"). The Benefits Service Managers, not the Plan Sponsor, are responsible for determining claims.

The Benefits Service Managers are the Named Fiduciary for benefit claims (i.e., Claims Fiduciary) and is responsible for:

- 1) Determining eligibility for a benefit and the amount of any benefits payable under the Plan; and
- 2) Providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

The Benefits Service Managers also have the authority to require eligible individuals to furnish them with such information as they determine is necessary for the proper administration of the Plan.

## **ALLOCATION OF RESPONSIBILITIES AMONG NAMED FIDUCIARIES**

### **Duties of Named Fiduciaries**

The named fiduciaries with respect to the plan and the fiduciary duties and other responsibilities allocated to each, which shall be carried out in accordance with the other applicable terms and provisions of the plan, shall be as follows:

- 1) Plan Administrator
  - a) To interpret the provisions of the Plan and determine the rights of participants under the Plan, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;
  - b) To administer the Plan in accordance with its terms, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;
  - c) To file such reports as may be required with the United States Department of Labor, the Internal Revenue Service and any other government agency to which reports may be required to be submitted from time to time;
  - d) To comply with requirements of the law for disclosure of plan provisions and other information relating to the plan to participants and other interested parties; and
  - e) To administer the claims procedure to the extent allocated to it in this SPD.

2) Claims Fiduciary.

- a) To adjudicate claims for benefits under the Plan;
- b) To administer the claims procedures to the extent allocated to it in this SPD.

3) Compensation and Human Capital Committee.

- a) The Compensation and Human Capital Committee of the Board will be responsible for approving the Charter of the Employee Benefits Plan Committee; and
- b) The Compensation and Human Capital Committee of the Board may delegate its responsibilities to the appropriate officers of the Plan Sponsor.

**Co-fiduciary Liability**

Except as otherwise provided in ERISA, a named fiduciary shall not be responsible or liable for any act or omission of another named fiduciary with respect to fiduciary responsibilities allocated to such other named fiduciaries. A named fiduciary of the plan shall be responsible and liable only for its own acts or omissions with respect to fiduciary duties specifically allocated to it and designated as its responsibility.

**CLAIMS PROCEDURES**

Claims as to eligibility to participate in this Plan shall be decided by the Committee. As part of such duty, the Committee has full discretionary authority to interpret and construe the provisions of the Plan and decide any dispute which may arise regarding the rights of participants, including the discretionary authority to make determinations as to an employee's eligibility to enter the Plan.

The Plan has designated and named the Benefits Service Managers as the Claims Fiduciary for benefits provided under the Plan. The Claims Fiduciaries have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

The interpretations and determinations by the Benefits Service Managers will apply uniformly to all persons similarly situated and will be binding and conclusive upon all interested persons. Such interpretations and determinations will only be set aside if a court of competent jurisdiction finds that the Committee or Claims Fiduciaries acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

**Benefit Claim**

The Benefits Service Managers are responsible for evaluating all benefit claims under the Plan. Benefits Service Managers will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the Program Documents referenced under Appendix A and Appendix C for information about how to file a claim and applicable claims procedures.

## **Appealing Denied Claim**

If your claim is denied (that is, not paid in part or in full), you will be notified and you may appeal to the Benefits Service Managers for a review of the denied claim. The Benefits Service Managers will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the Program Documents referenced under Appendix A and Appendix C for information about how to file a claim and applicable claims procedures.

## **Important Appeal Deadlines**

If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court). See the Program Documents referenced under Appendix A and Appendix C for information about how to file a claim and applicable claims procedures.

## **Exhaustion of Administrative Remedies; Limitations of Action**

Claimants shall not be entitled to challenge the Committee's or Benefits Service Managers' determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in this SPD, as appropriate. All such claims must be brought within the timeframes set forth above for the Claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party.

If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within 12 months following the date on which he submitted the last required appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal) under such procedures unless the claim is a claim for benefits, which is determined by the Insurance Company—and not a claim related to eligibility to participate, which is determined by the Committee—and a different period is provided in the Certificate of Insurance. If the Claimant does not bring such action within such 12-month period, the Claimant shall be barred from bringing an action under ERISA related to his claim.

## **Communications that Are Not Claims for Benefits**

Certain inquiries will not be considered a claim for benefits. These include:

- 1) Questions concerning an individual's eligibility for coverage under a plan without making a claim for benefits;
- 2) Requests for advance information on the plan's possible coverage of items or services or advance approval of covered items or services where the plan does not otherwise require prior authorization for the benefit or service; and
- 3) Casual inquiries about benefits or circumstances under which benefits might be paid under the terms of the plan.

## **Incompetency**

If any person entitled to payments under the Plan is a minor or under other legal disability or otherwise

incapacitated so as to be unable to manage his financial affairs or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. If the payment is to be made by an Insurance Company or Third-party Administrator, such payment shall be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Committee, in its discretion, may direct that all or any portion of such payment be made:

- 1) To such person;
- 2) To such person's legal guardian or conservator; or
- 3) To such person's Spouse or to any other person,

in any manner the Committee considers advisable, to be expended for his benefit. The decision of the Committee (or, where applicable, that of the Claims Fiduciaries) shall, in each case, be final and binding upon all persons.

### **QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)**

If a qualified medical child support court order (QMCSO) issued that requires you to provide health coverage to a child who is not in your custody, you may do so under the Plan. To be considered qualified, a medical child support order must include:

- 1) Name and last known address of the parent who is covered by the Plan;
- 2) Name and last known address of each child to be covered under the Plan;
- 3) Type of coverage to be provided each child; and
- 4) Period of time the coverage is to be provided.

Medical child support orders should be sent to Benefits Administration. If the order is determined to be qualified, you may cover the children under the Plan. The QMCSO procedures are available upon request from Benefits Administration.

### **EFFECTS OF MEDICARE ON BENEFITS**

Under the Medicare Secondary Payer (MSP) rules, employer-provided health plans are generally primary to Medicare. Although Medicare is designed to provide health coverage for individuals over age 65, it will pay on a secondary basis if a retiree or Spouse is covered under an employment-related plan and either the retiree or the retiree's Spouse works.

Under the MSP rules, Medicare is generally the secondary payer of medical bills with respect to the following three types of Medicare beneficiaries:

- 1) Medicare beneficiaries age 65 and older (and their Spouses age 65 and older) who are covered under an employer group health plan by virtue of their current employment status (these individuals are sometimes referred to as the 'working aged');
- 2) As described more fully below, disabled individuals who have current employment status and are covered under an employer group health plan; and
- 3) Individuals with end-stage renal disease (ESRD), or permanent kidney failure (the employer group health plan must provide coverage for the first 30 months, and then Medicare becomes primary).



If you are entitled to Medicare benefits on the basis of disability (Medicare generally requires that you be disabled for 29 months), Medicare is primary unless you have “current employment status” with your Employer in which case your Employer. If you reach age 65, and become eligible for normal retirement Medicare benefits, Medicare will be primary even if you have not been disabled for 29 months.

### **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

USERRA provides for continuation of health care coverage if you are called for active-duty military service. Except to the extent greater benefits are provided by the Employer, the maximum length of extended coverage under USERRA is the lesser of (1) 24 months beginning on the date that the military leave begins, or (2) a period beginning on the day that the leave began and ending on the day after your reemployment application deadline. If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

### **LEGAL INFORMATION**

No legal action to recover benefits may be brought later than one year from the date your claim for benefits is denied at the end of the appeals process. If you choose to pursue a second level appeal, the one-year period for bringing a legal action will begin to run once that final second- level decision has been issued.

### **Interpretation of Plan Provisions**

The Truist Employee Benefits Plan Committee (Committee) shall have the duty and discretionary authority to interpret and construe the provisions of the Plan and decide any dispute which may arise regarding the rights of participants, including the discretionary authority to interpret the Plan and to make determinations as to any employee’s eligibility to enter the Plan [and a participant’s benefits under the Plan] However, the Benefits Services Manager has been given discretionary authority to make final determinations regarding benefit payments under the Plan.

Interpretations and determinations made by the Committee shall apply uniformly to all persons similarly situated and shall be binding and conclusive upon all interested persons. Such interpretations and determinations shall only be set aside if the Committee are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

### **Plan Amendment/Termination**

Truist has reserved the right, by written action of its Board of Directors or its authorized officer, to modify, amend or terminate the Plan as applied to each employer-party. Except as otherwise provided in the Plan, the right to modify, amend or terminate the Plan will not in any way affect your right to claim benefits, or diminish or eliminate any claims for benefits under the Plan to which you may have become entitled to claim prior to such termination or amendment. The Plan is not a contract, and Truist does not guarantee

and makes no promise to offer a specific level of benefits in the future. The right to future benefits under the Plan will never vest.

### **No Contract of Employment**

The Plan, including the component benefit programs, is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

### **Intentional Misrepresentations**

If you commit fraud or make an intentional misrepresentation of a material fact about your participation in the health care plans, the plans have the right to retroactively terminate coverage permanently for you and all of your eligible dependents. Also, the plan may seek financial damages caused by the misrepresentations and may pursue legal action against you. Material misrepresentation includes, but is not limited to, submitting falsified claims or covering a dependent who is ineligible (for instance, adding a Spouse before you are married or after you are divorced, or adding a child who doesn't meet the plan qualifications of an eligible dependent).

### **Governing Law and Venue**

This Plan is governed by and will be construed in accordance with ERISA, and to the extent not preempted by ERISA, by the laws of the state of North Carolina, without regard for any choice of law principles thereof. Unless otherwise provided in this SPD, any legal action related to this Plan shall be brought only in the United States District Court for the Western District of North Carolina and of any court situated in Charlotte, North Carolina.

## **STATEMENT OF YOUR ERISA RIGHTS**

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- 1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- 2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- 3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- 4) Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your plan — called “fiduciaries” of the Plan — have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA.

If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$159 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## APPENDIX A

The following benefits and their applicable Program Documents are consolidated and incorporated into the Plan. This list, the Benefit Service Managers, and the Program Documents may be amended by the Plan Sponsor and/or Plan Administrator at any time without formal amendment to the Plan or this SPD. Participants should refer to the Program Documents for more complete information regarding the benefits listed below.

<b>BENEFIT</b>	<b>INSURED / SELF-FUNDED</b>	<b>INSURER / CLAIMS ADMINISTRATOR BENEFITS SERVICE MANAGERS</b>	<b>PROGRAM DOCUMENTS<sup>1</sup></b>
Medical <ul style="list-style-type: none"> <li>• BCBSNC \$500 PPO</li> <li>• BCBSNC HDHP \$2,000</li> <li>• BCBSNC HDHP \$4,500</li> </ul>	Self-funded	Contract Administration BlueCross NC PO Box 2291 Durham NC 27702 (800) 621-8876 BlueConnectNC.com	Administrative Services Only Booklet issued by BCBSNC
Medical <ul style="list-style-type: none"> <li>• Aetna \$500 PPO</li> <li>• Aetna HDHP \$2,000</li> <li>• Aetna HDHP \$4,500</li> </ul>	Self-funded	Contract Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229	Administrative Services Only Booklet issued by Aetna
Medical <ul style="list-style-type: none"> <li>• Kaiser \$2,000 Plan</li> <li>• Kaiser HMO Plan</li> </ul>	Insured Policy Number(s): 47308, 10275, 10479, 24347, 26887, 602825, 605314, 22872, 230003, 233278, 26287	Insurer Administration Kaiser Permanente	Certificate of Insurance Booklets issued by Kaiser Permanente
Prescription Drug	Self-funded	Contract Administration Prime Therapeutics Mail Route: Commercial PO Box	Appendix B and Applicable Program Documents from Benefit Services Manager

<sup>1</sup> The Program Documents can be viewed at [benefits.truist.com](https://benefits.truist.com). You may also obtain a paper copy upon written request to the Plan Administrator.

		25136 Lehigh Valley, PA 18002-5136	
Teladoc Health Services	N/A	Contract Administration Teladoc Health, Inc. 1 800-TELADOC	Teladoc Health Services Summary Plan Description
Dental - Cigna Dental PPO	Self-funded	Contract Administration CIGNA PO Box 188037 Chattanooga TN 37422-8037 (855) 678-0046 my.cigna.com	Administrative Services Only Booklet issued by Cigna
Dental - Cigna Dental DHMO	Insured Policy Number: 3207296-DHMO1	Insurer Administration Cigna PO Box 188037 Chattanooga TN 37422-8037 (855) 678-0046 my.cigna.com	Certificate of Insurance Booklets issued by Cigna
Vision - Base Plan	Self-funded	Contract Administration Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com	Administrative Services Only Booklet issued by Vision Service Plan
Vision - Premier Plan	Self-funded	Contract Administration Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com	Administrative Services Only Booklet issued by Vision Service Plan

## **APPENDIX B**

### **PRESCRIPTION DRUGS<sup>1</sup>**

Your prescription drug benefits cover insulin or other self-administered injectable medications and prescription drugs, including contraceptive drugs and devices, for all members. Prescription drugs approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of clinical obesity are also covered.

Some Prescription drugs related to treatment of infertility and sexual dysfunction are also covered. Infertility drugs are limited to quantity lifetime maximums per member

Your prescription drug benefits also cover the following diabetic supplies: insulin needles, syringes, glucose testing strips, lancets and lancet devices.

You may receive your prescription drugs and diabetic supplies from an in-network pharmacy only. When you visit an in-network pharmacy, always present your Blue Cross NC ID card or BlueRx card (if your medical coverage is with Aetna) along with your prescription. You will pay the applicable co-insurance or co-payment. See "Schedule of Medical Benefits" for the co-insurance amount that the Plan pays. If you fail to show your id card or the in-network pharmacy's records do not show you as eligible for coverage, you will have to pay the full cost of the prescription and file a claim. In order to recover the full cost of the prescription minus any applicable copayment or coinsurance you owe, return to the in-network pharmacy within 14 days of receiving your prescription so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive in-network benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the member.

If you would like to receive an extended supply of prescription drugs through the mail, please have your provider write a new prescription for up to 90 days, and contact Blue Cross NC to ask for a home delivery order form. Prescription Drugs under the Consumer Option apply to the deductible.

You cannot refill a prescription until:

- Three-fourths of the time period has passed that the prescription was intended to cover, or
- The full time period has passed that the prescription was intended to cover if quantity limits apply, except during a government-declared state of emergency or disaster in the county in which you reside. During these circumstances, you must request a refill within 29 days after the date of the emergency or disaster (not the date of the declaration). A refill of a prescription with quantity limitations may take into account the proportionate dosage use prior to the disaster.

Your prescription drug benefit has an open formulary or list of prescription drugs, divided into categories or tiers. Blue Cross NC determines the tier placement of prescription drugs in the formulary, and this determines the amount you pay.

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<sup>1</sup> Prescription Drug Benefits for employees who have medical coverage with BlueCross NC and those who have coverage with Aetna are all provided through BlueCross NC.

Tier placement of prescription drugs in the formulary may be determined by: the effectiveness and safety of the drug, the cost of the drug, and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally- recognized drug databases (e.g., Medispan).

The following information applies to the \$500 PPO: The lowest cost prescription drugs, such as generics, are generally located on the lowest tiers (Tier 1 and Tier 2). Higher cost prescription drugs, such as brand-name prescription drugs are generally located on the higher tiers. All tiers of the formulary may contain generic and brand-name prescription drugs. Specialty drugs, if applicable, are located on the highest tiers of the plan, even though they may be classified as generic, brand-name, biologic, or biosimilar prescription drugs. Visit Blue Cross NC's website at [bluecrossnc.com](http://bluecrossnc.com) for additional information on the tier classification of prescription drugs.

The prescription drugs listed in the formulary or their tier placement may change from time to time due to a change in the cost of the drug and/or in the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally- recognized drug databases (e.g., Medispan).

From time to time, members may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce prescription drug costs or to encourage members to seek appropriate, high, quality, efficient care based on Blue Cross NC criteria.

**Mandatory Generic (\$500 PPO Only):** If a generic form of the drug is available, the medical program requires employees and covered dependents to ask their physician if there is a generic drug option. The physician should give you the option of receiving the brand name version of the drug or the generic equivalent. You have the choice of which drug to receive. If you choose the generic drug, you will pay the lowest co-payment for a drug that is chemically identical to the brand name. If you choose to have the brand name drug, you will pay the co-payment at the higher tier plus the difference in the cost between the generic and brand name drug.

## **Certification Requirements**

Some prescription drugs may require certification, also known as prior approval, in order to be covered. Blue Cross NC may change the authorization period for which a previously reviewed or certified drug was granted. Should this occur, you will be notified. It is very important to make sure that prior approval is received before you go to the pharmacy. If you need a prescription drug that requires prior approval, your provider should call Blue Cross NC to request prior approval. Additionally, some prescription drugs may be subject to quantity limits based on criteria developed by Blue Cross NC. Prior approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure that your provider has received prior approval before going to the pharmacy. To get a list of the prescription drugs that require prior approval to be covered or require prior approval for additional quantities, you may call Blue Cross NC at 800-621-8876 or visit the Blue Cross NC website at [bluecrossnc.com](http://bluecrossnc.com). Blue Cross NC may change the list of these prescription drugs from time to time.

## **Limitations**

Coverage for certain drugs may be subject to a lifetime dollar maximum. Refer to "Summary of Benefits."

Certain prescription drugs are subject to benefit limitations which may include, but not limited to:

(1) The amount dispensed per prescription, which may include the amount dispensed per day or for a defined time period; (2) the amount dispensed per lifetime; (3) the amount dispensed per month's supply; or (4) the amount dispensed per single co-payment. In these cases, excess quantities will not be covered. You may call Blue Cross NC for a list of these prescription drugs or visit the Blue Cross NC website at [bluecrossnc.com](http://bluecrossnc.com). The benefit for any prescription drug used for the purpose of smoking cessation is limited to 12 weeks of treatment and 24 weeks of treatment per lifetime.

Coverage will be provided for a restricted-access drug or device to a member without requiring prior review or certification or use of a nonrestricted formulary drug(s) if a member's physician certifies in writing that the member has previously used an alternative nonrestricted-access drug(s) or device(s) and the alternative drug or device has been detrimental to the member's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the member's health or ineffective in treating the condition again.

If you have multiple prescriptions and need to align your refill dates you may need a prescription for less than a 30-day supply. If your doctor or pharmacy agrees to give you a prescription for less than a 30-day supply for this purpose you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for drugs covered under your prescription drug benefit, received at an in-network pharmacy, and when prior review requirements have been met.

In addition, the drugs must:

- Be used for treatment and management of chronic conditions and are subject to refills;
- NOT be a Schedule II or Schedule III controlled substance containing hydrocodone;
- Be able to be split over short-fill periods; and
- Not have quantity limits or dose optimization criteria that would be affected by aligning refill dates.

## **Pharmacy Network**

The Plan provides prescription drug coverage through a network of pharmacies throughout the United States. The list of network pharmacies may change during your period of enrollment. Participating pharmacies are listed on the Blue Cross NC website at [bluecrossnc.com](http://bluecrossnc.com). You may also contact Blue Cross NC at 800- 621- 8876 for information about a specific pharmacy.

## **Specialty Drugs**

Certain medications are only available from the Plan through a specialty pharmacy called Alliance Rx Walgreens Prime Specialty. This pharmacy is designed to obtain these often expensive drugs at the best cost and to assure that participants receive the appropriate information regarding their drugs. You will not be able to fill a specialty drug prescription through a retail pharmacy. More information about specialty drugs can be found on the Blue Cross NC website [bluecrossnc.com](http://bluecrossnc.com).

## **Prescription Drug Benefits Exclusions**

- Any prescription drug not specifically covered in the Plan



- Any portion of the prescription drug or refill which exceeds the maximum supply for which benefits will be provided when dispensed under any one prescription
- Any drug purchased over-the-counter, unless specifically listed as a covered drug in the formulary and a written prescription is provided
- Any drug that is therapeutically equivalent to an over-the-counter drug
- Any prescription drugs in excess of the stated quantity limits
- Any compounded drug that does not contain at least one ingredient that is defined as a prescription drug. Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage.
- Any prescription drug purchased to replace a lost, broken or destroyed prescription drug except under certain circumstances during a state of emergency or disaster

Drug Therapy for infertility is limited to quantity lifetime maximum per member. Please visit this site for the list of limitations: <https://www.bcbsnc.com/content/services/formulary/rxnotes.htm>

- A prescription drug that is contraindicated (should not be used) due to age, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA's approved product labeling.
- A medical device, unless specifically listed as a covered medical device in the formulary and written prescription is provided.
- A medication that has been repackaged – a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

## **APPENDIX C**

### **CLAIMS PROCEDURES FOR THE PLAN**

Except as provided below, claims for benefits under the Plan will be reviewed in accordance with procedures contained in the Program Documents or other written materials for such Plan benefits. All other general claims or requests should be directed to the Plan Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator<sup>1</sup> will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

### **CLAIMS PROCEDURES FOR GROUP HEALTH PLANS**

These claims procedures shall apply to claims made under the Plan to the extent (1) the Program Documents to provide claims procedures or the Benefits Service Manager does not maintain claims procedures; and /or (2) the claims procedures in such Program Documents and/or maintained by the Benefits Service Manager do not comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.7152719, as applicable to the Plan.

### **BENEFIT DETERMINATIONS**

#### **Post-Service Claims**

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

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<sup>1</sup> For eligibility to participate, the Plan Administrator is the Claims Administrator. For eligibility for benefits, the Benefits Service Manager is the Claims Administrator.

A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

### **Pre-Service Claims**

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

### **Urgent Care Claims**

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

## **Concurrent Care Claims**

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

## **Claim Denial Notices**

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision.

## **How to Appeal a Claim Decision**

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

## **Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all

documents, records, and other information relevant to your claim for benefits.

## **APPEALS DETERMINATIONS**

### **Pre-Service and Post-Service Claim Appeals**

You will be provided with written or electronic notification of the decision on your appeal as follows:

- For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see “Urgent Care Claim Appeals” below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator’s decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

### **Urgent Care Claim Appeals**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator’s decisions are conclusive and binding.

## **External Review**

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. The external review process does not apply to eligibility appeals. It also does not apply to appeals for dental or vision benefits. Please consult the Claims Administrator for further details.

## **APPENDIX D**

### **PARTICIPATING EMPLOYERS**

As of January 1, 2021, the list of participating employer is provided below. This list may be updated by separate agreement between such employer and a Senior Executive Vice President of Truist and without formal amendment to the Plan.

AFCO Acceptance Corporation  
AFCO Credit Corporation  
AmRisc, LLC  
BB&T Collateral Service Corporation  
BB&T Commercial Equipment Capital (divested 1/29/21)  
BB&T Equipment Finance LLC  
BB&T Institutional Investment Advisors, Inc.  
BB&T Merchant Services LLC  
BB&T Real Estate Funding, LLC  
BB&T Securities, LLC  
CB Finance, Inc.  
CRC Insurance Services, Inc.  
Crump Life Insurance Services, Inc.  
GFO Advisory Services, LLC  
Grandbridge Real Estate Capital. LLC  
J. H. Blades Co, Inc.  
McGriff Insurance Services, Inc.  
Peak Health  
Prime Rate Premium Finance Corp  
Regional Acceptance Corporation  
Sterling Capital Management, LLC  
Truist Advisory Services, LLC  
Truist Community Capital, LLC  
SunTrust Delaware Trust Company  
SunTrust Equity Funding, LLC  
SunTrust Institutional & Government  
Truist Investment Services, Inc.  
Tapco Insurance Underwriters, Inc.  
Truist Bank  
Truist CIG, LLC  
Truist Equipment Finance Corp  
Truist Insurance Holdings, Inc.  
Truist Leadership Institute, Inc.  
Truist Leasing Corp  
Truist Securities

## **APPENDIX E NOTICES**

### **Availability of Coverage under PPACA (Health Care Exchanges)**

Under the Patient Protection and Affordable Care Act, insurance exchanges are available which allow individuals to purchase health insurance coverage. For additional information about exchanges (also known as the Health Insurance Marketplace) please refer to [www.healthcare.gov](http://www.healthcare.gov).

### **HIPAA Privacy Rules**

The Health Insurance Portability and Accountability Act (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice which is published at [benefits.truist.com](http://benefits.truist.com).

This Plan and Truist will not use or further disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Truist.

Under HIPAA, you have certain rights with respect to your Protected Health Information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact HR Central or visit [benefits.truist.com](http://benefits.truist.com). If you have questions about the privacy of your health information, please contact the Director of Benefits in Human Resources.

### **Newborns' Act Disclosure**

This Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **Notice of Rights under the Women's Health and Cancer Rights Act (WHCRA)**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the



Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 1) All stages of reconstruction of the breast on which the mastectomy was performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 3) Prostheses; and,
- 4) Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan.

### **Nondiscrimination Act of 2008 (GINA)**

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo. Genetic information does not include information about the sex or age of any individual.

### **Mental Health Parity**

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

### **Compliance with Applicable Laws**

The Plan Sponsor will administer the Benefit Plans in compliance with applicable laws. Any interpretation of this document or the Program Document incorporated by reference that is prohibited by law is void and will not be relied on for the administration of this Plan.

## PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	Website: <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>	Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584
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<b>IOWA – Medicaid and CHIP (Hawki)</b>	<b>MONTANA – Medicaid</b>
Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562	Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084
<b>KANSAS – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
<b>KENTUCKY – Medicaid</b>	<b>NEVADA – Medicaid</b>
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718  Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>	Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900
<b>LOUISIANA – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/la hipp">www.ldh.la.gov/la hipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
<b>MAINE – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-442-6003 TTY: Maine relay 711  Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>MASSACHUSETTS – Medicaid and CHIP</b>	<b>NEW YORK – Medicaid</b>
Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a>  Phone: 1-800-862-4840	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
<b>MINNESOTA – Medicaid</b>	<b>NORTH CAROLINA – Medicaid</b>

Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739	Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100
<b>MISSOURI – Medicaid</b>	<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>UTAH – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>OREGON – Medicaid</b>	<b>VERMONT– Medicaid</b>
Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
<b>PENNSYLVANIA – Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a> Phone: 1-800-692-7462	Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
<b>RHODE ISLAND – Medicaid and CHIP</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
<b>SOUTH CAROLINA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>SOUTH DAKOTA - Medicaid</b>	<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565