



Truist Financial Corporation
Retiree Health Plan

Summary Plan Description

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 Retiree 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.¹ This document, together with the Program Documents listed under Appendix A, is the SPD for the Plan as of January 1, 2021. The material contained this SPD is taken from the actual legal plan documents that governs the principles and provisions under which a plan operates. Therefore, if any conflict exists between the SPD and the actual plan provisions, the terms of the legal plan document will govern.

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")² 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.

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

² The Benefits Service Managers are listed in Appendix A.

FACTS ABOUT THE PLAN

Plan Name	Truist Financial Corporation Retiree Health Care Plan.
Plan Sponsor Address and Telephone Number	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 715-2455, option 1 benefits@truist.com
Employer Identification Number	56-0939887
Effective Date	This is a summary of the Truist Financial Corporation Health Care Plan effective January 1, 2021
Plan Administrator	Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, Charlotte NC 28202
Name and Address of Agent for Legal Service	Chairman, Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, Charlotte NC 28202
Plan Number	520
Type of Plan	Welfare Plan providing medical, dental and vision benefits.
Plan Year/Benefit Period	January 1 through December 31

DEFINITIONS

Active Employer Plan means any group health plan offered under the Truist Financial Corporation Employee Benefit Plan.

Company means Truist Financial Corporation and any successor or assign thereof that adopts the Plan by action of its governing body or which contractually assumes the obligations of the Company under the Plan.

Covered Dependent means any individual who is eligible to receive benefits under a Benefit Program, in accordance with the terms of the applicable Program Document, by virtue of being a Dependent.

Eligible Retiree means each former Employee who retired from a Company on or after January 1, 2021, and who, as of the date of such retirement is age 55 or older and has completed ten (10) or more Years of Service; or (ii) each former Employee of the Company who is entitled to a Benefit Credit under the Health Reimbursement Arrangement set forth under Appendix G.

Employee means any common-law employee of an Employer who is paid by an Employer and is treated by an Employer as an employee for federal payroll tax withholding purposes.

The term "Employee" shall not include:

- 1) Any individual who is performing services for the Employer (i) under an independent contractor or consultant agreement or arrangement with the Employer; (ii) pursuant to an agreement between the Employer and a third party; or (iii) who is treated for payroll purposes as other than an Employee of the Employer (except as noted above), even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee;
- 2) Any individual who performs services pursuant to a services agreement between an Employer and a staffing firm under which the staffing firm has agreed to provide medical coverage;
- 3) Any individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that the type of benefits provided under the Plan were the subject of good faith bargaining between the individual's bargaining representative and an Employer;
- 4) Any individual who is not defined as an Employee in a Program Document for that particular Benefit Program;
- 5) Any individual who is categorized by any Employer as a temporary or contract employee.

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.

Employer means the Company or any Participating Employer that has adopted the Plan. The list of Employers is set forth in Appendix D.

Year of Service means each twelve (12)-consecutive-calendar-month period beginning on an individual's

date of employment or reemployment with an Employer as the case may be, in which such individual is an employee during each month of such period. Periods of employment will be aggregated for the purpose of determining whether an employee or retired employee has satisfied the eligibility requirements set forth below.

ELIGIBILITY

In order for an individual to participate in this Plan, he or she must be (i) an Eligible Retiree and (ii) immediately prior to such enrollment, a Participant in the Active Employee Plan. In no event will an Employee be covered as both a Participant and Dependent, or a Dependent be covered as a Dependent of more than one Participant. An Employee who is eligible to participate in the Plan will become a Participant as of the date set forth in the Program Documents.

Becoming a Participant

As a condition of participation and receipt of benefits under the Plan, each Eligible Retiree who elects to participate in the Plan, shall:

- 1) Complete and timely submit an Election Form to the Committee, on which the Eligible Retiree shall indicate which Dependents shall be covered under the Plan;
- 2) Observe all Plan rules and regulations;
- 3) Consent to the Committee's inquiries with respect to an individual's status as a Spouse, Domestic Partner, or Dependent or with respect to any physician, hospital or other medical care provider, or services involved in a determination for eligibility of coverage or a claim for benefits under the Plan.

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 underage 26.

For purposes of this Plan, "Spouse" means the individual legally married to a Participant, including by reason of the common law statutes in the state of the Participant's principal residence; provided, however, that such term shall not include an individual legally separated from the Participant under a decree of divorce or separate maintenance.

For purposes of this Plan, "Domestic Partner" is any person who, with the Eligible Retiree, 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 Retiree 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 Eligible Retiree, only one Eligible Retiree may cover the child. In addition, an Eligible Retiree cannot cover another Eligible Retiree 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.

ENROLLMENT

Time of Election

You may enroll for coverage under a Benefit Program either upon becoming initially eligible for participation or during Annual Enrollment. Unless otherwise determined by the Committee in a writing adopted by the Committee, once you enroll for coverage in a Benefit Program, the elections shall stay in effect for the remainder of the coverage period until changed by you or such coverages end as described under "Termination of Coverage" below. Upon becoming initially eligible or during Annual Enrollment, you shall be furnished with an Election Form and a current description of the Benefit Programs.

Initial Eligibility

To complete a valid enrollment, the Election Form must be completed and returned to the Committee on or before the date set forth in the Program Document. After timely completion and submission of an Election Form, coverage under a Benefit Program shall become effective on the date set forth in the applicable Benefit Program.

Annual Enrollment

You may enroll in and/or change his elections for a subsequent Period of Coverage during Annual Enrollment for such period. To complete a valid enrollment, the Election Form must be completed and returned to the Committee on or before the end of the designated Annual Enrollment for the period of coverage to which it applies. After timely completion and submission of an Election Form, coverage under a Benefit Program shall become effective on the later of the (1) January 1 immediately following Annual Enrollment or (2) pursuant to the provisions of the applicable Benefit Program.

Election Form

On the Election Form, you must designate the Benefit Programs which you elect to participate in for the applicable period of coverage and the Dependents you elect to have covered under such Benefit Programs. The Election Form shall specify how contributions shall be applied, and in what amounts or proportions, and shall supply any other pertinent information that the Committee reasonably requires. The Election Form shall be delivered to the Committee in accordance with the procedures established by the Committee from time to time.

Modifying and Revoking Elections

Your elections made under this Article shall be irrevocable after they are filed with the Committee. The Participant may modify and revoke his elections only as set forth in the Program Documents.

TERMINATION OF COVERAGE

Eligible Retiree

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

- 1) You fail to timely pay any required contributions;
- 2) As specified in any eligibility audit communication, the date you and/or your Dependent fail to provide any information required with respect to an eligibility audit (regardless of whether such individual is otherwise eligible);
- 3) You cancel participation or elect not to participate in the Plan. In such case, you shall not be eligible to re-enroll in the Plan at any future date. You may cancel coverage for (1) your Dependents, or (2) yourself and your Dependents, effective as of the first day of the month following the Plan Administrator's receipt of his cancellation election. The individuals for whom any such cancellation is effective shall not be eligible to re-enroll in the Plan at any future date.
- 4) The date a Participant attains age 65;
- 5) The Plan Sponsor terminates the Plan or amends the Plan in a manner that it no longer applies to you or your Dependent; and
- 6) The date the Committee determines you or your Dependent has engaged in gross misconduct which the Committee finds to be detrimental to the best interests of the Employer during your employment with any Employer.

Dependents

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

- 1) You cease to be covered;
- 2) As specified in any eligibility audit communication, the date you and/or your Dependent fails to provide any information required with respect to an eligibility audit (regardless of whether such individual is otherwise eligible); or
- 3) The date your Covered Dependent becomes eligible for Medicare; and
- 4) The Covered Dependent is no longer an eligible Dependent.

Temporary Continuance of Coverage

Except in the case of your death, no benefits shall be paid for any claims incurred after the date as of which coverage terminates for any reason and the acceptance of any untimely premiums or premium for any period after coverage terminates shall not be deemed an extension of coverage and any such premium shall be returned to the payor without interest.

If you die while enrolled in this Plan, your Covered Dependents at your death shall be eligible to continue their coverage under any Benefit Program in which they are then enrolled at the same level in which they were enrolled, provided such Covered Dependents continue to timely pay the applicable premiums for such coverage.

Notwithstanding the foregoing, coverage continued under this section shall terminate upon the earliest of the following dates:

- 1) The date as of which:
 - The Plan Sponsor terminates the Plan or amends the Plan in a manner that
 - it no longer applies to the Eligible Retiree or Dependent;
 - There is a failure to timely pay any required contributions;
 - The Covered Dependent is no longer an eligible Dependent; and
 - The date the Covered Dependent becomes eligible for Medicare.
- 2) For a Covered Dependent (other than a surviving Spouse or Domestic Partner), the first date as of which such Covered Dependent would cease to be a Dependent (as defined in this Plan) if you had survived.

In no event shall a surviving Spouse/Domestic Partner of such a Retiree be entitled to add a new Spouse/Domestic Partner to coverage received under this Plan.

FUNDING

Eligible Retirees pay for the cost of the Plan. 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.

Certain benefits shall be paid from the Retiree Health Trust (the "Trust"). The Trust is a non-exempt welfare benefit fund under the Internal Revenue Code Section 419(e)(1) and is the vehicle used for funding medical, prescription drug, and dental benefits for individuals who meet the eligibility rules for the Plan.

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.

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 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 health 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
- 2) 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;
- 3) 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;
- 4) 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;
- 5) 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
- 6) To administer the claims procedure to the extent allocated to it in this SPD.
- 7) Claims Fiduciary.
- 8) To adjudicate claims for benefits under the Plan;
- 9) To administer the claims procedures to the extent allocated to it in this SPD.
- 10) Compensation and Human Capital Committee.

- The Compensation and Human Capital Committee of the Board will be responsible for approving the Charter of the Employee Benefits Plan Committee; and
- 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 Eligible Retiree'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 QMSCO procedures are available upon request from Benefits Administration.

EFFECTS OF MEDICARE ON BENEFITS

Except as provided below, each Medicare-eligible Retiree or Covered Dependent covered by a Benefit Program providing medical benefits shall continue to be covered by such Benefit Program, unless he elects, in writing, to have Medicare for primary coverage.

Medicare shall automatically be the primary coverage for a Medicare-eligible Retiree or Covered Dependent Medicare purposes, at the earliest time at which Medicare who is covered by an applicable Benefit Program and who:

- 1) Begins a regular course of renal dialysis;
- 2) Receives a kidney transplant without first beginning dialysis; or
- 3) Becomes disabled for Medicare purposes

at the earliest time at which Medicare is permitted to be primary under Section 1862(b) of the Social Security Act and regulations thereunder, regardless of whether such person actually enrolls for Medicare.

To the extent permitted by law, Medicare shall be the primary coverage for a Participant or Covered Dependent who attains age 65

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 Eligible Retiree'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 an 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.

BENEFIT	INSURED / SELF-FUNDED	INSURER / CLAIMS ADMINISTRATOR BENEFITS SERVICE MANAGERS	PROGRAM DOCUMENTS³
Medical 1) BCBSNC \$500 PPO 2) BCBSNC HDHP \$2,000 3) BCBSNC HDHP \$4,500	Self-funded	Contract Administration Blue Cross NC PO Box 2291 Durham NC 27702 (800) 621-8876 BlueConnectNC.com	Administrative Services Only Booklet issued by BCBSNC
Medical 1) Aetna \$500 PPO 2) Aetna HDHP \$2,000 3) Aetna HDHP \$4,500	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 1) Kaiser \$2,000 Plan 2) Kaiser HMO Plan	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 25136 Lehigh Valley, PA 18002-5136	Appendix B, as applicable, and Applicable Program Documents from Benefit Services Manager

³ The Program Documents can be viewed at benefits.truist.com. You may also obtain a paper copy upon written request to the Plan Administrator.

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
FOR INDIVIDUALS WHO HAVE MEDICAL COVERAGE WITH BLUECROSS NC
AND
THOSE WHO HAVE COVERAGE WITH AETNA ⁴

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:

- 1) Three-fourths of the time period has passed that the prescription was intended to cover, or
- 2) 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.

⁴ 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.

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.

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 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 participants 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. 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. 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:

- 1) Be used for treatment and management of chronic conditions and are subject to refills;
- 2) NOT be a Schedule II or Schedule III controlled substance containing hydrocodone;
- 3) Be able to be split over short-fill periods; and
- 4) 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. 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.

Prescription Drug Benefits Exclusions

- 1) Any prescription drug not specifically covered in the Plan
- 2) 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
- 3) Any drug purchased over-the-counter, unless specifically listed as a covered drug in the formulary and a written prescription is provided
- 4) Any drug that is therapeutically equivalent to an over-the-counter drug
- 5) Any prescription drugs in excess of the stated quantity limits
- 6) 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.
- 7) 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>

- 1) 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.
- 2) A medical device, unless specifically listed as a covered medical device in the formulary and written prescription is provided.
- 3) 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 Administrator⁵ 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 applicable Program Documents fail 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.

⁵ 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:

- 1) 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.
- 2) Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- 3) 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:

- 1) The Claims Administrator's receipt of the requested information; or
- 2) 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:

- 1) The patient's name.
- 2) The plan identification number.
- 3) The date(s) of health care service(s).
- 4) The provider's name.
- 5) The reason(s) you believe the claim should be paid.
- 6) 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:

- 1) 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.
- 2) 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:

- 1) The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- 2) 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 the Plan Sponsor 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.

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.

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. 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:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- 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.

APPENDIX G
HEALTH REIMBURSEMENT ARRANGEMENT FOR MEDICARE ELIGIBLE
RETIREES FORMERLY COVERED UNDER THE SUNTRUST BANKS, INC.
RETIREE HEALTH PLAN

INTRODUCTION

The SunTrust Banks, Inc. Retiree Health Plan, now the Truist Financial Corporation Retiree Health Plan (the “Plan”), initially provided for a self-insured Medicare supplement (“Medicare Supplement”) program for retirees and their dependents eligible for Medicare. The Plan was subsequently amended to discontinue Company contribution towards the Medicare Supplement program for retirees who become eligible for Medicare on or after January 1, 2003. Effective April 1, 2014, the plan was further amended to discontinue the Medicare Supplement program. Retirees who were receiving a Company contribution for the Medicare Supplement received this Health Reimbursement Arrangement. This Health Reimbursement Arrangement (“HRA”) provide participants with notional accounts funded by the Company, in the form of Benefit Credits” with which they can obtain reimbursement of eligible medical expenses, including, premiums for individual Medicare Supplement insurance policies. The Company intends this HRA to qualify as a “health reimbursement arrangement” as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Code Sections 105 and 106, and the HRA will be interpreted at all times in a manner consistent with such intent.

Capitalized terms in this Appendix G will have the meanings given to them in Section G.6 or, if not defined therein, the definitions given in Article II of the Plan.

G.1. ELIGIBILITY

The Health Reimbursement Arrangement is available to retirees and their dependents who were receiving (or would have received) a Company contribution towards the Medicare Supplement program as of the Effective Date. The following former Employees and Dependents are eligible for Benefit Credits under the HRA.

- a) An Eligible Retiree who, immediately prior to the Effective Date, (i) was enrolled in Medicare Coverage; (ii) was covered by the Plan’s Medicare Supplement program (with or without prescription drug coverage) and/or Dental Benefit Option and/or the Vision Benefit Option and (iii) was receiving a Company contribution greater than fifteen percent (15%) of the Retiree’s premium for the Medicare Supplement as of the Effective Date.
- b) A Covered Dependent who is a Spouse of an Eligible Retiree who immediately prior to the Effective Date (i) was enrolled in Medicare Coverage; (ii) was covered by the Plan’s Medicare Supplement program (with or without prescription drug coverage) and/or Dental Benefit Option and/or the Vision Benefit Option; was receiving a Company contribution greater than fifteen percent (15%) of the Covered Dependent’s applicable premium as of the Effective Date.
- c) A Covered Dependent who is a Spouse of an Eligible Retiree (as described in paragraph G.1(a) above) who, immediately prior to the Effective Date, (i) participated in the Company Retiree Health Plan and (ii) are recorded in the Company’s records in cost sharing groups as set forth in section G.7.

G.2. PARTICIPATION.

a) Agreement to Participate.

- i. An Eligible Retiree shall become a Participant in the HRA on the Effective Date, provided that:
 - 1) He is eligible for Medicare Coverage;
 - 2) He has obtained an individual health insurance policy through Willis Towers Watson or any affiliate; and
 - 3) He has completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.
- ii. A Covered Dependent (as described in paragraph G.1. (b) shall become a Participant in the HRA on the Effective Date, provided that he satisfies the requirements in subparagraphs (i)(1), (i)(2) and (i)(3) above.
- iii. A Covered Dependent (as described in paragraph G.1. (c) not eligible for Medicare shall become a Participant in the HRA when they attain age 65 provided that they satisfy the requirements in subparagraph (i)(2) and (i)(3) above.

Eligible Retirees and Covered Dependents must satisfy the requirements in subparagraph (i)(2) and (i)(3) above upon the later of the Effective Date or the date they attain age 65 in order to participate in the HRA.

b) Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

- i. With respect to an Eligible Retiree, the date they cease to be an Eligible Retiree for any reason, including death;
- ii. With respect to a Covered Dependent, the date they cease to be an Eligible Dependent for any reason, including death;
- iii. With respect to a Covered Dependent, the date they are no longer a Covered Dependent (e.g., divorce);
- iv. With respect to an Eligible Retiree, the date he is rehired as an active employee of the Company or any Affiliate;
- v. The effective date of any Plan amendment that renders an Eligible Retiree or Covered Dependent ineligible to participate; or
- vi. The termination of the Plan or the HRA.

Reimbursement from the Participant's HRA Account after termination of participation shall be governed by subsection G.4(c).

G.3 ACCOUNTS.

- a) Accounts. Each HRA Account established pursuant to the Plan shall be a notional account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the HRA or that are protected from the reach of the Company's creditors. In no event may any benefits under the Plan be funded with Participant contributions.
- b) Benefit Credits. The Company shall credit HRA Accounts of Participants with the Benefit Credits specified in subsection G.3(c) and Section G.7 below on an annual basis as of the first day of the Plan Year. Benefit Credits to be made on behalf of a Covered Dependent shall be made to a combined HRA Account. No earnings shall be credited at any time with respect to any HRA Account. Benefit Credits are determined in accordance with subsection G.7.
- c) Initial Allocation/Cost-of-living Increase. The allocation in the first Plan Year for which the HRA is effective will be prorated to reflect an Effective Date that is not the first day of the Plan Year. The Company, in its absolute discretion, may provide for cost-of-living increases on the annual Benefit Credits.

G.4 BENEFITS

- a) Provision of Benefits. The HRA will reimburse Participants and Covered Dependents for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this HRA only for Health Care Expenses incurred after they becomes a Participant in the HRA and before their participation has ceased. In no event shall any benefits under this HRA be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.
- b) Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this HRA for payment of Health Care Expenses in an amount that does not exceed the balance of his HRA Account. Each reimbursement hereunder shall be a charge to such HRA Account available to pay Health Care Expenses under the HRA.
- c) Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this paragraph (c).
 - i. Timing: A Participant desiring to receive reimbursement for Health Care Expenses under this HRA shall submit a written application to the Provider. Notwithstanding the preceding, upon loss of eligibility as provided in subsection G.2 (a), coverage under the HRA ceases, the Participant shall receive no further Benefit Credits under the HRA, and his Health Care Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to his loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days of such loss of eligibility.
 - ii. Claims Substantiation: The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation

to pay Health Care Expenses. The Provider will reimburse the Participant for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Each request for reimbursement shall include the following information:

- 1) The amount of the Health Care Expense for which reimbursement is requested;
- 2) The date the Health Care Expense was incurred;
- 3) A brief description and the purpose of the Health Care Expense;
- 4) The name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;
- 5) The name of the person, organization or other provider to whom the Health Care Expense was or is to be paid;
- 6) A statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction in the current year) for such Health Care Expense under Code Section 213; and
- 7) A written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Participant is enrolled must be submitted first to all appropriate Claims Administrators for such plans before submitting the expenses to the Provider for reimbursement under the HRA.

Claims will be paid in the order in which they are filed with the Provider and will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

- iii. Timing: The Provider shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Provider determines that an extension is necessary due to matters beyond the control of the Plan, the Provider will notify the claimant within the initial thirty (30)-day period that the Provider needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Provider. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Provider shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

- 1) The specific reason or reasons for the denial;

- 2) Specific reference to pertinent plan provisions on which denial is based;
 - 3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
 - 4) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
 - 5) A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.
- iv. Claims Denied: Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in subsection G.5
- v. Trust Fund: Reimbursements shall be paid from the Trust Fund in accordance with the directions of the Company or the Plan Administrator; provided, however, no medical coverage, dental coverage or vision coverage shall be payable from the Trust Fund to, or on behalf of, a Participant after his retirement (within the meaning of Code § 419A(d)) if such person had been a "key employee" (as such term is defined in Code § 416(i)) while he was an employee of the Company or an Affiliate.
- d) Carryover of Accounts. To the extent there is a balance in a HRA Account at the end of a Plan Year, the balance shall be carried over to the following Plan Year to reimburse Participants for Health Care Expenses incurred during subsequent Plan Years.
- e) Death.
- i. In the event the Eligible Retiree dies with no Covered Dependent who is a Participant, his HRA Account shall be immediately forfeited upon their death; provided, however, that his estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.
 - ii. In the event the Eligible Retiree dies with a Covered Dependent, his HRA Account shall continue and the remaining Participant may continue to submit Health Care Expenses for reimbursement in the normal course.
 - iii. In the event that the Covered Dependent dies with no Eligible Retiree who is a Participant, their HRA Account shall be immediately forfeited upon their death; provided, however, that his estate or representatives may submit claims for Health Care Expenses incurred by the Covered Dependent prior to the Covered Dependent's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Covered Dependent's death.
- f) Nondiscrimination. The Plan Administrator may limit, reallocate or deny any benefit to any Participant who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

G.5 CLAIMS PROCEDURES

- a) Within one hundred and eighty (180) days of receipt by a claimant of a notice under subsection G.4(c)(iii) denying a claim in whole or in part, the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:
 - i. Specific reasons for the decision;
 - ii. Specific references to the pertinent plan provisions on which the decision is based;
 - iii. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
 - iv. A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
 - v. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.
- b) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the HRA, subject to applicable law. A claimant must challenge the decision in a court of law within one year. If claimant challenges the decision of the Plan Administrator within one year after the date of the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.
- c) Nondiscriminatory Operation. All rules, decisions, interpretations and designations by the Plan Administrator under the HRA shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

G.6 DEFINITIONS

- a) "HRA Account" means the hypothetical account established for a Participant to hold his Benefit Credits.

- b) "Benefit Credit" means the amount credited to a Participant's HRA Account for the provision of benefits under the HRA as provided in subsection G.3(c) and section G.7.
- c) "Effective Date" means April 1, 2014.
- d) "Health Care Expense" means an expense incurred by a Participant or Covered Dependent for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant or the Covered Dependent. In addition, Health Care Expenses shall include an expense incurred for a medicine or drug only if such medicine or drug is a prescribed drug (without regard to whether such medicine or drug is available without a prescription) or is insulin. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses.
- e) "Medicare Coverage" means coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare).
- f) "Provider" means any entity with which SunTrust or Plan Administrator has entered into a contract for the purpose of processing claims under the HRA or otherwise administering benefits under the HRA.

G.7 BENEFIT CREDITS

Company Contribution as a Percentage of the applicable premium immediately prior to the Effective Date		Annual Benefit Credit	
Medicare Supplement (Age 65 Plus)			
Eligible Retiree	Covered Dependent	Eligible Retiree	Covered Dependent
100%	100%	\$2,400	\$2,400
100%	<15%	\$2,400	\$0
>50% but <100%	>50% but <100%	\$900	\$900

>49% but <50%	>49% but <50%	\$800	\$800
>15% but < 49%	>15% but < 49%	\$700	\$700

Covered Dependents not Eligible for Medicare on the Effective Date	Covered Dependent Annual Benefit Credit upon attaining age 65
Cost Sharing Group (on the books and records of the Company)	
ST A/B	\$900
C ST1	\$2,400
C ST2	\$700
C ST3	\$800
C ST9	\$2,400
NCF BOD	\$900

Dental Coverage			
Eligible Retiree	Covered Dependent	Eligible Retiree	Covered Dependent
100%	100%	\$300	\$300

Exceptions: For certain Eligible Retirees the Benefit Credits shall be determined by the amount stated in written instructions from SunTrust.