TRUIST

TRUIST FINANCIAL CORPORATION
EMPLOYEE BENEFIT PLAN

Short Term Disability Plan and Long Term Disability Plan
Summary Plan Description

As of January 1, 2025

FOREWORD

Introduction

Truist Financial Corporation ("Truist") maintains the Short Term Disability Plan and the Long Term Disability Plan ("Plan") for eligible employees.[1] The purpose of the Plan is to provide disability benefits to eligible employees as specified in this document.

Purpose of this Document

This document, together with the attached booklets, is the Summary Plan Description ("SPD") for the Plan as of January 1, 2025. Benefits under the Plan are described in the attached booklets.[2]

We encourage plan participants to read this SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed below. It is your responsibility to become familiar with the SPD and to ask questions if you do not understand how the requirements impact you.

REQUESTS FOR PLAN DOCUMENTS

Requests for plan documents must be in writing and sent to:

Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

Failure to send a written request to the address above will not constitute a request for plan documents.

[1] The Plan is a component benefit of the Truist Financial Corporation Employee Benefit Plan. This SPD should be read in conjunction with the SPD for the Truist Financial Corporation Employee Benefit Plan.

[2] This SPD only summarizes the provisions of the formal plan document and does not attempt to cover all of the details contained in the plan document. The operation of the Plan and the benefits to which you may be entitled will be governed solely by the terms of the official plan document. To the extent that any of the information contained in this SPD or any information you receive orally is inconsistent with the official plan document, the provisions set forth in the plan document will govern. If you wish to review the Plan document, please contact the Plan Administrator.

SHORT TERM DISABILITY

INTRODUCTION

This Short Term Disability ("Plan") is subject to certain requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in the attached Booklet are provided under an administrative services only ("ASO") agreement between the Plan and the Hartford Life and Accident Insurance Company (the "Claims Administrator").

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Except as provided otherwise in the attached Short Term Disability Booklet ("Booklet"), you are eligible to participate in this Plan if you are an Employee of Truist Financial Corporation ("Truist") or a Participating Employer[3] (collectively, "Employer") and are scheduled to work 20 or more hours per week. For more information regarding whether you are eligible to participate in the Plan and /or when coverage begins and ends, please read the eligibility information contained in the attached Booklet.

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" does 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 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 Plan;
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

[3] Participating Employers are listed below.

Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable.

SUMMARY OF PLAN BENEFITS

A summary of the benefits provided under the Plan is set forth in the attached Booklet.

HOW THE PLAN IS ADMINISTERED

Plan Operations

Because benefits are provided through an administrative services only ("ASO"), the Plan is administered by both the Plan Sponsor and the Claims Administrator.

Plan Administration

The Plan Sponsor has named the Employee Benefits Plan Committee (the "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.

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.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator decides in its discretion that the applicant is entitled to them.

The Committee has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Power and Authority of Claims Administrator

The Plan is self-insured. Benefits are paid from the general assets of the Plan Sponsor. Claims for benefits are sent to the Claims Administrator. The Claims Administrator, not the Plan Sponsor, is responsible for determining claims.

The Claims Administrator is the named fiduciary for administering claims and is responsible for:

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

The Claims Administrator has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

ALLOCATION OF RESPONSIBILITIES AMONG NAMED FIDUCIARIES

Duties of Named Fiduciaries

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

1) Plan Administrator:

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

2) Claims Fiduciary:

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

3) Compensation and Human Capital Committee:

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

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

The Plan has designated and named the Claims Administrator as the claims fiduciary for benefits provided under the Plan. The Claims Administrator has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator decides in its discretion that the applicant is entitled to them.

Benefit Claim

The Claims Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Booklet issued by the Claims Administrator for information about how to file a claim and for details regarding the Claims Administrator's 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 Claims Administrator for a review of the denied claim. The Claims Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Booklet issued by the Claims Administrator for information about how to file a claim and for details regarding the Claims Administrator's 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 attached Booklet for information about how to appeal a denied claim, and for details regarding the Claims Administrator's appeals procedures.

Exhaustion of Administrative Remedies; Limitations of Actions

Claimants shall not be entitled to challenge the Committee's or Claims Administrator's 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. If the Claimant does not bring such action within such 12-month period, the Claimant shall be barred from bringing an action related to his claim.

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, 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:

(i) to such person;
(ii) to such person's legal guardian or conservator; or
(iii) 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 Insurance Company) shall, in each case, be final and binding upon all persons.

ANTI-ASSIGNMENT

Neither the assets of, nor the benefits payable under the Plan, shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability that is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, before actually being received by the individual entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. This prohibition on assignment includes but is not limited to assignment to any health care provider, practitioner, facility or institution and includes a prohibition on assigning any cause of action or claim in any court. Further, a direct payment to or a communication with a healthcare provider will not constitute an assignment of benefits or rights under the Plan. Any attempt to assign any payment, benefit or cause of action under the Plan will be null and void and will not be recognized or given effect.

AMENDMENT AND TERMINATION

The Plan Sponsor has reserved the right, by written action of its Board of Directors or its authorized officer, to modify, amend or terminate the Plan at anytime. 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.

Neither the Plan nor the benefits provided under this Plan can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, the Claims Administrator, by any delegate of the Plan Administrator or Claims Administrator, or by other party. Only written statements that are consistent with the terms of the Plan and made by the Plan Administrator and /or Claims Administrator can bind the Plan.

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. These future payments may involve this Plan or other 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.

No Contract of Employment

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

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.

Time Limit on Legal Action

Any suit or legal action initiated by a claimant under this Plan must be brought by the claimant no later than 12 months following a final decision on the claim under the Plan's claims procedures. The 12 month statute of limitations on suits shall apply in any forum where a claimant initiates such suit or legal action. If a civil action is not filed within this 12 months period, the claimant's claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it.

Impact on other Benefit Plans

It is not the responsibility of Truist Financial Corporation, the Plan Administrator, the Claims Administrator, or any other party to advise you how your eligibility under this Plan may affect your eligibility for any other benefits for which you are or may be eligible and no party shall be liable for failing to provide you with such advice.

Questions

If you have any general questions regarding the Plan, please contact the Committee.

If you have questions regarding eligibility for a benefit and/or the amount of any benefits payable under the Plan, please contact the Claims Administrator.

PARTICIPATING EMPLOYERS

As of January 1, 2025, the list of Participating Employers is provided below. This list may be updated at any time without formal amendment to this SPD.

AFCO Acceptance Corporation
AFCO Credit Corporation
BB&T Collateral Service Corporation
BB&T Real Estate Funding, LLC
CB Finance, Inc.
GFO Advisory Services, LLC
Grandbridge Real Estate Capital, LLC
Prime Rate Premium Finance Corporation, Inc.
Regional Acceptance Corporation
Service Finance Holdings, LLC
SunTrust Equity Funding, LLC
Truist Commercial Equity
Truist Advisory Services, Inc.
Truist Bank
Truist CIG, LLC
Truist Community Capital, LLC
Truist Delaware Trust Company
Truist Equipment Finance Corp
Truist Investment Services, Inc.
Truist Leasing Corp
Truist Merchant Services LLC
Truist Securities, Inc.

LONG TERM DISABILITY

INTRODUCTION

This Long Term Disability ("Plan") is subject to certain requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This summary plan description ("SPD") and the attached Certificate of Insurance serve to meet ERISA's disclosure requirements and provide important information about the Plan.

The benefits described in the attached Certificate of Insurance are provided under a group insurance policy ("Policy") issued by the Hartford Life and Accident Insurance Company ("Insurance Company").

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Except as provided otherwise in the attached Certificate of Insurance, you are eligible to participate in this Plan if you are an Employee of Truist Financial Corporation ("Truist") or a Participating Employer[1] (collectively, "Employer") and are scheduled to work 20 or more hours per week. For more information regarding whether you are eligible to participate in the Plan and /or when coverage begins and ends, please read the eligibility information contained in the attached Certificate of Insurance.

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 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 Plan;
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.

[1] Participating employers are listed below.

Summary of Benefits

A summary of the benefits provided under the Plan is set forth in the attached Certificate of Insurance.

How the Plan Is Administered

Plan Operations

Because benefits are provided through an insurance contract, the Plan is administered by both the Plan Sponsor and the Insurance Company.

Plan Administration

The Plan Sponsor has named the Employee Benefits Plan Committee (the "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.

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.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard).

The Committee has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Power and Authority of Insurance Company

The Plan is fully insured. Benefits are provided under a group insurance contract entered into between the Plan Sponsor and the Insurance Company. Claims for benefits are sent to the Insurance Company. The Insurance Company, not the Plan Sponsor, is responsible for determining and paying claims.

The Insurance Company is the named fiduciary for administering claims and is responsible for:

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

The Insurance Company has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Allocation of Responsibilities Among named Fiduciaries

Duties of Named Fiduciaries

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

1) Plan Administrator

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

2) Claims Fiduciary.

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

3) Compensation and Human Capital Committee.

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

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

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Plan. The Insurance Company has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan, to the extent permitted by applicable state law. The interpretations and determinations by the Insurance Company 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 Insurance Company acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

The Insurance Company has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Insurance Company decides in its discretion that the applicant is entitled to them.

Benefit Claim

The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Certificate of Insurance issued by the Insurance Company for information about how to file a claim and for details regarding the Insurance Company's 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 Insurance Company for a review of the denied claim. The Insurance Company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Certificate of Insurance issued by the Insurance Company for information about how to file a claim and for details regarding the Insurance Company's 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 attached Certificate of Insurance for information about how to appeal a denied claim, and for details regarding the Insurance Company's appeals procedures.

Exhaustion of Administrative Remedies; Limitations of Actions

Claimants shall not be entitled to challenge the Committee's or Claims Administrator's 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. If the Claimant does not bring such action within such 12-month period, the Claimant shall be barred from bringing an action related to his claim.

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, 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:

(i) to such person;
(ii) to such person's legal guardian or conservator; or
(iii) 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 Insurance Company) shall, in each case, be final and binding upon all persons.

ANTI-ASSIGNMENT

Neither the assets of, nor the benefits payable under the Plan, shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability that is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, before actually being received by the individual entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. This prohibition on assignment includes but is not limited to assignment to any health care provider, practitioner, facility or institution and includes a prohibition on assigning any cause of action or claim in any court. Further, a direct payment to or a communication with a healthcare provider will not constitute an assignment of benefits or rights under the Plan. Any attempt to assign any payment, benefit or cause of action under the Plan will be null and void and will not be recognized or given effect.

AMENDMENT AND 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 at anytime. 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.

Neither the Plan nor the benefits provided under the Plan can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, the Insurance Company, by any delegate of the Plan Administrator or Insurance Company, or by other party. Only written statements that are consistent with the terms of the Plan and made by the Plan Administrator and / or Insurance Company can bind the Plan.

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.. These future payments may involve this Plan or other 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.

No Contract of Employment

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

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.

Time Limit on Legal Action

Any suit or legal action initiated by a claimant under this Plan must be brought by the claimant no later than 12 months following a final decision on the claim under the Plan's claims procedures. The 12 month statute of limitations on suits shall apply in any forum where a claimant initiates such suit or legal action. If a civil action is not filed within this 12 months period, the claimant's claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it.

Impact on other Benefit Plans

It is not the responsibility of any other party, including, but not limited to, Truist Financial Corporation, the Plan Administrator, the Insurance Company, or any other party to advise you how your eligibility under this Plan may affect your eligibility for any other benefits, plans, or programs that you are or may become eligible for and no party shall be liable for providing or failing to provide you with such advice.

Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan), please contact the Committee.

If you have questions regarding eligibility for a benefit and/or the amount of any benefits payable under the Plan, please contact the Insurance Company.

PARTICIPATING EMPLOYERS

As of January 1, 2025, the list of Participating Employers is provided below. This list may be updated at any time without formal amendment to this SPD.

AFCO Acceptance Corporation
AFCO Credit Corporation
BB&T Collateral Service Corporation
BB&T Real Estate Funding, LLC
CB Finance, Inc.
GFO Advisory Services, LLC
Grandbridge Real Estate Capital, LLC
Prime Rate Premium Finance Corporation, Inc.
Regional Acceptance Corporation
Service Finance Holdings, LLC
SunTrust Equity Funding, LLC
Truist Commercial Equity
Truist Advisory Services, Inc.
Truist Bank
Truist CIG, LLC
Truist Community Capital, LLC
Truist Delaware Trust Company
Truist Equipment Finance Corp
Truist Investment Services, Inc.
Truist Leasing Corp
Truist Merchant Services LLC
Truist Securities, Inc.

THE STD AND LTD BOOKLETS
FOLLOW IMMEDIATELY AFTER THIS PAGE.

SHORT TERM DISABILITY
BOOKLET

YOUR BENEFIT PLAN

TRUIST FINANCIAL CORP.

Short Term Disability

EMPLOYER: TRUIST FINANCIAL CORP.
PLAN NUMBER: GRH-071407

PLAN EFFECTIVE DATE: January 1, 2004

BENEFITS UNDER THE GROUP SHORT TERM
DISABILITY PLAN DESCRIBED IN THE FOLLOWING
PAGES ARE PROVIDED AND FUNDED BY THE EMPLOYER.

THE EMPLOYER HAS FULL RESPONSIBILITY FOR
PAYMENT OF ANY BENEFITS DUE ACCORDING
TO THE TERMS AND CONDITIONS OF THE PLAN.

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SCHEDULE OF BENEFITS

The Plan of short term Disability provides You with short term income protection if You become Disabled from a covered Injury, Sickness, or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

The benefits described herein are those in effect as of January 1, 2025.

Cost of Coverage:
Option 1 - You do not contribute toward the cost of coverage under Option 1.

Option 2 - You must contribute toward the cost of coverage under Option 2.

Eligible Class(es) For Coverage:
All Full-time and Part-time Active Regular Teammates who are U.S. citizens or U.S. residents, excluding temporary, leased or seasonal teammates.

Regular Employment: at least 20 hours weekly

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:
The first day of the month following the date You were hired

The time period(s) referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Teammate with the Employer under the Prior Plan.

Benefits Commence on the later of:

1) for Disability caused by Injury or Sickness: on the 15th day of Total Disability or Disabled and Working; for a Total Disability period or a Disabled and Working Disability period of 15 days or more, benefits commence on the first day of Disability; or
2) the day following the date You have exhausted all available sick leave of absence days for the calendar year in which You become Disabled.

Weekly Benefit:
The lesser of:

1) 50% of Your Pre-disability Earnings if You have elected Option 1; or
2) 60% of Your Pre-disability Earnings if You have elected Option 2; or
3) $8,077;

reduced by Other Income Benefits.

Maximum Duration of Benefits Payable:

1) 180 day(s) if caused by Injury from date of Disability; or
2) 180 day(s) if caused by Sickness from date of Disability.

Additional Benefits:

Disabled and Working Benefit
See Benefit

Rehabilitative Employment Benefit

See benefit

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Benefits will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:

1) the Plan Effective Date; or
2) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Benefits, if applicable.

Enrollment: *How do I enroll for coverage?*
For coverage under Option 1, all eligible Active Teammates will be enrolled automatically by the Employer.

For coverage under Option 2, You must enroll.
To enroll for coverage you must complete an enrollment process which is satisfactory to Us.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:

1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse's loss or commencement of employment;
7) You or Your spouse have a change in classification from part-time to full-time or from full-time to part-time.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
If You are not required to contribute toward The Plan's cost, Your coverage will start on the date You become eligible.

If You must contribute toward The Plan's cost, Your coverage will start on the earliest of:

1) the date You become eligible; or
2) the January 1st following the Annual Enrollment Period if You enroll, during an Annual Enrollment Period.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your coverage, or increase in coverage, would otherwise have become effective, Your coverage, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage: *Can I change my benefit options?*
You may change Your benefit option only:

1) during an Annual Enrollment Period; or
2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option.

When will a requested change in benefit option take effect?
If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the January 1st following the Annual Enrollment Period.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the date You enroll for the change.

Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre existing Conditions Limitations.

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Teammate; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date the Claims Administrator receives notice of the change.

What happens if the Employer changes The Plan?
Any increase or decrease in coverage because of a change in The Plan will become effective on the date of the change subject to the following provisions:

1) Deferred Effective Date; and
2) Pre existing Conditions Limitations.

Continuity From A Prior Plan: *Is there continuity of coverage from a Prior Plan?*
If You were:

1) insured under the Prior Plan; and
2) not eligible to receive benefits under the Prior Plan;

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Plan subject to the Pre-existing Condition Limitation?
If You become insured under The Plan on the Plan Effective Date and were covered under the Prior Plan on the day before the Plan Effective Date, the Pre-existing Conditions Limitation will end on the earliest of :

1) the Plan Effective Date, if Your coverage for the Disability was not limited by a preexisting condition restriction under the Prior Plan; or
2) the date the restriction would have ceased to apply had the Prior Plan remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Plan.

The amount of the Weekly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the Weekly Benefit which was paid by the Prior Plan; or
2) the Weekly Benefit provided by The Plan.

The Pre-existing Conditions Limitation will apply after the Plan Effective Date to the amount of a benefit increase which results from a change from the Prior Plan to The Plan, a change in benefit options, a change of class or a change in The Plan.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) at the end of the month following the date The Plan terminates;
2) at the end of the month following the date The Plan no longer covers Your class;
3) the last day of the period for which You make any required contribution;
4) at the end of the month following the date Your Employer terminates Your employment; or
5) if You cease to be an Active Regular Teammate in an eligible class between the 1st and the 15th of the month Your coverage will terminate on the 15th of the month; If You cease to be an Active Regular Teammate in an eligible class between the 16th and the last day of the month, Your coverage will terminate on the last day of the month. unless continued in accordance with one of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in The Plan; and
2) terminates if:
   a) The Plan terminates; or
   b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence: If You are on a documented leave of absence, other than Family or Medical Leave, Your coverage may be continued for 12 months after the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 month(s). If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks after or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: Does my coverage continue while I am Disabled and no longer an Active Teammate? If You are Disabled and You cease to be an Active Teammate, Your coverage wil be continued:

1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive short term Disability Benefits.

After short term Disability benefit payments have ceased, Your coverage will be reinstated, provided:

1) You return to work for one full day as an Active Regular Teammate in an eligible class; and
2) The Plan remains in force.

Extension of Coverage for Total Disability: *Does coverage continue if The Plan terminates?* If You are entitled to coverage while Disabled and The Plan terminates, coverage:

1) will continue as long as You remain Disabled by the same Disability; but
2) wil not be provided beyond the date We would have ceased to pay coverage had the coverage remained in force. Termination of The Plan for any reason wil have no effect on The Employer's liability under this provision.

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Plan?*
If, while covered under this Benefit, You:

1) become Totally Disabled;
2) remain Totally Disabled; and
3) submit Proof of Loss to the Claims Administrator;

The Plan will pay the Weekly Benefit.

The amount of any Weekly Benefit payable will be reduced by:

1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and
2) any income received from the Employer for the period You are Totally Disabled.

Minimum Weekly Benefit: *Is there a Minimum Weekly Benefit?*
Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Benefits.

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*
If a Weekly Benefit is payable for less than a week, The Plan will pay 1/5 of the Weekly Benefit for each day You were Disabled.

Recurrent Disability: *What happens to my benefits if I return to work as an Active Teammate and then become Disabled again?*
When Your return to work as an Active Teammate is followed by a Disability, and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
6) within 14 consecutive calendar days of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Plan remains in force.

If You return to work as an Active Teammate for 14 consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Plan.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*
If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions and Pre-existing Conditions Limitations will apply to the new cause of Disability.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse the Claims Administrator's request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits;
8) the date Your Current Weekly Earnings exceed 80% of Your Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
9) the date no further benefits are payable under any provision in The Plan that limits benefit duration.

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*
If, while covered under this benefit, You are Disabled and Working, as defined, the Claims Administrator will use the following calculation to determine Your Weekly Benefit:

$$\text{Weekly Benefit} = \frac{\mathbf{(A - B)\ x\ C}}{\mathbf{A}}$$

Where

A = Your Weekly Pre-disability Earnings.
B = Your Current Weekly Earnings.
C = The Weekly Benefit payable if You were Totally Disabled.

If You are participating in a program of Rehabilitative Employment approved by the Claims Administrators, the Claims Administrator will determine Your Weekly Benefit by the Rehabilitative Employment Benefit.

Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

Rehabilitative Employment Benefit: *What happens to my benefits if I accept Rehabilitative Employment?*
If, while You are Totally Disabled or Disabled and Working, You accept Rehabilitative Employment, the Claims Administrator will continue to pay a Weekly Benefit.

The Weekly Benefit the Claims Administrator will pay will be equal to Your Total Disability Weekly Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the Weekly Benefit and total income received from Rehabilitative Employment may not exceed 100% of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the Weekly Benefit paid by the Claims Administrator will be reduced by the excess amount.

The Claims Administrator reserves the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Plan.

If You remain Totally Disabled or Disabled and Working after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit or Disabled and Working Benefit, subject to the Maximum Payment Period for such benefit.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Plan does not cover, and will not pay a benefit for any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation;
5) caused or contributed to by an intentionally self inflicted Injury;
6) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
7) sustained as a result of doing any work for pay or profit for another employer.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Plan; no

benefits will be payable for the Disability under The Plan.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*
The Claims Administrator will not pay any benefit, or any increase in benefits, under The Plan for any Disability that results from, or is caused by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 90 consecutive day(s) while covered under The Plan; or
2) You have been continuously covered under The Plan for 365 consecutive day(s).

Pre-existing Conditions means:

1) any Injury, Sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations relating to or resulting from such Injury, Sickness, Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the 90 day(s) period that ends the day before:
Your effective date of coverage; or
The effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes or provides Treatment.

Treatment includes, but is not limited to:

1) medical examinations, tests, attendance, or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

GENERAL PROVISIONS

Claims Administrator: *What is the role of the Claims Administrator?*
The Claims Administrator is delegated the duties of the Employer to:

1) determine benefits payable according to the terms and conditions of The Plan; and
2) make payment for benefits payable.

The Claims Administrator has the responsibility for deciding appeals of claims which were initially denied by the Claims Administrator. The Employer has responsibility for making final determination regarding eligibility for coverage.

Notice of Claim: *When should the Claims Administrator be notified of a claim?*
You, your supervisor or your physician must give the Claims Administrator notice of claim by calling the special claims telephone number provided to Employees. Such notice must be given on the fifth day of an absence due to the same or a related Disability.

Claim Forms: *Are special forms required to file a claim?*
The Claims Administrator will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If the Claims Administrator does not send the forms within 15 days, You may submit any other telephonic proof which fully describes the nature and extent of Your claim.

Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after a notice of claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current Weekly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for the Claims Administrator to obtain and release:
   a) medical, employment and financial information; and
   b) any other information the Claims Administrator may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to the Claims Administrator.

Additional Proof of Loss: *What additional proof of loss is the Claims Administrator entitled to?*
To assist the Claims Administrator in determining if You are Disabled, or to determine if You meet any other term or condition of The Plan, the Claims Administrator has the right to require You to:

1) meet and interview with the Claims Administrator; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of the Claims Administrator's choice.

Any such interview, meeting or examination will be:

1) at the Claims Administrator's expense; and
2) as reasonably required by the Claims Administrator.

Your Additional Proof of Loss must be satisfactory to the Claims Administrator. Unless the Claims Administrator determines You have a valid reason for refusal, the Claims Administrator may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by the Claims Administrator.

Sending Proof of Loss: *When must proof of Loss be given?*
Written Proof of Loss must be sent to the Claims Administrator within 90 day(s) after the start of the period for which the Claims Administrator is liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due, unless You are not legally competent.

The Claims Administrator may request Proof of Loss throughout Your Disability. In such cases, the Claims Administrator must receive the proof within 30 day(s) of the request.

Claim Payment: *When are benefit payments issued?*
When the Claims Administrator determines that You:

1) are Disabled; and
2) eligible to receive benefits;

the Claims Administrator will pay accrued benefits at the end of each month that You are Disabled. The Claims Administrator may, at their option, make an advance benefit payment based on the Claims Administrator's estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to the Claims Administrator is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then the Claims Administrator may pay up to $1,000 to a person who is Related to You and who, at the Claim Administrator's sole discretion, is entitled to it. Any such payment shall fulfill the Claim Administrator's responsibility for the amount paid.

Claim Denial: *What notification will ! receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to The Plan provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do ! have if my claim is denied?*
On any claim, You or Your representative may appeal to the Claims Administrator for a full and fair review. To do so You:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires the Claims Administrator to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require the Claims Administrator to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) may submit written comments, documents, records and other information relating to Your claim.

The Claims Administrator will respond to You in writing with the final decision on the claim.

Social Security: *When must ! apply for Social Security Benefits?*
The Employer may require that You apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of the request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates: *How does the Claims Administrator 15 estimate Disability benefits under the United States Social Security Act?*
The Claims Administrator reserves the right to reduce Your Weekly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive.

When the Claims Administrator determines that You or Your Dependent may be eligible for benefits, the Claims Administrator may estimate the amount of these benefits. The Claims Administrator may reduce Your Weekly Benefit by the estimated amount.
Your Weekly Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to the Claims Administrator.

If the Claims Administrator has reduced Your Weekly Benefit by an estimated amount and:

1) You or Your Dependent are later awarded Social Security disability benefits, the Claims Administrator will adjust Your Weekly Benefit when the Claims Administrator receives proof of the amount awarded, and determine if it was higher or lower than the Claims Administrator estimates; or
2) Your application for Social Security disability benefits has been denied, the Claims Administrator will adjust Your Weekly Benefit when You provide the Claims Administrator proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than the Claims Administrator estimated, and the Claims Administrator owes You a refund, the Claims Administrator wil make such refund in a lump sum. If Your Social Security Benefits were higher than the Claims Administrator estimated, and If Your Weekly Benefit has been overpaid, You must make a lump sum refund to the Claims Administrator equal to al overpayments, in accordance with the Overpayment Recovery provision

Subrogation: *What are the Employer's subrogation rights?*
If You:

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Plan in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time; then the Employer will be subrogated to any rights You may have against the Third Party and may, at its option, bring legal action against the Third Party to recover any payments made by The Plan in connection with the Disability.

Third Party as used in this provision means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Plan.

Legal Actions: *When can legal action be taken against the Employer?*
Legal action cannot be taken against the Employer:

1) sooner than 60 days after the date proof of loss is furnished; or
2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Plan.

Misstatements: *What happens if facts are misstated?*
If material facts about You were not stated accurately, the true facts will be used to determine if, and for what amount, coverage should have been in force.

Plan Interpretation: *Who interprets the terms and conditions of The Plan?*
The Employer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Plan. This provision applies where the interpretation of The Plan is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

DEFINITIONS

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays.
On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for Your usual number of hours.

You will be considered Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Regular Teammate means a Teammate who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Benefits.

Bonuses means the weekly average of bonuses You received from Your Employer over:

1) the 12 calendar month period beginning on October 1st and ending on September 30th immediately prior to the anniversary date You became Disabled; or
2) the total period of time You worked for Your Employer, if less than the above period.

Claims Administrator means Hartford Life and Accident Insurance Company.

Current Weekly Earnings means Weekly earnings You receive from:

1) Your Employer; and
2) other employment;

while You are Disabled and eligible for the Disabled and Working Benefit.
However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month period just before You became Disabled will count as Current Weekly Earnings.

Current Weekly Earnings also includes the pay You could have received for another job or a modified job if:

1) such job was offered to You by Your Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
    a) Your education, training and experience; and
    b) Your capabilities as medically substantiated by Your Physician.

Disabled and Working means that You are prevented by:

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy

from performing some, but not all of the Essential Duties of the Occupation for the Employer, are working on a part-time or limited duty basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

Disability or Disabled means Total Disability or Disabled and Working Disability.

Essential Duty means a duty that:

1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Injury means bodily injury resulting:

1) directly from accident; and
2) independently of all other causes;

which occurs while You are covered under The Plan. However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Plan, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Plan. This includes any such benefits for which You or Your family are eligible or that are paid to You, or Your family or to a third party on Your behalf, pursuant to any:

1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;
4) individual insurance policy where the premium is wholly or partially paid by Your Employer;
5) mandatory "no fault" automobile insurance plan;
6) disability benefits under:
    a) the United States Social Security Act or alternative plan offered by a state or municipal government;
    b) the Railroad Retirement Act;
    c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
    d) similar plan or act;

that You, Your spouse and/or children are eligible to receive because of Your Disability; or

7) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
    a) that begins after You become Disabled; or
    b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or Your family, or to a third party on Your behalf, pursuant to any:

1) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
3) retirement benefits under:

a) the United States Social Security Act or alternative plan offered by a state or municipal government;
b) the Railroad Retirement Act;
c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
d) similar plan or act;

that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that the Claims Administrator recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not Related to You by blood or marriage.

With respect to All Teammates except highly incented teammates whose non-base salary earnings comprise at least 50% of their total compensation

Pre-disability Earnings means Your total annual compensation, not including equity program payments, calculated on the September 30th immediately prior to the anniversary date You become Disabled, divided by 52. Total annual compensation is determined using the annual base pay calculated on the September 30th immediately prior to the anniversary date You become Disabled, plus all incentives, overtime shift differential and bonuses paid during the previous 12 month period beginning on October 1st and ending on September 30th immediately prior to the anniversary date You become Disabled.

With respect to highly incented Teammates (teammates whose target incentive is at least 50% of their base salary) **Pre-disability Earnings** is calculated as above. However, if Your Pre-disability Earnings calculation includes less than 12 months of earnings history, Your Pre-disability Earnings will be adjusted to equal Your annualized total cash compensation divided by 52.

With respect to New Hires

Pre-disability Earnings means Your annualized salary during Your first year of coverage, not including equity program payments, divided by 52. If Your total annual compensation is less than $1,000, Your total annual compensation will be increased to $40,000 for the purposes of calculating Pre-disability Earnings.

Prior Plan means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:

a) consistent with the diagnosis of the disabling condition;
b) according to guidelines established by medical, research, and rehabilitative organizations; and
c) administered as often as needed;

to achieve the maximum medical improvement.

Rehabilitative Employment means employment or service which:

1) prepares a Disabled person to resume gainful work; and
2) is approved, in writing, by the Claims Administrator.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Sickness means a Disability which is:

1) caused or contributed to by:
   a) any condition, illness, disease or disorder of the body;
   b) any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
   c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Plan; or
   d) pregnancy;
2) caused or contributed to by any medical or surgical treatment for a condition shown in item 1) above.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

The Plan means the Plan which the Claims Administrator issued to the Contractholder under the Plan number in the Schedule of Benefits.

Total Disability or Totally Disabled means that You are prevented by:

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

from performing the Essential Duties of the Occupation for the Employer, and as a result, You are earning less than 20% of Your Pre-disability Earnings. If You are in an occupation that requires You to maintain a license, Your failure to pass a physical examination required to maintain that license does not alone mean that You are disabled from the Occupation.

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

You or Your means the person to whom this Plan is issued.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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. The Truist Financial Corporation Employee Benefits Plan ("Plan") provides eligible employees and their dependents with health, dental, vision, disability, life insurance and accidental death and dismemberment insurance benefits. Each benefit available under the Plan is summarized in a separate booklet. These booklets, taken together, comprise the SPD for the Plan.

This booklet summarizes the Truist Short Term Disability insurance program and is referred to in this booklet as the Plan. The Disability insurance program is designed to prevent a lapse in pay if you're out of work due to non-work related illness or disability.

The material contained in each booklet 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.

We encourage Plan participants to read the SPD carefuly. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed under "ERISA INFORMATION" for the benefit program.

A listing of all the benefits available under the Plan and the SPD booklets are available on benefits.truist.com. You may also obtain a copy of the Plan document by calling Truist HR Central, 800-7162455,
Option 1. These documents together make up the legal plan document for Truist Employee Benefit Plan.

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1. Plan Name

Group Short Term Disability Plan for Teammates of TRUIST FINANCIAL CORPORATION EMPLOYEE BENEFIT PLAN.

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2. Plan Number

WD - 508

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3. Employer/Plan Sponsor

Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

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4. Employer Identification Number

56-0939887

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5. ___ Type of Plan

Welfare Benefit Plan providing Group Short Term Disability.

6. Plan Administrator

Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

0. Agent for Service of Legal Process

For the Plan:
Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

For the Claims Administrator:
Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

~~In addition to the above, Service of Legal Process may be made on a plan trustee.~~

1. Sources of Contributions The Employer pays the cost of the coverage, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

0. Type of Administration The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan Document.

7. The Plan and its records are kept on a Plan year basis.

0 . L a b o r Organizations

None

1 . Names and Addresses of Trustees

None

2 . Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.
The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Funding - the Plan is unfunded. Benefits are paid from the general assets of the Employer.

Statement of 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), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
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 administrator may make a reasonable charge for the copies.
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.

2. Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 $110 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan 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.

4. Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits 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, D.C. 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.

CLAIM PROCEDURES

The Employer has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan.

Claim Procedures for Claims Requiring a Determination of Disability.

Claims for Benefits:

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Claim Administrator. The Claim Administrator will evaluate your claim and determine if benefits are payable.

The claim decision will be made no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond the control of the Plan, that the notice identifies those matters and gives the date by which a decision is expected to be made. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Plan provisions on which the decision is based, 3) a description of any additional material information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal, and 6)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denial of Claims for Benefits:

On any wholly or partially denied claim, you or your representative may appeal to the Employer for a full and fair review. Your appeal request must be in writing and be received by the Employer no later than the expiration of 180 days from the date you received your claim denial.

As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Employer's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Employer will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Employer notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Employer receives your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon

in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Employer will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Employer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Plan provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Claim Administrator. The Claim Administrator will evaluate your claim and determine if benefits are payable.

The claim decision will be made no more than 90 days after receipt of your properly filed claim. However, if there are special circumstances that require an extension, the time for claim decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and are given the date by which a decision is expected to be made. If extended, a decision shall be made no more than 180 days after your claim was received. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Plan provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the Employer for a full and fair review. Your appeal request must be in writing and be received by the Employer no later than the expiration of 60 days from the date you received your claim denial.

As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Employer's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Employer will make a final decision no more than 60 days after it receives your timely appeal. However, if the Employer determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Employer notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Employer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Plan provisions on which the decision is based, 2) a statement that you are 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, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

LONG TERM DISABILITY
BOOKLET

YOUR BENEFIT PLAN

TRUIST FINANCIAL CORP.

Long Term Disability

Amendatory Rider

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

This rider forms a part of a certificate given in connection with Policy Number 674861 issued to Truist Financial Corp., where 674861 is the Policy Number and Truist Financial Corp. is the Policyholder.

This rider becomes effective on January 1, 2025.

With respect to All Full-time Active Employees who are pilots, Your Certificate is hereby amended in the following manner:

The **Disability or Disabled** provision shown in the **Definitions** section of the **Disability Insurance** portion of Your certificate is amended to read as follows:

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:
1) Your Occupation during the Elimination Period; and
2) Your Occupation following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first.

Your Disability must result from:
1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

If the Federal Aviation Administration revokes or suspends Your license to fly a commercial aircraft due to injury or sickness, You will be considered to be prevented from performing the Essential Duties of Your Occupation. We will not consider You to be Disabled under any circumstance if the revocation or suspension of Your license to fly a commercial aircraft is due to a non-medical reason.
GBD-1200 C13 (10/08) (Rev-1)

In all other respects the certificate remains the same.

Signed for Hartford Life and Accident Insurance Company

Kevin Barnett, *Secretary*

Michael J. Fish, ***Head of Group Benefits***

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at https://www.thehartford.com/. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **For Your Questions and Complaints:**
   Arkansas Insurance Department
   Consumer Services Division
   1200 West Third Street
   Little Rock, AR 72201-1904
   Toll Free:1(800) 852-5494
   Local: 1(501) 371-2640

2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

California:

1. **NOTICE:** READ YOUR CERTIFICATE CAREFULLY
   You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

   PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.

2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply

to you. The following requirement applies to you:

Eligibility Determination: *How will We determine Your eligibility for benefits?*
We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility or Your beneficiaries for benefits for any claim You or Your beneficiaries make on The Policy. We will:

1) obtain with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
2) as a part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**. In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.

3. **For Your Questions and Complaints:**
State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions.
3. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
4. The **Complications of Pregnancy** provision, if shown in the **Definitions** section of the Certificate, is revised as follows:

Complications of Pregnancy means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:

1) acute nephritis or nephrosis;
2) cardiac decompensation;
3) missed abortion; and
4) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will also include:

1) pre-eclampsia;
2) placenta previa;
3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
4) termination of ectopic pregnancy;
5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;
6) non-elective Cesarean section; and
7) similar medical and surgical conditions of comparable severity.

However, the term Complications of Pregnancy will not include:

1) elective Cesarean section;
2) false labor, occasional spotting, or morning sickness;
3) hyperemesis gravidarum; or
4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.

Florida: 1 . **NOTICE: The benefits o f the policy providing you coverage may b e governed primarily b y the laws o f a state other than Florida.**

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **For Your Questions and Complaints:**
   Illinois Department of Insurance
   Consumer Services Station
   Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431
3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Kansas:

1. The following requirement applies to you:

   Policy Interpretation: *Who interprets Policy terms and conditions?*
   Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are a fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

Louisiana:

1. The following requirement is applicable to you:

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?* If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

   The reinstated coverage will:
   1) be the same coverage amounts in force on the date coverage ended;
   2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
   3) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The benefits under the policy are subject to reduction due to other sources of income.

   This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under the policy.

   Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

   What comprises other sources of income under the policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully.** A full description of the plans and types of plans considered to be other sources of income under the policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.
2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.
3. The following **requirement is applicable to you**:

Reinstatement: *Can my coverage be reinstated after it ends?*
We will reinstate The Policy upon receipt of all current and late premiums if:

1) You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and
2) all current and late premium payments are received within 15 days of Our request.

We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

Massachusetts:

1. The **Surviving Children** definition in the **Survivor Income Benefit** will also include a child in the process of adoption.
2. The following continuation requirement is applicable to you

In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first. You must pay the required premium for continued coverage.

Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:

1) 90 days from the date You were no longer eligible for coverage as a Full-time Active Employee;
2) the date You become eligible for similar benefits under another group plan;
3) the last day of the period for which required premium is made;
4) the date the group insurance policy terminates; or
5) the date Your Employer ceases to be a Participant Employer, if applicable.

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Missouri:

1. The **Exclusions** provision shall only exclude for intentionally self-inflicted Injury, suicide or attempted suicide, which occur while You are sane.

Montana:

1. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate
2. Pregnancy will be covered, the same as any other sickness, anything in The Policy to the contrary notwithstanding.

New Hampshire:

1. If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.

New Jersey:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions and domestic partners, provided You continue to meet the requirements described in the domestic partner affidavit, civil union license or civil union certificate or as required by law. Same sex relationships entered into under the laws of another State or Country, which closely approximate a civil union or a domestic partnership under New Jersey law, wil be recognized as civil unions or domestic partners under New Jersey law.

New York:

1. The **Other Income Benefits** definition will not include a portion of a settlement or judgment of a lawsuit that represents or compensates for Your loss of earnings.
2. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
4. If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:

1) you are both are legally and mentally competent to consent to contract in the state in which you reside;
2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
3) you have been living together on a continuous basis prior to the date of the application;
4) neither of you have been registered as a member of another domestic partnership within the last six months; and
5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

1) a joint bank account;
2) a joint credit card or charge card;
3) joint obligation on a loan;
4) status as an authorized signatory on the partner's bank account, credit card or charge card;
5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
6) listing of both partners as tenants on the lease of the shared residence;
7) shared rental payments of residence (need not be shared 50/50)
8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
0) shared household budget for purposes of receiving government benefits;
1) status of one as representative payee for the other's government benefits;
2) joint responsibility for child care (e.g., school documents, guardianship);
3) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
4) execution of wills naming each other as executor and/or beneficiary;
5) designation as beneficiary under the other's life insurance policy;
6) designation as beneficiary under the other's retirement benefits account;
7) mutual grant of durable power of attorney;
8) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
9) affidavit by creditor or other individual able to testify to partners' financial interdependence;

10) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. The **Other Income Benefits** definition will not include a mandatory "no-fault" automobile insurance plan.
3. You are not required to be under the **Regular Care of a Physician** if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
4. The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
5. Within the **Misstatements** provision reference to fraudulent misstatements will not apply to You.
6. The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within 180 days following the completion of the **Elimination Period**.
7. The **Claims to be Paid** provision is amended to state that We may pay up to $3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
8. **Notice of Claim** may also be given to Our representative, if applicable.
9. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 5850-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
   1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN
      COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
   2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS.
   VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

PRE-EXISTING LIMITATION
READ CAREFULLY

NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE
NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THE

CERTIFICATE.

READ YOUR CERTIFICATE CAREFULLY.

Oregon:

1. The definition of **Surviving Spouse** within the **Survivor Income Benefit** will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Surviving Children** definition within the **Survivor Income Benefit** will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:
   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
2. If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:
   1) the Policy Effective date, if Your coverage for the Disability was not limited by a preexisting condition restriction under the Prior Policy; or
   2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

   This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.
2. The **Other Income Benefits** definition will not include the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable
2. **I M P O R T A N T N O T I C E A V I S O I M P O R T A N T E**

To obtain information or make a complaint: You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-523-2233

Para obtener información o para presentar una queja: Usted puede llamar al número de teléfono gratuito de The Hartford's para obtener información o para presentar una queja al:

1-800-523-2233

You may also write to The Hartford at:

P.O. Box 2999
Hartford, CT 06104-2999

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

Usted tam bién puede escribir

P.O. Box 2999
Hartford, CT 06104-2999

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas

ATTACH THIS NOTICE TO YOUR POLICY: ADJUNTE ESTE AVISO A SU PÓLIZA:

This notice is for information only and does not become a part or condition of the attached document.

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Utah:

1. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

Vermont:

1. The following requirement applies:

Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

Definitions, Terms, Conditions and Provisions: The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

1) Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.
2) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

3) Terms that mean or refer to family relationships arising from a marriage, such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.
4) "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.
5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under the policy,

contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Virginia:

1. **For Your Questions and Complaints:**
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23209
   1(804) 371-9691 (Local number)
   1(800) 552-7945 (Virginia toll free number)
   1(877) 310-6560 (National toll free number)

Washington:

1. The following continuation applies to you:

   General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage for a period not exceeding 6 months. If the work stoppage ends, this continuation will cease immediately.

Wisconsin:

1. For Your Questions and Complaints:
   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873
   1(800) 236-8517 (outside of Madison)
   1(608) 266-0103 (in Madison)

Group Disability Income Insurance

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

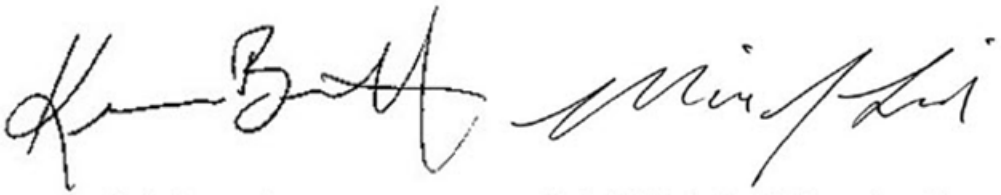
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

CERTIFICATE OF INSURANCE

Policyholder: TRUIST FINANCIAL CORP.
Policy Number: GLT-674861
Policy Effective Date: January 1, 2004
Policy Anniversary Date: January 1, 2026

We have issued The Policy to the Policyholder. The Policy is a legal contract between the Policyholder and Us. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company



Kevin Barnett, *Secretary* Michael J. Fish, *Head of Group Benefits*

READ YOUR CERTIFICATE CAREFULLY

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

LTD TABLE OF CONTENTS

SCHEDULE OF INSURANCE

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

The benefits described herein are those in effect as of January 1, 2025.

Cost of Coverage:
Option 1 - Depending upon the coverage for which You are enrolled, You are not required to contribute toward the cost of coverage under Option 1.

Option 2 - Depending upon the coverage for which You are enrolled, You must contribute toward the cost of coverage under Option 2.

Disclosure of Fees:
We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Teammates.

Eligible Class(es) For Coverage: All Active Regular Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding employees in Salary Grade 179, temporary, leased or seasonal teammates as follows:

Class 1: Employees with a Salary Grade of 112 or higher, Employees with a Salary Grade of H07 or higher (Truist Insurance Holdings, Inc., McGriff Insurance Services, Inc., CRC Insurance Services, Inc., and Crump Life Insurance Services, Inc. only)

Class 2: Employees with a Salary Grade below 112 (or H07)

Class 3: pilots

Regular Employment: scheduled to work at least 20 hours weekly

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:
The first day of the month following the date You were hired

The time period(s) referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time Active Teammate with the Employer under the Prior Policy.

Elimination Period: 180 day(s)

Maximum Monthly Benefit: $35,000

Minimum Monthly Benefit: $50

Benefit Percentage:
Option 1: 50%
Option 2: 60%

Maximum Duration of Benefits

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

Additional Benefit:

Family Care Credit Benefit
see benefit

Survivor Income Benefit
see benefit

Workplace Modification Benefit
see benefit

GBD-1200 B04 (10/08) (Rev-1)

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.
GBD-1200 D01 (10/08)

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:

1) the Policy Effective Date; or
2) the date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

GBD-1200 D02 (10/08)

Enrollment: *How do I enroll for coverage?*
For coverage under Option 1, all eligible Active Teammates will be enrolled automatically by the Employer.

For coverage under Option 2, You must enroll. To enroll for coverage You must:

1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to Your Employer.

You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:

1) You must give Us Evidence of Insurability satisfactory to Us; and
2) You may only enroll:
   a) during an Annual Enrollment Period designated by the Policyholder; or
   b) within 31 days of the date You have a Change in Family Status.

The dates of the Annual Enrollment Period are shown in the Schedule of Insurance.
GBD-1200 D03 (10/08) (Rev-1)

Change in Family Status: *What constitutes a Change in Family Status?* A
Change in Family Status occurs when:

1) You get married;
2) You and Your spouse divorce or legally separate (recorded through the Clerk of Court);
3) Your child is born or You adopt or become the legal guardian of a child or a child is placed with You for foster care;
4) Your spouse or child dies;
5) Your spouse's loss or commencement of employment; or
6) Your spouse moves into or out of a country with socialized medicine;
7) Your or Your spouse's start or end a military leave of absence;
8) Your loss of coverage under Medicare or Medicaid;
9) Your COBRA coverage expires or COBRA subsidiary expires;
10) You or Your spouse have a significant change in health care costs under Your spouse's plan;
11) You lose Your eligibility under Your parent's health care plan; or
12) You have a change in day care coverage for your child (Dependent Care FSA Only).

GBD-1200 D05 (10/08)

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
If You are not required to contribute toward The Policy's cost, Your coverage will start: on the date You become eligible.
If You must contribute toward The Policy's cost, Your coverage will start on the earliest of:

1) the date You become eligible, if You enroll or have enrolled by then;
2) the date on which You enroll, if You do so within 31 days after the date You are eligible; or
3) on the January 1st following the Annual Enrollment Period if You enroll, during

an Annual Enrollment Period. GBD-1200 E01 (10/08)

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?* If You are absent from work due to:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.
GBD-1200 E05 (10/08)

Changes in Coverage: *Can I change my benefit options?*
You may change Your benefit option only:

1) during an Annual Enrollment Period; or
2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

When will a requested change in benefit option take effect?

f You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of the January 1st following the Annual Enrollment Period.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the later of the date You enroll for the change.

Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre-existing Conditions Limitation.

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Teammate; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes The Policy?
Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

1) the Deferred Effective Date provision; and
2) Pre-existing Conditions Limitation.

GBD-1200 E07 (10/08) (Rev-1)

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*
If You were:

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?
If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

1) the Policy Effective Date, if Your coverage for the Disability was not limited by a preexisting condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the Monthly Benefit which was paid by the Prior Policy; or
2) the Monthly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?
If You received monthly benefits for disability under the Prior Policy, and You returned to work as a Active Teammate before the Policy Effective Date, then, if within 6 months of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.
GBD-1200 E08 (10/08)

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the end of the month following the date The Policy terminates;
2) the end of the month following the date The Policy no longer insures Your class;
3) the end of the month following the date premium payment is due but not paid;
4) the last day of the period for which You make any required premium contribution;
5) the 15th of the month in which Your employment terminates if Your employment terminates from the 1st to the 15th of the month; or the last day of the month in which Your employment terminates if Your employment terminates from the 16th through the last day of the month; or
6) the 15th of the month or the end of the month following the date You cease to be a Full-time Active Teammate in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.
GBD-1200 E10 (10/08)

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all teammates the same way. Continued coverage:

1) is subject to any reductions in The Policy;
2) is subject to payment of premium by the Employer; and
3) terminates if:
   a) The Policy terminates; or
   b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave, Your coverage may be continued for 12 month(s) after the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Severance: If Your employment terminates and continuation of long term disability insurance is available to You in a severance plan sponsored by the Employer, Your coverage may be continued. Your coverage will continue until the earliest of:

1) the date The Policy terminates;
2) the date You become covered under another group long term disability insurance policy;
3) the date specified in Your severance plan; or
4) 24 months from the date Your employment terminates.

Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 month(s). If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately. GBD-1200 E13 (10/08) (Rev-1)

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Teammate?* If You are Disabled and You cease to be an Active Teammate, Your insurance will be continued:

1) during the Elimination Period while You remain Disabled by the same Disability; and
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.

GBD-1200 E14 (10/08)

Waiver of Premium: *Am I required to pay premiums while I am Disabled?*
No premium will be due for You:

1) after the Elimination Period; and
2) for as long as benefits are payable.

GBD-1200 E19 (10/08) (Rev-1)

Extension of Benefits for Disability: *Do my benefits continue if The Policy terminates?*
If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.
GBD-1200 E21 (10/08)

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Policy?*
We will pay You a Monthly Benefit if You:

1) become Disabled while insured under The Policy;
2) are Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.
GBD-1200 F01 (10/08)

Mental Illness and Substance Abuse Benefits: *Are benefits limited for Mental Illness or Substance Abuse?* If You are Disabled because of:

1) Mental Illness that results from any cause;
2) any condition that may result from Mental Illness;
3) alcoholism; or
4) the non-medical use of narcotics, sedatives, stimulants, halucinogens, or any other such

substance; then, subject to al other provisions of The Policy, We wil limit the Maximum Duration of Benefits.

Benefits will be payable:

1) for as long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) if not confined, or after You are discharged and still Disabled, for a total of 24 months for all such disabilities during Your lifetime.

GBD-1200 F05 (10/08)

Recurrent Disability: *What happens if I Recover but become Disabled again?*
Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Teammate are less than one-half (1/2) the number of days of Your Elimination Period.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Teammate and then become Disabled and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 6 months of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Teammate for 6 months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.
GBD-1200 F07 (10/08)

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*
If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

1) multiply Your Pre-disability Earnings by the Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.
GBD-1200 F12 (10/08) (Rev-1)

Calculation of Monthly Benefit: *What happens if the sum of my Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of my Pre-disability Earnings?*
If the sum of Your Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.
GBD-1200 F14 (10/08)

Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*
Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.
GBD-1200 F15 (10/08)

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*
If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Monthly Benefit for each day You were Disabled.
GBD-1200 F16 (10/08)

With respect to Class 1 & 3:
Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician, unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;
4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits Table;
8) the date Your Current Monthly Earnings are equal to or greater than 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation;

9) the date no further benefits are payable under any provision in The Policy that limits benefit duration; or
10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try: a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;
provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

GBD-1200 F18 (10/08) (NC)

With respect to Class 2:

Termination of Payment: *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician; unless qualified medical professionals have determined that further medical care and treatment will be of no benefit to You;
4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits Table; or
8) the date Your Current Monthly Earnings:
a) are equal to or greater than 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
b) are greater than the lesser of the product of Your Indexed Pre-disability Earnings and the Benefit Period Percentage or the Maximum Monthly Benefit if You are receiving benefits for being Disabled from Any Occupation;
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;
10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;
provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

GBD-1200 F18 (10/08) (NC)

Family Care Credit Benefit: *What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?*
If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

1) Family Care means the care or supervision of:
    a) Your children under age 13; or
    b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2) the maximum monthly deduction allowed for each qualifying child or family member is:
    a) $350 during the first 12 months of Rehabilitation; and
    b) $175 thereafter;
    but in no event may the deduction exceed the amount of Your monthly earnings;
    3) Family Care Credits may not exceed a total of $2,500 during a calendar year;
    4) the deduction will be reduced proportionally for periods of less than a month;
    5) the charges for Family Care must be documented by a receipt from the caregiver;
    6) the credit will cease on the first to occur of the following:
        a) You are no longer in a Rehabilitation program; or
        b) Family Care Credits for 24 months have been deducted during Your Disability; and
7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings. GBD-1200 F25 (10/08) (Rev-1)

Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability Benefits?*
If You were receiving a Monthly Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:

1) of Your death; and
2) that the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

The Survivor Income Benefit will only be paid:

1) to Your Surviving Spouse; or
2) if no Surviving Spouse, in equal shares to Your Surviving Children.

If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

The Survivor Income Benefit is calculated as 3 times the lesser of:

1) Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or
2) The Maximum Monthly Benefit.

Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner provided You:

1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
2) have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are under age 26.

The term Surviving Children will also include any other children related to You by blood or marriage or domestic partnership and who:

1) lived with You in a regular parent-child relationship; and
2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

GBD-1200 F27 (10/08) (Rev-1)

Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*
We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Teammate. You qualify for this benefit if:

1) Your Disability is covered by The Policy;
2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
4) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such Workplace Modification shall not exceed $25,000.

We have the right, at Our expense, to have You examined or evaluated by:

1) a Physician or other health care professional; or
2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

1) the proposed modifications made on Your behalf are complete;
2) We have been provided written proof of the expenses incurred to provide such modification; and
3) You have returned to work as an Active Teammate.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of The Policy.
GBD-1200 F29 (10/08) (Rev-1)

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Policy does not cover, and We will not pay a benefit for, any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war, whether declared or not;
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by Your Employer; and
2) was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.
GBD-1200 G01 (10/08) (NC)

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*
We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 90 consecutive day(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 365 consecutive day(s).

Pre-existing Condition means any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse, or first manifestation thereof, for which You received Medical Care during the 90 consecutive day period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) gives medical advice, diagnosis or care; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

GBD-1200 G04 (10/08) (Rev-2) (NC)

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*
You must give Us, or Our representative, written notice of a claim within 30 days after Disability or loss occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address and the Policy Number.
GBD-1200 H01 (10/08) (NC)

Claim Forms: *Are special forms required to file a claim?*
We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.
GBD-1200 H02 (10/08)

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:

1) documentation of:
    a) the date Your Disability began;
    b) the cause of Your Disability;
    c) the prognosis of Your Disability;
    d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
    e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
    a) medical, employment and financial information; and
    b) any other information We may reasonably require;
5) disclosure of all information and documentation required by Us relating to Other Income Benefits;
6) proof that You and Your dependents have applied for all Other Income Benefits which are available; and
7) disclosure of all information and documentation required by Us in order to exercise Our Subrogation or Reimbursement rights.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.
GBD-1200 H03 (10/08) (Rev-1)

Additional Proof of Loss: *What Additional Proof of Loss is the Company entitled to?*
To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with Our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.
GBD-1200 H04 (10/08)

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss must be sent to Us within 180 days following the completion of the Elimination Period. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not reasonably possible to give proof within the required time; and

2) proof is given as soon as reasonably possible; but
3) not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability, as reasonably required. In such cases, We must receive the proof within 30 day(s) of the request.
GBD-1200 H05 (10/08) (NC)

Claim Payment: *When are benefit payments issued?*
When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Benefits may be subject to interest payments as required by applicable law.
GBD-1200 H06 (10/08)

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
GBD-1200 H08 (10/08) (NC)

Claim Denial: *What notification will ! receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to The Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

GBD-1200 H09 (10/08)

Claim Appeal: *What recourse do ! have if my claim is denied?*
On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.
GBD-1200 H10 (10/08)

Social Security: *When must ! apply for Social Security Benefits?*
You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals. GBD-1200 H11 (10/08)

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?* We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive.

When We determine that You or Your dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1) You or Your dependent are later awarded Social Security disability benefits, We wil adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than We estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security benefits were higher than We estimated, and if Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.
GBD-1200 H12 (10/08) (Rev-1)

Overpayment: *When does an overpayment occur?*
An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.

GBD-1200 H13 (10/08)

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*
We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;

3) refer Your unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

GBD-1200 H14 (10/08)

Reimbursement: *What are Our reimbursement rights?*

We have the right to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover any funds from a Third Party.

If You recover any funds from a Third Party as:

1) a legal judgment;
2) an arbitration award; or
3) a settlement or otherwise;

You or Your attorney shall hold in constructive trust the lesser of:

1) the entire amount of the benefit payment(s) made or required to be made by Us; or
2) the total amount of the recovered funds;

less Our pro rata share of any reasonable attorneys' fees and court costs associated with the recovered funds. We have the right of first reimbursement regardless of:

1) whether You are made whole;
2) how the recovered funds are characterized; or
3) whether the particular funds recovered are still in Your possession.

By accepting benefit payment(s) under The Policy, You:

1) agree to cooperate fully with Our reimbursement rights, including disclosure of all information and documentation required by Us in order to exercise Our reimbursement rights; and
2) will not do anything to prejudice Our reimbursement rights.

You or Your attorney's failure to cooperate fully with Our reimbursement rights may result in denial or termination of Your benefits under The Policy.

Third Party as used in this provision, means:

1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

GBD-1200 H16 (10/08) (Rev-1)

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than 60 days after the date Proof of Loss is given; or
2) more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy. GBD-1200 H17 (10/08)

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

GBD-1200 H18 (10/08)

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

All statements made by the Policyholder, the Employer or You under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.
GBD-1200 H19 (10/08) (NC)

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).
GBD-1200 H20 (10/08)

Physical Examinations and Autopsy: *Will I be examined during the course of my claim?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a loss examined by a Physician when and as often as reasonably necessary; and
2) to make an autopsy in case of death where it is not forbidden by law.

GBD-1200 H21 (10/08)

DEFINITIONS

Actively at Work means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.
GBD-1200 C01 (10/08)

Active Teammate means a teammate who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance. GBD-1200 C03 (10/08)

Any Occupation means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:

1) the product of Your Indexed Pre-disability Earnings and the Benefit Percentage; or
2) the Maximum Monthly Benefit.

GBD-1200 C05 (10/08) (Rev-1)

Bonuses means the monthly average of monetary bonuses You received from Your Employer over:

1) the 12 calendar month period beginning on October 1st and ending on September 30th immediately prior to the anniversary date You became Disabled; or
2) the total period of time You worked for Your Employer, if less than the above

period. GBD-1200 C06 (10/08)

Current Monthly Earnings means monthly earnings You receive from:

1) Your Employer; and
2) other employment;

while You are Disabled.
GBD-1200 C09 (10/08) (Rev-1)

With respect to Class 1:

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period; and
2) Your Occupation following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first.

Your Disability must result from:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.
GBD-1200 C13 (10/08) (Rev-1)

With respect to Class 2:

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period;
2) Your Occupation during the Elimination Period for 36 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first.

Your Disability must result from:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.
GBD-1200 C15 (10/08) (Rev-1)

Elimination Period means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term disability benefits or salary continuation program, excluding benefits required by state law.
GBD-1200 C16 (10/08)

Employer means the Policyholder.
GBD-1200 C17 (10/08)

Essential Duty means a duty that:

1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.
GBD-1200 C18 (10/08) (Rev-1)

Indexed Pre-disability Earnings means Your Pre-disability Earnings adjusted annually by adding the lesser of:

1) 10%; or
2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.
GBD-1200 C19 (10/08)

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

GBD-1200 C21 (10/08)

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy. GBD-1200 C22 (10/08)

Monthly Income Loss means Your Pre-disability Earnings minus Your Current Monthly Earnings. GBD-1200 C23 (10/08)

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You or Your family, or to a third party on Your behalf, pursuant to any:

1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;

4) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, Your spouse and/or children, are eligible to receive because of Your Disability; or

5) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means the amount of any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under Your Employer's Retirement Plan;
2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
3) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) You were receiving it prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or
4) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We wil assume the entire sum to be for loss of income, and the time period to be 24 month(s). We may make a retroactive alocation of any retroactive Other Income Benefit. A retroactive alocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such

benefits. GBD-1200 C24 (10/08) (NC)

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

GBD-1200 C27 (10/08)

With respect to teammates except highly incented teammates whose non-base salary earnings comprise at least 50% of their total compensation:
Pre-disability Earnings means Your total annual compensation, not including equity program payments, calculated on the September 30th immediately prior to the anniversary date You become Disabled, divided by 12. Total annual compensation is determined using the annual base pay calculated on the September 30th immediately prior to the anniversary date You become disabled, plus all incentives, overtime shift differential and bonuses paid during the previous 12 month period beginning on October 1st and ending on September 30th immediately prior to the anniversary date You become Disabled.

With respect to highly incented teammates (teammates whose target incentive is at least 50% of their base salary):
Pre-disability Earnings is calculated as above. However, if Your Pre-disability Earnings calculation includes less than 12 months of earnings history, Your Monthly Rate of Earnings will be adjusted to equal Your annualized total cash compensation divided by 12.

With respect to New Hires:
Pre-disability Earnings means Your annualized salary during Your first year of coverage, not including equity program payments, divided by 12. If Your total annual compensation is less than $10,000, Your total annual compensation will be increased to $40,000 for the purposes of calculating the Monthly Rate of Earnings.
GBD-1200 C29 (10/08)

Prior Policy means the long term disability insurance carried by the Employer on the day before the Policy Effective Date. GBD-1200 C34 (10/08) (Rev-1)

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;
   to achieve the maximum medical improvement.

You are not required to be under the Regular Care of a Physician if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
GBD-1200 C35 (10/08) (NC)

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

1) vocational testing;
2) vocational training;
3) alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; or
   d) speech therapy;
4) work-place modification to the extent not otherwise provided;
5) job placement;
6) transitional work; and
7) similar services.

GBD-1200 C36 (10/08)

Related means Your spouse, or someone in a similar relationship in law to You, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.
GBD-1200 C38 (10/08)

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) a profit sharing plan;
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

GBD-1200 C39 (10/08)

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.
GBD-1200 C42 (10/08)

The Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page. GBD-1200 C43 (10/08)

We, Our, or Us means the insurance company named on the face page of The Policy.
GBD-1200 C48 (10/08)

Your Occupation means the Essential Duties of the job You are performing for Your Employer. If You are a physician or attorney Your Occupation means Your specialty in the practice of medicine or law.
GBD-1200 C49 (10/08)

You or Your means the person to whom this certificate is issued.
GBD-1200 C50 (10/08)

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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. The Truist Financial Corporation Employee Benefits Plan (“Plan”) provides eligible employees and their dependents with health, dental, vision, d isability, life insurance and accidental death and dismemberment insurance benefits. Each benefit available under the Plan is summarized in a separate booklet. These booklets, taken together, comprise the SPD for the Plan.

This booklet summarizes the Truist Short Term Disability and Long Term Disability insurance program and is referred to in this booklet as the Plan. The Disability insurance program is designed to prevent a lapse in pay if you're out of work due to non-work related illness or disability.

The material contained in each booklet 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.

We encourage Plan participants 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 “ERISA INFORMATION” for the benefit program.

A listing of all the benefits available under the Plan and the SPD booklets are available on benefits.truist.com. You may also obtain a copy of the Plan document by calling Truist HR Central, 800-7162455, Option 1. These documents together make up the legal plan document for Truist Employee Benefits Plan.

1. Plan Name

Group Long Term Disability Plan for teammates of TRUIST FINANCIAL CORPORATION EMPLOYEE BENEFIT PLAN.

2. Plan Number

LTD - 508

3. Employer/Plan Sponsor

Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

4. Employer Identification Number

56-0939887

4. Type of Plan

Welfare Benefit Plan providing Group Long Term Disability.

5. Plan Administrator

Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

6 **Agent for Service of Process**

For the Plan
Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

5. **Sources of Contributions (Long Term Disability)** The Employer pays the premium for the insurance, but may allocate part of the cost to the teammate, or the teammate may pay the entire premium. The Employer determines the portion of the cost to be paid by the teammate. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

6. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

7. The Plan and its records are kept on a Policy Year basis.

8. **Labor Organizations**

   None

9. **Names and Addresses of Trustees**

   None

10. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

11. **Funding - the Plan is unfunded. Claims are paid by the insurer.**

STATEMENT OF 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), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) 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 administrator may make a reasonable charge for the copies.

c) 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.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 $110 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan 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.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits 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, D.C. 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.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company 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.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a

disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company wil make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shal be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are 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, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.