TRUIST FINANCIAL CORPORATION
EMPLOYEE BENEFIT PLAN

Summary Plan Description

As of
January 1, 2026

REQUESTS FOR PLAN DOCUMENTS

Requests for plan documents must be in writing and sent to the Plan Administrator at:

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

Requests that are not submitted in writing to the address above will not be treated as valid requests for Plan documents.

FOREWORD

Truist Financial Corporation ("Truist") maintains the Truist Financial Corporation Employee Benefit Plan (the "Plan") for the exclusive benefit of Truist's and the Plan's Participating Employers'[1] (collectively, "Employer") eligible employees and other persons made eligible by their relationship to the eligible employee. This Plan is comprised of different Benefit Plans some of which are subject to Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Plan is designed to provide you and your covered dependents coverage for various health and welfare benefits. Benefits under the Plan are described in the Program Documents listed in Appendix A.[2] This document, together with Program Documents listed under Appendix A, is the summary plan description ("SPD") for the Plan.

Self-funded benefits described in this SPD are provided under administrative services only ("ASO") agreements between the Plan and various Third-party Administrators. Fully-insured benefits described in this SPD are provided under Certificates of Insurance issued by various Insurance Companies. The Third-party Administrators and Insurance Companies (collectively, the "Benefits Service Managers")[3] have been designated and named the claims fiduciary for benefits provided under the Plan. The Benefits Service Managers have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions under the Plan, to the extent permitted by applicable law. Benefits under the Plan are described in the Program Documents.

We encourage you to read the SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed under "Facts About the Plan." If there is a conflict between the information in this SPD and the plan documents, the plan documents will govern. Plan documents include any Program Documents describing the self-insured benefits as well as the Program Documents detailing the fully-insured benefits.

[1] Participating Employers are listed in Appendix B.

[2] Appendix A may be amended by the Plan Sponsor and/or Plan Administrator at any time without formal amendment to the Plan. Applicable Program Documents are available at benefits.truist.com

[3] The Benefits Service Managers are listed in Appendix A.

FACTS ABOUT THE PLAN	
Plan Name	Truist Financial Corporation Employee Benefit Plan
Plan Sponsor Address and Telephone Number	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 716-2455, option 1 benefits@truist.com A List of Participating Employers is available under Appendix B.
Employer Identification Number	56-0939887
Effective Date	This is a summary of the Plan as amended and restated effective January 1, 2021, and including all subsequent amendments thereto.
Name of Plan Administrator	Truist Financial Corporation Employee Benefits Plan Committee
Name and Address of Plan Administrator and Agent for Legal Service	Chairman, Employee Benefits Plan Committee Truist Financial Corporation 214 N. Tryon Street, 45th Floor Charlotte NC 28202
Plan Number	508
Type of Plan	Welfare Benefit Plan
Plan Year/Benefit Period	January 1 through December 31

PLAN BENEFITS

The Truist Financial Corporation Employee Benefit Plan ("the Plan") includes the component benefit(s) identified in Appendix A ("Benefit Plans"). Each Benefit Plan is described within the documents that are incorporated by reference and referred to as the Program Documents.

PROGRAM DOCUMENTS

The Program Documents expressly incorporated by reference and listed in Appendix A include the following items that are applicable to the type of coverage provided:

1) Schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances where benefits will be coordinated with other sources of payment;
2) Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
3) The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part;
4) Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the participant or beneficiary will be responsible;
5) Any annual or lifetime caps and all other limits on benefits;
6) The extent to which preventive services are covered;
7) Whether, and under what circumstances, existing and new drugs are covered;
8) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
9) Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
10) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;
11) A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to participants and beneficiaries as a separate document at no charge;
12) Any circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits; and,
13) Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third Party Administrator.

ELIGIBILITY

Eligibility to Participate

Except as provided in an applicable Program Document or in this Plan, you are eligible to participate in this Plan if you are an employee of an Employer and are scheduled to work 20 or more hours per week; provided, however, that no former employee or dependents will be covered by any Benefit Plan unless such Benefit Plan expressly covers the individual as a former employee or as a dependent of a former

employee, such as in the case of COBRA continuation coverage.

An employee who is eligible to participate in a Benefit Plan will become a participant as of the date set forth in the Program Document.

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

Eligibility for Benefits

Your eligibility and right to enroll in and maintain coverage under a Benefit Plan is governed by and described in each Benefit Plan's applicable Program Document. The Program Documents and the enrollment materials are expressly incorporated by reference.

Participation Conditions

As a condition of participation and receipt of benefits under the Plan, each eligible employee who elects to participate in one or more Benefit Plans, shall:

1) Complete and timely submit an election form to the Plan Administrator on which the eligible employee shall indicate which dependents shall be covered under the Benefit Plan, designate a portion of his compensation as a participant contribution and consent to have such amount withheld as a salary reduction contribution;
2) Observe all Plan and Benefit Plan rules and regulations;
3) Consent to the Committee's inquiries with respect to an individual's status as a spouse, domestic

partner, or dependent or with respect to any physician, hospital or other medical care provider, or services involved in a determination for eligibility of coverage or a claim for benefits under the Benefit Plans; and
4) Submit to the Benefits Service Managers all reports, bills and other information that the Benefits Service Managers may reasonably require to properly administer the Benefit Plans.

A participant's rights to enroll in and maintain coverage under the Benefit Plans are described in detail in the Program Documents or enrollment materials provided by the Employer. The Program Documents and the enrollment materials are expressly incorporated by reference.

Note that when you enroll a Spouse, Domestic Partner, or Dependent in a Benefit Plan, you represent the following:

1) The individual is eligible under the terms of the Benefit Plan; and
2) You will provide evidence of eligibility on request.

Further, you understand that:

1) This Plan and the Benefit Plan is relying on your representation of eligibility in accepting the enrollment of your family members;
2) Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
3) Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual become ineligible for plan coverage, as determined by the plan administrator.

Termination of Participation

Except as otherwise specifically provided herein or in the applicable Program Documents, coverage for a participant under a Benefit Plan shall terminate when the first of the following events occurs:

1) The participant ceases to be an Employee of all Employers;
2) The participant is no longer eligible to participate in the Plan;
3) The participant fails to timely pay any required Participant contributions;
4) The date the participant or dependent fails to provide any information required with respect to an eligibility audit (regardless of whether such individual is otherwise eligible);
5) The participant elects not to participate in a Benefit Plan for the subsequent Plan Year during annual enrollment;
6) The Plan Sponsor terminates the Benefit Plan or amends the Benefit Plan in a manner that it no longer applies to the participant or dependent; or
7) The date the Committee determines the participant or dependent has engaged in gross misconduct, which the Committee finds to be detrimental to the best interests of the Employer during the participant's employment with any Employer.

Except as otherwise specifically provided herein or in the applicable Program Document, coverage for a participant's covered dependent under a Benefit Plan shall terminate when the first of the following occurs:

1) The participant ceases to be covered;
2) As specified in any eligibility audit communication, the date the participant or dependent fails to provide any information required with respect to an eligibility audit (regardless of whether such individual is otherwise eligible); or
3) The covered Dependent is no longer an eligible dependent.

Unless the Program Documents provide otherwise, in the event that coverage under a Benefit Plan terminates upon one of the events identified above, such termination shall be effective at the end of the day on which such event occurs. However, if a Benefit Plan terminates due to a dependent child attaining age 26, coverage shall terminate at the end of the month that includes the child's 26th birthday. Notwithstanding the foregoing, if a participant and/or his covered dependent are eligible for and elect COBRA, participation shall terminate at the end of the applicable COBRA continuation coverage period.

CHANGES IN COVERAGE

Prior to January 1 of each year, there will be an enrollment period for employees who wish to add or drop coverage for themselves or their dependents, or change Benefit Plan options. Benefit changes made during the enrollment period will be binding for the Plan Year unless a change in status is experienced and the employee timely requests a change as described in the applicable Program Documents. It is your responsibility to request changes in coverage after a change in status. If you fail to request a change within the applicable time period, you must wait until the next re-enrollment period unless you experience another, unrelated change in status event.

Employees can request changes through Workday.

CONTINUATION OF PARTICIPATION DURING A LEAVE OF ABSENCE

Except as otherwise provided in the Program Documents, if you are enrolled for coverage under a Benefit Plan and taking a Leave of Absence[1], you can continue your coverage under the Benefit Plan according to your benefit election that is in effect on the day immediately preceding the first day of such Leave of Absence as provided below. To the extent that the Leave of Absence constitutes a change in status, you may drop your elective coverage. Notwithstanding the foregoing, you are allowed to maintain coverage under the Benefit while on a Leave of Absence only if you continue to have an employment relationship with an Employer, maintain your eligibility to participate in the applicable Benefit Plan (subject to any requirements under FMLA, USERRA, or any other federal law), and make all required participant contributions.

Participation during an Unpaid Leave of Absence

While on unpaid Leave of Absence, you may continue or drop your elective coverages during the Leave of Absence. In such circumstance, coverage shall continue unless you file an election to revoke coverage during such Leave of Absence. If you continue participation during such Leave of Absence, you shall pay your

[1] Leave of Absence means a period of Employer-approved absence from service that is not treated as a termination of employment in accordance with the Employer's employment policies, including an absence under the Family Medical Leave Act (FMLA) or to perform Uniformed Service protected under Uniformed Services Employment and Reemployment Rights Act of 1994.

required participant contributions during a Leave of Absence with after-tax dollars by remitting the required participant contributions on a monthly basis by the end of the grace period established by the Committee.

If you terminate your participation under a Benefit Plan or your coverage is terminated because of failure to pay required participant contributions and you return from Leave of Absence in the same Plan Year during which such Leave of Absence commences, coverage in such Benefit Plan shall be reinstated, at the level in effect when the Leave of Absence commenced, except that for purposes of the Health and Dependent Care Flexible Spending Accounts, deductions shall resume as provided below. If you return from Leave of Absence in the immediately following Plan Year, you shall be given 31 days during which to make new coverage elections (unless you made new elections during the immediately preceding annual enrollment).

Participation during a Paid Leave of Absence

Coverage under a Benefit Plan for a participant who is on a paid Leave of Absence shall continue during the participant's Leave of Absence, and his / her required contributions will be deducted, on a pre-tax or after-tax basis, as applicable, from paychecks he / she receives during the paid Leave of Absence.

Family Medical Leave

If you take a Leave of Absence under FMLA, you will continue to participate in your elected Benefit Plan while on such Leave of Absence as provided above and the requirement that your contributions continue on a pre-tax or after-tax basis as applicable.

A qualifying event for purposes of COBRA continuation coverage occurs if, after the end of an unpaid Leave of Absence under the FMLA (as determined under Department of Labor regulations) you do not return to work and, but for COBRA continuation coverage, you would lose group health coverage. In such a case, the qualifying event shall be deemed to have occurred on the last day of your Leave of Absence and you may elect COBRA continuation coverage.

Uniformed Services Employment and Reemployment Rights Act of 1994

A participant who is entitled to the protection of USERRA when taking a Leave of Absence to perform Uniformed Service shall have the following additional rights:

Uniformed Service for 30 Days or Less. If you take a Leave of Absence to perform Uniformed Service for a period of 30 days or less, you shall be treated as being actively at work during such Leave of Absence under a Benefit Plan providing group health plan coverage (within the meaning of USERRA). During such period, you shall pay the same amount, if any, that a participant who does not take such Leave of Absence pays for such coverage.

Uniformed Service for 31 Days or More. If you take a Leave of Absence to perform Uniformed Service for a period of 31 days or more, you may continue group health plan coverage under the applicable Benefit Plan for yourself and each of your covered Dependents. Such continued coverage shall begin on the effective date of your Leave of Absence to perform Uniformed Service and end on the earliest of the following dates:

1) the last day of the 24th month after such date;

2) the date you fail to make a required USERRA contribution payment; or
3) the date the your reemployment rights under USERRA expire.

A participant who elects continued coverage while on such Leave of Absence shall be required to pay the total amount of the cost of the coverage provided under the Benefit during the period of such Leave of Absence for the participant and his / her covered Dependents, as determined by the Committee, plus 2%.

Relationship with COBRA. The USERRA continuation rights described above are independent of the participant's right to elect COBRA continuation coverage. Notwithstanding the foregoing, if the participant's Leave of Absence to perform Uniformed Service results in a loss of group health plan coverage, the participant shall be entitled to elect COBRA continuation coverage and, if elected, COBRA continuation coverage shall begin after the 30-day period described above ends. In all other respects, the participant's COBRA continuation rights shall run concurrently with the USERRA continuation rights.

Other Benefits. A Benefit that does not provide group health plan benefits shall provide continuation coverage for participants entitled to protection under USERRA to the same extent such coverage is made available to a participant under the Employer's Leave of Absence policy that provides the most favorable continuation treatment under that Benefit.

Reinstatement of Benefits. A participant whose benefits have terminated during his Leave of Absence to perform Uniformed Service shall be entitled to have such benefits reinstated upon his reemployment, to the extent provided under USERRA.

Health Care Flexible Spending Account

If your employment terminates and you do not elect COBRA continuation coverage, you shall be deemed to have revoked your participation under the Health Care Flexible Spending Account Program. You shall continue to be eligible to claim reimbursement for expenses incurred before the effective date of your termination of employment.

In the event you do not have coverage under the Health Care Flexible Spending Account Program during an unpaid Leave of Absence, (because you chose to revoke coverage or do not pay the required participant contributions for any reason during the Leave of Absence) upon returning from such Leave of Absence within the same Plan Year as such Leave of Absence began, the Plan Administrator shall reinstate your Health Care Flexible Spending Account Program coverage. Upon reinstatement of coverage, you may choose to:

1) Resume participant contributions at the same annual contribution level, in which case your per pay period deduction under the Health Care Flexible Spending Account Program shall be adjusted to an amount equal to the annual participant contributions less the actual participant contributions, divided by the number of pay periods remaining in the Plan Year; or
2) Reinstate your per pay period deduction under the Health Care Flexible Spending Account Program, in which case your elected annual participant contributions shall be reduced for the period during which no contributions were paid. Notwithstanding the foregoing, if the Plan has already made disbursements to you that exceed the participant contributions that will be paid for the Plan Year, the Plan Administrator may not require you to pay any more than the remaining participant contributions due.

In no event shall reimbursements be permitted for any Covered Expense incurred during such Leave of Absence.

If your Health Care Flexible Spending Account Program coverage continues during your Leave of Absence, your participant contributions shall continue as though you are is not on a Leave of Absence.

Limited Purpose Health Care Flexible Spending Account

If your employment terminates and you do not elect COBRA continuation coverage, you shall be deemed to have revoked your participation under the Limited Purpose Health Flexible Spending Account Program. You shall continue to be eligible to claim reimbursement for expenses incurred before the effective date of your termination of employment.

In the event you do not have coverage under the Limited Purpose Health Flexible Spending Account Program during an unpaid Leave of Absence, (because you chose to revoke coverage or do not pay the required participant contributions for any reason during the Leave of Absence) upon returning from such Leave of Absence within the same Plan Year as such Leave of Absence began, the Plan Administrator shall reinstate your Limited Purpose Health Flexible Spending Account Program coverage. Upon reinstatement of coverage, you may choose to:

1) Resume participant contributions at the same annual contribution level, in which case your per pay period deduction under the Limited Purpose Health Flexible Spending Account Program shall be adjusted to an amount equal to the annual participant contributions less the actual participant contributions, divided by the number of pay periods remaining in the Plan Year; or
2) Reinstate your per pay period deduction under the Limited Purpose Health Flexible Spending Account Program, in which case your elected annual participant contributions shall be reduced for the period during which no contributions were paid. Notwithstanding the foregoing, if the Plan has already made disbursements to you that exceed the participant contributions that will be paid for the Plan Year, the Plan Administrator may not require you to pay any more than the remaining participant contributions due.

In no event shall reimbursements be permitted for any Covered Expense incurred during such Leave of Absence.

If the Limited Purpose Health Flexible Spending Account Program overage continues during your Leave of Absence, your participant contributions shall continue as though you are not on a Leave of Absence.

Dependent Care Flexible Spending Accounts

If you cease to be a participant in the Dependent Care Flexible Spending Account Program for any reason during a Plan Year, your election to contribute to the Dependent Care Flexible Spending Account Program shall terminate and you shall be entitled to reimbursement only for Dependent Care Expenses incurred within the same Plan Year before termination of employment, and only if you apply for such reimbursement. No such reimbursement shall exceed the remaining balance, if any, in your Dependent Care Flexible Spending Account for the Plan Year in which the expenses were incurred. In the event of your death, your spouse (or, if none, your executor or administrator) may apply on your behalf for reimbursement.

In the event you do not have coverage under the Dependent Care Flexible Spending Account during an Unpaid Leave of Absence (because you chose to revoke coverage or you do not pay the required participant contributions for any reason during such Leave of Absence), upon returning from such Leave of Absence within the same Plan Year as such Leave of Absence began, the Plan Administrator shall reinstate your Dependent Care Flexible Spending Account coverage. Upon reinstatement of coverage, you may choose to:

1) Resume participant contributions at the same annual contribution level, in which case your per pay period deduction under the Dependent Care Flexible Spending Account shall be adjusted to an amount equal to the annual participant contributions less the actual participant contributions, divided by the number of pay periods remaining in the Plan Year; or

2) Reinstate your per pay period deduction under the Dependent Care Flexible Spending Account Program, in which case your elected annual participant contributions shall be reduced for the period during which no contributions were paid. Notwithstanding the foregoing, if the Plan has already made disbursements to you that exceed the participant contributions that will be paid for the Plan Year, the Employer may not require you to pay any more than the remaining participant contributions due.

In no event shall reimbursements be permitted for any otherwise eligible expenses incurred during such Leave of Absence.

If the Dependent Care Flexible Spending Account Program coverage continues during your Leave of Absence, your participant contributions shall continue as though you are not on a Leave of Absence.

REINSTATEMENT OF FORMER PARTICIPANT

Subject to your right to continue certain coverage as described above and below, if you move to an ineligible job classification (e.g., less than 20 hours per week) or terminate employment, you shall be deemed to have revoked your elections and terminated your benefits with respect to expenses incurred after the effective date of your coverage termination. If you subsequently move to an eligible job classification or are rehired as an eligible employee, the following shall apply:

Waiting Period. If you move to an ineligible job classification or terminate employment with the Company and all Affiliates and subsequently reclassified as an eligible employee or rehired as an employee, you shall be subject to the waiting period, if any, set forth in the Program Documents.

Election Modifications. If you are reclassified or rehired within 30 days of your loss of eligibility or termination of employment, the coverages in effect immediately before your termination shall be reinstated, provided you are otherwise eligible to participate. If you are reclassified or rehired 30 or more days following your termination, but in the same Plan Year, you may enroll for coverage upon your reemployment, provided the Participant is otherwise eligible to participate.

CONTINUATION OF BENEFITS (COBRA)

The 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA) requires the Plan to offer continuation of medical, dental or vision care coverage to employees and their eligible dependents when certain events

occur. As an employee of Truist covered by the Plan, you and your eligible dependents have the right to choose this continuation coverage if you lose your medical coverage because of a qualifying event. Refer to the applicable Program Documents or other materials provided by the Plan Sponsor for more information on COBRA continuation coverage.

See Appendix D for more information, including continuation periods, related to COBRA. See Appendix E for information related to temporary extension of COBRA deadlines.

FUNDING

Generally, the cost of the Plan is shared by you and Truist and its participating affiliates (collectively, "Employer"). By sharing the cost of the Plan, we can provide the best possible coverage for you and your dependents at a reasonable cost.

Fully-insured benefits are provided under an insurance contract entered into between the Plan Sponsor and the Insurance Company identified in Appendix A.

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

If employee contributions are required for any Benefit Plan, the Plan Administrator will determine and communicate the employee's required contribution and the method of payment at open enrollment and as needed throughout the Plan Year. The Plan Administrator can change that determination at any time. These communications are expressly incorporated by reference. The Plan Administrator may use plan assets to pay plan administrative expenses. Plan assets may be used to pay reasonable administrative expenses as needed.

NO ASSIGNMENT OF BENEFITS

No Assignment or Transfer

No Participant, Covered Dependent, beneficiary, or any other person (collectively, a "Covered Person") may assign, transfer, convey, pledge, encumber, or otherwise alienate, whether voluntarily or involuntarily, any benefit, payment, right, interest, or cause of action under the Plan, including but not limited to rights to payment, rights to appeal, rights to request Plan documents or information, and rights to pursue statutory penalties, damages, or other relief under ERISA § 502(c) [29 U.S.C. § 1132(c)] or ERISA § 104(b) [29 U.S.C. § 1024(b)], whether characterized as a benefit, remedy, or otherwise.

Void and Unenforceable

Any attempted assignment, transfer, designation, or conveyance, including but not limited to, assignments to health care providers, suppliers, facilities, attorneys, or other third parties shall be void, invalid, and unenforceable and shall confer no rights of any kind on any purported assignee or third party.

No Authorized Representative or Power of Attorney Workaround

The designation of a health care provider or any other third party as an "authorized representative," agent, attorney-in-fact, or similar representative, whether by assignment, power of attorney, consent, or otherwise, shall not be deemed to create or evidence an assignment, shall not confer standing, and shall not grant any right to pursue benefits, appeals, or legal action under the Plan or ERISA. The Plan may, in its sole discretion, communicate with such individuals for administrative convenience only, without waiving this provision.

Direct Payment Not an Assignment

Any direct payment of benefits to a provider or other third party, or any communication or interaction with a provider or third party, shall not constitute an assignment of benefits or rights, shall not be construed as a waiver of this provision, and shall not create any enforceable rights in any third party.

No Waiver by Conduct

No act or omission by the Plan, the Plan Administrator, any Claims Fiduciary, or any Benefits Service Manager, including but not limited to direct payment of benefits, acceptance or review of claims or appeals submitted by a provider, or failure to assert this provision at any particular time, shall be deemed a waiver of this No Assignment provision. Any waiver must be in writing and expressly executed by the Plan Administrator.

Supremacy

This No Assignment of Benefits provision controls and supersedes any contrary or inconsistent language in any other document, including but not limited to schedules of benefits, certificates of coverage, summary materials, enrollment materials, provider communications, explanations of benefits, or other plan-related documents, regardless of source.

Limited Exception

This provision shall not apply to the extent an assignment is expressly required by a Qualified Medical Child Support Order ("QMCSO") recognized by the Plan in accordance with applicable law.

SUBROGATION AND RIGHT OF RECOVERY PROVISION

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

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your

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

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

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

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

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

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

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within thirty (30) days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claim Administrator or its representative

including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

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

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

Recovery of Overpayment

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's Benefits Service Managers. Under this process, the Benefits Service Managers reduce 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.

HOW THE PLAN IS ADMINISTERED

Plan Operations

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

Plan Administration

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

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

The Committee shall consist of a Chairman, designated in the Committee's charter and not less than three (3) individuals appointed by the Chairman. The Chairman may appoint a secretary who will not be a Committee member. Any member of the Committee may resign, and his successor, if any, shall be appointed by the Chairman.

Determining Eligibility to Participate

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

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

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

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

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

ALLOCATION OF RESPONSIBILITIES AMONG NAMED FIDUCIARIES

Duties of Named Fiduciaries

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

1) Plan Administrator

    a) To interpret the provisions of the Plan and determine the rights of participants under the Plan, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;

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

2) Claims Fiduciary.

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

3) Compensation and Human Capital Committee.

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

Co-fiduciary Liability

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

CLAIMS PROCEDURES[2]

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

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

Benefit Claim

The Benefits Service Managers are responsible for evaluating all benefit claims under the Plan. Benefits Service Managers will decide your claim in accordance with its reasonable claims procedures, as required by

[2] *See* Appendix E for information related to temporary extension of ERISA claims and appeals deadlines.

ERISA and other applicable law. See the Program Documents referenced under Appendix A for information about how to file a claim and applicable claims procedures.

Appealing Denied Claim

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

Important Appeal Deadlines

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

Exhaustion of Administrative Remedies; Limitations of Action

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

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

Communications that Are Not Claims for Benefits

Certain inquiries will not be considered a claim that trigger the Plan's claims procedures. These include:

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

Incompetency

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

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

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

LEGAL INFORMATION

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

Discretion

The Committee, 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 Committee, or its delegate, in its discretion that the applicant is entitled to them.

Plan Amendment/Termination

Truist has reserved the right to modify, amend or terminate the Plan as applied to each employer-party. Except as otherwise provided in the Plan, the right to modify, amend or terminate the Plan will not in any way affect your right to claim benefits, or diminish or eliminate any claims for benefits under the Plan to which you may have become entitled to claim prior to such termination or amendment. The Plan is not a contract, and Truist does not guarantee and makes no promise to offer a specific level of benefits in the future. The right to future benefits under the Plan will never vest.

Neither the Plan nor the Benefit Plans can be amended, modified, or supplemented except by a written amendment duly adopted in accordance with the terms of the Plan. No oral or informal statements, representations, writings, or communications, whether contained in enrollment materials or portals, benefit guides, summaries, presentations, or otherwise, shall be effective to amend, modify, or supplement the Plan or the Benefit Plans, regardless of the source. Only written statements that are

expressly authorized and issued by the Plan Administrator (or its duly authorized delegate), and that are consistent with the formal terms of the Plan and the Benefit Plans, shall be binding.

No Contract of Employment

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

Intentional Misrepresentations

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

Governing Law and Venue

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

Impact on other Benefit Plans

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

Beneficiary Designations

The following shall apply to all Benefit Plans in which you are permitted to designate your beneficiary: To be valid and accepted by the Benefit Plan, your beneficiary designation must be received by the Plan Administrator, Insurer, or Claim Administrator, as applicable, on or before the date of your death. You are solely responsible for ensuring that your beneficiary designation is complete, up-to-date, and received by the Plan Administrator, Insurer, or Claim Administrator.

In the event that the Plan Administrator, Insurer, or Claim Administrator is unable to determine the identity of your beneficiary under circumstances of competing claims or otherwise, the Plan Administrator, Insurer, or Claim Administrator, as applicable may, in its sole discretion, file an interpleader action seeking an order of the court as to the determination of the beneficiary. The Plan Administrator, Insurer, or Claim Administrator may act in reliance upon any proper order issues in maintaining, distributing or otherwise

disposing of your benefit under the terms of the Benefit Plan, to any beneficiary specified in the court order.

Legal Notices

Other Legal Notices are available at benefits.truist.com.

STATEMENT OF YOUR ERISA RIGHTS

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

1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

4) Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $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 that is denied, or ignored, in whole or in part, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen

that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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

APPENDIX A
BENEFIT PLANS

The following Benefit Plans and their applicable Program Documents are consolidated and incorporated into the Plan. This list and the Benefit Plans listed herein may be amended by the Plan Sponsor and/or Plan Administrator at any time without formal amendment to the Plan. Participants should refer to the Program Documents for more complete information regarding the Benefit Plan listed below. The Program Documents can be viewed at benefits.truist.com. You may also obtain a paper copy upon written request to the Plan Administrator.

PLAN NAME / TYPE	INSURED / SELF-FUNDED	INSURER / BENEFITS SERVICE MANAGER	PROGRAM DOCUMENT
Truist Financial Corporation Flexible Benefit Plan	Self-funded	Various – see Summary Plan Description	Summary Plan Description for the Truist Financial Corporation Flexible Benefit Plan
Truist Financial Corporation Dental and Vision Plan • Dental - Aetna PPO	Self-funded	Contract Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229	Summary Plan Description for the Truist Financial Corporation Dental and Vision Plan and the Schedule of Benefit Booklets issued by Aetna
Truist Financial Corporation Dental and Vision Plan • Dental - Aetna DMO	Insured Policy Number: 141938	Insurer Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229	Summary Plan Description for the Truist Financial Corporation Dental and Vision Plan and the Schedule of Benefit Booklets issued by Aetna
Truist Financial Corporation Dental and Vision Plan • Vision - Base Plan	Self-funded	Contract Administration Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com	Summary Plan Description for the Truist Financial Corporation Dental and Vision Plan and the Evidence of Coverage Booklet issued by Vision Service Plan
Truist Financial Corporation Dental and Vision Plan • Vision - Premier Plan	Self-funded	Contract Administration Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	Summary Plan Description for the Truist Financial Corporation Dental and Vision Plan and the Evidence of Coverage Booklet issued by

		www.vsp.com	Vision Service Plan
Truist Financial Corporation Health Care Flexible Spending Account	Self-funded	Contract Administration McGriff Employee Benefit Solutions 800-930-2429	Summary Plan Description for the Truist Financial Corporation Flexible Benefit Plan
Truist Financial Corporation Limited Purpose Health Care Flexible Spending Account	Self-funded	Contract Administration McGriff Employee Benefit Solutions 800-930-2429	Summary Plan Description for the Truist Financial Corporation Flexible Benefit Plan
Truist Financial Corporation Dependent Care Flexible Spending Account[1]	Self-funded	Contract Administration McGriff Employee Benefit Solutions 800-930-2429	Summary Plan Description for the Truist Financial Corporation Flexible Benefit Plan
Truist Financial Corporation Heath Savings Account[2]	Self-funded	Contract Administration McGriff Employee Benefit Solutions 800-930-2429	Summary Plan Description for the Truist Financial Corporation Flexible Benefit Plan
Truist Financial Corporation Life Insurance • Group Basic Life • Supplemental Term Life • Supplemental Dependent Life	Insured Policy Number: GL-674861	Insurer Administration Hartford Life and Accident Insurance Company	Summary Plan Description for the Truist Financial Corporation Life and Accidental Death & Dismemberment Insurance Plan and the Certificate of Insurance Booklets issued by Hartford
Truist Financial Corporation Accidental Death & Dismemberment	Insured Policy Number: ADD-007284	Insurer Administration Hartford Life and Accident Insurance Company	Summary Plan Description for the Truist Financial Corporation Life and Accidental Death & Dismemberment Insurance Plan and the Certificate of Insurance Booklets issued by Hartford

[1] The Dependent Care Flexible Spending Account is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA").
[2] Health Savings Account is not subject to ERISA.

Truist Financial Corporation Short Term Disability Plan	Self-funded	Contract Administration Hartford Life and Accident Insurance Company	Summary Plan Description for the Truist Financial Corporation Short Term and Long Term Disability Plan and the Schedule of Benefit Booklets issued by Hartford
Truist Financial Corporation Long Term Disability Plan	Insured Policy Number: GLT-674861	Insurer Administration Hartford Life and Accident Insurance Company	Summary Plan Description for the Truist Financial Corporation Short Term and Long Term Disability Plan and the Schedule of Benefit Booklets issued by Hartford
Truist Financial Corporation Vacation Purchase Program[3]	Self-funded		Summary Plan Description for the Truist Financial Corporation Flexible Benefit Plan
Truist Financial Corporation Your Specified Disease Plan	Insured	Insurer Administration Unum Insurance Company	Unum Group Critical Illness Insurance Summary Plan Description
Progyny Services	Self-funded	Contract Administration Progeny Services 844-930-3295	Summary Plan Description for Progeny Services
Truist Financial Corporation – Accident Plan – Specified Disease Plan – Hospital Indemnity Plan	Insured	Insurer Administration Unum Insurance Company	Unum Group Accident Insurance Summary Plan Description

[3] The Vacation Purchase component is not subject to ERISA.

APPENDIX B
PARTICIPATING EMPLOYERS

As of January1, 2026, 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.

APPENDIX C
NOTICES

HIPAA Privacy Rules

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

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

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

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

Compliance with Applicable Laws

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

APPENDIX D
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

For more information related to COBRA, please see:

- https://benefits.truist.com/content/dam/bbt/benefitstruist/pdfs/truist-benefits/cobra-benefits-guide.pdf
- Appendix I for information related to temporary extension of COBRA deadlines.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility.

If your coverage terminates due to termination of your employment for any reason other than gross misconduct or your loss of eligibility under this Plan due to a reduction in the number of hours you work, you may elect to continue coverage for yourself and your dependents or your dependents may each elect to continue their own coverage. You will be notified by the COBRA Administrator if you become eligible for this continuation coverage because of termination or reduction in hours. Truist's notification will include an election form, more information about the cost of coverage, payment methods and the period of coverage.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event that caused coverage to terminate.
- The end of a 29-month period after the date of the event that caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to the COBRA Administrator, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event that caused coverage to terminate. Coverage may be continued for the individual determined to be disabled and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date Truist no longer provides a group health plan.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan.
- The first day after the date of the COBRA election that the individual becomes enrolled in benefits under Medicare.

If the employee became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the event described in Section A, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee's Medicare entitlement. For example, if the employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for the employee's covered spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage under Other Circumstances

If coverage for a dependent terminates due to:

- Your death;
- Your divorce; or
- The dependent's ceasing to be a dependent child as defined under this Plan

The dependent may elect to continue his or her own coverage. The election must include an agreement to pay any required contribution.

C. Coverage for a dependent who experiences an event described in Section B will terminate on the first to occur of:

- The end of a 36-month period after the date of the event that caused coverage to terminate.
- The date Truist no longer provides a group health plan.

- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health Plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events

If another qualifying event occurs during the first 18 months of continuation coverage, your dependents can receive up to an additional 18 months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is timely provided to the COBRA Administrator.

This extension may be available to your dependents receiving continuation coverage if you die, get divorced or if your dependent child is no longer eligible under the terms of the Plan as a dependent child. A second event will be considered a qualifying event only if the second event would have caused your dependent to lose coverage under the Plan had the first qualifying event not occurred.

E. Notice Requirements

If coverage for you or your dependents:

- Is being continued for 18 months in accordance with section A; and
- It is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A that caused coverage to terminate you or your dependent must notify the COBRA Administrator of such determination within 60 days after the date of the determination and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent terminates due to:

- Your divorce; or
- Your dependent ceasing to be a dependent as defined under this Plan, you or your dependent must provide notice to the COBRA Administrator of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage terminates due to the occurrence of the event. If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

Summary of Qualifying Events

Qualifying Event	Who Is Eligible	Maximum Extension	Who Must Notify Plan Administrator	Time Period for Notification[1]
Termination of				

[1] If the member is disabled at the time or within the first 60 days of termination, coverage may be extended an additional 11 months at 150% of the full premium.

employment (other than for gross misconduct)	Employee/Spouse/ Domestic Partner/ Eligible Dependents	18 months[2]	Employer	30 days
Reduction in hours which renders Employee ineligible	Employee/Spouse/ Domestic Partner / Eligible Dependents	18 months	Employer	30 days
Death of Employee	Spouse / Domestic Partner / Eligible Dependents	36 months	Employer	30 days
Employee becomes eligible for and selects Medicare (as described under A above)	Spouse/ Domestic Partner / Eligible Dependents	36 months	Employer	30 days
Divorce or legal separation	Spouse/ Domestic Partner / Eligible Dependents	36 months	Spouse /Dependents	60 days
Dependent no longer meets eligibility requirements	Dependent	36 months	Dependent	60 days

Are there other coverage options besides COBRA Continuation Coverage?

When making the decision of whether to elect COBRA continuation coverage, you should consider that there may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for this coverage or a tax credit through the Marketplace. However, once you elect COBRA, these options are affected. Before you make a decision to enroll in coverage offered through the Marketplace, you can see what premiums, deductibles and out-of-pocket costs will be. You should compare plans so that you can see which coverage is right for you. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You can learn more about many of these options at www.healthcare.gov.

[2] Maximum period which runs from the date of the qualifying event.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[3] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

[3] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Truist Financial Corporation Employee Benefit Plan
214 N Tryon Street
Charlotte NC 28202
(800) 716-2455, option 1
benefits@truist.com