TRUIST FINANCIAL CORPORATION
EMPLOYEE BENEFIT PLAN

Flexible Benefit Plan
Summary Plan Description

As of
January 1, 2023

FOREWORD

This booklet contains the Summary Plan Description ("SPD") for the flexible benefit component (the Truist Financial Corporation Flexible Benefits Plan") of the Truist Financial Corporation Employee Benefit Plan (the "Employee Benefit Plan"). The Plan allows eligible employees to (1) pay for and purchase certain benefits, and (2) pay for certain types of medical and dependent care expenses with pre-tax money, as described herein. The Plan is intended to qualify as "cafeteria plan," as applicable, within the meaning of Section 125 of the Internal Revenue Code (the "Code").

Summary Plan Descriptions "SPDs" are intended to summarize and explain a plan's principal provisions. The material contained in this SPD is taken from the actual legal plan document that governs the principles and provisions under which the Plan operates. Therefore, if any conflict exists between this SPD and the actual plan provisions, the terms of the legal plan document will govern. We encourage participants to read the SPD carefully. If you have any questions regarding the information in the SPD or want a copy of the legal plan document, contact the plan administrator whose name and address are listed under "Facts About the Plan

The Plan Sponsor has the sole authority to interpret the terms and conditions of, and address questions that arise under the Plan.

FACTS ABOUT THE PLAN

Plan Name: Plan	Truist Financial Corporation Flexible Benefit Plan. The is a component plan of the Truist Financial Corporation Employee Benefit Plan (Plan Number 508).
Employer Name, Address and Telephone Number:	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 716-2455 benefits@truist.com
Plan Sponsor / Company	Truist Financial Corporation
Effective Date:	This Summary Plan Description (SPD) is a description of the Plan as amended and restated effective January 1, 2021, and including all subsequent amendments thereto.
Name and Address of Plan Administrator Agent for Legal Process	Employee Benefits Plan Committee Truist Financial Corporation 214 N Tryon Street, 45th Floor Charlotte NC 28202
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.
Employer Identification Number:	56-0939887
Plan Number:	508
Type of Plan:	Flexible benefit plan providing payment of premiums for selected benefits on a pre-tax basis and reimbursement for certain health care and dependent care expenses and "welfare benefit plan" within the meaning of Section 3(1) of the Employee Retirement Income Security Act ("ERISA").
Plan Year:	January 1 through December 31

Type of Administration:	General administration is provided by the Employee Benefits Plan Committee working through the Benefits Department of Truist Financial Corporation. Claims for benefits under the Reimbursement Accounts portion of the Plan are paid by the Benefit Services Manager.
Benefit Services Manager:	McGriff Insurance Services, Inc. P.O. Box 6400 Greenville, SC 29606 (800) 930-2429 mcgriffinsurance.com

INTRODUCTION

The Truist Financial Corporation Flexible Benefit Plan ("Plan") enables you to (1) pay for and purchase certain benefits, and (2) pay for certain medical and dependent care expenses with pre-tax money. Truist Financial Corporation ("Truist") and any Participating Employer[1] (collectively, "Employer") that has adopted the Plan with the written consent of Truist may offer the benefits provided under the Plan to eligible employees. For a listing of all benefits available under the Plan ("Benefit Plans"), you should refer to Appendix A of this Plan.[2] For a detailed description of the benefits offered under the Plan, you should refer to the individual Program Documents / summary plan descriptions ("Program Documents" or "SPDs") provided for each Benefit Plan.[3]

This SPD summarizes the Plan's:

1) Pre-tax salary reduction component, which permits eligible employees to pay for certain benefits on a pre-tax basis.[4]

2) Health Care Flexible Spending Account component, which permits eligible employees to pay for his or her qualifying medical expenses (defined below) on a pre-tax basis. An election under this Plan may be for the:

    - Health Care Flexible Spending Account; or
    - Limited Purpose Health Care Flexible Spending Account.

3) Dependent Care Flexible Spending Account component, which permits eligible employees to pay for his or her qualifying Dependent Care Expenses on a pre-tax basis.

4) Health Savings Account component, which permits eligible employees to make pre-tax contributions to a Health Savings Account.

5) Vacation Purchase component, which permits eligible employees to purchase additional days of vacation with pre-tax dollars.

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[1] Participating Employers are listed under Appendix B. Appendix B may be updated by separate agreement between such employer and a Senior Executive Vice President of the Company at any time without formal amendment to the Plan and/or this SPD.

[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] For a list of Program Documents, see the Truist Financial Corporation Employee Benefit Plan Summary Plan Description available at benefits.truist.com.

[4] As required by law, premiums for (non-dependent) domestic partner coverage are deducted from your pay on an after-tax basis for income tax purposes, and the value of any employer contribution toward the cost of coverage is considered imputed income.

ELIGIBILITY

Eligibility to Participate

Except as provided otherwise in this SPD, you are eligible to participate in this Plan if you are an employee of Truist or a Participating 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 continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

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 a Participating 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.

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.

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

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.

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 Benefits, 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 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 rules and regulations;
3) Consent to the Committee's inquiries with respect to an individual's status as a spouse, domestic partner, or dependent or with respect to any physician, hospital or other medical care provider, or services involved in a determination for eligibility of coverage or a claim for benefits under the Plan; and

4) Submit to the Benefits Service Manager all reports, bills and other information that the Benefits Service Manager may reasonably require to properly administer the Plan.

A participant's rights to enroll in and maintain coverage under the Plan is 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.

HOW THE PLAN WORKS

How to Enroll

Enrollment is completed in Workday. Initially, you must enroll in the Plan within 31 days of your employment date. If you fail to enroll at that time, you must wait until the next re-enrollment period unless you have a status change. (See Section entitled "Annual Flexibility)".

As a condition to your participation in the Plan, you must agree to:

1) Follow all Plan rules;
2) Consent to inquiries by the plan administrator about any doctor, dentist, hospital or other provider of health care or other services in a claim for health care benefits from the Plan;
3) Consent to inquiries by the plan administrator with respect to any individual involved in a claim for dependent care benefits from the Plan; and
4) Submit all required reports, bills and other information needed by the Benefit Service Manager.

Annual Flexibility

Each Plan Year, you will be given the opportunity to change your elections for the next Plan Year. During the annual re-enrollment period, you will be asked to review your current benefit elections and provided with information about benefits available in the coming Plan Year.

Unless mandatory enrollment is announced, you will automatically retain the same coverage you had elected for the prior Plan Year, incurring any price increases effective with the new Plan Year unless you make new elections during the annual re-enrollment period with the exception of the Vacation Purchase program. You must make an election regarding Vacation Purchase each year you wish to participate.

CHANGING YOUR COVERAGE DURING THE YEAR

Because flexible benefits are generally paid with pre-tax dollars, the IRS requires that elections remain in effect for the entire Plan Year. This mean that you ***will not*** be able to change your elections until the next annual re-enrollment period unless you experience a change in status and you request a change within 31 days of the change in status. It is your responsibility to timely 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. Changes in elections resulting from a change in status must be on account of and correspond with the change in status. The Plan Administrator may require written documentation of a status change event. Employees can request changes by logging on to Workday.

Change in status events are:

1) Birth[5], Adoption, Placement for Adoption, Legal Guardianship
2) Gain Spouse / Domestic Partner
3) Divorce, Legal Separation[6], Annulment, Dissolution of Domestic Partnership
4) Death of Spouse / Domestic Partner or Child
5) Change in employment status of Employee that results in gain or loss of benefit eligibility
6) Change in employment status of Spouse / Domestic Partner or Dependent that results in gain or loss of benefit eligibility under Spouse / Domestic Partner or Dependent's Plan
7) Dependent loss of eligibility due to no longer satisfying eligibility criteria (e.g., attainment of a specified age, etc.)
8) Loss of child(ren)'s coverage under a parent's plan (due to plan's eligibility requirements)
9) Loss of employee's coverage under a parent's plan (due to plan's eligibility requirements)
10) Gain or loss of coverage during spouse or domestic partner's annual benefits enrollment (other than January 1)
11) COBRA coverage expires or COBRA subsidy expires
12) Start or End of Unpaid Leave of Absence
13) Start or End of Military Leave
14) Spouse / domestic partner moves into or out of the USA
15) Significant change in health care cost of Spouse / Domestic Partner's coverage
16) Gain or Loss of coverage under Medicare or Medicaid
17) Loss of coverage due to loss of eligibility for Medicaid or CHIP[7]
18) Eligibility for premium assistance under Medicaid or CHIP[7]
19) Judgment, decree, or court order

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

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether you qualify for a change in status and whether a requested change is on account of and corresponds with a change in status.

*****Note that Vacation Purchase cannot be changed during the year except as described on the***

[5] For birth, you are allowed a 45-day period to initiate the change.

[6] Available only in states that recognize legal separation.

[7] For this change, you are allowed a 60-day period to initiate the change.

Vacation Purchase section below**

****In 2020, the U.S. Departments of Labor and Treasury (together, the "Departments") issued COVID-19- related extension relief. This relief provides for an Outbreak Period (as defined below) during which your deadlines for requesting HIPAA special enrollment. *See* Appendix D for more information****

CONTINUATION OF PARTICIPATION DURING A LEAVE OF ABSENCE

Except as otherwise provided in the Program Documents, if you are enrolled for coverage under a component benefit plan and taking a Leave of Absence, you can continue your coverage 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 component benefit while on a Leave of Absence only if the you continue to have an employment relationship with an Employer, maintain your eligibility to participate in the component benefit (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[8], 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 required participant contributions during the 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 Employee Benefits Plan Committee (the "Committee").

If you terminate your participation under any component benefit 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 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 elections (unless you made new elections during the immediately preceding Annual Enrollment).

[8] 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.

Participation during a Paid Leave of Absence

Coverage under a component benefit 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 or 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 benefits 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 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 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 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. 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 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. 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 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, 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 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. 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 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. 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 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, 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 coverage 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 for any reason during a Plan Year, your election to contribute to the Dependent Care Flexible Spending Account 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, 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 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 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.

PRE-TAX SALARY REDUCTION COMPONENT

The pre-tax salary reduction component of the Plan allows eligible employees to choose to use regular compensation, before taxes are deducted (i.e., pre-tax), to pay for and /or purchase certain benefits based on their own particular goals, desires and needs. Benefits that can be paid for and /or purchased under this component are listed in Appendix A.

Benefit Plans

The specific benefits, types, and amounts of coverage, requirements for participation, and other terms and conditions of the coverage provided under this component are explained in the plan documents for each of these benefits.

Funding the benefits available under the Benefit Plans

All Benefit Plans offered under this component are provided in accordance with the plan document for those plans. All claims to receive benefits and issues of coverage will be subject to and governed by the terms and conditions of the applicable plan documents.

Contributions to Benefit Plans

The amount that employees will be required to contribute to the cost of the Benefit Plans will be communicated to eligible employees when first eligible and each year at open enrollment.

COBRA COVERAGE FOR BENEFIT OPTIONS

Some, but not all, of the Benefit Plans under the pre-tax salary reduction component are eligible for continuation coverage under COBRA. Additional information can be found in the Program Documents for those benefits and in the general COBRA Notice provided in the SPD for the Employee Benefit Plan at benefits.truist.com.

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Accounts are a way to pay for certain dental, vision, health care, and dependent care expenses with pre-tax dollars. It is an important way to meet anticipated health and dependent care expenses in a tax-efficient manner. The Plan features flexibility in letting you choose how much to contribute up to a maximum limit and how to divide those contributions between your Flexible Spending Accounts.

You are eligible to participate in the Health Care Flexible Spending Account if you enroll in the Kaiser HMO, $500 PPO, $250 ACO, or decline medical coverage. You cannot participate in the Health Care Flexible Spending Account if you participate in the High Deductible ($2,000 or $4,500) Health Plan; however, you may enroll in the Limited Purpose Health Care Flexible Spending Account. Only employees can enroll in the Flexible Spending Accounts, but the Flexible Spending Accounts can be used to

reimburse your dependents' eligible expenses, as well as your own.

Contributions to the Flexible Spending Accounts come from pre-tax contributions made by you through payroll deduction.

When you enroll in the Plan, you will authorize the amount to be allocated to your Health Care Flexible Spending Account / Limited Purpose Health Flexible Spending Account and/or the Dependent Care Flexible Spending Account. You should carefully plan expenses prior to designating the amount to be allocated to either of these Accounts. Contributions made during a calendar year can only be used for expenses incurred during that same calendar year and only for services rendered while you are enrolled in the Plan. In addition, you cannot transfer money between Accounts during the Plan Year or carry over Account balances from one Plan Year to the next.

Effective January 1, 2023, you may carry over up $610 in unused fund in the Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible Spending Account. If you join Truist midyear, be sure that your total contribution to any (your prior employer's plan and Truist's plan) Flexible Spending Account does not exceed:

- For the Health Care Flexible Spending Account - $3,050
- Limited Purpose Health Care Flexible Spending Account - $3,050
- For the Dependent Care Flexible Spending Account - $5,000 for individuals or married couples filing jointly (or $2,500 for a married person filing separately)

Health Care Flexible Spending Account Program

Each employee of an Employer shall be eligible to participate in the Health Care Flexible Spending Account Program as of the date he or she becomes eligible to elect such benefits under this Plan as provided above. Such an individual will become a participant on the first day of the first Plan Year for which he or she elects under the Plan to contribute, by means of an election form providing for salary reduction contributions to a Health Care Flexible Spending Account. An individual who is permitted, under the terms of this Plan, to execute an election form with respect to this Health Care Flexible Spending Account Program which is effective other than at the beginning of a Plan Year shall become a participant no later than the beginning of the first full pay period for which his or her election will apply.

An eligible employee may elect to contribute a portion of his compensation to a Health Care Flexible Spending Account on a pre-tax basis. The amounts contributed to the Health Care Flexible Spending Account are then used to reimburse the Participant for Medical Care Expenses defined above.

This Account will provide reimbursement for health care expenses that are not covered or are not fully reimbursable under the Truist Financial Corporation Health Care program (the "Health Care Program"). Examples of expenses for which you may be reimbursed are those that are incurred for vision care expenses, routine physicals and non-covered medical expenses (see "Items Covered by Health Care Flexible Spending Account").

You may file claims under your Health Care Flexible Spending Account for you or your dependents, even if they are not covered under the Health Care Program. In other words, health care coverage through Truist is not required for expenses to be reimbursed. There must, however, be a record of the individual as one of your dependents on file in Workday. You may generally obtain reimbursement for claims on dependent children until the end of the calendar year in which they turn 26.

Limited Purpose Health Care Flexible Spending Account Program

Each employee of an Employer who participates in a High Deductible Health Plan shall be eligible to participate in the Limited Purpose Health Flexible Spending Account Program as of the date he or she becomes eligible to elect such benefits under the Plan as provided above. Such an individual will become a participant on the first day of the first Plan Year for which he or she elects under the Plan to contribute, by means of an election form providing for salary reduction contributions to a Limited Purpose Health Care Flexible Spending Account. An individual who is permitted, under the terms of the Plan, to execute an election form with respect to this Limited Purpose Health Flexible Spending Account Program which is effective other than at the beginning of a Plan Year shall become a participant no later than the beginning of the first full pay period for which his or her election will apply.

An eligible employee may elect to contribute a portion of his compensation to a Limited Purpose Health Care Flexible Spending Account on a pre-tax basis. The amounts contributed to the Limited Purpose Health Care Flexible Spending Account are then used to reimburse the Participant for Covered Expenses defined above.

This Account will provide reimbursement for expenses that are not medical expenses covered under the Health Care Program. Examples of expenses for which you may be reimbursed are those that are incurred for vision care expenses and dental care expenses.

You may file claims under your Limited Purpose Health Care Flexible Spending Account for you or your dependents, even if they are not covered under the Health Care program. In other words, health care coverage through Truist is not required for expenses to be reimbursed. There must, however, be a record of the individual as one of your dependents on file in Workday. You may generally obtain reimbursement for claims on dependent children until the end of the calendar year in which they turn 26.

Dependent Care Flexible Spending Account Program

Each eligible employee of an Employer shall be eligible to participate in this Dependent Care Flexible Spending Account Program as of the date he or she becomes eligible to elect such benefits under this Plan as provided above. Such an individual will become a participant in the Dependent Care Program on the first day of the first Plan Year for which he or she elects under the Plan to contribute, by means of an election form providing for salary reduction contributions, to a Dependent Care Flexible Spending Account. An individual who is permitted, under the terms of the Plan, to execute an election form with respect to this Dependent Care Flexible Spending Account Program which is

effective other than at the beginning of a Plan Year shall become a participant no later than the beginning of the first full pay period for which the election will apply.

This Account will provide reimbursement for dependent care expenses, including day care and babysitter expenses (see "Items Covered by Dependent Care Flexible Spending Account"). Contributions to this Account cannot exceed the lesser paid spouse's income for the calendar year. Both spouses must be employed to participate in this Plan.

FILING CLAIMS[9]

You may use your Benefit Access VISA® Debit Card to pay for health care and dependent care expenses incurred or send a claim to the Benefit Services Manager listed on page 1. Please refer to the directions sent along with your Benefits Access VISA® Debit Card for specific directions as the directions, vary depending on the account to which the card is tied. Please be sure to save all of your receipts. McGriff Insurance Services, Inc. will request copies of any receipts they require to process your claims.
Claims should be processed through the Health Care Program, even if the expense will be applied toward the deductible. This will ensure that you have proper credit for the expense in both programs. The Explanation of Benefits that you receive from your insurance company should be attached to the appropriate claim form and filed with McGriff for reimbursement. All claims must include:

1) The amount of the expense for which reimbursement is required;
2) The purpose of the expense;
3) The name of the person for whom the expense was incurred and the person's
4) relationship to you;
5) The name of the person, organization or entity to whom the expense was paid;
6) A copy of the bill from the health care provider or any statement from an independent person indicating that the expense has been incurred and the date of such expense; and
7) The amount (if any) paid by insurance.

Health Care Flexible Spending Account reimbursements will be limited to the annualized amount of contributions to your Health Care Flexible Spending Account. You will be allowed 90 days after the end of the Plan Year in which to file claims for expenses incurred during that Plan Year.

Under IRS regulations, a claim for reimbursement must be filed, along with proof of payment, before a reimbursement can be made.

Reimbursement of Dependent Care Flexible Spending Account Claims

To be reimbursed for dependent care expenses not paid with your Benefit Access VISA® Debit Card, you must complete a claim form and send it directly to McGriff. Dependent care reimbursements are limited to the current contributions to your Dependent Care Flexible Spending Account and the current expenses incurred. You will be allowed 90 days after the end of the Plan Year in which to file claims for dependent care expenses incurred during that Plan Year.

[9] *See* Appendix C for information related to temporary extension of certain ERISA claims and appeals deadlines.

All claims must include:

1) The amount of the expense for which reimbursement is required;
2) The purpose of the expense;
3) The name of the individual for whom the expense was incurred and that person's relationship to you; and
4) The name and taxpayer identification number of the person or dependent care center to whom the expense was paid and a receipt or other statement from such person or center indicating that the expense has been incurred and the date such expense was incurred.

Under IRS regulations, a claim for reimbursement must be filed, along with proof of payment, before a reimbursement can be made.

CHANGES IN PARTICIPATION

As mentioned earlier, changes in contributions to your Flexible Spending Accounts are allowed only in the event of an applicable change in status. You must make changes to your elections through Workday.

TERMINATION OF EMPLOYMENT

If your employment terminates for whatever reason, you may continue to use the balance in your Health Care or Dependent Care Flexible Spending Account for expenses incurred during the period of employment and while you were contributing to the Plan.

To continue unrestricted access to your Health Care Flexible Spending Account, you must elect to continue contributions on an after tax basis under COBRA below.

COBRA FOR THE HEALTH FSA AFTER COVERAGE TERMINATES

You may elect to continue coverage under your Health Care Flexible Spending Account, if there is a positive balance in your Health Care Flexible Spending Account at the time of termination, only up until the end of the current Plan Year after you are no longer employed or otherwise lose coverage because of a "qualifying event". You will need to follow the procedures set forth in the COBRA election notice that you will receive when participation ends. Coverage will continue only if you make direct, after-tax payments through the end of the Plan Year. There is no continuation of coverage available for the Dependent Care Flexible Spending Account.

Qualifying events include termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of dependent. A participating employee or dependent who is covered under the Plan must notify the Plan Administrator of any divorce, legal separation, or a child ceasing to be considered a Dependent under the Plan within 60 days after the event. This notice must be in writing and addressed to the Plan Administrator. In addition, if a second qualifying event occurs during COBRA continuation coverage or if the former employee becomes entitled to Medicare or dies during the COBRA coverage, the participating employee or Dependent must notify the Employer. Finally, a COBRA participating employee must notify the Employer before the start or end of any disability that is

determined under the Social Security Act to be a covered disability.

Any notice described in the above paragraph must be provided in writing to the Plan's COBRA administrator within 60 days of the occurrence of the applicable event (except that if there is a change in the participating employee's disability status, notice must be given within 30 days). If the participating employee, spouse or dependent fails to provide notice within the required time period, he or she may no longer be eligible for COBRA continuation coverage. In this event, the COBRA Administrator may send Notice of Unavailability of COBRA Coverage upon receipt of the late notice.

Additional information about COBRA rights are included in the general COBRA notice, which has been provided in the SPD for the Employee Benefit Plan, which is available at benefits.truist.com.

BALANCES IN ACCOUNT AT YEAR END

You will have 90 days following December 31 (i.e., the last day of each Plan Year) to submit expenses incurred during the prior Plan Year. Money remaining in either or both of the Health Flexible Spending Accounts after that time will be forfeited to the Company in accordance with IRS regulations. However, you may carry over up to $610 in unused funds in the Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible Spending Account.

Money remaining in the Dependent Care Spending Accounts as of December 31st will be forfeited to the Company in accordance with IRS regulations.

ITEMS COVERED BY HEALTH CARE FLEXIBLE SPENDING ACCOUNT

An eligible medical expense is an expense incurred by you and/or your eligible dependents that satisfies these conditions:

1. The expense is for medical care as defined by Internal Revenue Code Section 213(d). Whether an expense is for medical care is within the sole discretion of the plan administrator; and
2. The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The following are representative expenses eligible for reimbursement via the Health Care Flexible Spending Account (specific eligible expenses will vary depending upon individual plan provisions). *Please note that charges for cosmetic procedures cannot be reimbursed by the Plan.*

Medical Expenses

Baby/Child to Age 13:
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*

Medical Procedures/Services:
- Acupuncture
- Alcoholism (inpatient and outpatient treatment)
- Ambulance
- Drug Addiction
- Hospital Services
- Infertility Treatment

Medication:
- Birth Control
- Homeopathic Medications*
- Insulin
- Prescription Drugs

Obstetric Services:
- Lamaze Class

- Well Baby Care

Dental Services:
- Dental X-Rays
- Dentures and Bridges
- Exams/Teeth Cleaning
- Extractions and Fillings
- Gun Treatment
- Oral Surgery
- Orthodontia/Braces

Hearing:
- Hearing Devices and Batteries
- Hearing Exams

Lab Exams/Tests:
- Blood Tests and Metabolism Tests
- Body Scans
- X-Rays
- Cardiographs
- Laboratory Fees
- Spinal Fluid Tests
- Urine/Stool Analysis

Vision Services:
- Eye Examinations
- Eyeglasses
- Contact Lenses and Contact Lens Supplies
- Laser Eye Surgeries
- Artificial Eyes
- Prescription Sunglasses
- Radial Keratotomy/LASIK
- Reading Glasses

- In Vitro Fertilization
- Norplant Insertion or Removal
- Physical Exam (non employment-related)
- Reconstructive Surgery (if medically necessary due to congenital defector accident)
- Service Animals*
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*
- Vaccinations/Immunizations
- Vasectomy and Vasectomy Reversal

Medical Equipment/Supplies:
- Abdominal/Back Supports
- Air Purification Equipment*
- Arches/Orthopedic Shoes
- Band-Aids
- Braces and Supports
- Contraceptive Devices
- Crutches and Wheelchairs
- Elastic Bandages and Wraps
- Exercise Equipment*
- First Aid Supplies
- Hospital Bed
- Mattresses*
- Medic Alert Bracelet or Necklace
- Oxygen*
- Pregnancy Test Kits
- Post Mastectomy Clothing
- Prosthesis
- Splints/Casts
- Support Hose*
- Syringes
- Wigs

- Midwife Expenses
- OB/GYN Exams
- OB/GYN Prepaid maternity Gees (reimbursable after date of birth)
- Pre and postnatal Treatments

Practitioners:
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath or Naturopath*
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy:
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise*
- Hypnosis
- Massage
- Occupational
- Physical
- Speech
- Weight Loss Programs*

**Expenses must be accompanied by a doctor's certification specifying the medical condition and treatment needed, and how the treatment will alleviate the condition.*

Other items may be covered as regulated by the Internal Revenue Service. Please visit mcgriffinsurance.com for more details.

ITEMS COVERED BY DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

- Payments to nursery schools, day care centers or individuals for care of preschool children.
- Payments for before-school care or after-school care for children from kindergarten through age 12.

- Payments to providers outside the home for care of disabled dependents of any age.
- Services of a housekeeper, maid or cook if the services were partly for the care of a child under age 13 or a disabled dependent. This includes meals, lodging and payroll taxes of the housekeeper.
- Payments to relatives for care of qualifying dependents; however, the relative cannot be your dependent or your child if under age 19 as of the end of the year.
- Payments (in lieu of regular day care) to summer day camp or other summer programs, but not overnight camps.

Please note: Payments for private schools are not reimbursable.

REVIEW OF CLAIMS THAT ARE DENIED

In the event the Benefit Services Manager ("BSM") should determine that you are not entitled to all or a portion of the benefits to which you claim, you will be notified within 30 days after the BSM receives your claim. If special circumstances require that the BSM be given additional time to make a decision on your claim, the BSM may have an additional 15 days by notifying you before the end of the first 30-day period.

If your claim is denied, in whole or in part, you will receive a statement which includes:

1. The specific reason or reasons for the denial;
2. Specific reference to applicable sections of the Plan on which the denial is based;
3. A description of any additional material or information necessary for you to supply in order to perfect your claim and why such material or information is necessary;
4. An explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

If the BSM does not provide you with any notice or statement about your claim within 30 days of the time it is received, you may consider your claim denied.

Within 180 days after a claim is denied by the BSM or deemed to have been denied, you may appeal the denial of the claim by filing a written application for review with the Employee Benefits Plan Committee under the Plan (the "Committee"). The Committee will review the decision denying the claim within 60 days after your request for review (unless there are special circumstances, in which case the time period is 120 days), and will give you a written decision. You will receive a notice if special circumstances require additional time. If the Committee fails to provide you with any notice or statement about your claim within the 60-day period referred to above, you may consider your claim to have been denied upon review. Before the Committee decides on the claim, you or your authorized representative may review pertinent documents and submit issues and comments in writing. It is important for you or your authorized representative to submit in writing to the Committee for its review any and all issues, comments and

evidence relevant or pertinent to your claim for benefits.

If the Committee denies your claim, in whole or in part, its written decision will set forth specific reasons for the decision and will cite specific Plan sections on which the decision is based. The decision of the Committee will be final and conclusive.

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 BSM decides in its discretion that the applicant is entitled to them.

HEALTH SAVINGS ACCOUNT[10]

You are eligible to participate in the Health Savings Account component of the Plan if you are a participant in a High Deductible Health Plan ("HDHP") offered under the Plan and qualify as an HSA-eligible individual under rules that apply under federal tax law. You may elect to make salary reduction contributions to a Health Savings Account ("HSA") established in your name. Any limits on the amount you may contribute to your HSA will be determined by the Plan Administrator and announced to participants in advance of the dates they become effective.

HSA contributions also are subject to annual limits that apply under the Internal Revenue Code. The maximum annual amount that an HSA Eligible Individual may elect to contribute to his HSA shall be the statutory maximum amount for HSA contributions applicable to the Participant's high deductible health plan coverage option (i.e., single or family) for the calendar year in which the contribution has been made.

The Company may limit the amount you may contribute to your HSA through the Plan if it appears that contributions to the HSA exceed any limit that applies to you.

To be an "eligible individual" for purposes of HSA contributions, in addition to being enrolled in a High Deductible Health Plan, you cannot be covered by another health plan, such as a health plan sponsored by your spouse/domestic partner's employer, a general purpose Health Care Flexible Spending Account, or Medicare parts A, B, or D. In addition, if you've received VA benefits within the last three months, are enrolled in Tricare, or can be claimed as a dependent on another individual's federal tax return, you're not eligible to make pretax contributions. Whether you are an eligible individual is determined on a monthly basis. If you participate in the HDHP offered under the Plan and actively participate in an HSA, you may elect to have salary reduction contributions credited to a Limited Flexible Spending Account for dental and vision expenses only. If you have any questions about whether any other coverage you have disqualifies you from being an "eligible individual," please contact the Plan Administrator.

[10] A Health Savings Account is an account established by you in your name for payment of certain medical expenses on a tax free basis. The Health Savings Account component is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Therefore, the portions of this booklet that relate to ERISA-covered benefits (such as the benefit claims and appeals provisions, and the election change rules) do not apply to the Health Savings Account.

Your HSA is considered your property and is not an employer-sponsored plan and is not subject to ERISA. Instead, it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Payments provided through your HSA are not provided under this Plan. Generally, your HSA can be used to pay or reimburse eligible medical expenses, including amounts that are counted towards the deductible for your High Deductible Health Plan. For details about the HSAs that may be funded through the Plan, you should contact the financial institution that maintains your HSA.

Your HSA election is part of the annual election for High Deductible Health Plan coverage, and may be increased, decreased, or revoked prospectively during the Plan Year as specified in the enrollment materials and in accordance with this Plan, effective no later than the first day of the next calendar month following the date that the election change was filed.

The Plan Sponsor may make employer contributions to your HSA. Such contributions, if any, will be specified in the enrollment materials.

VACATION PURCHASE[11]

You may purchase up to 96 hours of vacation in 8-hour units. Part-time employees are limited based on their scheduled hours. For example, an employee scheduled for 25 hours per week, could purchase only 48 hours (6 8-hour units) of vacation.

Scheduled Hours	Eligibility for Purchased Vacation
Less than 20 hours per week	Not eligible
20 to 31 hours per week	Purchase up to 6 8-hour units [48 hours]
32 to 39 hours per week	Purchase up to 9 8-hour units [72 hours]
40 hours per week	Purchase up to 12 8-hour units [96 hours]

Vacation can only be purchased during the annual enrollment period held in November. Generally, you cannot make changes to your vacation purchase election during the plan year. The only time you would have a mid-year change is:

- If your schedule changes to make the associate ineligible for vacation (i.e., their scheduled hours drop to less than 20 per week).
- If you are approved for long term disability.

Deductions will be made on pre-tax basis. The deduction will be based on your September 30 pay rate. If you are on an unpaid leave of absence, the deduction will be drafted from your checking account (in the same manner as all benefit plan deductions).

If you terminate employment, any unused purchased vacation will be paid out at the current rate of pay. Any vacation used but not paid for will be deducted from your final pay. Certain states (for example, California) have special rules about vacation accruals.

At year end, all unused purchased vacation will be forfeited and ***cannot*** be cashed-out, reimbursed, or

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

converted to any other taxable or nontaxable benefit. In certain states (for example, California), state law does not allow for the forfeiture of vacation.

Vacation is used in the following prioritized order:

1) Carried-over vacation from the previous Plan Year
2) Vacation accrued during the current Plan Year, and
3) Vacation purchased through annual enrollment.

PROTECTION UNDER ERISA

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 and union halls, all documents governing the Plan, including insurance contracts and 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.

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

you to pay these costs and fees (for example, if it finds your claim is frivolous).
If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER IMPORTANT PLAN INFORMATION

Plan Amendment and Termination

The Company has reserved the right, to amend or terminate the Plan. Except as otherwise provided in the Plan, the right to 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 the Company 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 described in this SPD 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, by any delegate of the Plan Administrator, or by Employer management. Only written statements that are consistent with the terms of the Plan and the benefits described in this SPD and made by the Plan Administrator can bind the Plan.

ERISA

Nothing in this SPD shall subject any flexible benefit to ERISA if the flexible benefit would not otherwise be covered by ERISA.

Your Rights

Neither the establishment of this Plan, nor any future modifications, nor any payments from the Plan shall be construed as giving any employee any legal or equitable rights against the Company, its shareholders, directors, or officers, as such, or as giving any employee the right to be retained in the employ of the Company.

Non-Assignment of Benefits

Except as may be required by the terms of a QMCSO, neither the assets of the Plan 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 under all circumstances. 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 or other party 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 under all circumstances.

Legal Action and Exhaustion of Appeals

You must use and fully exhaust all of your actual or potential rights under the Plan's administrative claims and appeals procedures by filing an initial claim and then filing a timely appeal of any denial before filing suit in court. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit must be filed within one year after receiving a final adverse benefit determination on appeal or two years after the date the claim arose. Failure to follow the Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to bring legal action.

Restriction of Venue

Any claim, suit or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Claimant shall only be brought or filed in the United States District Court for the Western District of North Carolina and of any court situated in Charlotte, North Carolina.

Communications that Are Not Claims

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.

Further Questions

If you have a question that is not answered here, please contact the Plan Administrator. The Plan text governs the operation of the Plan and contains the complete Plan details which are summarized above. In the event of any conflict between this SPD and the Plan text, the Plan text is the controlling document and will govern in all cases. The Plan text is available for review at the Company during regular office hours.

Legal Notices

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

APPENDIX A

As of January 1, 2023, the list of flexible benefits offered under the Plan is below. This list may be amended by the Plan Sponsor and/or Plan Administrator at any time without formal amendment to the Plan and/or this SPD. Participants should refer to the program documents / SPDs for more complete information regarding the benefits listed below.

BENEFIT PLAN	INSURED / SELF-FUNDED	SOURCE OF CONTRIBUTIONS
Salary Reduction Component		
Truist Financial Corporation Health Care Plan	Self-Insured / Insured	Employer and Employee
Medical - BCBSNC $500 PPO	Self-funded	Employer and Employee
Medical - BCBSNC HDHP $2,000	Self-funded	Employer and Employee
Medical - BCBSNC HDHP $4,500	Self-funded	Employer and Employee
Medical - Aetna $500 PPO	Self-funded	Employer and Employee
Medical - Aetna HDHP $2,000	Self-funded	Employer and Employee
Medical - Aetna HDHP $4,500	Self-funded	Employer and Employee
Medical - Aetna ACO	Self-funded	Employer and Employee
Medical - Kaiser $2,000 Plan	Insured	Employer and Employee
Medical - Kaiser HMO Plan	Insured	Employer and Employee
Dental - Cigna Dental PPO	Self-funded	Employee
Dental - Cigna Dental DHMO	Insured	Employee
Vision - Base Plan	Self-funded	Employee
Vision - Premier Plan	Self-funded	Employee
Health Savings Account[12]	Self-funded	Employer and Employee
Accidental Death and Dismemberment (AD&D)	Insured	Employee
Life Insurance	Insured	Employee
Short term and Long term Disability	Self-funded / Insured	Employee
Vacation Purchase Plan[12]	Self-funded	Employee
Flexible Spending Accounts		
Health Care Flexible Spending Account	Self-funded	Employee
Limited Purpose Health Care Flexible Spending	Self-funded	Employee

[12] This benefit is not subject to ERISA.

Account		
Dependent Care Flexible Spending Account[12]	Self-funded	Employee

APPENDIX B
PARTICIPATING EMPLOYERS

As of January 1, 2023, the list of Participating Employers is provided below. This list may be updated by separate agreement between such employer and a Senior Executive Vice President of Truist and without formal amendment to the Plan.

AFCO Acceptance Corporation
AFCO Credit Corporation
AmRisc, LLC[13]
BB&T Collateral Service Corporation
BB&T Real Estate Funding, LLC
CB Finance, Inc.
Centerstone Insurance and Financial Services
CRC Insurance Services, Inc.
Crump Life Insurance Services, Inc.
GFO Advisory Services, LLC
Grandbridge Real Estate Capital. LLC
J. H. Blades Co, Inc.
KV Ultimate Holdings, LLC[14]
McGriff Insurance Services, Inc.
Norman Spencer Agency
Peak Health Services, LLC
Prime Rate Premium Finance Corporation, Inc
Regional Acceptance Corporation
Service Finance Holdings, LLC
Sterling Capital Management, LLC
SunTrust Equity Funding, LLC
Truist Commerical Equity
Tapco Insurance Underwriters, Inc.
Truist Advisory Services, Inc.
Truist Bank
Truist CIG, LLC
Truist Community Capital, LLC
Truist Delaware Trust Company
Truist Equipment Finance Corp
Truist Insurance Holdings, Inc.
Truist Investment Services, Inc.

[13] Includes Wellington Specialty, Wellington Risk Consulting and WIG Holdings.
[14] Includes GRS Title Services, H Land Services, KV National Land Services of TX, KV Englewood, KV Metro, Lakeland Title, Legal 1031, Momentous Title, National Land Service Onward Title, Nations Land Services, Onward Title, Partners Land Services, Property Title Group,

Truist Leasing Corp
Truist Merchant Services LLC
Truist Securities, Inc.
Wellington Insurance Services

APPENDIX C
PRIVACY AND SECURITY[15]

Use of PHI

The Plan will use a participating employee's, spouse's, or dependent's protected health information ("PHI"), in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), only to make required disclosures or for purposes related to treatment, payment for healthcare, and the healthcare operations of the Plan or to make any other disclosures that are required by law. However, if a participating employee, spouse or dependent requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

Obligations of Employer with respect to PHI

With respect to PHI, the Employer will:

1) Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
4) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual that is the subject of the PHI;
5) Make PHI available to an individual in accordance with HIPAA's access requirements;
6) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
7) Make available upon request an accounting of disclosures;
8) Make available to the Secretary of the Department of Health and Human Services internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA;
9) Provide written notice or a substitute notice (if the last known contact address is insufficient) for each individual within 60 days following discovery of any breach of Unsecured PHI. The notice will include:
10) A brief description of what happened including the date of the breach and the date of discovery, if known;
11) A description of the types of unsecured PHI that were involved in the breach;
12) Any steps the individual should take to protect him/herself from potential harm resulting from the breach;

[15] This Appendix only applies to Benefit Plans that are subject to HIPAA (i.e.., plans that provide group health coverage).

13) A brief description of what the Employer is doing to investigate the breach in accordance with HIPAA breach notification requirements;
14) Contact procedures for individuals to ask questions or learn additional information
15) If a breach of unsecured PHI involves more than 500 residents of a state, provide notice to local media outlets serving the state within 60 days of discovering the breach;
16) If a breach of unsecured PHI involves more than 500 covered persons, provide notice to the DHHS not later than 60 days after the end of the calendar year in with the breach occurred;
17) If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
18) Use DHHS approved methods to secure and destroy PHI.

With respect to Electronic PHI, the Employer will (if PHI is or has been stored on the Employer's computer system):

1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
2) Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
3) Ensure that any agent or business associate to whom the Plan Sponsor provides electronic PHI agrees to comply with the HIPAA Security Requirements and to provide notice to the Plan of any breach of unsecured PHI, once the breach is known to the agent or business associate or should reasonably have been known to the agent or business associate;
4) Report to the Plan any security incident of which the Employer becomes aware; and
5) Use methods to encrypt PHI that are approved by the Department of Health and Human Services.

Access to PHI

Only specified employees of the Plan Administrator may be given access to PHI, and they may use and disclose PHI only for plan administration functions (which includes both Payment and Health Care Operations) that the Plan Administrator performs for the Plan. If any of these persons do not comply with the HIPAA provisions of this Plan Document, the Employer will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

HIPAA Definitions

1) Breach means the unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by HIPAA privacy rules that compromises the security or privacy of the PHI.
2) DHHS means the federal Department of Health and Human Services.
3) Electronic PHI is health information about a plan participating employee that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.
4) Health Care Operations means activities of the Plan related to its health care functions, including quality assessment, case management, care coordination, reviewing competence of

health care professionals, evaluating provider performance, health plan performance, cost management, resolution of grievances, or any other related activities.

5) Payment includes all activities regarding the provision of benefits under the Plan.
6) Protected Health Information or PHI shall mean any individually identifiable health information in electronic, oral or written form that pertains to the past, present or future mental or physical condition of an individual. Protected Health Information is limited to the information created or received by the Employer or its business associate on behalf of the Health FSA Plan. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.
7) Unsecured PHI means PHI that is not secured through the use of a technology or methodology described in regulations to the HITECH Act or otherwise approved by the Secretary of the DHHS

APPENDIX D
TEMPORARY COVID-19 DEADLINES

The U.S. Department of Labor and the Department of Treasury have announced an extension of various ERISA and COBRA deadlines and time periods which ordinarily apply to employee benefit programs. Under this new rule, the deadlines and time periods that apply to individuals for taking the actions described below are suspended during the period that begins on March 1, 2020 and ends 60 days after the date the Federal government declares an end to the COVID-19 national emergency (the "National Emergency"). However, in no event will the time period for taking action be suspended for a period of longer than one year for any individual. The period during which these deadlines and time periods are suspended is referred to as the "COVID-19 Extension Period."

The Plan will disregard the COVID-19 Extension Period when determining whether you have taken any of the following actions in a timely manner:

- Claims and Appeals Deadlines: The deadline to file a claim for benefits or an appeal of an adverse benefit determination under the Plan's claims procedures.

- HIPAA Special Enrollment: The 30-calendar-day period (or 60-calendar-day period, if applicable) to request HIPAA special enrollment as a result of:

    - Loss of eligibility for group health coverage or individual health insurance coverage[16],
    - Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption,
    - Loss of Medicaid/CHIP eligibility, and
    - Becoming eligible for a state premium assistance subsidy under Medicaid/CHIP.

- COBRA:

    - The 60-calendar-day election period for COBRA continuation coverage,
    - The 45-calendar-day deadline for making an initial COBRA premium payment and the 30-calendarday grace period for making subsequent COBRA premium payments, and
    - The 60-calendar-day deadline to notify the Plan of a COBRA qualifying event such as divorce/legal separation or a dependent child losing eligibility under the Plan or a disability determination.

    The time period for taking any of the actions described above is suspended during the COVID-19 Extension Period and will begin running again once the COVID-19 Extension Periods ends.

[16] The following medical plans or insurance do not constitute "group health coverage" or "individual health insurance coverage" for this purpose:

- Medicare, Medicaid, TRICARE, a medical care program of the Indian Health Service or of a Tribal organization, a state health benefits risk pool, the Federal Employee Health Benefit Program, a public health plan (defined to be a plan of a state, county, or other political subdivision of the state), or a health benefit plan under the Peace Corps Act.