



**TRUIST FINANCIAL CORPORATION  
EMPLOYEE BENEFIT PLAN**

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

As of  
January 1, 2023

## FOREWORD

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

This SPD summarizes the Truist Financial Corporation Health Plan (the “Plan”). The Plan is designed to provide you and your covered dependents coverage for medical, dental and vision care expenses. Benefits under the Plan (“Benefits”) are described in the Program Documents listed in Appendix A.<sup>1</sup> This document, together with Program Documents listed under Appendix A and the plan document for the Truist Financial Corporation Employee Benefit Plan, is the SPD for the Plan as of January 1, 2023. This SPD only summarizes the provisions of the formal Plan document and does not attempt to cover all of the details contained in the Plan document. The operation of the Plan and the benefits to which you (or your beneficiaries) may be entitled will be governed solely by the terms of the official Plan document. To the extent that any of the information contained in this SPD or any information you receive orally is inconsistent with the official Plan document, the provisions set forth in the Plan document will govern. If you wish to review the Plan document, please contact the Plan Administrator. Plan documents include the Program Documents.

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 group insurance policies issued by various Insurance Companies. The Third-party Administrators and Insurance Companies (collectively, the “Benefits Service Managers”)<sup>2</sup> have been designated and named the claims fiduciary for benefits provided under the Plan. The Benefits Service Managers have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions under the Plan, to the extent permitted by applicable law. Benefits under the Plan are described in the Program Documents.<sup>3</sup>

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.”

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<sup>1</sup> Appendix A may be amended by the Plan Sponsor and/or Plan Administrator at any time without formal amendment to the Plan or this SPD. Applicable Program Documents are available at [benefits.truist.com](https://benefits.truist.com).

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

<sup>3</sup> Applicable Program Documents are listed in Appendix A and are available at [benefits.truist.com](https://benefits.truist.com).

## FACTS ABOUT THE PLAN

<b>Plan Name</b>	Truist Financial Corporation Health Care Plan. The Plan is a component plan of the Truist Financial Corporation Employee Benefit Plan (Plan Number 508).
<b>Plan Sponsor Address and Telephone Number</b>	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 715-2455, option 1 <a href="mailto:benefits@truist.com">benefits@truist.com</a>
<b>Employer Identification Number</b>	56-0939887
<b>Effective Date</b>	This is a summary of the Plan as amended and restated effective January 1, 2021, and including all subsequent amendments thereto.
<b>Plan Administrator</b>	Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, 45 <sup>th</sup> Floor Charlotte NC 28202
<b>Name and Address of Agent for Legal Service</b>	Chairman, Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, 45 <sup>th</sup> Floor Charlotte NC 28202
<b>Requests for Plan Documents</b>	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.
<b>Plan Number</b>	508
<b>Type of Plan</b>	Welfare Benefit Plan providing medical, dental, and vision benefits.
<b>Plan Year/Benefit Period</b>	January 1 through December 31

## ELIGIBILITY

You are eligible to participate in this Plan if you are an employee of Truist Financial Corporation (“Truist”) or a Participating Employer<sup>4</sup> (collectively, “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.

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

The term “Employee” shall not include:

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

If an individual is 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.

### **Becoming a Participant**

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

If an Eligible Employee does not elect to participate in the Plan, he or she may choose to become a participant by making an appropriate election during the Plan’s annual enrollment period. Other entry dates may be available under certain specific circumstances. Please see “Changes in Coverage.”

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

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<sup>4</sup> Participating Employers are listed in Appendix D.

## **Dependents**

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

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

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

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

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

For purposes of this Plan, "Child" or "Children" includes (i) a natural or adopted child of the participant, (ii) a child placed with the participant for adoption, (iii) a stepchild or foster child, and (iv) a child for whom the participant is a legal guardian.

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

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

## **Dependent Eligibility**

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

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

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

### **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 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 Plan; 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 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.

## **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 elections made during the enrollment period will be binding for the Plan year unless you experience a change in status and you requests a change within 31 days of the status change date. 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. Changes in elections resulting from a change in status must be on account of and correspond with the status change event. The Plan Administrator may require written documentation of a change in status. Employees must request changes by logging on to Workday or through [www.benefits.truist.com](http://www.benefits.truist.com).

Change in status events are:

- 1) Birth<sup>5</sup>, Adoption, Placement for Adoption, Legal Guardianship
- 2) Gain Spouse / Domestic Partner
- 3) Divorce, Legal Separation<sup>6</sup>, 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<sup>7</sup>
- 18) Eligibility for premium assistance under Medicaid or CHIP<sup>7</sup>
- 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.

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

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 I for more information.

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<sup>5</sup> For birth, you are allowed a 45-day period to initiate the change.

<sup>6</sup> Available only in states that recognize legal separation.

<sup>7</sup> For this change, you are allowed a 60-day period to initiate the change.

## TERMINATION OF COVERAGE

### Employees

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

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

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

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

### Dependents

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

- 1) The date your coverage ends;
- 2) The date you stop participating in the Plan;
- 3) The end of the month a dependent child ceases to be a dependent child (e.g., reaching the age limit);
- 4) The date the Plan is amended to terminate dependent coverage;
- 5) The date you fail to provide required information on your disabled dependent children or qualifying child;
- 6) The date you and your Spouse become divorced; or
- 7) The date you and your Domestic Partner end your partnership.

If coverage 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.



## CONTINUATION OF PARTICIPATION DURING A LEAVE OF ABSENCE

If you are enrolled in coverage and taking a Leave of Absence, you can continue your coverage 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 coverage.

Notwithstanding the foregoing, you are allowed to maintain coverage 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 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 coverage 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 coverage 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 shall be reinstated, at the level in effect when the Leave of Absence commenced. 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).

### **Participation during a Paid Leave of Absence**

Coverage 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 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. 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 coverage 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 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.

### **REINSTATEMENT OF FORMER PARTICIPANT**

Subject to your right to continue 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 to participate and terminated your coverage 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:

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.

## ON-SITE HEALTH CLINICS

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

## EMPLOYEE ASSISTANCE PROGRAM

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

## LIFEFORCE

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

## NO 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.

## CONTINUATION OF BENEFITS (COBRA)

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

For more information related to COBRA, please see:

- Appendix F for information, including continuation periods, related to COBRA;
- The COBRA Benefit Guide available at <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.

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

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

## 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.

If the Covered Person does not attempt a recovery of the benefits paid by the Plan or for which the Plan may be obligated, the Plan shall, if in the Plan's best interest and at its sole discretion, be entitled to institute legal action or claim against the Responsible Party, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Plan in order that the Plan may recover all amounts paid to the Covered Person or paid on their behalf. In the event of any recovery by judgment or settlement against the Responsible Party or by payment by any uninsured or under-insured insurance coverage or any other first-party or third-party contract or claim, the Plan's or delegate's attorneys' fees expended in the collection of the subrogation lien, if any, shall first be deducted. The Plan's subrogation interest, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall next be deducted. The remainder or balance of any recovery shall then be paid to the Covered Person and their attorneys if applicable

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

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

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

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

### **Recovery of Overpayment**

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

## **HOW THE PLAN IS ADMINISTERED**

### **Plan Operations**

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

Companies and the Third-party Administrators.

### **Plan Administration**

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

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

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

### **Power and Authority of the Benefit Service Managers**

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 for benefits.

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

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

The Benefits Service Managers 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

### **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;<sup>8</sup>
- 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; and
- 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<sup>9</sup>**

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

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<sup>8</sup> When the Committee makes such interpretations and determinations, it does so with full discretionary authority and the interpretations and determinations made by the Committee will (i) apply uniformly to all persons similarly situated, and (ii) 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 acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

<sup>9</sup> See Appendix I for information related to temporary extension of ERISA claims and appeals deadlines.



The interpretations and determinations by the Committee and 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 Benefits Service Managers acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

### **Benefit Claim**

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

### **Appealing Denied Claim**

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

### **Important Appeal Deadlines**

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

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

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

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

## Communications that Are Not Claims for Benefits

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

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

## Incompetency

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

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

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

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

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

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

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

## EFFECTS OF MEDICARE ON BENEFITS

Under the Medicare Secondary Payer ("MSP") rules, employer-provided health plans are generally primary to

Medicare. Although Medicare is designed to provide health coverage for individuals over age 65, it will pay on a secondary basis if a retiree or Spouse is covered under an employment-related plan and either the retiree or the retiree's Spouse works.

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

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

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

## FUNDING

The cost of the Plan is generally shared by you and your Employer. By sharing the cost of the Plan, we can provide the best possible coverage for you and your dependents at a reasonable cost. Fully-insured benefits are provided under an insurance contract entered into between Truist and the Insurance Company identified in appendix A.

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.

## YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

There may be times when you unknowingly receive services or do not consent to receive services from an out-of-network provider, even where you try to stay in the network for your covered services. You may then get a bill at a rate that you didn't expect. This is called a surprise bill. A federal law called the No Surprises Act protects you from surprise bills by limiting cost sharing and prohibiting balance billing by out-of-network providers. For more information regarding surprise billing can be found on [benefits.truist.com](https://benefits.truist.com).

### **Limitation of Action**

No legal action to recover benefits may be brought later than one (1) 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, by written action of its Board of Directors or its authorized officer, to modify, amend or terminate the Plan as applied to each employer-party. Except as otherwise provided in the Plan, the right to modify, amend or terminate the Plan will not in any way affect your right to claim benefits, or diminish or eliminate any claims for benefits under the Plan to which you may have become entitled to claim prior to such termination or amendment. The Plan is not a contract, and Truist does not guarantee and makes no promise to offer a specific level of benefits in the future. The right to future benefits under the Plan will never vest.

Neither the Plan nor the component Benefits under the Plan can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by any delegate of the Plan Administrator, or by Employer management. Only written statements that are consistent with the terms of the Plan and made by the Plan Administrator can bind the Plan.

### **No Contract of Employment**

The Plan, including the component Benefits, 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 Plan has the right to retroactively terminate coverage permanently for you and all of your eligible dependents. The plan may also 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 any court situated in Charlotte, North Carolina.

## **STATEMENT OF YOUR ERISA RIGHTS**

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

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

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

If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$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 federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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

## APPENDIX A

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

BENEFIT	INSURED / SELF-FUNDED	INSURER / CLAIMS ADMINISTRATOR BENEFITS SERVICE MANAGERS	PROGRAM DOCUMENTS <sup>1</sup>
Medical <ul style="list-style-type: none"> <li>• BCBSNC \$500 PPO</li> <li>• BCBSNC HDHP \$2,000</li> <li>• BCBSNC HDHP \$4,500</li> </ul>	Self-funded	Contract Administration BlueCross NC PO Box 2291 Durham NC 27702 (800) 621-8876 BlueConnectNC.com	Administrative Services Only Booklet issued by BCBSNC
Medical <ul style="list-style-type: none"> <li>• Aetna \$500 PPO</li> <li>• Aetna HDHP \$2,000</li> <li>• Aetna HDHP \$4,500</li> <li>• Aetna ACO</li> </ul>	Self-funded	Contract Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229	Administrative Services Only Booklet issued by Aetna
Medical <ul style="list-style-type: none"> <li>• Kaiser \$2,000 Plan</li> <li>• Kaiser HMO Plan</li> </ul>	Insured Policy Number(s): 47308, 10275, 10479, 24347, 26887, 602825, 605314, 22872, 230003, 233278, 26287	Insurer Administration Kaiser Permanente	Certificate of Insurance Booklets issued by Kaiser Permanente
Prescription Drug	Self-funded	Contract Administration Prime Therapeutics	Appendix B <sup>2</sup> and Certificate of Insurance Booklets <sup>3</sup>

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

<sup>2</sup> Prescription Drug benefits for employees who have medical coverage with BlueCross NC and those who have coverage with Aetna are provided through BlueCross NC and are described in Appendix B.

<sup>3</sup> Prescription Drug benefits for employees who have medical coverage with Kaiser Permanente are provided through Kaiser Permanente.

		Mail Route: Commercial PO Box 25136 Lehigh Valley, PA 18002-5136	
Teladoc Health Services	N/A	Contract Administration Teladoc Health, Inc. 1 800-TELADOC	Teladoc Health Services Summary Plan Description
Progeny Services	N/A	Contract Administration Progeny Services 844-930-3295	Progeny Services Summary Plan Description
Dental - Cigna Dental PPO	Self-funded	Contract Administration CIGNA PO Box 188037 Chattanooga TN 37422-8037 (855) 678-0046 my.cigna.com	Administrative Services Only Booklet issued by Cigna
Dental - Cigna Dental DHMO	Insured Policy Number: 3207296-DHMO1	Insurer Administration Cigna PO Box 188037 Chattanooga TN 37422-8037 (855) 678-0046 my.cigna.com	Certificate of Insurance Booklets issued by Cigna
Vision - Base Plan	Self-funded	Contract Administration Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com	Administrative Services Only Booklet issued by Vision Service Plan
Vision - Premier Plan	Self-funded	Contract Administration Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com	Administrative Services Only Booklet issued by Vision Service Plan



**APPENDIX B  
PRESCRIPTION DRUGS  
FOR PARTICIPANTS  
WHO HAVE MEDICAL COVERAGE WITH BLUECROSS NC OR AETNA**

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

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

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

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

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

You cannot refill a prescription until:

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

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

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

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

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

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

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

## **Certification Requirements**

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

## **Limitations**

Coverage for certain drugs may be subject to a lifetime dollar maximum. Refer to "Summary of Benefits." Certain prescription drugs are subject to benefit limitations which may include, but not limited to:

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

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

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

In addition, the drugs must:

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

## **Pharmacy Network**

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

## **Specialty Drugs**

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

## **Prescription Drug Benefits Exclusions**

- Any prescription drug not specifically covered in the Plan
- Any portion of the prescription drug or refill which exceeds the maximum supply for which benefits

will be provided when dispensed under any one prescription

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

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

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

## APPENDIX C CLAIMS PROCEDURES FOR THE PLAN

Except as provided below, claims for benefits under the Plan will be reviewed in accordance with procedures contained in the Program Documents or other written materials for the Plan.

### CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

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

### BENEFIT DETERMINATIONS

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

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

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

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

#### **Pre-Service Claims**

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

## **Urgent Care Claims**

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

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

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

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

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

## **Concurrent Care Claims**

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

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

## **Claim Denial Notices**

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

appeals procedures and other relevant information regarding the claim decision.

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

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

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

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

### **Appeal Process**

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

## **APPEALS DETERMINATIONS**

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

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

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

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

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

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

### **Urgent Care Claim Appeals**

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

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

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

### **External Review**

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



## APPENDIX D PARTICIPATING EMPLOYERS

As of January 1, 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<sup>1</sup>  
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<sup>2</sup>  
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.  
Truist Leasing Corp  
Truist Merchant Services LLC  
Truist Securities, Inc.  
Wellington Insurance Services

<sup>1</sup> Includes Wellington Specialty, Wellington Risk Consulting and WIG Holdings.

<sup>2</sup> 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.

## APPENDIX E NOTICES

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

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

### **Newborns' Act Disclosure**

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

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

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

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

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

about the sex or age of any individual.

### **Mental Health Parity**

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

### **Compliance with Applicable Laws**

The Plan Sponsor will administer the Benefit 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.

### **Legal Notices**

Other Legal Notices are available at [benefits.truist.com](http://benefits.truist.com).

## APPENDIX F<sup>1</sup>

### COBRA CONTINUATION COVERAGE RIGHTS

#### 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 Truist Financial Corporation Health Care 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.

#### 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

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<sup>1</sup> See Appendix I for information related to temporary extension of COBRA deadlines.

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**

<b>Qualifying Event</b>	<b>Who Is Eligible</b>	<b>Maximum Extension</b>	<b>Who Must Notify Plan Administrator</b>	<b>Time Period for Notification<sup>1</sup></b>
Termination of employment (other than for	Employee/Spouse/ Domestic Partner/	18 months <sup>2</sup>	Employer	30 days

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

<sup>2</sup> Maximum period which runs from the date of the qualifying event.

gross misconduct)	Eligible Dependents			
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](http://www.healthcare.gov).

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<sup>1</sup> 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](http://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](http://www.HealthCare.gov).

### **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

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<sup>1</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.



Charlotte NC 28202  
(800) 715-2455, option 1  
[benefits@truiist.com](mailto:benefits@truiist.com)

## APPENDIX H PRIVACY AND SECURITY

### 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;
  - 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 which 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 I TEMPORARY COVID-19 EXTENSIONS

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<sup>1</sup>, 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-calendar-day 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.

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<sup>1</sup> 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.