TRUIST

TRUIST FINANCIAL CORPORATION
EMPLOYEE BENEFIT PLAN

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

As of
January 1, 2024

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.[1] 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, 2024. 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")[2] have been designated and named the claims fiduciary for benefits provided under the Plan. The Benefits Service Managers have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions under the Plan, to the extent permitted by applicable law. Benefits under the Plan are described in the Program Documents.[3]

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."

[1] 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.

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

[3] Applicable Program Documents are listed in Appendix A and are available at benefits.truist.com.

FACTS ABOUT THE PLAN

Plan Name	Truist Financial Corporation Health Care Plan. The Plan is a component plan of the Truist Financial Corporation Employee Benefit Plan (Plan Number 508).
Plan Sponsor Address and Telephone Number	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 715-2455, option 1 benefits@truist.com
Employer Identification Number	56-0939887
Effective Date	This is a summary of the Plan as amended and restated effective January 1, 2021, and including all subsequent amendments thereto.
Plan Administrator **Name and Address of Agent for Legal Service**	Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, 45th Floor Charlotte NC 28202 Chairman, Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, 45th Floor Charlotte NC 28202
Requests for Plan Documents	Requests for plan documents must be in writing and sent to: Chairman, Employee Benefits Committee Truist Financial Corporation 214 N Tryon Street, 45th Floor Charlotte NC 28202 Failure to send a written request to the address above will not constitute a request for plan documents.
Plan Number	508
Type of Plan	Welfare Benefit Plan providing medical, dental, and vision benefits.
Plan Year/Benefit Period	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[4] (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.

[4] Participating Employers are listed in Appendix C.

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.

Only individuals who qualify as your Dependents can be enrolled for coverage in the Plan.

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" means:

(1) A child of the Participant under age 26 who is a (a) natural or adopted child of the Participant, (b) child placed with the Participant for adoption, (c) stepchild or foster child of the Participant, and / or (d) child for whom the Participant is a legal guardian.

(2) A child of the Participant who meets the definition of "Qualifying Child" in Section 152(f) of the Internal Revenue Code ("Code"). A Qualifying Child is generally an individual (a) who bears a familial relationship to the taxpayer (i.e., is a child or stepchild of the Participant or a descendant of such a child, or a brother, sister, stepbrother, or stepsister of the Participant or a descendant of any such relative); (b) who has the same principal place of abode as the taxpayer for more than one-half of the Participant's taxable year; (c) who has not attained the age of 19 as of the close of the Plan Year, or is a full-time student who has not attained the age of 24 as of the close of the Plan Year; and (d) who has not provided over one-half of such individual's own support for the calendar year in which the taxable year of the Participant begins.

(3) A child of the Participant age 26 or older who, due to a mental or physical disability, resides with the Participant and depends on the Participant for financial support. 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. Proof of incapacity may be required from time to time.

(4) A child of the Participant's Domestic Partner under age 26 who lives with the Participant and is dependent upon the Participant for financial support.

(5) A child of a Domestic Partner age 26 or older who, due to a mental or physical disability, resides with the Participant and depends on the Participant for financial support. If you want to continue to cover the 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. Proof of incapacity may be required from time to time.

(6) An individual who is determined to be an alternate recipient of a Participant under a Qualified Medical Child Support Order or National Medical Support Notice.

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 who is the Spouse or Domestic Partner of the Employee as a dependent. If you have questions regarding Dependent coverage, contact Benefits Administration.

Notwithstanding the foregoing, individuals who are otherwise "Dependents" shall not be eligible for coverage under the Plan if they serve in the military of any country or reside outside of the United States or Canada.

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.

Note that when you enroll a dependent in the Plan, you represent the following:

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

Further, you understand that:

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

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 change in status 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.

Change in status events are:

1) Birth[5], Adoption, Placement for Adoption, Legal Guardianship[6]

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

[6] The effective date for this change in status event is the date of the event.

2) Gain Spouse / Domestic Partner
3) Divorce, Legal Separation[7], Annulment, Dissolution of Domestic Partnership[6]
4) Death of Spouse / Domestic Partner or Child[6]
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[8]
18) Eligibility for premium assistance under Medicaid or CHIP[8]
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.

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;

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

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

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.

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, the program's wellness notice, and the data collected by the program can be found at benefits.truist.com. Please contact Teammate Care at 800-716-2455 or visit benefits.truist.com for more information regarding this program.

Note that Peak Health coordinates LifeForce. A Peak Health nurse will help you establish realistic and attainable health goals. Peak Health does not offer medical advice and does not engage in the practice of medicine. The information that Peak Health provides to you is for informational purposes only. Peak Health is not a substitute for your physician's professional medical judgment. Reliance on any of the information provided by Peak Health is solely at your own risk.

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 E for information, including continuation periods, related to COBRA;
- The COBRA Benefit Guide available at https://benefits.truist.com/content/dam/truistbenefits/us/en/documents/benefits/cobra-

benefits-guide.pdf

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

When you or your covered dependent (together referred to as "you") are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical and dental) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

(1) Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
(2) May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
(3) May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the program has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the

extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses or how it is characterized.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury or any other equitable principle. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds. The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

(1) Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
(2) Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
(3) Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
(4) Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

(1) Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this SPD.
(2) Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
(3) Provide all information requested by the Plan, the claims administrator or their representatives, or the Plan Administrator or its representatives.
(4) Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan rights.

The Plan may terminate your Plan participation and/or offset your future benefits for the value of benefits advanced in the event that that the Plan does not recover, if you do not provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract

will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Plan rights under this section remain enforceable against the heirs and estate of any covered person.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider) from the Plan, the covered individual 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 individual's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered individual which is insufficient to make the covered individual whole or to compensate the covered individual 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 any attorney hired by the covered individual to pursue the covered individual's damage claim. No other equitable principle shall affect the Plan's rights.

Applicability to All Settlements and Judgments

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 individual 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, non-economic damages and/or general damages only.

Cooperation

The covered individual shall fully cooperate with the Plan's efforts to recover benefits paid. It is the duty of the covered individual to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered individual's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered individual. The covered individual and his/her agents shall provide all information requested by the Plan, the claims 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, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the covered person, may result in the termination of health benefits for the covered person or the institution of court proceedings against the covered person.

The covered individual 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.

The covered individual acknowledges that Truist has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. Truist reserves the right to notify responsible party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

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

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider) from the Plan, the covered individual 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 individual 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 (collectively, the "Benefits Service Managers").

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:

    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;[9]
    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;

[9] 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.

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

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

The interpretations and determinations by the 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 B 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 B 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 B for information about how to file a claim and applicable claims procedures.

Exhaustion of Administrative Remedies; Limitations of Action

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

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

Communications that Are Not Claims for Benefits

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

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

Incompetency

If any person entitled to payments under the Plan is a minor or under other legal disability or otherwise

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

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

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

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

EFFECTS OF MEDICARE ON BENEFITS

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 in 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 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.

Use of Funds

To the maximum extent permitted by applicable law, Truist shall be entitled to retain any policy dividend or refund, or portion thereof, it receives from any insurance company, administrative services organization, EPO, DMO, service plan, or any other organizations or individuals.

Plan's Use of Funds

All amounts paid to and held by the Plan, as well as any policy dividends and/or refunds not belonging to Truist or an Employer, shall be available to fund the benefits provided by any benefit plan included in the Plan and / or to pay the benefit plan's administrative expenses.

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. More information regarding surprise billing can be found on benefits.truist.com.

LEGAL INFORMATION

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).

No Estoppel of Plan

No person is entitled to any benefit under the Plan or any benefit plan except and to the extent expressly provided under the Plan or the benefit plan. The fact that payments have been made from the Plan or benefit plan in connection with any claim for benefits under the Plan or benefit plan does not (a) establish the validity of the claim, (b) provide any right to have such benefits continue for any period of time, or (c) prevent the Plan or benefit plan from recovering the benefits paid to the extent that the Plan Administrator ultimately determines that there in fact was no right to payment of the benefits under the Plan or benefit plan. Thus, if a benefit is paid to a person under the Plan or benefit plan and it is thereafter determined by the Plan Administrator or Benefit Service Manager that such benefit should not have been paid (whether or not attributable to an error by such person, the Plan Administrator, the Benefit Service Manager, or any other person), then the Plan Administrator and/or Benefit Service Manager may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or benefit plan or from any amounts due or owing to such person by a participating employer or under any other plan, plan or arrangement benefiting the employees or former employees of the Employer, or otherwise recovering such overpayment from whoever has benefited from it.

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[1]
Medical • Aetna $500 PPO • Aetna $2,500 HDHP • Aetna $4,000 HDHP • Aetna ACO • Aetna $1500 UA PPO	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 • Kaiser $2,500 Plan • Kaiser EPO Plan	Self-funded	Contract Administration Kaiser Permanente (877) 224-0101	Administrative Services Only Booklet issued by Kaiser Permanente
Prescription Drug	Self-funded	Contract Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229 Contract Administration Kaiser Permanente (877) 224-0101	Certificate of Insurance Booklets
Teladoc Health Services	N/A	Contract Administration	Teladoc Health Services

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

		Teladoc Health, Inc. 1 800-TELADOC	Summary Plan Description
Progyny Services	N/A	Contract Administration Progyny Services 844-930-3295	Progyny Services Summary Plan Description
Dental - Aetna Dental PPO	Self-funded	Contract Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229	Administrative Services Only Booklet issued by Cigna
Dental - Aetna Dental DMO	Insured Policy Number: 141938	Contract Administration Aetna 151 Farmington Avenue Hartford CT 06156 www.aetna.com (888) 402-1229	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
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 C
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[1]
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[2]
McGriff Insurance Services, Inc.
Norman Spencer Agency
Peak Health Services, LLC
Prime Rate Premium Finance Corporation
Regional Acceptance Corporation
Service Finance Holdings, LLC
Starwind Specialty Insurance Services, LLC
Sterling Capital Management, LLC
SunTrust Equity Funding, LLC
Truist Commercial 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

[1] Includes Wellington Specialty, Wellington Risk Consulting and WIG Holdings.
[2] 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 D
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.

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.

Transparency in Coverage

In 2020, the Departments of the Treasury, Labor, and Health and Human Services issued the Transparency in Coverage Final Rules. The final rules require publication of machine-readable files containing in-network and out-of-network rates for providers. Links for the machine-readable files can be found at benefits.truist.com.

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.

APPENDIX E
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 determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or

within 60 days of, the event that caused coverage to terminate. Coverage may be continued for the individual determined to be disabled and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued and for your newborn or newly adopted child who was added after the date continued coverage began.

- The date Truist no longer provides a group health plan.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan.
- The first day after the date of the COBRA election that the individual becomes enrolled in benefits under Medicare.

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

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

B. Continuation of Coverage under Other Circumstances

If coverage for a dependent terminates due to:

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

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

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

- The end of a 36-month period after the date of the event that caused coverage to terminate.
- The date Truist no longer provides a group health plan.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health Plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events

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

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

E. Notice Requirements

If coverage for you or your dependents:

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

If coverage for a dependent terminates due to:

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

Summary of Qualifying Events

Qualifying Event	Who Is Eligible	Maximum Extension	Who Must Notify Plan Administrator	Time Period for Notification[1]
Termination of employment (other than for gross misconduct)	Employee/Spouse/ Domestic Partner/ Eligible Dependents	18 months[2]	Employer	30 days

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

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

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.

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[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Truist Financial Corporation Employee Benefit Plan
214 N Tryon Street
Charlotte NC 28202
(800) 715-2455, option 1

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

benefits@truist.com

APPENDIX F
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 with the breach occurred;
17) If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
18) Use DHHS approved methods to secure and destroy PHI.

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

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

Access to PHI

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

HIPAA Definitions

1) Breach means the unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by HIPAA privacy rules that compromises the security or privacy of the PHI.
2) DHHS means the federal Department of Health and Human Services.
3) Electronic PHI is health information about a plan participating employee that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.
4) Health Care Operations means activities of the Plan related to its health care functions, including quality assessment, case management, care coordination, reviewing competence of health care professionals, evaluating provider performance, health plan performance, cost management, resolution of grievances, or any other related activities.
5) Payment includes all activities regarding the provision of benefits under the Plan.
6) Protected Health Information or PHI shall mean any individually identifiable health information in electronic, oral or written form that pertains to the past, present or future mental or physical condition of an individual. Protected Health Information is limited to the information created or received by the Employer or its business associate on behalf of the Health FSA Plan. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.

7) Unsecured PHI means PHI that is not secured through the use of a technology or methodology described in regulations to the HITECH Act or otherwise approved by the Secretary of the DHHS.