progyny
Smarter Fertility Benefits

Summary Plan Description for Progyny Services

A component of the Truist Financial Corporation Health Care Plan

January 2022

An Introduction to Progyny Services

Truist Financial Corporation ("Truist") maintains the Truist Financial Corporation Health Care Plan (the "Plan").[1] This document provides a summary of the Progyny Services program under the Plan and administered through Progyny, Inc. This document is part of the summary plan description ("SPD") of the Plan. You should read this document in conjunction with the other sections of the Plan's SPD, including:

- Overview;
- Eligibility and Enrollment; and
- Administration.

Overview

Progyny is the premier fertility benefit designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist any member wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care. If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate, or you can call the Progyny line for Truist teammates at 844-930-3295.

Eligibility

All teammates and spouses/domestic partners who enroll in a Truist-Sponsored medical plan.

Administration

Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage. Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

Artificial Insemination (IUI), Cryopreservation of oocytes and sperm, FDA Bloodwork and Testing, Fresh IVF Cycle, Frozen Embryo Transfer (FET), Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer), IVF Freeze-All, Patient Care Advocate (PCA) Concierge Support, pre-authorized fertility medications (via Progyny Rx), PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability, PGT-M (PGD, or Pre-implantation Genetic Diagnosis), Pregnancy Gap Coverage (Pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider), Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities), and the purchase of donor tissue (eggs and sperm).

Progyny's benefit has the following standard exclusions:
Home ovulation prediction kits, dependent child/children, services and supplies furnished by an out-of-network provider or not listed as covered in the Progyny Member Guide, all charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to laboratory tests, and treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine.

[1] The Truist Financial Corporation Health Care Plan is incorporated into and, thus, a component plan of the Truist Financial Corporate Employee Benefit Plan, Plan 508.

How to File a Claim or an Appeal

Request

- In order to initiate the Progyny Services you must activate your benefit by calling Progyny at 844-930-3295

Denial

It is very unlikely that you would be denied the use of Progyny Services, however, if you are denied services you have the rights outlined in this section. Denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a service, supply, or benefit is called an "Adverse Benefit Determination". With respect to the Progyny Services, such Adverse Benefit Determination may be based on:

- Your eligibility for the Services, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit); or
- Your intention to use the Services for litigation or legal reasons, e.g. medical malpractice case; or
- Your refusal to sign an authorization form for Progyny to collect your medical information when such information is necessary for the type of service you requested.

Appeals

If you are denied the use of Progyny Services, you will receive notification from Progyny of denial of services with an explanation of the reason for the denial. You have the right to file an appeal of such Adverse Benefit Determination by contacting Progyny within 30 days of receipt of the notice of denial.

If Progyny upholds its denial, you have the right to seek an appeal. You have a timeframe of 12 months following the date on which you submitted the last required appeal.

Appeals should be sent within the prescribed time period as stated above to:

Employee Benefits Plan Committee
Truist Financial Corporation
214 N Tryon Street
Charlotte NC 28202
(800) 716-2455
benefits@truist.com

COBRA Continuation of Coverage

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant. A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA. Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

For more information regarding COBRA, please refer to the Plan's plan document.

FACTS ABOUT THE PLAN

Plan Name:	The Truist Financial Corporation Health Care Plan, which is a component plan of the Truist Financial Corporate Employee Benefit Plan (Plan # 508)
Employer Name, Address and Telephone Number:	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 716-2455 benefits@truist.com
Plan Sponsor / Company	Truist Financial Corporation
Plan Administration	Employee Benefits Plan Committee
Effective Date:	January 1, 2022
Name and Address of Plan Administrator	Employee Benefits Plan Committee
Agent for Legal Process	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202
Employer Identification Number:	56-0939887
Plan Number:	508
Type of Plan:	**"**Welfare benefit plan" within the meaning of Section 3(1) of the Employee Retirement Income Security Act ("ERISA").
Plan Year:	January 1 through December 31
Type of Administration:	General administration is provided by the Employee Benefits Plan Committee working through the Benefits Department of Truist Financial Corporation. Claims for benefits under the Reimbursement Accounts portion of the Plan are paid by the Claims Administrator.
Claims Administrator:	Progyny, Inc.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan document, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except to the extent that the Plan Administrator has delegated certain responsibilities to

any third parties for this Plan. Any interpretation, determination or other action of the Plan Administrator or the third-party shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the third party at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the third party make, in its sole discretion, and further, means that the participant consents to the limited standard and scope of review afforded under law.

PROTECTION UNDER ERISA

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

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

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

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

If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

Subject to the terms of the Plan, if you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court

costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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

OTHER IMPORTANT PLAN INFORMATION

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

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

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