Truist Financial Corporation
Retiree Health Plan[1]

Summary Plan Description

As of
January 1, 2025

[1] Includes the Health Reimbursement Arrangement for Medicare Eligible Retirees Formally Covered under the SunTrust Banks, Inc. Retiree Health Plan. *See* Appendix F.

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 Summary Plan Description ("SPD) summarizes the Truist Financial Corporation Retiree 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 the Program Documents listed under Appendix A, is the SPD for the Plan.[2]

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

We encourage you to read the SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed under "Facts About the Plan."

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

[2] 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 see "Facts about the Plan" below.

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

FACTS ABOUT THE PLAN

Plan Name	Truist Financial Corporation Retiree Health Care Plan
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
	This is a summary of the Truist Financial Corporation Retiree Health Care Plan effective January 1, 2021
Plan Administrator	Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, 45th Floor Charlotte NC 28202
Name and Address of Agent for Legal Service	Chairman, Employee Benefits Committee Truist Financial Corporation 214 N. Tryon Street, 45th Floor Charlotte NC 28202
Plan Number	516
Type of Plan	Welfare Benefit Plan providing medical, dental and vision benefits.
Plan Year/Benefit Period	January 1 through December 31

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.

DEFINITIONS

Active Employer Plan means any group health plan offered under the Truist Financial Corporation Employee Benefit Plan.

Company means Truist Financial Corporation and any successor or assign thereof that adopts the Plan by action of its governing body or which contractually assumes the obligations of the Company under the Plan.

Covered Dependent means any individual who is eligible to receive benefits under a Benefit Program, in accordance with the terms of the applicable Program Document, by virtue of being a Dependent.

Eligible Retiree means each former Employee who retired from a Company on or after January 1, 2021, and who, as of the date of such retirement is age 55 or older and has completed ten (10) or more Years of Service; or (ii) each former Employee of the Company who is entitled to a Benefit Credit under the Health Reimbursement Arrangement set forth under Appendix F.

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

The term "Employee" does not include:

1) Any individual who is performing services for the Employer (i) under an independent contractor or consultant agreement or arrangement with the Employer; (ii) pursuant to an agreement between the Employer and a third party; or (iii) who is treated for payroll purposes as other than an Employee of the Employer (except as noted above), 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 Program;
5) Any individual who is categorized by any Employer as a temporary or contract employee.

If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by an Employer, a governmental body, or the judiciary as an employee, such person, for purposes of the Plan, shall be deemed to be an employee from the actual (and not effective) date of such classification by Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable.

Employer means the Company or any Participating Employer that has adopted the Plan. The list of Employers is set forth in Appendix C.

Year of Service means each twelve (12)-consecutive-calendar-month period beginning on an individual's date of employment or reemployment with an Employer as the case may be, in which such individual is an

employee during each month of such period. Periods of employment will be aggregated for the purpose of determining whether an employee or retired employee has satisfied the eligibility requirements set forth below.

ELIGIBILITY

In order for an individual to participate in this Plan, the individual must be (i) an Eligible Retiree and (ii) immediately prior to becoming eligible to participant in this Plan, a Participant in the Active Employee Plan. In no event will an Employee be covered as both a Participant and Dependent, or a Dependent be covered as a Dependent of more than one Participant. An Employee who is eligible to participate in the Plan will become a "Participant" as of the date set forth in the Program Documents.

Becoming a Participant

As a condition of participation and receipt of benefits under the Plan, each Eligible Retiree who elects to participate in the Plan, shall:

1) Complete and timely submit an Election Form to the Employee Benefits Plan Committee (the "Committee"), on which the Eligible Retiree shall indicate which Dependents shall be covered under the Plan;
2) Observe all Plan rules and regulations;
3) Consent to the Committee's inquiries with respect to an individual's status as a Spouse, Domestic Partner, or Dependent or with respect to any physician, hospital or other medical care provider, or services involved in a determination for eligibility of coverage or a claim for benefits under the Plan.

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 individual legally married to a Participant, including by reason of the common law statutes in the state of the Participant's principal residence; provided, however, that such term shall not include an individual legally separated from the Participant under a decree of divorce or separate maintenance.

For purposes of this Plan, "Domestic Partner" means any person who, with the Eligible Retiree, meets the following requirements:

1) Both persons are at least 18 years of age;
2) Both persons must share a common primary residence;
3) Neither person should be 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 must be legally capable of consenting to a domestic partnership; and
6) Both persons have lived together 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, which includes (a) a natural or adopted child of the Participant, (b) a child placed with the Participant for adoption, (c) a stepchild or foster child of the Participant, and (d) a 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 Participant (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 Participant 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 the 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.

(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 Eligible Retiree, only one Eligible Retiree may cover the child. In addition, an Eligible Retiree cannot cover another Eligible Retiree or an Employee who is the Spouse or Domestic Partner of the Eligible Retiree 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.

Participation Conditions

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

1) Complete and timely submit an election form to the Plan Administrator on which the eligible employee shall indicate which dependents shall be covered under the Plan, designate a portion of his compensation as a participant contribution and consent to have such amount withheld as a salary reduction contribution;
2) Observe all Plan rules and regulations;
3) Consent to the Committee's inquiries with respect to an individual's status as a spouse, domestic partner, or dependent or with respect to any physician, hospital or other medical care provider, or services involved in a determination for eligibility of coverage or a claim for benefits under the Plan; and
4) Submit to the Benefits Service 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.

ENROLLMENT

Time of Election

You may enroll for coverage under the Plan either upon becoming initially eligible for participation or during Annual Enrollment. Unless otherwise determined by the Committee in a writing adopted by the Committee, once you enroll for coverage in the Plan, the elections shall stay in effect for the remainder of the coverage period until changed by you or such coverages end as described under "Termination of Coverage" below. Upon becoming initially eligible or during Annual Enrollment, you shall be furnished with an election form and a current description of benefit options.

Initial Eligibility

To complete a valid enrollment, the election form must be completed and returned to the Committee on or before the date set established by the Committee.

Annual Enrollment

You may enroll in and/or change your elections for a subsequent Plan Year during annual enrollment. To complete a valid enrollment, the election form must be completed and returned to the Committee on or before the end of the designated annual enrollment for the Plan Year to which it applies. After timely completion and submission of an election form, coverage under the Plan shall become effective on the later of the (1) January 1 immediately following Annual Enrollment or (2) pursuant to the provisions of the applicable benefit option.

TERMINATION OF COVERAGE

Eligible Retiree

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

1) You fail to timely pay any required contributions;
2) As specified in any eligibility audit communication, the date you and/or your Dependent fail to provide any information required with respect to an eligibility audit (regardless of whether such individual is otherwise eligible);
3) You cancel participation or elect not to participate in the Plan. In such case, you shall not be eligible to re-enroll in the Plan at any future date. You may cancel coverage for (1) your Dependents, or (2) yourself and your Dependents, effective as of the first day of the month following the Plan Administrator's receipt of his cancellation election. The individuals for whom any such cancellation is effective shall not be eligible to re-enroll in the Plan at any future date.
4) The date a Participant attains age 65;
5) The Plan Sponsor terminates the Plan or amends the Plan in a manner that it no longer applies to you or your Dependent; and
6) The date the Committee determines you or your Dependent has engaged in gross misconduct which the Committee finds to be detrimental to the best interests of the Employer during your employment with any Employer.

Dependents

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

1) You cease to be covered;
2) As specified in any eligibility audit communication, the date you and/or your Dependent fails to provide any information required with respect to an eligibility audit (regardless of whether such individual is otherwise eligible); or
3) The date your Covered Dependent becomes eligible for Medicare; and
4) The Covered Dependent is no longer an eligible Dependent.

Temporary Continuance of Coverage

Except in the case of your death, no benefits shall be paid for any claims incurred after the date as of which coverage terminates for any reason and the acceptance of any untimely premiums or premium for any period after coverage terminates shall not be deemed an extension of coverage and any such premium shall be returned to the payor without interest.

If you die while enrolled in this Plan, your Covered Dependents at your death shall be eligible to continue their coverage under any Benefit Program in which they are then enrolled at the same level in which they were enrolled, provided such Covered Dependents continue to timely pay the applicable premiums for such coverage.

Notwithstanding the foregoing, coverage continued under this section shall terminate upon the earliest of the following dates:

1) The date as of which:

    - The Plan Sponsor terminates the Plan or amends the Plan in a manner that
    - it no longer applies to the Eligible Retiree or Dependent;
    - There is a failure to timely pay any required contributions;
    - The Covered Dependent is no longer an eligible Dependent; and
    - The date the Covered Dependent becomes eligible for Medicare.

2) For a Covered Dependent (other than a surviving Spouse or Domestic Partner), the first date as of which such Covered Dependent would cease to be a Dependent (as defined in this Plan) if you had survived.

In no event shall a surviving Spouse/Domestic Partner of such a Retiree be entitled to add a new Spouse/Domestic Partner to coverage received under this Plan.

FUNDING

Eligible Retirees pay for the cost of the Plan.

Fully-insured benefits are provided under an insurance contract entered into between Truist 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.

Certain benefits shall be paid from the Retiree Health Trust (the "Trust"). The Trust is a non-exempt welfare benefit fund under the Internal Revenue Code Section 419(e)(1) and is the vehicle used for funding medical, prescription drug, and dental benefits for individuals who meet the eligibility rules for the Plan.

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.

HOW THE PLAN IS ADMINISTERED

Plan Operations

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

Plan Administration

The Plan Sponsor has named the Employee Benefits Plan Committee (the "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 Insurance Companies and Third-party Administrators

Claims for insured benefits are sent to the applicable Insurance Company and claims for self-funded benefits are sent to the applicable Third-party Administrator (collectively, the "Benefits Service Managers").

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

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

The Benefits Service Managers 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;[1]
    b) To administer the Plan in accordance with its terms, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;
    c) To file such reports as may be required with the United States Department of Labor, the Internal Revenue Service and any other government agency to which reports may be required to be submitted from time to time;
    d) To comply with requirements of the law for disclosure of plan provisions and other information relating to the plan to participants and other interested parties; and
    e) To administer the claims procedure to the extent allocated to it in this SPD.

2) Claims Fiduciary:

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

3) Compensation and Human Capital Committee:

[1] 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.

1) The Compensation and Human Capital Committee of the Board will be responsible for approving the Charter of the Employee Benefits Plan Committee; and
2) 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 Benefit Service Managers as the claims fiduciary for benefits provided under the Plan. The Benefit Service Managers have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan, to the extent permitted by applicable state law. The interpretations and determinations by the Benefit 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 Benefit Service Managers acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

Benefit Claim

The Benefit 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 issued by the Benefit Service Managers for information about how to file a claim and for details regarding the Benefit Service Managers' 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 applicable Benefit Service Manager for a review of the denied claim. The Benefit Service Manager will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the Program Documents issued by the Benefit Service Managers for information about how to file a claim and for details regarding the Benefit Service Managers' 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 for information about how to appeal a denied claim, and for details regarding the Benefit Service Managers' appeals procedures.

Exhaustion of Administrative Remedies; Limitations of Actions
Claimants shall not be entitled to challenge the Committee's or the Benefit 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. If the Claimant does not bring such action within such 12-month period, the Claimant shall be barred from bringing an action related to his claim.

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 Benefit Service Managers, 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:

(i) to such person;
(ii) to such person's legal guardian or conservator; or
(iii) 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 Benefit Service Managers) 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

Except as provided below, each Medicare-eligible Retiree or Covered Dependent covered by a Benefit providing medical benefits shall continue to be covered by such Benefit, unless he elects, in writing, to have Medicare for primary coverage.

Medicare shall automatically be the primary coverage for a Medicare-eligible Retiree or Covered Dependent Medicare purposes, at the earliest time at which Medicare who is covered by an applicable Benefit Program and who:

1) Begins a regular course of renal dialysis;
2) Receives a kidney transplant without first beginning dialysis; or
3) Becomes disabled for Medicare purposes

at the earliest time at which Medicare is permitted to be primary under Section 1862(b) of the Social Security Act and regulations thereunder, regardless of whether such person actually enrolls for Medicare.

To the extent permitted by law, Medicare shall be the primary coverage for a Participant or Covered Dependent who attains age 65.

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.

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.

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

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

Discretion

The Committee, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Committee, or its delegate, in its discretion that the applicant is entitled to them.

Plan Amendment/Termination

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

Neither the Plan nor the benefits provided 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, the Insurance Company, by any delegate of the Plan Administrator or Insurance Company, or by other party. Only written statements that are consistent with the terms of the Plan and

made by the Plan Administrator and /or Insurance Company can bind the Plan.

No Contract of Employment

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

Intentional Misrepresentations

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

Governing Law and Venue

This Plan is governed by and will be construed in accordance with ERISA, and to the extent not preempted by ERISA, by the laws of the state of North Carolina, without regard for any choice of law principles thereof. Unless otherwise provided in this SPD, any legal action related to this Plan shall be brought only in the United States District Court for the Western District of North Carolina of 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 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 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 $1500 PPO • Aetna $250 ACO • Aetna HDHP $2,500 • Aetna HDHP $4,000 •	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 $2,000 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	Administrative Services Only Booklet issued by Aetna and Kaiser Permanente
Progyny Services	N/A	Contract Administration Progyny Services	Progyny Services Summary Plan Description

[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.

		844-930-3295	
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
Health Reimbursement Arrangement for Medicare Eligible Retirees Formally Covered under the SunTrust Banks, Inc. Retiree Health Plan	Self-funded	Contract Administration VIA Benefits https://my.viabenefits.com/truist 1-855-832-0972	See Appendix F

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.

CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

These claims procedures shall apply to claims made under the Plan to the extent (1) the applicable Program Documents fail to provide claims procedures or the Benefits Service Manager does not maintain 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:

3) 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.
4) Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
5) 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:

1) The Claims Administrator's receipt of the requested information; or
2) 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:

1) The patient's name.
2) The plan identification number.
3) The date(s) of health care service(s).
4) The provider's name.
5) The reason(s) you believe the claim should be paid.
6) 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:

1) 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.
2) 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:

3) The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
4) 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, 2025, the list of Participating Employers is provided below. This list may be updated at any time without formal amendment to the Plan or this SPD.

AFCO Acceptance Corporation
AFCO Credit Corporation
BB&T Collateral Service Corporation
BB&T Real Estate Funding, LLC
CB Finance, Inc.
GFO Advisory Services, LLC
Grandbridge Real Estate Capital, LLC
Prime Rate Premium Finance Corporation, Inc.
Regional Acceptance Corporation
Service Finance Holdings, LLC
SunTrust Equity Funding, LLC
Truist Commercial Equity
Truist Advisory Services, Inc.
Truist Bank
Truist CIG, LLC
Truist Community Capital, LLC
Truist Delaware Trust Company
Truist Equipment Finance Corp
Truist Investment Services, Inc.
Truist Leasing Corp
Truist Merchant Services LLC
Truist Securities, Inc.

APPENDIX 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. The Plan will comply with MHPAEA, to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require the Plan to provide coverage for mental health and/or substance use disorder benefits.

Compliance with Applicable Laws

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

Other Legal Notices

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

APPENDIX E
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.

APPENDIX F
HEALTH REIMBURSEMENT ARRANGEMENT FOR MEDICARE ELIGIBLE RETIREES FORMERLY COVERED UNDER THE SUNTRUST BANKS, INC. RETIREE HEALTH PLAN

INTRODUCTION

The SunTrust Banks, Inc. Retiree Health Plan, now the Truist Financial Corporation Retiree Health Plan (the "Plan"), initially provided for a self-insured Medicare supplement ("Medicare Supplement") program for retirees and their dependents eligible for Medicare. The Plan was subsequently amended to discontinue Company contribution towards the Medicare Supplement program for retirees who become eligible for Medicare on or after January 1, 2003. Effective April 1, 2014, the plan was further amended to discontinue the Medicare Supplement program. Retirees who were receiving a Company contribution for the Medicare Supplement received this Health Reimbursement Arrangement. This Health Reimbursement Arrangement ("HRA") provide participants with notional accounts funded by the Company, in the form of Benefit Credits" with which they can obtain reimbursement of eligible medical expenses, including, premiums for individual Medicare Supplement insurance policies. The Company intends this HRA to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Code Sections 105 and 106, and the HRA will be interpreted at all times in a manner consistent with such intent.

Capitalized terms in this Appendix F will have the meanings given to them in Section G.6 or, if not defined therein, the definitions given in Article II of the Plan.

G.1. ELIGIBILITY

The Health Reimbursement Arrangement is available to retirees and their dependents who were receiving (or would have received) a Company contribution towards the Medicare Supplement program as of the Effective Date. The following former Employees and Dependents are eligible for Benefit Credits under the HRA.

a) An Eligible Retiree who, immediately prior to the Effective Date, (i) was enrolled in Medicare Coverage; (ii) was covered by the Plan's Medicare Supplement program (with or without prescription drug coverage) and/or Dental Benefit Option and/or the Vision Benefit Option and (iii) was receiving a Company contribution greater than fifteen percent (15%) of the Retiree's premium for the Medicare Supplement as of the Effective Date.

b) A Covered Dependent who is a Spouse of an Eligible Retiree who immediately prior to the Effective Date (i) was enrolled in Medicare Coverage; (ii) was covered by the Plan's Medicare Supplement program (with or without prescription drug coverage) and/or Dental Benefit Option and/or the Vision Benefit Option; was receiving a Company contribution greater than fifteen percent (15%) of the Covered Dependent's applicable premium as of the Effective Date.

c) A Covered Dependent who is a Spouse of an Eligible Retiree (as described in paragraph G.1(a) above) who, immediately prior to the Effective Date, (i) participated in the Company Retiree Health Plan and (ii) are recorded in the Company's records in cost sharing groups as set forth in section G.7.

G.2. PARTICIPATION.

a) Agreement to Participate.

i. An Eligible Retiree shall become a Participant in the HRA on the Effective Date, provided that:

1) He is eligible for Medicare Coverage;
2) He has obtained an individual health insurance policy through Willis Towers Watson or any affiliate; and
3) He has completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.

ii. A Covered Dependent (as described in paragraph G.1. (b) shall become a Participant in the HRA on the Effective Date, provided that he satisfies the requirements in subparagraphs (i)(1), (i)(2) and (i)(3) above.

iii. A Covered Dependent (as described in paragraph G.1. (c) not eligible for Medicare shall become a Participant in the HRA when they attain age 65 provided that they satisfy the requirements in subparagraph (i)(2) and (i)(3) above.

Eligible Retirees and Covered Dependents must satisfy the requirements in subparagraph (i)(2) and (i)(3) above upon the later of the Effective Date or the date they attain age 65 in order to participate in the HRA.

b) Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

i. With respect to an Eligible Retiree, the date they cease to be an Eligible Retiree for any reason, including death;

ii. With respect to a Covered Dependent, the date they cease to be an Eligible Dependent for any reason, including death;

iii. With respect to a Covered Dependent, the date they are no longer a Covered Dependent (e.g., divorce);

iv. With respect to an Eligible Retiree, the date he is rehired as an active employee of the Company or any Affiliate;

v. The effective date of any Plan amendment that renders an Eligible Retiree or Covered Dependent ineligible to participate; or

vi. The termination of the Plan or the HRA.

Reimbursement from the Participant's HRA Account after termination of participation shall be governed by subsection G.4(c).

G.3 ACCOUNTS.

a) Accounts. Each HRA Account established pursuant to the Plan shall be a notional account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the HRA or that are protected from the reach of the Company's creditors. In no event may any benefits under the Plan be funded with Participant contributions.

b) Benefit Credits. The Company shall credit HRA Accounts of Participants with the Benefit Credits specified in subsection G.3(c) and Section G.7 below on an annual basis as of the first day of the Plan Year. Benefit Credits to be made on behalf of a Covered Dependent shall be made to a combined HRA Account. No earnings shall be credited at any time with respect to any HRA Account. Benefit Credits are determined in accordance with subsection G.7.

c) Initial Allocation/Cost-of-living Increase. The allocation in the first Plan Year for which the HRA is effective will be prorated to reflect an Effective Date that is not the first day of the Plan Year. The Company, in its absolute discretion, may provide for cost-of-living increases on the annual Benefit Credits.

G.4 BENEFITS

a) Provision of Benefits. The HRA will reimburse Participants and Covered Dependents for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this HRA only for Health Care Expenses incurred after they becomes a Participant in the HRA and before their participation has ceased. In no event shall any benefits under this HRA be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

b) Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this HRA for payment of Health Care Expenses in an amount that does not exceed the balance of his HRA Account. Each reimbursement hereunder shall be a charge to such HRA Account available to pay Health Care Expenses under the HRA.

c) Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this paragraph (c).

    i. Timing: A Participant desiring to receive reimbursement for Health Care Expenses under this HRA shall submit a written application to the Provider. Notwithstanding the preceding, upon loss of eligibility as provided in subsection G.2 (a), coverage under the HRA ceases, the Participant shall receive no further Benefit Credits under the HRA, and his Health Care Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to his loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days of such loss of eligibility.

    ii. Claims Substantiation: The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation

to pay Health Care Expenses. The Provider will reimburse the Participant for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Each request for reimbursement shall include the following information:

1) The amount of the Health Care Expense for which reimbursement is requested;
2) The date the Health Care Expense was incurred;
3) A brief description and the purpose of the Health Care Expense;
4) The name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;
5) The name of the person, organization or other provider to whom the Health Care Expense was or is to be paid;
6) A statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction in the current year) for such Health Care Expense under Code Section 213; and
7) A written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Participant is enrolled must be submitted first to all appropriate Claims Administrators for such plans before submitting the expenses to the Provider for reimbursement under the HRA.

Claims will be paid in the order in which they are filed with the Provider and will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

iii. Timing: The Provider shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Provider determines that an extension is necessary due to matters beyond the control of the Plan, the Provider will notify the claimant within the initial thirty (30)-day period that the Provider needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Provider. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Provider shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

1) The specific reason or reasons for the denial;

2) Specific reference to pertinent plan provisions on which denial is based;
3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
5) A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

iv. Claims Denied: Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in subsection G.5

v. Trust Fund: Reimbursements shall be paid from the Trust Fund in accordance with the directions of the Company or the Plan Administrator; provided, however, no medical coverage, dental coverage or vision coverage shall be payable from the Trust Fund to, or on behalf of, a Participant after his retirement (within the meaning of Code § 419A(d)) if such person had been a "key employee" (as such term is defined in Code § 416(i)) while he was an employee of the Company or an Affiliate.

d) Carryover of Accounts. To the extent there is a balance in a HRA Account at the end of a Plan Year, the balance shall be carried over to the following Plan Year to reimburse Participants for Health Care Expenses incurred during subsequent Plan Years.

e) Death.

i. In the event the Eligible Retiree dies with no Covered Dependent who is a Participant, his HRA Account shall be immediately forfeited upon their death; provided, however, that his estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

ii. In the event the Eligible Retiree dies with a Covered Dependent, his HRA Account shall continue and the remaining Participant may continue to submit Health Care Expenses for reimbursement in the normal course.

iii. In the event that the Covered Dependent dies with no Eligible Retiree who is a Participant, their HRA Account shall be immediately forfeited upon their death; provided, however, that his estate or representatives may submit claims for Health Care Expenses incurred by the Covered Dependent prior to the Covered Dependent's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Covered Dependent's death.

f) Nondiscrimination. The Plan Administrator may limit, reallocate or deny any benefit to any Participant who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

G.5 CLAIMS PROCEDURES

a) Within one hundred and eighty (180) days of receipt by a claimant of a notice under subsection G.4(c)(iii) denying a claim in whole or in part, the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

   i. Specific reasons for the decision;

   ii. Specific references to the pertinent plan provisions on which the decision is based;

   iii. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

   iv. A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

   v. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

b) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the HRA, subject to applicable law. A claimant must challenge the decision in a court of law within one year. If claimant challenges the decision of the Plan Administrator within one year after the date of the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

c) Nondiscriminatory Operation. All rules, decisions, interpretations and designations by the Plan Administrator under the HRA shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

G.6 DEFINITIONS

a) "HRA Account" means the hypothetical account established for a Participant to hold his Benefit Credits.

b) "Benefit Credit" means the amount credited to a Participant's HRA Account for the provision of benefits under the HRA as provided in subsection G.3(c) and section G.7.

c) "Effective Date" means April 1, 2014.

d) "Health Care Expense" means an expense incurred by a Participant or Covered Dependent for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant or the Covered Dependent. In addition, Health Care Expenses shall include an expense incurred for a medicine or drug only if such medicine or drug is a prescribed drug (without regard to whether such medicine or drug is available without a prescription) or is insulin. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses.

e) "Medicare Coverage" means coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare).

f) "Provider" means any entity with which SunTrust or Plan Administrator has entered into a contract for the purpose of processing claims under the HRA or otherwise administering benefits under the HRA.

G.7 BENEFIT CREDITS

Company Contribution as a Percentage of the applicable premium immediately prior to the Effective Date		Annual Benefit Credit	
Medicare Supplement (Age 65 Plus)			
Eligible Retiree	Covered Dependent	Eligible Retiree	Covered Dependent
100%	100%	$2,400	$2,400
100%	<15%	$2,400	$0
>50% but <100%	>50% but <100%	$900	$900

>49% but <50%	>49% but <50%	$800	$800
>15% but < 49%	>15% but < 49%	$700	$700

Covered Dependents not Eligible for Medicare on the Effective Date	Covered Dependent Annual Benefit Credit upon attaining age 65
Cost Sharing Group (on the books and records of the Company)	
ST A/B	$900
C ST1	$2,400
C ST2	$700
C ST3	$800
C ST9	$2,400
NCF BOD	$900

Dental Coverage			
Eligible Retiree	Covered Dependent	Eligible Retiree	Covered Dependent
100%	100%	$300	$300

Exceptions: For certain Eligible Retirees the Benefit Credits shall be determined by the amount stated in written instructions from SunTrust.