TRUIST

Summary Plan Description

Truist Financial Corporation

Retiree Health Reimbursement Arrangement (HRA) Plan

FOREWORD

This document contains a summary of the Truist Financial Retiree Health Reimbursement Arrangement (HRA) Plan (the Plan). The purpose of the Plan is to reimburse Eligible Retirees for certain medical expenses, which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

This document is intended to summarize and explain the Plan's principal provisions. The material contained in this summary is taken from the actual legal plan document that governs the principals and provision under which the Plan operates. Therefore, if any conflict exists between the summary and the actual plan provisions, the terms of the legal plan document will govern.

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

FACTS ABOUT THE PLAN

Plan Name:	Truist Financial Corporation Retiree Health Reimbursement Arrangement (HRA) Plan
Employer Name, Address and Telephone Number:	Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202 (800) 716-2455 benefits@truist.com
Effective Date:	This summary is a description of the Plan benefits as effective January 1, 2020.
Name and Address of Plan Administrator and Agent for Legal Service:	Employee Benefits Plan Committee Truist Financial Corporation 214 N Tryon Street Charlotte NC 28202
Employer Identification Number:	56-0939887
Type of Plan:	Qualified Health Reimbursement Arrangement under Internal Revenue Service Notice 2002-45
Plan Year:	January 1 through December 31
Plan Number:	515
Type of Administration:	General administration is provided by the Employee Benefits Plan Committee working through the Benefits Department of Truist Financial Corporation. Claims for benefits under the Reimbursement Accounts are paid by the Benefit Services Manager.
Benefit Services Manager:	YSA (Your Spending Account) (888) 628-2393

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

Affiliate means (i) any corporation that is a member of a controlled group of corporations (As defined in Section 414(b) of the Code) which includes the Company; any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company; (iii) any organization (whether or not incorporated) that is a member of an affiliated service group (as defined in Section 414(m) of the Code) which includes the Company; and (iv) any other entity required to be aggregated with the Company pursuant to Section 414(o) of the Code.

Code means the Internal Revenue Code of 1986, as amended from time to time. Reference to a section of the Code includes such section and any comparable section or sections of any future legislation that amends, supplements, or supersedes such section.

Committee means the Employee Benefits Plan Committee appointed by the Board of Directors of Truist Financial Corporation to administer this Plan

Company means Truist Financial Corporation, a North Carolina corporation with its principal office in Charlotte, NC or any successor thereto by merger, consolidation or otherwise.

Eligible Retiree means a former employee of the Company or its affiliates who has attained age 65 and had at least 10 years of service with the Company at retirement. Only employees who retired from BB&T Corporation or its affiliates prior to December 31, 2019 can be eligible.

Eligible Spouse means the spouse of an Eligible Retiree who is at least 65 years old.

ELIGIBILITY

You will become a participant in this Plan if you are an Eligible Retiree, you enroll for coverage through Aon Retiree Health Exchange, and the Company identifies you as a participant who will receive contributions under the Plan.

Eligibility under the Plan shall end upon the earlier of:

1) The Company terminates the Plan; or
2) The date on which the Retiree ceases to be an Eligible Retiree provided that eligibility may continue beyond such date for purposes of COBRA coverage.

BENEFITS OFFERED

An HRA account will be established for Eligible Retirees to receive benefits in the form of reimbursements for Medical Care Expenses. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

FUNDING

All contributions to this Plan are made by the Company. No employee contributions are required or allowed.

ELIGIBLE MEDICAL CARE EXPENSES

Under the HRA, a participant may receive reimbursement for medical premiums paid to purchase coverage through Aon Retiree Health Exchange and for premiums paid for coverage in Medicare Part B.

UNUSED AMOUNTS

The Plan does not allow for carryover of unused balances. Any balance that remains in the Participant's HRA after all reimbursements have been processed for the calendar year will be forfeited.

TERMINATION OF EMPLOYMENT

Expenses incurred through the last day of the month in which employment terminates may be reimbursed in accordance with the terms of the Plan. Claims for such expenses must be received by the Benefit Services Manager before the date that is 90 days after the end of the Plan Year in which the expenses were incurred.

CLAIMS

To submit a clam related to eligibility under the Plan, you must submit a claim, in writing, to the Plan Administrator. Such claim must include:

1) Your name and address;

2) The reason(s), in clear and concise terms, that you are eligible to participate in the Plan; and

3) All documentation supporting your claim for eligibility.

All benefits from the HRA are paid through an automatic reimbursement by the Benefit Services Manager.
All benefits from the HRA are paid through an automatic reimbursement by the Benefit Services Manager.
To submit a claim for reimbursement under the Plan, you must submit an application, in writing, to the Benefit Services Manager in such form as the Benefit Services Manager may require no later than March 31 following the close of the Plan Year in which the eligible medical care expense was incurred. The application must:

1) Set forth:

    a) the individual(s) on whose behalf Medical Care Expenses have been incurred;
    b) the nature and date of the Medical Care Expenses so incurred;
    c) the amount of the requested reimbursement; and
    d) a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

2) Be accompanied by bills, invoices, or other statements from an independent third party (e.g., private insurance issuer, pharmacy benefit manager, or government insurance program) showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Benefit Services Manager may request.

Except for the final reimbursement claim for a period of coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $25.

The Plan Administrator or Benefit Services Manager, as applicable, will notify you in writing within 30 days of its receipt of your claim. If more time or information is needed to make the determination, the applicable party will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the applicable party will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the applicable party will make the decision based on the information that it has. If you do not receive a written response from the applicable party within the designated time period, your appeal will be considered to have been denied.

APPEALING A DENIED CLAIM[1]

If your claim is denied and you wish to appeal, you may file an appeal with the Plan Administrator within 180 days after you receive the notice of denial. The decision on appeal will not afford deference to the initial claim decision.

Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

1) Your name and address;

2) The fact that you are disputing a denial of a claim;

3) The date of the notice that informed you of the denied claim; and

4) The reason(s), in clear and concise terms, for disputing the denial of the claim.

The Plan Administrator will notify you in writing within 60 days after your appeal is received. If more time or information is needed to make the determination, the Plan Administrator will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

If your appeal is denied, the notice that you receive from the Plan Administrator will include the following information:

1) Information about your claim;

2) The specific reason for the denial upon review;

[1] External review of denied appeals may be available once you complete the regular claims and appeal process noted above. However, external review is limited to only adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).

3) A reference to the specific HRA Plan provision(s) on which the denial is based;

4) A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;

5) If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

6) A statement of your right to bring a Final-Level appeal or a civil action under ERISA Section 502(a).

LEGAL ACTION AND EXHAUSTION OF APPEALS

If you are dissatisfied with the final decision after you have pursued the steps, you have a right to file a lawsuit in a state or federal court; however, you shall not be entitled to challenge the any determinations in judicial or administrative proceedings without first complying with the administrative claims procedures specified above. All such claims must be brought within the timeframes set forth above. The decisions made pursuant to applicable administrative claims procedures are final and binding on you and any other party.

If you have complied with and exhausted the claims procedures and intend to exercise your right to bring civil action under ERISA Section 502(a), you must bring such action within 12 months following the date on which you last submitted a written appeal. If you do not bring such action within such 12-month period from that date, you shall be barred from bringing any action related to your claim. Any action brought under ERISA or otherwise must be brought in the United States District Court for the Western District of North Carolina and of any court situated in Charlotte, North Carolina.

NONASSIGNMENT OF BENEFITS AND CLAIMS

Benefits available under this Plan are not assignable by any individual. No Eligible Retiree or his or her spouse and /or dependent may at any time assign his or her right under the Plan or any of the benefits available under the Plan to any party, including, but not limited to, a provider of healthcare services/items, his/her right to benefits under this Plan, nor may he/she assign any administrative, statutory, or legal rights or causes of action he/she may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be null and void and unenforceable under all circumstances. Under no circumstances shall any payments or communications made to any party be interpreted or considered as a waiver of this anti-assignment provision.

DISCRETIONARY AUTHORITY

The Plan Administrator and the Benefit Services Manager (with respect to any matters delegated to the Benefit Services Manager) have 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 their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the Plan will be paid only

if the Plan Administrator or the Benefit Services Manager, as applicable, decides in its discretion that an individual is entitled to them.

OVERPAYMENT ERRORS

If it is later determined that you received an overpayment or a payment was made in error you will be required to refund the overpayment or erroneous reimbursement. If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Participating Affiliate. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

AMENDMENT AND TERMINATION

The Company reserves the right to amend or terminate the Plan at any time; provided, however, that no amendment or termination of the Plan will affect the rights of Participants with respect to expenses incurred prior to the effective date of the amendment or termination.

Nothing set forth herein shall be construed as a commitment or agreement on the part of any person employed by the Employer to continue his employment with the Employer, and nothing herein contained shall be construed as a commitment on the part of the Employer to continue the employment or the annual rate of compensation of any person for any period, and all Employees shall remain subject to discharge to the same extent as if the Plan had never been put into effect.

HIPAA PRIVACY RULES

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice which is published at benefits.truist.com.

This Plan and Truist will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Truist.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Human Systems Service Center. If you have questions about the privacy of your health information, please contact the Truist Director of Benefits in the Human Resources Division.

COBRA

Notwithstanding any provision to the contrary in this Plan and to the extent required by the Consolidated Omnibus Budget Reconciliation Act (COBRA), Eligible Retirees who experience a COBRA qualifying event and lose HRA coverage as a result will be offered the opportunity to continue their HRA as a COBRA participant at the full COBRA rate. In most cases, the rate will be based on the date of the Qualifying Event.

A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits;
- Your Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

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.

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

If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

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

NO EMPLOYMENT OR OTHER RIGHTS

The Plan and this SPD do not create a contract of employment. Eligibility to participate in a plan or program or receipt of benefits does not constitute a promise or right of continued employment or render any person an employee of the Company or any affiliate or constitute any commitment by the Company to continue any plan or benefit.

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