2017 BB&T BENEFITS PROGRAM GUIDE

INFORMATION TO HELP YOU PREPARE FOR BENEFITS ENROLLMENT

November 1 - November 15, 2016, at 11:59 p.m. ET.
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A MESSAGE FROM BENEFITS ADMINISTRATION

Welcome to 2017 Annual Benefits Enrollment.

We have some important changes to share with you for 2017.

You will see that the medical premiums for 2017 will have a small increase or even a decrease, depending on the option you select. Dental premiums will be decreasing 8% due to our new contract with Ameritas Group (see more about this change on page 4).

We will again offer associates the ability to purchase up to five days of additional vacation. This option is available only during our annual enrollment period. **Your 2016 election will not roll into 2017. If you wish to purchase vacation days for 2017, you must make a new election.**

During the annual enrollment period, you can also take advantage of two voluntary benefit programs offered through Aflac®: Critical Illness Coverage and Group Accident Coverage. You’ll see additional information about these plans on page 24 and on BBTBenefits.com.

Those associates who participate in the LifeForce program will see that we are adding the annual completion of a Health Assessment to that program’s requirements. Spouses of LifeForce participants who are covered by our medical program will also need to complete this annual online assessment.

**Finally, please note that enrollment this year runs November 1 through November 15. After November 15, we cannot allow changes to your 2017 benefit elections due to the reporting requirements of our vendors. If you wish to make changes to your current benefit elections, you must complete enrollment by November 15.**

If you have any questions regarding your benefits, please feel free to call Benefits Administration at 800-716-2455, option 1.

Steve Reeder
Benefits Manager
CHANGES FOR 2017

NEW PROVIDER FOR THE BB&T DENTAL PROGRAM AND DENTAL REWARDS®

Starting in 2017, the BB&T Dental Program will be administered by Ameritas. Ameritas will provide us with a larger network of dentists and that will translate into lower premiums for 2017.

In addition to the benefits currently available under the BB&T Dental Program, participants can enjoy the Dental Rewards® program from Ameritas. Through this program, you can “earn” additional money toward your future annual maximum benefit ($1,000 per covered person). Participants in the BB&T Dental Program will be able to carry over part of their unused annual maximum from one plan year to the next.

Participants in the BB&T Dental Program can qualify for Dental Rewards® by:

- Submitting at least one dental claim per year; and
- Keeping total paid claims for the year under the plan’s annual benefit threshold ($500 per covered person).

Additionally, participants who submit claims for an in-network provider will be eligible for an extra $100 reward, called the PPO Bonus.

See pages 16 and 17 for more information on the Dental Rewards® program.

SICK PAY AND OTHER TIME OFF POLICIES

In 2017, BB&T will replace the Short-Term Absence Pay policy with two new policies: the Sick Pay policy and Other Time Off policy. Here is a brief overview of the two policies:

Sick Pay Policy: Under this policy, associates can use up to 10 Sick days for Associate Illness or Family Illness if needed during the calendar year. Associates who go on a Leave of Absence (out for more than 10 consecutive business days) may have up to an additional 30 Sick Leave of Absence days available while on Leave of Absence. Of the 30 Sick Leave of Absence days available, an associate may use all 30 for their own sickness or injury. If the Leave of Absence is for the care of a family member, an associate may only use 10 of the 30 Sick Leave of Absence days. In total, associates can take no more than 40 days total time off with pay under the Sick Pay Policy.

Other Time Off Policy: In addition to vacation, holidays, and sick time, BB&T will allow eligible associates to take paid time away from work for:

- Natural disasters;
- Bereavement;
- Parental bonding;
- Emergency closings;
- Jury duty;
- Involvement in community service; and
- Legal proceedings related to adoption and foster care.
The amount of time you can take for these benefits is not changing in 2017. However, any time for these benefits will no longer deduct from your Sick days and will instead be covered under the new Other Time Off Policy.

If you anticipate that you will need more time away from work than is available under these policies, you may consider purchasing additional vacation time through the Vacation Purchase option during 2017 Annual Benefits Enrollment. Through the Vacation Purchase program, associates can purchase up to 40 hours of vacation in 8-hour units with pre-tax dollars (part-time associates are limited based on their scheduled hours). See pages 25 and 26 for information on Vacation Purchase.

**EVIDENCE OF INSURABILITY**

In years past, associates electing Term Life Insurance coverage greater than $1 million were required to provide evidence of good health and insurability to The Hartford, BB&T’s plan administrator.

Starting in 2017, basic Term Life Insurance is a guaranteed issue and will not require any evidence of insurability. Only supplemental Term Life Insurance elected over $400,000 or four times Benefits Annual Rate, whichever is lower, will be required to provide evidence of insurability via a form mailed to your home from the Hartford.

Only those associates who elect supplemental coverage for the first time or increase their coverage level to the terms above will be subject to this requirement. Associates who currently have supplemental coverage over $400,000 or four times salary and do not make changes to this election during 2017 Annual Benefits Enrollment will not be subject to this requirement.

**LIFEFORCE**

Big changes are coming in 2017 to LifeForce, BB&T’s premier wellness program! We’re introducing a new Health Assessment, changing how medical credits are earned, and more. Read on to learn about the changes coming to the program.

**Introducing the New Health Assessment**

The Health Assessment (HA) is a confidential personal health questionnaire designed to provide you with insight into your overall health, including areas of strength and weakness and recommendations for improvement. The HA will be an integral part of the LifeForce program, completion of which will impact your medical credit (if applicable based on your LifeForce Phase and participation in the BB&T Medical Program).

Starting January 1, 2017, LifeForce participants will be required to complete the HA on an annual basis by the last day of the month of their first appointment of the year. Participants who complete the HA past their deadline will receive their medical credit (if applicable) starting the first pay of the month following completion.

For example, Mary has her first LifeForce appointment of the year with a Peak Health nurse in March of 2017. During her appointment, Mary is placed in Phase 5 of the program, which makes her eligible to receive a medical credit. However, she must complete her HA by March 31 in order to receive her medical credit on her next pay. Mary completes the HA on April 5 (past her deadline). As a result, she will not receive her medical credit in April and will instead begin receiving her medical credit on her May 15 pay.
Spouse Participation
If you are married and your spouse is covered under the BB&T Medical Program, he or she will also be required to complete the HA in order for you to receive your full medical credit (if applicable based on your LifeForce Phase). He or she must complete the HA by your same deadline (the last day of the month of your first appointment of the year). If your spouse does not complete the HA by the deadline, your medical credit will be lessened until the month following their completion.

For example, Anne covers her spouse John under the BB&T Medical Program and is a LifeForce participant. Her first LifeForce appointment of the year is in May 2017. Both Anne and John must complete the HA by May 31 for Anne to receive her full medical credit (if applicable). Anne completes her HA on May 3; John completes his HA on June 12 (past the deadline). As a result, Anne will receive a partial medical credit in June and will begin receiving her full medical credit on her July 15 pay.

Please Note: If a spouse completes the HA by the deadline and the associate does not, the associate will not receive any medical credit (if applicable) until the first pay of the month after he or she completes the HA.

Earning Medical Credits
LifeForce participants who elect medical coverage through the BB&T Medical Program and meet the goals they establish with the Peak Health nurse may be eligible to earn medical credits as they advance through the program. Starting January 1, 2017, both participants and their spouses covered under the BB&T Medical Program will be eligible to earn medical credits. See pages 11-13 for a complete explanation of how medical credits will be earned starting in 2017.

BASIC INFORMATION ABOUT BB&T’S BENEFITS

BENEFITS ELIGIBILITY
You are eligible for benefits if you are:

- Scheduled to work at least 20 hours per week; and
- Classified as a “regular” associate (not a temporary or contract associate).

BENEFITS ANNUAL RATE
Benefits Annual Rate (BAR) is used to calculate your Disability and Term Life Insurance coverage amounts. BAR is defined as your September 30 base pay annualized, plus any incentives, bonuses, overtime, and commissions you have received from October 1 through September 30. Special payments such as moving expenses are not included in your BAR. If you are a new associate or a newly benefits-eligible associate, your BAR is your annual salary. Your BAR will not increase or decrease during the calendar year, even if you have a salary change.

COVERAGE EFFECTIVE DATE
The elections you make during 2017 Annual Benefits Enrollment will be effective January 1, 2017, and will remain in effect for the entire year, unless you have a qualifying Life Event Change (see page 27 for more information).
COVERAGE FOR YOUR DEPENDENTS

Under the BB&T Medical, Dental, and Vision Programs, you have the option to cover yourself and any Qualified Dependents. Qualified Dependents include:

- Your legally married spouse;
- Your children under age 26; and
- Any other Qualified Dependents as defined in the Health Care Summary Plan Description (available on BBTBenefits.com).

An associate cannot cover another associate as a dependent. If you and your spouse are both employed by BB&T, only one of you can cover a dependent. In addition, you cannot elect to cover each other. If you and your child are both employed by BB&T, you cannot elect to cover your child.

A dependent child’s eligibility will end at the end of the month in which the child turns 26. For more information about covered dependents, refer to the Health Care Plan Summary Plan Description on BBTBenefits.com.

Coverage Levels
If you participate in the BB&T Medical, Dental, and/or Vision Programs, you may choose coverage for:

- Employee Only;
- Employee and Spouse;
- Employee and Child(ren); or
- Family.

COMPANY CONTRIBUTIONS

Your Total Compensation at BB&T extends well beyond your annual income. For example, BB&T provides your Basic Term Life Insurance, the 50% Disability Option, and approximately 75% of your BB&T Medical Program premiums.

The premiums you see during 2017 Annual Benefits Enrollment are net of the company contribution. You can see the BB&T contribution on your payslip.

PRE-TAX SAVINGS

You receive an added benefit by having your benefit premiums, except those for Dependent Life and Disability Insurance, deducted before taxes are applied to your earnings.
THE BB&T MEDICAL PROGRAM

BB&T offers health care coverage to all benefits-eligible associates. In 2017, BB&T will continue to offer two Medical Program Options: the Select Option and the Consumer Option. Both of these options are administered by BlueCross BlueShield of North Carolina (BCBSNC) under the BlueCard program, which enables you to take advantage of one nationwide network of physicians. You can access the most up-to-date list of participating providers in your area by accessing BlueConnectNC.com.

SELECT OPTION

The Select Option is designed to offer medical services at an affordable cost. Co-payments are available for doctors’ office visits and for most prescription medications without meeting the annual deductible.

Select Option Features

- $1,150 (in-network) deductible for Employee Only coverage;
- $2,875 (in-network) deductible for Employee and Spouse, Employee and Child(ren), and Family coverage;
- Ability to visit a specialist without a referral;
- Preventive care office visits for children under age six are covered with a co-payment if obtained in-network;
- In-network and out-of-network coverage;
- Preventive care is generally covered at:
  - 90% in-network with no deductible; and
  - 80% out-of-network with no deductible.
- Preventive mammograms and annual gynecological exams are covered at 100% if you are in Phase 1 or higher of the LifeForce Program (for more information regarding LifeForce, see pages 11-13).

The family deductible is met when any combination of covered persons has expenses totaling $2,875. However, if one family member meets the $1,150 individual deductible, that person’s deductible is satisfied, and insurance will begin paying on that individual’s claims.

Select Option Prescription Drug Benefits

BB&T partners with Prime Therapeutics to administer our retail pharmacy benefits, PrimeMail (mail order) pharmacy, and Specialty Pharmacy services. Covered associates will receive a BCBSNC member ID card to be used for medical and pharmacy benefits. The member ID card will display the Prime logo and customer service number on the back. When using a retail pharmacy, simply present your BCBSNC member ID card with your prescription.

The Select Option prescription drug benefits are set up on a four-tier benefit structure that separates medications into different groups:

- Tier 1 generally contains generic drugs that are cost effective alternatives to brand name medications.
• Tier 2 generally contains preferred brand drugs that are chosen for their clinical value and cost-effectiveness.

• Tier 3 generally contains non-preferred brand drugs. If your medication is not generic and not included on the preferred drug list or the specialty drug list, you will be required to pay the highest co-payment.

• Specialty drugs are selected medications such as gene therapies and biotechnological medications and most are in the fourth tier. Specialty drugs are considerably more expensive than drugs from the other tiers. For Tier 4 drugs, you will pay a percentage of the drug’s price rather than a co-payment. Specialty drugs that are in Tier 1, 2, or 3 are available for co-payment. In addition, some Tier 4 drugs are not designated as specialty and can be filled at retail.

<table>
<thead>
<tr>
<th>Select Option Prescription Drug Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
</tr>
<tr>
<td>Up to 30-day supply</td>
</tr>
<tr>
<td>Tier 1</td>
</tr>
<tr>
<td>Tier 2</td>
</tr>
<tr>
<td>Tier 3</td>
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<tr>
<td>Tier 4</td>
</tr>
</tbody>
</table>

The Select Option requires participants (including any covered dependents) to ask their physician if there is a generic drug option available. The physician should give the option of receiving the brand name version of the medication or the generic equivalent. If you choose the generic medication, you will pay the lowest co-payment for a drug that is chemically identical to the brand name. If you wish to have the brand name medication, you will pay the difference in the cost between the generic and the brand name medication in addition to the higher co-payment.

**Prime Specialty Pharmacy**
Prime Specialty Pharmacy, a wholly owned subsidiary of Prime Therapeutics, is a mail order pharmacy built on the strength of smart clinical solutions, solid benefit design, cost controls, and an unwavering commitment to the health and wellbeing of its members. Prime Specialty Pharmacy employs dedicated professionals to assist members with insurance verification, delivery scheduling, and billing. Additionally, nurses and pharmacists are available 24 hours a day, seven days a week.

Most specialty drugs are covered as follows:

• 25% co-insurance;

• Minimum cost of $50 and a maximum cost of $150;

• Up to 30-day supply limit (some drugs, including transplant and HIV drugs, are eligible for a 90-day supply); and

• Some specialty drugs are available with a co-payment (Tier 1, 2, or 3). Please refer to BlueConnectNC.com to confirm the tier of your medication.
CONSUMER OPTION

The Consumer Option is designed to encourage participants to be better consumers of health care and offers attractive tax advantages through a Health Savings Account (HSA).

Consumer Option Features

• $2,500 (in-network) deductible for Employee Only coverage;
• $5,000 (in-network) deductible for Employee and Spouse, Employee and Child(ren), and Family coverage;
• Lower premiums compared to the Select Option;
• Ability to visit a specialist without a referral;
• In-network and out-of-network coverage;
• Preventive care for children under age six is covered at 100% in-network and out-of-network;
• $500 annual company contribution (prorated per pay period) to the HSA for each associate enrolled in this option who has elected the HSA; and
• Preventive care is generally covered at:
  ○ 80% in-network with no deductible; and
  ○ 60% out-of-network with no deductible.

There is no individual deductible for Employee and Spouse, Employee and Child(ren), and Family coverage levels; the Consumer Option will not begin to pay benefits until any or all covered members combined have met the full $5,000 deductible. Once the entire deductible has been met, insurance will begin paying a benefit.

The Consumer Option does not include co-payments for doctors’ office visits or prescription drugs. It covers these services at 80% (in-network) after the deductible has been met. Therefore, you pay 100% of incurred charges until the deductible is met.

Health Savings Account

The Consumer Option offers a Health Savings Account (HSA), which allows you to save funds on a pre-tax basis to pay for qualified* health care expenses. BB&T contributes $500 (prorated monthly) to the HSA for each associate electing the Consumer Option to help offset the cost of out-of-pocket expenses. If you elect to contribute to the HSA, you will need to indicate during 2017 Annual Benefits Enrollment the amount you want deducted from your pay pre-tax per pay period for the entire 2017 calendar year.

You may only access up to the balance in your HSA at the time the expense is incurred. For example, you may elect to contribute $500 to your HSA during 2017. If you only have $125 in your account in March and you have a $200 expense, you can only pay $125 of the expense from your HSA.

The maximum annual contribution amount for the HSA in 2017 is $3,400 for Employee Only coverage or $6,750 for Employee and Spouse, Employee and Child(ren), or Family coverage. Persons age 55 and over can contribute an additional $1,000 catch-up contribution to the HSA.
The HSA is not a use-it-or-lose-it account. Any unused funds in your account at the end of 2017 will roll over and be available for future expenses. For additional guidance on HSAs, please refer to IRS Publication 969.

*Qualified expenses are determined by the Internal Revenue Service. For guidance on qualified health care expenses, refer to IRS Publication 502, available at www.IRS.gov. Over-the-counter medications cannot be reimbursed through your HSA unless prescribed by a doctor.

In addition to the HSA, participants in the Consumer Option can also take advantage of the Limited Use Flexible Spending Account to save pre-tax dollars on dental and vision care expenses. See page 20 for more information.

**MEDICAL PROGRAM OPTIONS PREMIUMS**

<table>
<thead>
<tr>
<th></th>
<th>2017 Semi-Monthly Premiums</th>
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<tbody>
<tr>
<td>Medical Plan</td>
<td>Coverage Level</td>
</tr>
<tr>
<td>Select Option</td>
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<td>Employee and Spouse</td>
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<tr>
<td></td>
<td>Employee and Child(ren)</td>
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<tr>
<td></td>
<td>Family</td>
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<tr>
<td>Consumer Option</td>
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<td>Employee and Child(ren)</td>
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<tr>
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<td>Family</td>
</tr>
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</table>

**PREMIUM SAVINGS THROUGH THE LIFEFORCE PROGRAM**

LifeForce, BB&T’s premier wellness program, was designed to create a healthier you! The program provides you with health and fitness education, including information about disease prevention and adverse behaviors that may affect your physical well-being, and direct access to evaluations by a health care professional on a regular basis.

BB&T contracts with Peak Health to administer LifeForce. Through the program, you will work with a Peak Health nurse to establish realistic and attainable health goals. As you work toward those goals, you can advance to new Phases of the program. All information and evaluations conducted for this program are completely confidential.

LifeForce participants and their spouses have the opportunity to earn medical credits which can lower medical premiums by up to 20%. Participants and their spouses who are covered under the BB&T Medical Program will be eligible to earn medical credits if the participant is placed in Phases 2 - 5 of the program by the Peak Health nurse. Participants must meet the requirements of their Phase in order to earn their medical credit. Spouses must complete their Health Assessment in order to earn their medical credit (see pages 5 and 6 for more information on the Health Assessment, including deadlines for both participants and spouses).

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn a medical credit, you may be entitled to a reasonable accommodation or
an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting a Peak Health nurse practitioner at 252-237-5090.

Below are the potential medical credits that can be earned by participants and their spouses:

<table>
<thead>
<tr>
<th>Medical Plan</th>
<th>Coverage Level</th>
<th>Premium</th>
<th>Associate Credit</th>
<th>Spouse Credit</th>
<th>Total Medical Credit</th>
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<th>Medical Plan</th>
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<th>Associate Credit</th>
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<td>$12.23</td>
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</table>
To receive the medical credit amount listed in the “Total Medical Credit” column of the charts above, both the associate and their spouse must meet their requirements. If the spouse does not complete his or her required Health Assessment, the associate will only earn the credit listed in the “Associate Credit” column. If the spouse completes his or her required Health Assessment but the associate does not complete all requirements of his or her phase and/or does not complete the Health Assessment, the associate will not earn a medical credit. If both the associate and the spouse do not complete their respective requirements, the associate will not earn a medical credit.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn a medical credit, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting a Peak Health nurse practitioner at 252-237-5090.

If you want to enroll in the LifeForce program, now is a great time to join*. For enrollment instructions and more information about the program, visit the Wellness tab on BBTBenefits.com.

*Please Note: Prior to participating in the LifeForce program, please review Peak Health’s “Notice Regarding Wellness Program” document located on the LifeForce page on BBTBenefits.com under the Wellness tab.

**IMPORTANT NOTES**

**Prior Plan Approval for Diagnostic Imaging**

The Select Option and the Consumer Option require prior plan approval for high-tech diagnostic imaging procedures. Prior plan approval means that the procedures must be authorized before the Plan will pay a benefit. BCBSNC contracts with a vendor, American Imaging Management, Inc. (AIM), to authorize this service.

Procedures that require prior plan approval are:

- MRI (Magnetic Resonance Imaging);
- MRA (Magnetic Resonance Angiogram);
- MRS (Magnetic Resonance Spectroscopy);
- CT (Computerized Tomography);
- Nuclear Cardiology Studies;
- Echocardiography;
- CTA (Computerized Tomography Angiogram); and
- PET (Positron Emission Tomography).

Prior plan approval is required only when these procedures are performed in an outpatient or office setting. Tests done on an emergency, inpatient, or observation basis will not require prior plan approval. In addition, low-tech imaging services such as x-rays and mammograms will not require approval.

Generally, your physician will contact AIM to request prior plan approval for a high-tech diagnostic imaging procedures; however, it is your responsibility to make sure the physician completes this required step.

**Medical Premiums and LifeForce**

The full amount of your medical premium is deducted pre-tax from your pay. The amount you save as a LifeForce participant is credited to your pay and reflected as a separate line item (“Medical Credit”) on your Payslip.
## 2017 SUMMARY OF BB&T MEDICAL PROGRAM OPTIONS

### SELECT OPTION
- Choice of in-network and out-of-network providers
- Annual deductible (per person) of $1,150 in-network or out-of-network
- Annual deductible (per family) of $2,875 in-network or out-of-network
- Out-of-pocket max (per person per year) of $1,650 in-network or $2,150 out-of-network (includes deductible)
- You do not have to select a primary care physician (PCP)
- Covers all contraceptives (co-pays apply)
- Covers well child care through age 5 (co-pays apply)
- Preventive services are generally covered at 90% in-network (no deductible) or 80% out-of-network (no deductible)

### CONSUMER OPTION
- Choice of in-network and out-of-network providers
- Annual deductible (employee only coverage) of $2,500 in-network or $5,000 out-of-network
- Annual deductible (employee/spouse, employee/child(ren), or family coverage) of $5,000 in-network or $10,000 out-of-network
- Out-of-pocket max (employee only coverage) of $5,000 in-network or $7,500 out-of-network (includes deductible)
- You do not have to select a primary care physician (PCP)
- Covers all contraceptives (after deductible)
- Covers well child care through age 5 (no deductible)
- Preventive services are generally covered at 80% in-network (no deductible) or 60% out-of-network (no deductible)

### Services in the Physician’s Office

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Select Option Pays</th>
<th>Consumer Option Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>All charges except co-pay of $30</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>All charges except co-pay of $40 (in-network)</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
<tr>
<td>Diagnostic Imaging, Lab, and X-ray Services</td>
<td>After deductible: 90% in-network, 80% out-of-network</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
<tr>
<td>Maternity Care (pre- and post-natal)</td>
<td>After deductible: 90% in-network, 80% out-of-network</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
</tbody>
</table>

### Preventive Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Select Option Pays</th>
<th>Consumer Option Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Child Care through Age 5 (including immunizations)</td>
<td>All charges except $30 PCP or $40 Specialist co-pay in-network; no coverage out-of-network</td>
<td>All charges covered at 100% in-network or out-of-network (no deductible)</td>
</tr>
<tr>
<td>Annual Gynecological Exam</td>
<td>LifeForce: 100%; Non-LifeForce: 90% (no deductible)</td>
<td>80% in-network or 60% out-of-network (no deductible)</td>
</tr>
<tr>
<td>Annual PAP Smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Physicals and Other Well Care over Age 5 (including immunizations)</td>
<td>90% in-network (no deductible) or 80% out-of-network (no deductible)</td>
<td>80% in-network or 60% out-of-network (no deductible)</td>
</tr>
<tr>
<td>Colonoscopy Screenings</td>
<td>90% in-network (no deductible) or 80% out-of-network (no deductible)</td>
<td>80% in-network or 60% out-of-network (no deductible)</td>
</tr>
</tbody>
</table>

### Allergy Injections

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Select Option Pays</th>
<th>Consumer Option Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed with Office Visit</td>
<td>All charges except co-pay of $30 PCP or $40 Specialist in-network; 80% after deductible out-of-network</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
<tr>
<td>Billed without Office Visit</td>
<td>After deductible: 90% in-network, 80% out-of-network</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>All charges except $30 co-pay in-network; 80% after deductible out-of-network</td>
<td>After deductible: 80% in-network, 60% out-of-network</td>
</tr>
</tbody>
</table>

### Diabetic Supplies

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Select Option Pays</th>
<th>Consumer Option Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin, Test Strips, Syringes</td>
<td>Covered at pharmacy: $30 co-pay in-network; no coverage out-of-network</td>
<td>Covered at pharmacy: 80% after deductible in-network; no coverage out-of-network</td>
</tr>
<tr>
<td>Service</td>
<td>In-Network Coverage</td>
<td>Out-of-Network Coverage</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Glucose Meters, Insulin Pumps</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Diabetic Nutritional Counseling</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospital Charges</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Diagnostic Imaging and X-ray Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

- The Plan's benefit will not increase to 100% for preventive services, even after the out-of-pocket maximum has been met.
- Prior Plan approval is required for high-tech diagnostic imaging performed in an outpatient or office setting. If prior plan approval is not obtained, the service will not be covered.
- The Plan's benefit will not increase to 100% for精神科和物质滥用服务, even after the out-of-pocket maximum has been met.
- Pre-certification is required for all non-emergency and non-urgent elective services. If pre-certification is not obtained, the service will not be covered.
THE BB&T DENTAL PROGRAM

BB&T’s optional dental coverage is administered by Ameritas, which offers a large network of dentists. If you use a dentist who has contracted with Ameritas, the dentist may charge a lower negotiated rate for services. You won’t be penalized for using a non-network dentist, but you have the opportunity to save by using a participating dentist. A list of contracting dentists is available at Ameritas.com/group/olbc/bbt.

BENEFITS SUMMARY

The following chart is an overview of the benefits provided under the program. Payments for services are subject to reasonable and customary charges.

<table>
<thead>
<tr>
<th>Dental Service</th>
<th>Example</th>
<th>Annual Deductible</th>
<th>Plan Pays</th>
<th>Waiting Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative</td>
<td>Cleanings and X-rays</td>
<td>$0</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>Basic</td>
<td>Fillings and extractions</td>
<td>$25 individual</td>
<td>80%</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>$75 family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major</td>
<td>Crowns or bridges</td>
<td>$25 individual</td>
<td>50%</td>
<td>Six months</td>
</tr>
<tr>
<td></td>
<td>$75 family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia (only for dependent children up to age 19)</td>
<td>Braces</td>
<td>$0</td>
<td>50% (up to a max. lifetime benefit of $1,000 for each covered child under age 19)</td>
<td>One year</td>
</tr>
</tbody>
</table>

The maximum annual benefit payable for each covered person, exclusive of orthodontia, is $1,000.

PREMIUMS

<table>
<thead>
<tr>
<th></th>
<th>BB&amp;T Dental Program Semi-Monthly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$15.24</td>
</tr>
<tr>
<td>Employee and Spouse</td>
<td>$30.48</td>
</tr>
<tr>
<td>Employee and Child(ren)</td>
<td>$30.48</td>
</tr>
<tr>
<td>Family</td>
<td>$46.72</td>
</tr>
</tbody>
</table>

DENTAL REWARDS®

New for 2017 is the Dental Rewards® program from Ameritas. Through this program, you can “earn” additional money toward your future annual maximum benefit ($1,000 per covered person). Participants in the BB&T Dental Program will be able to carry over part of their unused annual maximum from one plan year to the next.

Participants in the BB&T Dental Program can qualify for Dental Rewards® by:

• Submitting at least one dental claim per year; and
- Keeping total paid claims for the year under the plan’s annual benefit threshold ($500 per covered person).

Additionally, participants who submit claims for an in-network provider will be eligible for an extra $100 reward, called the PPO Bonus.

**Example**

Mark has Employee Only coverage under the BB&T Dental Program. In 2017, he incurs a total of $400 in charges for dental services from his in-network provider and submits his claims to Ameritas. Because he did not exceed the $500 annual benefit threshold and he submitted his claims, Mark is eligible for Dental Rewards®. By visiting an in-network provider, Mark is also eligible for the PPO Bonus.

Here is how Mark’s Dental Rewards® will be calculated:

\[
\begin{align*}
&\text{\$500} \quad \text{annual benefit threshold} \\
&- \text{\$400} \quad \text{charges incurred through the plan year} \\
&\quad \text{\$100} \quad \text{Dental Rewards® earned} \\
&+ \text{\$100} \quad \text{PPO Bonus earned} \\
&\quad \text{\$200} \quad \text{total rewards earned}
\end{align*}
\]

The total amount of rewards Mark earned in 2017 will be added to his annual maximum ($1,000) for 2018. Therefore, Mark’s annual maximum in 2018 will be $1,200.

**Restrictions**

Under the Dental Rewards® program, the following restrictions apply:

- **Annual Carryover Amount:** The total amount of Dental Rewards® that can be added to the following year’s annual maximum is $250.

- **Maximum Carryover:** The maximum possible accumulation for Dental Rewards® and PPO Bonus combined is $1,000.

Additionally, if a participant has no dental claims for covered procedures submitted during the year, no reward will be earned and all accumulated rewards from previous years will be forfeited. Participants can, however, be accumulating rewards the following plan year.

**WAITING PERIODS**

BB&T’s Dental Program contains waiting periods for major services and orthodontia that may decrease your benefit. If you had coverage under another group dental program, you may be able to reduce or eliminate the waiting periods by providing a Certificate of Coverage from your previous dental plan as proof of prior coverage. Please send your Certificate of Coverage, if applicable, to Ameritas at PO Box 81889, Lincoln, NE 68501, to receive proper credit for your prior coverage.

**YOUR DENTAL IDENTIFICATION (ID) CARD**

Participants in the Dental Program will receive an ID card for dental coverage.
## THE BB&T VISION PROGRAM

BB&T’s vision coverage is administered by Vision Service Plan (VSP). The BB&T Vision Program provides discounted coverage through VSP network doctors and the flexibility to see out-of-network providers. These affiliate providers include over 400 Costco locations and other retail chains.

<table>
<thead>
<tr>
<th>BB&amp;T Vision Program Semi-Monthly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
</tr>
<tr>
<td>$8.16</td>
</tr>
<tr>
<td>Employee and Spouse</td>
</tr>
<tr>
<td>$12.85</td>
</tr>
<tr>
<td>Employee and Child(ren)</td>
</tr>
<tr>
<td>$13.13</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>$21.17</td>
</tr>
</tbody>
</table>

There are no identification cards or claim forms required for the BB&T Vision Program. To use your benefits, make sure to tell your doctor you are a VSP member when you make your appointment. Your doctor will ask for your ID number, which is your Social Security number. Your doctor and VSP will handle the rest by verifying your benefits and eligibility for services.

The chart on the next page is an overview of the benefits provided under the program. There are no waiting periods for vision benefits. To access a list of VSP and affiliate providers, please visit VSP.com or call 800-877-7195.
<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>BENEFITS THROUGH A VSP PREFERRED PROVIDER</th>
<th>BENEFITS THROUGH A RETAIL PARTNER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>VSP network, our largest provider network</td>
<td>Approximately 400 Costco retail dispensary locations.</td>
</tr>
<tr>
<td></td>
<td>27,988 VSP Preferred Providers</td>
<td>Not all Costco locations provide exam services under your VSP plan. Check with the Costco provider to see if they are a VSP affiliate provider before your appointment.</td>
</tr>
<tr>
<td></td>
<td>54,869 access points</td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Thorough VSP WellVision Exam(^1) covered in full(^1)</td>
<td>Thorough eye exam covered in full(^1)</td>
</tr>
<tr>
<td>Lenses</td>
<td>Glass or plastic, single vision, lined bifocal, lined trifocal, Progressive lenses, or lenticular prescription lenses are covered in full(^1)</td>
<td>Glass or plastic, single vision, lined bifocal, lined trifocal, or lenticular prescription lenses are covered in full(^1)</td>
</tr>
<tr>
<td>Lens Options</td>
<td>Anti-reflective coatings are covered in full</td>
<td>Lens option availability varies</td>
</tr>
<tr>
<td></td>
<td>Other lens options are covered in full with copay, saving VSP members an average of 35-40%</td>
<td>Special pricing at Costco</td>
</tr>
<tr>
<td></td>
<td>Patient Cost(^2):</td>
<td>20% off at other affiliate locations</td>
</tr>
<tr>
<td></td>
<td>Photochromics:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$62 - $76 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scratch resistant coating:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Polycarbonate:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$23 - $28 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dependent children are eligible for covered-in-full polycarbonate prescriptions lenses (every 12 months)</td>
<td>Dependent children are eligible for covered-in-full polycarbonate prescriptions lenses (every 24 months)</td>
</tr>
<tr>
<td>Frames</td>
<td>Frames are covered in full(^1) up to the retail allowance of $70 at Costco(^3) and $150 at other affiliate locations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% off any amount above the allowance</td>
<td>Offers and discounts vary</td>
</tr>
<tr>
<td></td>
<td>30% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses(^4)</td>
<td>Offers and discounts vary</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>15% off contact lens services (fitting and evaluation), excluding materials, up to $60 copay</td>
<td>15% off contact lens services, excluding materials, up to $60</td>
</tr>
<tr>
<td></td>
<td>Instead of eyeglasses, elective contact lens materials are covered up to $150 toward any type of prescription contact lenses</td>
<td>Instead of eyeglasses, elective prescription contact lenses are covered up to $150</td>
</tr>
<tr>
<td></td>
<td>Necessary contact lenses are covered in full(^1) for members who have specific conditions for which contact lenses provide better visual correction</td>
<td>Members may use their open access schedule</td>
</tr>
<tr>
<td>Laser VisionCare(^{5\text{SM}}) Program</td>
<td>Discounts averaging 15-20% off or 5% off a promotional offer for laser surgery including PRK, LASIK, and Custom LASIK(^5)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Members who have had vision correction surgery can use their frame benefit for sunglasses, instead of a pair of prescription glasses</td>
<td>Only available from a VSP Preferred Provider</td>
</tr>
<tr>
<td>Benefits through VSP Open Access(^{6\text{SM}})</td>
<td>Through VSP Open Access, members have the freedom to choose any provider. All providers can contact VSP directly to check eligibility and submit claims to VSP on behalf of members. The following is the generous reimbursement schedule for services obtained from other providers, including local or national chains.</td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$50</td>
<td>Lined Trifocal: $100</td>
</tr>
<tr>
<td>Single Vision</td>
<td>$50</td>
<td>Lenticular: $125</td>
</tr>
<tr>
<td>Lined Bifocal</td>
<td>$75</td>
<td>Progressive: $75</td>
</tr>
</tbody>
</table>

\(^1\)Less any applicable co-pay

\(^2\)Prices shown reflect the standard option price, prices on premium options may vary. Prices are valid only through VSP Preferred Providers and are subject to change without notice.

\(^3\)At Costco locations, frames will be covered in full up to a $80 retail allowance, which is equivalent to a $150 allowance at other affiliate locations.

\(^4\)30% discount applies to glasses purchased the same day as the member’s eye exam from the same VSP Preferred Provider who provided the exam. Members will also receive 20% off unlimited additional pairs of glasses valid through any VSP Preferred Provider within 12 months of the last covered eye exam.

\(^5\)Using wavefront technology with the microkeratome surgical device only. Other LASIK procedures may be performed at an additional cost to the member. Laser VisionCare discounts are only available from VSP-contracted facilities.
FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to save funds on a pre-tax basis to pay for qualified* health care or dependent care expenses. Since taxes are not deducted from these funds, you achieve a cost savings equal to your income tax rate on products and services you pay for with funds from these accounts. If you are in the 28% federal income tax bracket, for example, you will save at least 28% plus state and FICA taxes on such expenses.

FSAs are available to benefits-eligible associates (certain restrictions apply). You may enroll in a FSA even if you are not covered under the BB&T Medical Program.

*Qualified expenses are determined by the Internal Revenue Service. For guidance on qualified health care and dependent care expenses, refer to IRS Publications 502 and 503, available at www.irs.gov. Over-the-counter medications cannot be reimbursed through your FSA unless prescribed by a doctor.

HEALTH CARE FSA AND LIMITED USE HEALTH CARE FSA

The Health Care FSA and the Limited Use Health Care FSA allow you to save pre-tax dollars to pay for eligible expenses not covered by insurance.

The Health Care FSA is available to all benefits-eligible associates except those who participate in the Consumer Option. You may use Health Care FSA funds to pay for medical expenses not covered by insurance and qualified dependent medical expenses even if you do not elect coverage for your dependents under the BB&T Medical Program.

The Limited Use Health Care FSA is available to participants in the Consumer Option and can be used for eligible health care expenses that are not medical expenses (for example, dental and vision care).

During 2017 Annual Benefits Enrollment, you will elect the amount you want deducted from your pay pre-tax for the entire 2017 calendar year. You may contribute up to $2,600 per year into a Health Care FSA or Limited Use Health Care FSA, and you may access the full amount of your annual contribution at any time.

Important Note
If you plan to participate in the Health Care FSA or Limited Use Health Care FSA, plan your annual contribution amount carefully. Your per-pay period deductions may change in 2017 if you enrolled or made changes to your FSA elections after January 1, 2016. If you were hired after January 1, 2016, or made a change to your FSA during the 2016 calendar year, access Workday to verify your elections are correct for 2017. Additionally, FSAs are use-it-or-lose-it accounts, and any unused funds in your account at the end of 2017 will be forfeited. With our carryover feature, up to $500 in unused balance can be carried into 2017.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to save pre-tax dollars to help pay for employment-related dependent care expenses for children 12 and under. To participate in the Dependent Care FSA, both you and your spouse must be employed. You may contribute up to $5,000 per year into a Dependent Care FSA (your maximum contribution to our plan may be less than $5,000 if your spouse works part-
time, if you are married and file a separate tax return, or if your spouse contributes to a Dependent Care FSA. See the Flexible Spending Accounts Summary Plan Description available on BBTBenefits.com for more information). These funds are for expenses such as nursery school, day care, and summer day camps and may not be used for dependent medical expenses. For guidance on qualified dependent care expenses, refer to IRS Publication 503.

You may only access up to the balance in your Dependent Care FSA at the time an expense is incurred. For example, you may elect to contribute $500 to your Dependent Care FSA during 2017. If you only have $125 in your account in March and you have a $200 expense, you can only be reimbursed $125 of the expense from your Dependent Care FSA.

During 2017 Annual Benefits Enrollment, you will elect the amount you want deducted from your pay pre-tax for the entire 2017 calendar year. As a participant, you can use a BB&T Benefit Access VISA® Debit Card to pay for dependent care expenses.

If you plan to participate in the Dependent Care FSA, plan your annual contribution amount carefully. FSAs are use-it-or-lose-it accounts, and any unused funds in your account at the end of 2017 will be forfeited.

**MASS TRANSIT TRANSPORTATION SPENDING ACCOUNT**

BB&T offers a Mass Transit Transportation Spending Account (TSA), which allows you to set aside pre-tax dollars for qualified charges you incur traveling to and from work. The TSA is designed to pay a benefit for associates who rely on methods other than their personal automobiles to commute.

**TSA Qualified Charges**

- **Transit Pass Expenses**: Money paid for passes, tokens, fare cards, vouchers, etc. when riding on mass transit (train, bus, subway, or ferry). This includes publicly-owned vehicles, as well as vehicles owned by someone in the business of transporting people for hire, as long as the vehicle seats six or more adults (excluding the driver).

- **Commuter Highway Vehicle (Van Pool) Expenses**: Money paid for rides in a commuter highway vehicle between your home and work. The vehicle must seat at least six adults (excluding the driver), and at least 80% of the mileage per year must be for transporting commuters between home and work, or for trips where at least half of the seating is for work commuters.

You can enroll in the TSA through Workday during 2017 Annual Benefits Enrollment or at any point during the plan year. When you enroll, you will elect a semi-monthly amount to be deducted from your pay pre-tax and contributed to your TSA. The maximum monthly contribution amount is $255. You may change your contribution amount at any time. For example, if you elect the full amount ($255) for January and decide you will only need $100 a month, you can change your contribution amount through Workday. You may only access up to the balance in your TSA at the time an expense is incurred.

As a participant, you will use a BB&T Benefit Access VISA® Debit Card whenever you pay for your transit pass expenses or your commuter highway vehicle (van pool) expenses. The IRS will only allow electronic payment for TSA services. You must use the BB&T Benefit Access VISA® Debit Card to purchase passes, tokens, fare cards, vouchers, etc. If your transit authority does not accept VISA, you will not be able to use the TSA.
BB&T BENEFIT ACCESS VISA® DEBIT CARD

All participants in the Health Care FSA, Limited Use Health Care FSA, the Dependent Care FSA, the TSA, and/or the HSA receive a BB&T Benefit Access VISA® Debit Card. As you incur qualified expenses during the year, you may use your BB&T Benefit Access VISA® Debit Card to pay for them.

If you participated in the Health Care FSA, Limited Use Health Care FSA, Dependent Care FSA, and/or HSA in 2016, you will continue to use your current BB&T Benefit Access VISA® Debit Card. For new FSA and HSA participants, the card will come with directions for each of the accounts. These directions may vary, so be sure to read the directions carefully for the specific account(s) in which you enrolled. New FSA and HSA participants should allow 48 hours after activation before using the card to ensure their information has been entered into the system. A $5 fee will be charged for the replacement of each lost card.

You should save all itemized receipts for expenses paid from the accounts. You may receive a letter from Stanley, Hunt, DuPree, & Rhine (the plan administrator) asking you to submit any receipts as evidence the funds were used for qualified expenses.

You may not use your BB&T Benefit Access VISA® Debit Card prior to January 1, 2017, for your 2017 elections. In addition, you may not use your BB&T Benefit Access VISA® Debit Card in 2017 to pay bills for expenses you incurred in 2016. If you have a bill for 2016 services and you want to pay for them in 2017, you must file a paper claim. All incurred charges for 2016 must be submitted for reimbursement by March 31, 2017.

INSURANCE

BB&T offers a number of different insurance options to ensure that you and your family are financially protected from unexpected situations. Read on for an overview of the many insurance options available to you as a BB&T associate.

DISABILITY PROGRAM

Disability coverage protects you if you become disabled and are unable to work. If you exhaust your 10 annual Sick Pay days and are certified as disabled by The Hartford, the Disability coverage will pay you a percentage of your Benefits Annual Rate. If you ever need to use this benefit, you will not be subject to taxes or other withholdings since your premium is taxed on each paycheck.

During 2017 Annual Benefits Enrollment, you may choose from two disability coverage options:

<table>
<thead>
<tr>
<th>Option</th>
<th>Benefit Amount</th>
<th>Benefit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Income replacement equal to 50% of your Benefits Annual Rate.</td>
<td>Provided to you by BB&amp;T at no cost.</td>
</tr>
<tr>
<td>2</td>
<td>Income replacement equal to 60% of your Benefits Annual Rate.</td>
<td>Small portion of the premium based on your age and Benefits Annual Rate.</td>
</tr>
</tbody>
</table>

In the year you purchase the 60% option, you will be subject to pre-existing condition exclusions.
On your 11th day of illness or injury, you will be eligible to receive disability benefits if you are certified as disabled by The Hartford. If you are not approved for disability pay, any continued approved absence will be without pay.

TERM LIFE INSURANCE PROGRAM

BB&T provides all benefits-eligible associates with two times their Benefits Annual Rate in basic Term Life Insurance coverage.

You may also purchase one to six times your Benefits Annual Rate in supplemental Term Life Insurance coverage. The maximum coverage available (basic plus supplemental) is $2 million. You may only increase your supplemental coverage one level per year. If you cancel or decrease your coverage at any time, you will be limited to one level of increase during the next Annual Benefits Enrollment period.

If your coverage (basic plus supplemental) totals more than $50,000, federal tax laws specify that only the premiums for the first $50,000 can be paid for on a tax-free basis. The cost exceeding $50,000 in coverage is taxable. Your income will be adjusted for the cost of coverage exceeding the $50,000 limit. This amount will be reported as earnings and reflected each pay period on the earnings section of your payslip.

Evidence of Insurability

If you elect supplemental Term Life Insurance coverage greater than $400,000 or four times your salary, you will receive a form, mailed to your home, from The Hartford that you must complete and return as evidence of good health and insurability. You will need to provide evidence of good health and insurability the first time you elect supplemental Term Life Insurance coverage greater than $400,000 or four times your salary and any time you increase your coverage above $400,000 or four times your salary.

Please Note: Associates who currently have supplemental Term Life Insurance coverage over $400,000 or four times salary and do not make changes to this election during 2017 Annual Benefits Enrollment will not be subject to this requirement.

DEPENDENT LIFE INSURANCE PROGRAM

BB&T’s Dependent Life Insurance program offers a range of coverage options for spouses and dependent children. You may elect coverage for your spouse in $10,000 increments up to $200,000*. If you elect Dependent Life Insurance coverage for your spouse greater than $50,000, you must provide our insurance carrier, The Hartford, with evidence of good health and insurability before coverage greater than $50,000 can become effective.

In addition, you may select from coverage levels of $7,500, $10,000, or $15,000 for dependent children. Your dependent children are eligible from birth until the end of the month in which they reach age 26. If your children become ineligible, you will need to cancel their coverage through Workday.

These premiums are paid on an after-tax basis so the benefits received from the program are not taxable to you. You are the beneficiary for all Dependent Life Insurance coverage.

*Dependent Life Insurance coverage for your spouse cannot exceed 50% of your basic and
supplemental Life Insurance coverage with a maximum of $200,000. Workday will automatically calculate the maximum level of coverage you may elect.

ACCIDENTAL DEATH AND DISMEMBERMENT PROGRAM

You have the option of electing Accidental Death and Dismemberment (AD&D) insurance, which provides additional insurance coverage for you and your dependents. The death benefit is paid to your designated beneficiary(ies) if your death is the result of an accident. A percentage of the total benefit amount is paid to you if you suffer certain dismembering injuries, such as the loss of an arm, leg, hand, foot, or sight.

You may elect AD&D insurance in $10,000 increments up to a maximum coverage amount of $500,000 or 10 times your Benefits Annual Rate, whichever is lower. Please refer to the Summary Plan Description on BBTBenefits.com for more information.

CRITICAL ILLNESS COVERAGE AND GROUP ACCIDENT INSURANCE

While you are enrolling for your 2017 Flexible Benefits, you will also have an opportunity to enroll for two voluntary benefits: Critical Illness Coverage and Group Accident Insurance. These benefits are offered through Aflac® to benefits-eligible associates who are actively at work. For instructions on how to enroll in these plans, access the 2017 Voluntary Benefits Enrollment Workday User Guide on the “2017 Annual Benefits Enrollment” page on BBTBenefits.com.

Critical Illness Coverage can help protect you and your eligible family members in the event you or a family member is diagnosed with a covered critical illness. In such an event, the coverage can provide you with a lump sum payment to be used any way you choose. This payment is intended to help reduce the financial burden that often comes with the recovery time associated with a critical illness.

Group Accident Insurance can help protect you and your eligible family members in the event you or a family member is involved in a covered accident. In such an event, the coverage pays regardless of any other insurance you may have and provides benefits for both inpatient and outpatient treatment. This coverage provides benefits to help cover the costs associated with unexpected bills from a covered accident.

These plans offer coverage for serious illnesses or accident-related expenses. The benefits can be used not only for co-payments, deductibles, and out-of-pocket expenses, but also for the indirect expenses associated with illness or injury, such as care for dependents or loss of earnings by a caregiver.

For more information, visit BBTBenefits.com for Critical Illness Coverage and Group Accident Insurance enrollment brochures. Questions should be directed to the Aflac Group Critical Illness Insurance Customer Service Center at 800-749-1279. Representatives are available Monday through Friday, from 9:00 a.m. to 6:00 p.m. ET.
VACATION PURCHASE

Associates may purchase additional vacation with pre-tax dollars during Annual Benefits Enrollment. Benefits-eligible associates may purchase up to 40 hours of vacation in 8-hour units. Part-time associates are limited based on their scheduled hours. For example, an associate scheduled for 25 hours per week could purchase only 24 hours (three 8-hour units) of vacation.

<table>
<thead>
<tr>
<th>Vacation Purchase Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Hours</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Less than 19 hours per week</td>
</tr>
<tr>
<td>20 to 23 hours per week</td>
</tr>
<tr>
<td>24 to 31 hours per week</td>
</tr>
<tr>
<td>32 to 39 hours per week</td>
</tr>
<tr>
<td>40 hours per week</td>
</tr>
</tbody>
</table>

Generally, associates cannot make changes to their vacation purchase election during the year. The only time an active associate would have a mid-year change is:

- If an associate’s schedule changes to make the associate ineligible for vacation (i.e., their scheduled hours drop to less than 20 per week); or
- If an associate is approved for long term disability.

Deductions will be made on a pre-tax basis. The deduction will be based on the associate’s September 30 pay rate (not Benefits Annual Rate).

### Calculation for Full-Time Associate

<table>
<thead>
<tr>
<th>Calculation for Full-Time Associate</th>
<th>Example for Full-Time Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Pay Annualized</td>
<td>$30,000</td>
</tr>
<tr>
<td>÷ 2080 hours per year</td>
<td>÷ 2080 hours per year</td>
</tr>
<tr>
<td>Hourly Rate</td>
<td>$14.42 per hour</td>
</tr>
<tr>
<td>Hourly Rate</td>
<td>$14.42 per hour</td>
</tr>
<tr>
<td>x Number of 8-hour units of vacation</td>
<td>x One 8-hour unit of vacation</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$115.38</td>
</tr>
<tr>
<td>÷ 24 Pay Periods</td>
<td>÷ 24 Pay Periods</td>
</tr>
<tr>
<td>Cost per Pay Period</td>
<td>$4.80 per pay period cost</td>
</tr>
</tbody>
</table>

An associate on an unpaid Leave of Absence will have the deduction drafted from their checking account (in the same manner as all benefit plan deductions).

Associates who purchase vacation will see two different vacation balances on Workday. When requesting time off in Workday, associates will select either “Vacation” or “Vacation Purchased.” Paid company vacation time must be used before vacation purchase time.

If an associate terminates employment, any unused purchased vacation will be paid out at the current rate of pay. Any vacation used by the associate but not paid for will be deducted from the associate’s
final pay. Certain states (for example, California) have special rules about vacation accruals. Please see the California Supplement to the HS Policies for additional information.

At year end, any unused purchased vacation will be forfeited. In certain states (for example, California), state law does not allow for the forfeiture of vacation. Please see the California Supplement to the HS Policies for additional information.

2017 ANNUAL BENEFITS ENROLLMENT PROCESS

BB&T’s Annual Benefits Enrollment process is quick, easy, and convenient. Once you have reviewed the material in this guide and have decided which benefits best meet your needs and the needs of your family, follow the detailed steps outlined in the 2017 Annual Benefits Enrollment Workday User Guide to enroll or make changes to your current elections. This resource is posted on BBTBenefits.com in the Featured Documents section.

If you do not want to change the benefit elections you made for 2016, you do not need to enroll. All 2016 benefit elections will carry over into 2017 with the exception of Vacation Purchase*; however, it is important to review your beneficiaries and dependents. Steps to review your beneficiaries and dependents are outlined in the 2017 Annual Benefits Enrollment Workday User Guide.

Annual Flexible Spending Account (FSA) and Health Savings Account (HSA) elections will also roll over from 2016 to 2017 if you do not make changes. Your per-pay period deductions may change in 2017 if you enrolled or made changes to your FSA or HSA elections after January 1, 2016. If you were hired after January 1, 2016, or made a change to your FSA during the 2016 calendar year, access Workday to verify your elections are correct for 2017.

*Please Note: Any Vacation Purchase elections made for 2016 will not roll over to 2017. To purchase vacation for 2017, you must make that election in Workday during 2017 Annual Benefits Enrollment.

DESIGNATING BENEFICIARY(IES)

Designating your beneficiary(ies) and keeping all beneficiary information current is important. Even if you do not elect to participate in any of BB&T’s benefit programs, be sure to review or designate your beneficiary(ies) for Term Life Insurance, provided at no cost to you by BB&T. If you do not designate your beneficiary(ies), BB&T will not know who you want to receive these benefits in the event of your death. If you need to change your beneficiary(ies) for Term Life Insurance or Accidental Death and Dismemberment coverage, you may make these changes through Workday at any time during the year.

DEPENDENT INFORMATION

It is important for all dependent information to be kept up to date. Covered dependents can only be changed during 2017 Annual Benefits Enrollment or if you have a qualifying Life Event Change.

Dropping a dependent’s coverage? If you choose to drop a dependent from coverage during 2017 Annual Benefits Enrollment and he or she requires COBRA health care continuation or a HIPAA Certificate of Coverage, please contact the Human Systems Service Center at 800-716-2455, option 1, or Benefits@BBandT.com. These notices are not automatically generated during 2017 Annual Benefits Enrollment.
LIFE EVENT CHANGES

Federal tax laws prohibit making changes to your benefit elections after 2017 Annual Benefits Enrollment unless you have a qualifying Life Event Change. If you have a qualifying Life Event Change after January 1, 2017, you will need to access Workday to change your elections. Instructions to complete a Life Event Change are posted on BBTBenefits.com on the “Life Event Changes” page on the “Flexible Benefits” tab. All changes must be made within 31 days of the Life Event Change. Depending on the specific Life Event Change, you may be able to add or remove dependents from your insurance coverage.

QUALIFYING LIFE EVENT CHANGES

- Birth, adoption, placement for foster care, legal custody of a child;
- Marriage, divorce, legal separation (recorded through the Clerk of Court);
- Gain or loss of spouse’s coverage due to change in employment;
- Gain or loss of child’s eligibility;
- Gain or loss of coverage under Medicare or Medicaid;
- Death of spouse or child;
- COBRA coverage expires or COBRA subsidy expires;
- Start or end of unpaid Leave of Absence;
- Start or end of military Leave of Absence;
- Change in day care (Dependent Care FSA only);
- Spouse moves into or out of the United States (special rules apply);
- Significant change in health care cost of spouse’s plan;
- Gain or loss of coverage during spouse’s annual enrollment (other than January 1);
- Loss of child(ren)’s coverage under a parent’s plan (due to plan’s eligibility requirements); and
- Loss of associate’s coverage under a parent’s plan (due to plan’s eligibility requirements).

IMPORTANT DOCUMENTS AND REQUIRED NOTIFICATIONS

SUMMARY OF BENEFITS AND COVERAGE DOCUMENT AND UNIFORM GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS

As required by the Patient Protection and Affordable Care Act, group health plan administrators must provide health insurance consumers access to two documents: a Summary of Benefits and Coverage (SBC) and a Uniform Glossary of Health-Coverage and Medical Terms (Uniform Glossary).
Summary of Benefits and Coverage Document
The SBC document provides a summary of key features of the BB&T Medical Program, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The SBC document includes details, called “coverage examples,” which are comparison tools that allow you to see what the Medical Program would generally cover in two common medical situations. The intent of SBC document is to provide information that will make it easier for you to find the best coverage for yourself and your dependents.

Uniform Glossary of Health Coverage and Medical Terms
The Uniform Glossary is a resource that will help you understand medical coverage and medical terms of the most common, and sometimes confusing, language used in medical insurance documents.

Both of these documents are available on BBTBenefits.com in the Quick Links.

REQUIRED NOTIFICATIONS UNDER THE PATIENT PROTECTION AND
AFFORDABLE CARE ACT (PPACA)
The Plan will follow the guidelines outlined in the Patient Protection and Affordable Care Act (PPACA). The standards include limitations on the frequency of preventive care services. For a complete list of covered preventive services, please visit the BCBSNC website.

Coverage is available for children up to age 26. Please note that eligibility does not change based on school enrollment or marital status. The following notice is required to be provided to you under PPACA:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the BB&T Corporation Health Care Plan. Individuals may add coverage during Annual Benefits Enrollment. Coverage will be effective January 1, 2017. For more information, contact the Human Systems Service Center at 800-716-2455, Option 1.

Under the PPACA, we have chosen to maintain our plans as “Grandfathered Health Plans.” Because of their status, we are required to provide the following disclosure:

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be
directed to the plan administrator at 800-716-2455, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CONTACT INFORMATION

BlueCross BlueShield of North Carolina (Medical Claims, Provider Information, Disease Management Program, and Prime Therapeutics)
800-621-8876
mybcbsnc.com

Ameritas (Dental)
800-487-5553
Ameritas.com/group/olbc/bbt

Vision Service Plan (Vision)
800-877-7195
VSP.com

Stanley, Hunt, DuPree & Rhine, Inc. (Flexible Spending Accounts Health Care, Dependent Care, Health Savings Account and Transportation Accounts)
P.O. Box 6400, Greenville, SC 29606
800-930-2429
SHDR.com/BBandT

Peak Health (LifeForce)
P.O. Box 3014, Wilson, NC 27895-3014 or Interoffice Mail: 100-60-02-10
252-237-5090
Peak-Health.net

Magellan (Mental Health Services in the Medical Program)
800-359-2422

Aflac (Critical Illness Coverage and Group Accident Insurance)
800-749-1279

Human Systems Service Center – Benefits Administration
800-716-2455, option 1
Benefits@BBandT.com

This information is intended to provide you with an overview of the BB&T Benefits Program to aid your enrollment. This guide should not be construed as a contract. The Company reserves the right to make changes in content or application as it deems appropriate, and these changes may be implemented even if they have not been communicated or reprinted. The complete details of the plans are contained in the plan documents and insurance contracts. If a discrepancy occurs, the actual plan documents will prevail.