BENEFITS ADMINISTRATION

Summary Plan Description

for: **Flexible Spending Accounts**

FOREWORD

This section contains the Summary Plan Description for the BB&T Corporation Flexible Benefits Plan. Summary Plan Descriptions "SPDs" are intended to summarize and explain a plan's principal provisions. The material contained in this SPD is taken from the actual legal plan document that governs the principles and provisions under which the plan operates. Therefore, if any conflict exists between the SPD and the actual plan provisions, the terms of the legal plan document will govern.

The Flexible Benefits Plan allows employees to pay for their benefits on a pre-tax basis. In addition, Flexible Spending Accounts allow employees to pay for certain types of medical and dependent care expenses with pre-tax money, which may result in substantial tax savings. Combining benefits from these plans can help employees and their families in paying for the high cost of health care and dependent care expenses.

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

TABLE OF CONTENTS

FACTS ABOUT THE PLAN

Plan Name:	BB&T Corporation Flexible Benefits Plan
Employer Name, Address and Telephone Number:	BB&T Corporation 200 West Second Street P.O. Box 1215 Winston-Salem, NC 27102 (800) 716-2455 benefits@bbandt.com
Effective Date:	This summary is a description of the Plan benefits as effective January 1, 2018.
Name and Address of Agent for Legal Service:	Chairman, Employee Benefits Plan Committee Plan Administrator and BB&T Corporation 200 West Second Street P.O. Box 1215 Winston-Salem, NC 27102
Employer Identification Number:	56-0939887
Plan Number:	509
Type of Plan:	Flexible benefit plan providing payment of premiums for selected benefits on a pre-tax basis and reimbursement for certain health care and dependent care expenses
Plan Year:	January 1 through December 31
Type of Administration:	General administration is provided by the Employee Benefits Plan Committee working through the Benefits Department of BB&T Corporation. Claims for benefits under the Reimbursement Accounts portion of the Plan are paid by the Benefit Services Manager.
Benefit Services Manager:	Stanley, Hunt, DuPree & Rhine, Inc. P.O. Box 6400 Greenville, SC 29606 (800) 930-2429 www.shdr.com/bbandt

The above information, together with the information set forth on the following pages, comprises the Summary Plan Description for the BB&T Corporation Flexible Benefits Plan required by the Employee Retirement Income Security Act of 1974 (ERISA).

INTRODUCTION

The BB&T Corporation Flexible Benefits Plan (the "Plan") enables you to choose your benefits to fit your personal needs and preferences. It also provides the flexibility to change these benefits as your needs change. BB&T Corporation and any related employer that has adopted the Plan with the written consent of BB&T Corporation (the "Company") offers the following benefits:

- Medical Care
- Dental Care
- Vision Care
- Life Insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment Insurance
- Disability Insurance
- Vacation Purchase
- Reimbursement Accounts

For a detailed description of these benefits, you should refer to the Summary Plan Description booklets provided for each benefit. Information on the Vacation Purchase program and Flexible Spending Accounts can be found below.

ELIGIBILITY

An eligible employee is any regular (not temporary or contract) employee scheduled to work at least 20 hours per week. An eligible employee may become a participant on his or her first day of employment.

HOW THE PLAN WORKS

How to Enroll

Employees access Workday through InSite or BBTBenefits.com.

As permitted under current federal law, employee contributions for all options except Dependent Life and Disability are made on a pre-tax basis. Contributions are deducted from your pay before income taxes and Social Security taxes are withheld. This deduction results in a savings of tax dollars for you.

Initially, you must enroll in the Plan within 31 days of your employment date. If you fail to enroll at that time, you must wait until the next re-enrollment period unless you have a status change. (See Section entitled "Annual Flexibility)".

As a condition to your participation and benefits from the Plan, you must agree to:

1. Follow all Plan rules;
2. Consent to inquiries by the plan administrator about any doctor, dentist, hospital or other provider of health care or other services in a claim for health care benefits from the Plan;

3. Consent to inquiries by the plan administrator with respect to any individual involved in a claim for dependent care benefits from the Plan; and

4. Submit all required reports, bills and other information needed by the Plan Administrator.

Annual Flexibility
Each Plan year, you will be given the opportunity to change your flexible benefits and/or coverage selected for the next Plan year. During the annual re-enrollment period, you will be asked to review your current benefit elections and provided with information about benefits available in the coming Plan year.

Unless mandatory enrollment is announced, you will automatically retain the same coverage you had elected for the prior Plan year, incurring any price increases effective with the new Plan year unless you make new elections during the annual re-enrollment period with the exception of the Vacation Purchase program. You must make an election regarding Vacation Purchase each year you wish to participate.

Because benefits are generally paid with pre-tax dollars, the IRS requires that elections remain in effect for the entire Plan year. You will not be able to change your elections until the next annual re-enrollment period unless you have a status change, such as:

- Birth, Adoption, Placement for Foster Care, Legal Custody of a Child
- Marriage, Divorce, Legal Separation (recorded thought the Clerk of Court)
- Gain or Loss of Spouse's coverage due to change in employment
- 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 USA
- Significant change in health care cost of Spouse's plan
- Loss of Eligibility under a parent's coverage

Please note that Vacation Purchase cannot be changed during the year, even with a status change.

It is the employee's responsibility to request changes in coverage after a status change within 31 days of the status change date. Employees can request changes through Workday Benefits.com.

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Accounts are a way to pay for certain dental, vision, health care and dependent care expenses with pre-tax dollars. It is an important way to meet anticipated health and dependent care expenses in a tax-efficient manner.

You can set up a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account or both. The Plan also features flexibility in letting you choose how much to contribute up to a maximum limit and how to divide those contributions between your Flexible Spending Accounts. You cannot participate in the Health Care Flexible Spending Account if you participate in the Consumer medical option; however, you may enroll in the Limited Purpose Health Care Flexible Spending Account.

Contributions to the Flexible Spending Accounts may come from pre-tax contributions made by you through payroll deduction and credits from your employer.

When you enroll in the Plan, you will authorize the amount to be allocated to your Health Care Flexible Spending Account (Maximum of $2,650 per year), the Dependent Care Flexible Spending Account (Maximum of $5,000 per year), or both. You should carefully plan expenses prior to designating the amount to be allocated to either of these Accounts. Contributions made during a calendar year can only be used for expenses incurred during that same calendar year and only for services rendered while you are enrolled in the Plan. In addition, you cannot transfer money between Accounts during the Plan year or carry over Account balances from one Plan year to the next. However, you may carry over up $500 in unused fund in the Health Care Flexible spending Account or the Limited Use Health Care Flexible Spending Account. If you join BB&T midyear, be sure that your total contribution to any (your prior employer's plan and BB&T's plan) Flexible Spending Account does not exceed$2,650 for the Health Care Flexible Spending Account or $5,000 for the Dependent Care Flexible Spending Account for the year.

Health Care Flexible Spending Account
This Account will provide reimbursement for health care expenses that are not covered or are not fully reimbursable under the BB&T Corporation Health Care Plan (the "Health Care Plan"). Examples of expenses for which you may be reimbursed are those that are incurred for vision care expenses, routine physicals and non-covered medical expenses (see "Items Covered by Health Care Flexible Spending Account").

You may file claims under the Health Care Flexible Spending Account for you or your dependents, even if they are not covered under the Health Care Plan. In other words, health care coverage through the Company is not required for expenses to be reimbursed. There must, however, be a record of the individual as one of your dependents on file in the Compensation and Benefits Department. You may generally obtain reimbursement for claims on dependent children until the end of the calendar year in which they turn 26.

Limited Purpose Health Care Flexible Spending Account
This Account will provide reimbursement for expenses that are not medical expenses covered under the BB&T Corporation Health Care Plan (the "Health Care Plan"). Examples of expenses for which you may be reimbursed are those that are incurred for vision care expenses and dental care expenses.

You may file claims under the Limited Purpose Health Care Flexible Spending Account for you or your dependents, even if they are not covered under the Health Care Plan. In other words, health care coverage through the Company is not required for expenses to be reimbursed. There must, however, be a record of the individual as one of your dependents on file in the Compensation and Benefits Department. You may generally obtain reimbursement for claims on dependent children until the end of the calendar year in which they turn 26.

Dependent Care Flexible Spending Account
This Account will provide reimbursement for dependent care expenses, including day care and babysitter expenses (see "Items Covered by Dependent Care Flexible Spending Account"). Contributions to this Account cannot exceed the lesser paid spouse's income for the calendar year. Both spouses must be employed to participate in this Plan. In addition, if you are married and file a separate tax return, you are

limited to $2,650 in contributions to this Account.

FILING CLAIMS

You may use your BB&T Benefit Access VISA® Debit Card to pay for health care and dependent care expenses incurred or send a claim to the Benefit Services Manager listed on page 1. Please refer to the directions sent along with your BB&T Benefits Access VISA® Debit Card for specific directions as the directions, vary depending on the account to which the card is tied. Please be sure to save all of your receipts. Stanley, Hunt, DuPree & Rhine, Inc. (SHDR) will request copies of any receipts they require to process your claims.

Claims should be processed through the Health Care Plan, even if the expense will be applied toward the deductible. This will ensure that you have proper credit for the expense in both programs. The Explanation of Benefits that you receive from your insurance company should be attached to the appropriate claim form and filed with SHDR for reimbursement. All claims must include:

1. The amount of the expense for which reimbursement is required;
2. The purpose of the expense;
3. The name of the person for whom the expense was incurred and the person's
4. relationship to you;
5. The name of the person, organization or entity to whom the expense was paid;
6. A copy of the bill from the health care provider or any statement from an independent person indicating that the expense has been incurred and the date of such expense; and
7. The amount (if any) paid by insurance.

Health Care Flexible Spending Account reimbursements will be limited to the annualized amount of contributions to your Health Care Flexible Spending Account. You will be allowed 90 days after the end of the Plan year in which to file claims for expenses incurred during that Plan year.

Under IRS regulations, a claim for reimbursement must be filed, along with proof of payment, before a reimbursement can be made.

Reimbursement of Dependent Care Flexible Spending Account Claims
To be reimbursed for dependent care expenses not paid with your BB&T Benefit Access VISA® Debit Card, you must complete a claim form and send it directly to SHDR. Dependent care reimbursements are limited to the current contributions to your Dependent Care Flexible Spending Account and the current expenses incurred. You will be allowed 90 days after the end of the Plan year in which to file claims for dependent care expenses incurred during that Plan year.

All claims must include:

1. The amount of the expense for which reimbursement is required;
2. The purpose of the expense;

3. The name of the individual for whom the expense was incurred and that person's relationship to you; and

4. The name and taxpayer identification number of the person or dependent care center to whom the expense was paid and a receipt or other statement from such person or center indicating that the expense has been incurred and the date such expense was incurred.

Under IRS regulations, a claim for reimbursement must be filed, along with proof of payment, before a reimbursement can be made.

CHANGES IN PARTICIPATION

As mentioned earlier, changes in contributions to your Flexible Spending Accounts are allowed only in the event of a status change. Once an election has been made to contribute to your Health Care Flexible Spending Account, no reductions in your contribution amount are permitted during a Plan year, except in the event of death. Increases in your contributions are permitted if a status change occurs. Your contributions to the Dependent Care Flexible Spending Account may be increased or decreased during the Plan year in the event of a status change. Changes can only be made prospectively. You must make changes to your elections through Workday. Your election must be made within 31 days of the date of the change in status.

TERMINATION OF EMPLOYMENT

If your employment terminates for whatever reason, you may continue to use the balance in your Health Care or Dependent Care Flexible Spending Account for expenses incurred during the period of employment and while you were contributing to the Plan. To continue unrestricted access to your Health Care Flexible Spending Account, you may elect to continue contributions on an after tax basis by completing the appropriate COBRA enrollment form. Please contact the plan administrator regarding questions pertaining to the administration of the Health Care Flexible Spending Account in conjunction with COBRA.

BALANCES IN ACCOUNT AT YEAR END

You will have 90 days following December 31 (i.e., the last day of each Plan year) to submit expenses incurred during the prior Plan year. Money remaining in either or both Flexible Spending Accounts after that time will be forfeited to the Company in accordance with IRS regulations. However, you may carry over up to $500 in unused funds in the Health Care Flexible Spending Account or the Limited Use Health Care Flexible Spending Account.

ITEMS COVERED BY HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The following are representative expenses eligible for reimbursement via the Health Care Flexible Spending Account (specific eligible expenses will vary depending upon individual plan provisions). *Please note that charges for cosmetic procedures cannot be reimbursed by the Plan.*

Medical Expenses

Baby/Child to Age 13

- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby Care

Dental Services

- Dental X-Rays
- Dentures and Bridges
- Exams/Teeth Cleaning
- Extractions and Fillings
- Gun Treatment
- Oral Surgery
- Orthodontia/Braces

Hearing

- Hearing Devices and Batteries
- Hearing Exams

Lab Exams/Tests

- Blood Tests and Metabolism Tests
- Body Scans
- X-Rays
- Cardiographs
- Laboratory Fees
- Spinal Fluid Tests
- Urine/Stool Analysis

Vision Services

- Eye Examinations
- Eyeglasses
- Contact Lenses and Contact Lens Supplies
- Laser Eye Surgeries
- Artificial Eyes
- Prescription Sunglasses
- Radial Keratotomy/LASIK
- Reading Glasses

Medical Procedures/Services

- Acupuncture
- Alcoholism (inpatient and outpatient treatment)
- Ambulance
- Drug Addiction
- Hospital Services
- Infertility Treatment
- In Vitro Fertilization
- Norplant Insertion or Removal
- Physical Exam (non employment-related)
- Reconstructive Surgery (if medically necessary due to congenital defector accident)
- Service Animals*
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*
- Vaccinations/Immunizations
- Vasectomy and Vasectomy Reversal

Medical Equipment/Supplies

- Abdominal/Back Supports
- Air Purification Equipment*
- Arches/Orthopedic Shoes
- Band-Aids
- Braces and Supports
- Contraceptive Devices
- Crutches and Wheelchairs
- Elastic Bandages and Wraps
- Exercise Equipment*
- First Aid Supplies
- Hospital Bed
- Mattresses*
- Medic Alert Bracelet or Necklace
- Oxygen*
- Pregnancy Test Kits
- Post Mastectomy Clothing
- Prosthesis
- Splints/Casts
- Support Hose*
- Syringes
- Wigs

Medication

- Birth Control
- Homeopathic Medications*
- Insulin
- Prescription Drugs

Obstetric Services

- Lamaze Class
- Midwife Expenses
- OB/GYN Exams
- OB/GYN Prepaid maternity Gees (reimbursable after date of birth)
- Pre and postnatal Treatments

Practitioners

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath or Naturopath*
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy

- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise*
- Hypnosis
- Massage
- Occupational
- Physical
- Speech
- Weight Loss Programs*

*Expenses must be accompanied by a doctor's certification specifying the medical condition and treatment needed, and how the treatment will alleviate the condition.
Other items may be covered as regulated by the Internal Revenue Service. Please visit SHDR.com/bbandt for more details.

ITEMS COVERED BY DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

- Payments to nursery schools, day care centers or individuals for care of preschool children.
- Payments for before-school care or after-school care for children from kindergarten through age 12.
- Payments to providers outside the home for care of disabled dependents of any age.
- Services of a housekeeper, maid or cook if the services were partly for the care of a child under age 13 or a disabled dependent. This includes meals, lodging and payroll taxes of the housekeeper.
- Payments to relatives for care of qualifying dependents; however, the relative cannot be your dependent or your child if under age 19 as of the end of the year.
- Payments (in lieu of regular day care) to summer day camp or other summer programs, but not overnight camps.

Please note: Payments for private schools are not reimbursable.

REVIEW OF CLAIMS THAT ARE DENIED

In the event the Benefit Services Manager (BSM) should determine that you are not entitled to all or a portion of the benefits to which you claim, you will be notified within 30 days after the BSM receives your claim. If special circumstances require that the BSM be given additional time to make a decision on your claim, the BSM may have an additional 15 days by notifying you before the end of the first 30-day period.

If your claim is denied, in whole or in part, you will receive a statement which includes:

1. The specific reason or reasons for the denial;
2. Specific reference to applicable sections of the Plan on which the denial is based;
3. A description of any additional material or information necessary for you to supply in order to perfect your claim and why such material or information is necessary;
4. An explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

If the BSM does not provide you with any notice or statement about your claim within 30 days of the time it is received, you may consider your claim denied.

Within 180 days after a claim is denied by the BSM or deemed to have been denied, you may appeal the denial of the claim by filing a written application for review with the Employee Benefits Plan Committee

under the Plan (the "Committee"). The Committee will review the decision denying the claim within 60 days after your request for review (unless there are special circumstances, in which case the time period is 120 days), and will give you a written decision. You will receive a notice if special circumstances require additional time. If the Committee fails to provide you with any notice or statement about your claim within the 60-day period referred to above, you may consider your claim to have been denied upon review. Before the Committee decides on the claim, you or your authorized representative may review pertinent documents and submit issues and comments in writing. It is important for you or your authorized representative to submit in writing to the Committee for its review any and all issues, comments and evidence relevant or pertinent to your claim for benefits.

If the Committee denies your claim, in whole or in part, its written decision will set forth specific reasons for the decision and will cite specific Plan sections on which the decision is based. The decision of the Committee will be final and conclusive.

Both the Committee and the BSM have the duty and discretionary authority to interpret and construe the provisions of the Plan, subject to the objective terms of the Plan and the claims procedures described in this section. Interpretations and determinations made by the Committee and the BSM will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each participant and any other interested person. Such interpretations and determinations made by the committee and the BSM will only be overruled by a court of law if the committee and the BSM are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

VACATION PURCHASE

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 (3 8-hour units) of vacation.

Scheduled Hours	Eligibility for Purchased Vacation
Less than 19 hours per week	Not eligible
20 to 23 hours per week	Purchase up to 2 8-hour units [16 hours]
24 to 31 hours per week	Purchase up to 3 8-hour units [24 hours]
32 to 39 hours per week	Purchase up to 4 8-hour units [32 hours]
40 hours per week	Purchase up to 5 8-hour units [40 hours]

Vacation can only be purchased during the annual enrollment period held in November. 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)
- If an associate is approved for long term disability.

Deductions will be made on pre-tax basis. The deduction will be based on the associate's September 30

pay rate. 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 balances on Workday. When requesting time off in Workday, associates will select either "Vacation" or "Vacation Purchased".
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.

PROTECTION UNDER ERISA

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

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

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

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

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

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

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

OTHER IMPORTANT PLAN INFORMATION

Agent for Service of Legal Process

It is not anticipated that it will ever be necessary to have a lawsuit; however, if a lawsuit is to be brought, legal process may be served on the Plan Administrator at the address shown in "Facts About the Plan."

Plan Amendment and Termination

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

Your Rights

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

Further Questions

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