BENEFITS ADMINISTRATION

Summary Plan Description

for:

BB&T Corporation Retiree Health Reimbursement Arrangement (HRA) Plan

Foreword

This section contains a summary of the BB&T Corporation Subsidiary Health Reimbursement Arrangement (HRA) Plan. This document is intended to summarize and explain the plan's principal provisions. The material contained in this summary is taken from the actual legal plan document that governs the principals and provision under which the plan operates. Therefore, if any conflict exists between the summary and the actual plan provisions, the terms of the legal plan document will govern.

The HRA Plan provides a contribution to eligible retirees to pay for certain types of premiums for medical insurance.

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

TABLE OF CONTENTS

FACTS ABOUT THE PLAN

Plan Name:	BB&T Corporation Retiree Health Reimbursement Arrangement (HRA) Plan
Employer Name, Address and Telephone Number:	BB&T Corporation 200 West Second Street PO 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 Plan Administrator and Agent for Legal Service:	Chairman, Employee Benefits Plan Committee BB&T Corporation 200 West Second Street PO Box 1215 Winston-Salem, NC 27102
Employer Identification Number:	56-0939887
Type of Plan:	Qualified Health Reimbursement Arrangement under Internal Revenue Service Notice 2002-45
Plan Year:	January 1 through December 31
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 are paid by the Benefit Services Manager.
Benefit Services Manager:	YSA (Your Spending Account) (888) 628-2393

DEFINITIONS

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

Committee means the group appointed by the Board of Directors of BB&T Corporation to administer this Plan

Company means BB&T Corporation, a North Carolina corporation with its principal office in Winston- Salem, NC or any successor thereto by merger, consolidation or otherwise.

Eligible Retiree means a former employee of the Company or its affiliates who has attained age 65 and had at least 10 years of service with the Company at retirement.

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

HIPAA PRIVACY RULES

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

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

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

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Human Systems Service Center. If you have questions about the privacy of your health information, please contact the BB&T Benefits Manager in the Human Systems Division.

STATEMENT OF YOUR ERISA RIGHTS

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

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining

agreements (if any), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

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

(3) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

ELIGIBILITY

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

FUNDING

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

ELIGIBLE MEDICAL CARE EXPENSES

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

CLAIMS

Benefits from the HRA are paid through an automatic reimbursement by the Benefit Services Manager. If the insurance carrier you select does not provide for electronic notification of premium payments, you may need to file a claim form to request reimbursement of premium payments. Claim forms can be obtained by contacting the Benefit Services Manager.

UNUSED AMOUNTS

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

DEATH OF THE RETIREE

At the death of an Eligible Retiree, contributions will continue through the end of the current calendar year. However, unless a separate contractual agreement exists, no contributions will be made in any year following the death of the Eligible Retiree.

APPEALING A DENIED CLAIM

If your claim is denied and you wish to appeal, you must file your appeal with the Employee Benefit Plans Committee within 60 days after you receive the denial. Your appeal should include any additional information that you wish the Employee Benefit Plans Committee to consider.

The Employee Benefit Plans Committee will notify you in writing within 60 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait longer for a decision. The decision will be final and will be communicated to you in writing. If you do not receive a written response from the Employee Benefit Plans Committee within the designated time period, your appeal will be considered to have been denied.

If you are dissatisfied with the final decision after you have pursued these steps, you have a right to file a lawsuit in a state or federal court.

AMENDMENT AND TERMINATION

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

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