Fidelity Bank
FLEXIBLE SPENDING ACCOUNT PLAN SUMMARY PLAN DESCRIPTION ("SPD")

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Introduction to the Flexible Spending Account Plan Summary Plan Description

Fidelity Bank (the "Employer") is pleased to sponsor an employee benefit program known as The Flexible Spending Account Plan (the "Plan"). There are two types of flexible spending accounts provided under the Plan: a Health Flexible Spending Account ("Health FSA") and a Dependent Care Flexible Spending Account ("Dependent Care FSA"). Your Employer may offer a general purpose Health FSA and/or a limited purpose Health FSA. The types of Health FSAs available are described in the attached Plan Information Appendix.

The Plan is called a "flexible" spending account plan because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year and you elect to have the Employer withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the Health FSA and any amounts that you elect to have withheld for reimbursement of dependent day care expenses will be credited to the Dependent Care FSA. You must elect wisely because any amounts allocated to a flexible spending account that are not used for expenses incurred during the Plan Year will generally be forfeited. Limited exceptions to the forfeiture rules may be available if your Employer offers a Grace Period (for either type of FSA) or a Carryover Provision (for the Health FSA only). If available, these features are described in the attached Plan Information Appendix.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay for reimbursement of eligible medical and/or dependent day care expenses are withheld *before* any federal income and employment taxes (e.g., FICA and FUTA) are applied, and in most cases, before any applicable state taxes are applied. If you have unreimbursed medical and/or dependent day care expenses, participation in this Plan will actually increase your take home pay over what your net take home would be if you paid for such expenses with after-tax dollars.

The SPD is divided into four parts: Part I-General Information about the Plan; Part II-Health FSA Benefits; Part III-Dependent Care FSA Benefits; and Part IV-the Plan Information Appendix. The first three parts of the SPD are in Question and Answer format. We encourage you to read the entire SPD, but if you have questions about your rights and obligations under the Plan, please refer to the Table of Contents above for the Question that most resembles your question. Information relating to the Plan that is specific to your Employer is described in the Plan Information Appendix attached to this SPD. You will be referred to the Plan Information Appendix throughout the SPD. In addition, terms that are capitalized throughout are terms that are specifically defined in the SPD or the Plan document.

This SPD and the Plan Information Appendix attached hereto (collectively, the "SPD") describe the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a Plan document into which this SPD has been incorporated. If there is a conflict between the official Plan document and the SPD, the SPD will govern. The effective date of this SPD is set forth in the attached Plan Information Appendix.

If you have any questions regarding the terms of the Plan, the Health FSA and/or the Dependent Care FSA, contact the Plan Administrator identified in the Plan Information Appendix. The Plan Administrator's name, address and telephone number appear in the Plan Information Appendix attached to this SPD. Other important information has been provided in the Plan Information Appendix attached to this SPD.

Questions and Answers

Part I: General Information about the Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow Eligible Employees to use pre-tax dollars ("Pre-tax Contributions") to pay for certain otherwise unreimbursed medical and/or dependent day care expenses.

Q-2. Who can participate in the Plan?

Each Eligible Employee of the Employer who satisfies the Plan's eligibility requirements will be eligible to begin participating in this Plan on the applicable Entry Date. The eligibility requirements and the Entry Date are identified in the Plan Information Appendix. Note that different eligibility rules may apply for a general purpose Health FSA and a limited purpose Health FSA. Those employees who actually participate in the Plan are called "Participants."

For the Health FSA only. If you are a participant in the Health FSA option, your Eligible Dependents are also covered. Your Eligible Dependents, for purposes of the Health FSA option, are your Spouse (determined in accordance with the federal Defense of Marriage Act) and any other person who qualifies as your dependent under Code Section 105(b). An individual is a "dependent" for purposes of Code Section 105(b) if the individual satisfies any of the following criteria: (i) the individual is a dependent for income tax purposes under Code Section 152 (i.e., qualifies you for a personal exemption); (ii) the individual would qualify as your dependent under Code Section 152 but for the fact that (A) the individual has income in excess of the exemption amount (applicable to "Qualifying Relatives" as defined in Code Section 152), (B) the individual is a dependent of another taxpayer, (C) the individual is married and files a joint return with his or her spouse, or (D) the individual is a "child" as defined in Code Section 152(f)(1) who will not turn age 27 during the year. An individual qualifies as a child as defined by Code Section 152(f)(1) if he/she is any of the following: (i) natural child, (ii) adopted child or child "placed with you for adoption," (iii) step child, or (iv) child placed with you by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. In addition, a child to whom Code Section 152(e) applies (i.e., a child of divorced or separated parents) is considered a dependent of both parents for the purpose of the Health FSA without regard to who claims the child as a dependent on his or her tax return.

Q-3. When does my participation in the Plan end?

You continue to participate in the Plan until the earlier of the date that (i) you elect not to participate in this Plan; (ii) you no longer satisfy the eligibility requirements (e.g., you terminate employment); or (iii) the Plan is terminated or amended to exclude you or the class of employees of which you are a member.

If you cease to satisfy the eligibility requirements during the Plan Year but become eligible for the Plan again during the same Plan Year and more than 30 days after ceasing to satisfy the eligibility requirements, you may make new elections under the Plan. If you cease to satisfy the eligibility requirements during the Plan Year but become eligible for the Plan again during the Plan Year and within 30 days or less after ceasing to satisfy the eligibility requirements, your prior elections will be reinstated and will remain in effect for the remainder of the Plan Year.

Q-4. How do I become a Participant?

You become a Participant in the Plan by (i) completing the designated election form on which you indicate the amount of your pay you wish to have withheld and then allocated to the Health FSA and/or the Dependent Care FSA and (ii) timely submitting the election form to the entity/person designated on the election form during one of the enrollment periods described below. You will be provided with an election form (or you will be provided with access to an election form) on or before the beginning of the applicable enrollment period.

IMPORTANT: If you want tax-free reimbursement of unreimbursed medical expenses, you must affirmatively elect to participate in the Health FSA. If you want tax-free reimbursement of dependent day care expenses, you must affirmatively elect to participate in the Dependent Care FSA. You can choose either one or both.

You cannot become a Participant in this Plan prior to the date you complete and submit your election form.

You may be required to complete an election form via telephone or voice response technology, electronic communication, or any other method prescribed by the Plan Administrator. In order to utilize a telephone system or other electronic means, you may be required to sign an authorization form authorizing issuance of a personal identification number ("PIN") and allowing such PIN to serve as your electronic signature when utilizing the telephone system or electronic means. The Plan Administrator and all parties involved with Plan administration will be entitled to rely on your directions through use of the PIN as if such directions were issued in writing and signed by you.

Q-5. What are the enrollment periods under the Plan?

When you are first hired, you must enroll during the "Initial Enrollment Period" if you want to participate. The enrollment material provided by the Employer (or the Third Party Administrator identified in the Plan Information Appendix) will identify the beginning and end dates of the Initial Enrollment Period. If you make an election during the Initial Enrollment Period, your participation in the spending account(s) that you elect will begin on the later of your Entry Date or the date that your election is received and processed by the entity processing your election form. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a specified event that will allow a mid-year election change (see below for more details on mid-year election changes).

If you do not make an affirmative election to participate in either of the spending accounts during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year unless you experience an event that allows you to change that election during the Plan Year.

The Plan also has an "Annual Enrollment Period" during which you may enroll (if you did not enroll during the Initial Election Period), continue your previous election or change your previous elections for the next Plan Year. You will be notified each year of the beginning and end dates of the Annual Enrollment Period. You must make an affirmative election to participate, change your election, or continue your current election for the next Plan Year. The election that you

make during the Annual Enrollment Period is effective the first day of the following Plan Year and is irrevocable for the entire Plan Year unless you have experienced an event that allows a mid-year election change.

If you are a current Participant in the Plan and you fail to complete and submit an election form during the Annual Enrollment Period, you will be deemed to have elected not to participate during the next Plan Year.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Appendix.

Q-6. How are the contributions to the spending accounts made under the Plan?

When you become a Participant in the Plan, your share of the contributions for the elected spending accounts will be paid with Pre-tax Contributions that you elected on the election form. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal taxes (and in most cases, state taxes) have been deducted. In addition, all or a portion of the cost of the spending accounts may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards one or both of the cost of the spending accounts for each Participant is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount, if any, will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may provide you with Nonelective Contributions and then allow you to allocate the Nonelective Contributions towards one or both of the spending accounts (subject to restrictions described in the enrollment material).

Q-7. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution that you have elected to allocate to the Health FSA and/or the Dependent Care FSA. That being said, your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your Pre-tax Contribution elections only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There is an important exception to this general rule that you cannot revoke your elections during the Plan Year: You may change or revoke your elections during the Plan Year if you submit a written request (or where applicable, an electronic request) for an election change with the Plan Administrator (or the Third Party Administrator identified in the Plan Information Appendix) within 30 days of experiencing one of the following events. Note that not all of the events apply to Health FSA elections.

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new

election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
- A change in the number of your dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
- Any of the following events that change the employment status of you, your spouse, or your dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the plan of another employer) or other employee benefit plan of an employer of you, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student; and
- A change in your, your spouse's or your dependent's place of residence.

The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. With the exception of an election change to the Health FSA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage under the Plan. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

- *Dependent Care Reimbursement Plan Benefits.* With respect to the Dependent Care Reimbursement Plan benefit, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

2. **Special Enrollment Rights (NOTE: This applies only to Health FSA elections and only to the extent that the Health FSA is not an "excepted benefit" as defined by the Health Insurance Portability and Accountability Act of 1996).** If you, your spouse and/or a dependent are entitled to special enrollment rights under Health FSA as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment for yourself or your eligible dependents because of other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect Health FSA coverage for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 30-day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's Health FSA coverage. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's Health FSA coverage.

5. **Change in Cost (applies only to Dependent Care FSA elections)**. If you are notified that the cost of your Dependent Care FSA coverage under the Plan has *significantly* increased or decreased or will *significantly* increase or decrease during the Plan Year, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. For *insignificant* increases or decreases in the cost of Dependent Care FSA coverage, however, your Pre-tax Contributions will change automatically to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

6. **Change in Coverage (applies only to Dependent Care FSA elections)**. If your coverage under the Dependent Care FSA is significantly curtailed, you may revoke your election and either choose another day care provider or drop coverage altogether. Further, if you change day care providers, you may revise your elections to correspond to the new provider. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the plan year for this Plan is different from the plan year of the other employer plan.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

7. **Approved Leave of Absence.** If you take an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):

- If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Health FSA coverage on the same terms and conditions as though you were still active.
- Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions with Pre-tax Contributions withheld from pay you receive while on leave.
- In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your Health FSA, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave (not to exceed the end of the Plan Year) with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator.
- If your Health FSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Health FSA upon return from such leave on the same basis as you were participating in the Health FSA prior to the leave, or as otherwise required by the FMLA. Your Health FSA coverage may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

- The Employer may, on a uniform and consistent basis, continue your Health FSA coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.
- If you are commencing or returning from unpaid FMLA leave, your Dependent Care FSA election under this Plan shall be treated in the same manner that elections for non-health plans are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

Q-8. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-9. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Part II. Health FSA Benefits

The following Questions and Answers relate to the Health FSA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Contributions to the Health FSA.

Q-10. What is the "Health Flexible Spending Account"?

The Health Flexible Spending Account ("Health FSA") is the portion of the Plan that provides for reimbursement of Eligible Medical Expenses incurred by the Participant and his/her Eligible Dependents. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Medical Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-11. What is the difference between a general purpose Health FSA and a limited purpose Health FSA?

A general purpose Health FSA reimburses more types of Eligible Medical Expenses than a limited purpose Health FSA. A limited purpose Health FSA may only reimburse the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)) (and see Q-16 for further information):

(i) Services or treatments for dental care (excluding premiums)
(ii) Services or treatments for vision care (excluding premiums)
(iii) Services or treatments for "preventive care"

The distinction between general purpose Health FSAs and limited purpose Health FSAs is important if you want to make or receive tax-favored contributions to a Health Savings Account

(HSA). Individuals who are enrolled in a general purpose Health FSA can't make or receive tax-favored HSA contributions, but individuals who are enrolled in a limited purpose Health FSA can make or receive tax-favored HSA contributions (assuming all other HSA requirements are satisfied).

Your Employer may offer both a general purpose Health FSA and/or a limited purpose Health FSA, and may impose different eligibility rules for each type of Health FSA. The types of Health FSAs available to you are described in the attached Plan Information Appendix.

Q-12. What is the maximum annual reimbursement amount that I may elect under the Health Flexible Spending Account?

You may choose any reimbursement amount you desire subject to the maximum annual Health FSA Reimbursement Amount (and Health FSA Minimum Reimbursement Amount) described in the Plan Information Appendix. You should be aware that the IRS imposes an annual dollar limit on your Pre-tax Contributions to the Health FSA. This dollar limit is also described in the Plan Information Appendix.

In addition, any change in your election affecting annual contributions to the Health FSA will change the maximum available reimbursement for the remainder of the Plan Year. Such maximum available reimbursements will be determined on a prospective basis only by a method determined by the Plan Administrator that is in accordance with applicable law. The Plan Administrator (or its designated claims administrator) will notify you of the applicable method when you make your election change.

Q-13. How are amounts allocated to the Health FSA withheld from my pay?

When you enroll online, you specify the amount of reimbursement for Eligible Medical Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any non-elective Employer Contributions (if any) allocated to your Health FSA, will be withheld from each paycheck by your Employer.

Q-14. What amounts will be available for reimbursement of Eligible Medical Expenses at any particular time during the Plan Year?

The full annual amount of reimbursement you have elected under the Health FSA for a Plan Year (reduced by prior reimbursements for that Plan Year) will be available at any time during the Plan Year without regard to how much you have contributed to the Health FSA. If your Employer has adopted a Carryover Provision for the Health FSA, any carryover amounts will also be available for reimbursement of Eligible Medical Expenses.

Q-15. How do I receive reimbursement under the Health FSA?

Traditional Paper Claims

When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., a receipt, explanation of benefits or "EOB") associated with each expense that indicates the following:

- Name of person receiving service;
- Date service(s) incurred (e.g. the date the prescription was filled, the date a medical procedure was performed. The date an orthodontia adjustment was performed, etc. This is not necessarily the date that the service was paid for.);
- Name of doctor or provider of service(s) (e.g. the name of the doctor who performed the medical procedure, the store from where the prescription or over-the-counter item was purchased). If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy with the RX number; and

- Nature of expense (e.g., what type of service or treatment was provided); and

- The amount of the expense

You may be required to provide additional substantiation to the extent determined necessary to support your claim. The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination.

You must submit all claims for reimbursement for a Plan Year on or before the last day of the Run-Out Period for that Plan Year. The Run-Out Period is described in the Plan Information Appendix. If your Employer has adopted a Carryover Provision for the Health FSA, any available carryover amount will continue to be available for the next Plan Year.

NOTE: If your health plan administrator or insurance carrier automatically submits an EOB to the Third Party Administrator for processing, you may not have to provide any additional substantiation or certification.

You may also be able to use an electronic payment card to pay expenses at the time they are incurred. If the Employer provides an electronic payment card, the terms of the electronic payment card will be set forth in the Plan Information Appendix.

Q-16. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your Eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d), except that for a limited purpose Health FSA, “medical care” includes only “medical care” expenses for dental, vision and preventive services. Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "Eligible Dependent" is your legal spouse (in accordance with federal law) and any other individual who is a "dependent" as defined in Code Section 105(b) (i.e., a dependent who is

eligible to receive tax-free health coverage under the Code). Coverage for an individual covered as an Eligible Dependent under the Health FSA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and prescribed over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care," as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Over-the-counter drugs and medicines (other than insulin) that are for "medical care" will not constitute an Eligible Medical Expense unless you or your eligible dependents have obtained a prescription from a provider authorized by state law (e.g., a physician). Insulin and over-the-counter products and devices other than drugs or medicines will still constitute an Eligible Medical Expense even if not prescribed by a physician to the extent that they are for medical care.

In addition, certain other expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Appendix and/or enrollment material.

Q-17. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while a Participant. An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Health FSA election becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

If the Employer has adopted a Grace Period, you may also be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the Grace Period following the end of the Plan Year. The terms of the Grace Period, if adopted, will be described in the Plan Information Appendix.

If the Employer has adopted a Carryover Provision, you will be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the following Plan Year. Note that any carryover amounts from a Plan Year cannot be determined and are not available to you until after the last day of the Run-Out Period for that Plan Year. The terms of the Carryover Provision, if adopted, will be described in the Plan Information Appendix.

Note: An Employer may not adopt a Grace Period and a Carryover for the same Plan Year.

Q-18. What if the Eligible Medical Expenses I incur during the Plan Year are less than the annual amount I have allocated to the Health FSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the Health FSA will be forfeited by the Participant if it has not been applied by the end of the Run-Out Period to reimburse expenses incurred during the Plan Year. The Run-Out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

If the Employer has adopted a Grace Period following the end of the Plan Year, amounts allocated to the Health FSA that are unused at the end of the Plan Year may also be used to reimburse Eligible Medical Expenses incurred during the Grace Period following the end of the Plan Year.

If the Employer has adopted a Carryover Provision, amounts allocated to the Health FSA that are unused at the end of the Plan Year (determined as of the last day of the Run-Out Period for that Plan Year) may be used to reimburse Eligible Medical Expenses incurred in the subsequent Plan Year.

Q-19. What happens if a claim for benefits under the Health FSA is denied?

If you are denied a benefit under the Health FSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-20. What happens to unclaimed Health FSA reimbursements?

Any reimbursements under the Health FSA that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

Q-21. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health FSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

<u>When Coverage May Be Continued</u>

If you are a Participant in the Health FSA, then you generally have a right to choose continuation coverage under the Health FSA if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the spouse of a Participant, then you generally have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- The divorce or legal separation from the Participant.

In the case of a dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events." Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries." A child who is born to, or placed for adoption with, the Participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of the Health FSA reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse) must notify the COBRA Administrator identified in the Plan Information Appendix in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse is treated as notice to any covered dependents who reside with the spouse.

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under

the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage as a result of a Qualifying Event or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified in the Plan Information Appendix of this SPD. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day Grace Period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The first day of the month following the month for which you made a timely and complete premium payment (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation *after you have elected COBRA continuation coverage*;
- The date that you first become entitled to Medicare *after you have elected COBRA continuation coverage*; or
- The date the Employer no longer provides group health coverage to any of its employees.

Q-22. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate privacy notice that outlines the Employer's health privacy policies.

Q-23. How does this Health FSA interact with a Health Reimbursement Arrangement sponsored by my Employer?

Typically, a Health FSA is the payer of last resort. This means the Health FSA cannot reimburse expenses that are reimbursable from any other source. However, if you are also participating in a Health Reimbursement Arrangement or "HRA" that covers expenses covered by this Health FSA, the employer may require the Health FSA pay first, rather than the HRA. If the Health FSA pays first, you must exhaust your Health FSA balance before using funds allocated to your HRA. The Plan Information Appendix will indicate whether the Health FSA or HRA must pay first.

Q-24. How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Health FSA indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Other Important Health FSA Information

ERISA Rights

The Health FSA Plan is an ERISA welfare benefit plan. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all 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 SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (if any). The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage. You may continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your eligible dependents will have to pay for such coverage. You should review e COBRA section of this Health FSA appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the Health FSA is subject to HIPAA's portability rules) You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Health FSA when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan

Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforce Your Rights

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 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.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Part III. Dependent Care FSA Benefits

The following Questions and Answers relate to the Dependent Care FSA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Contributions to the Dependent Care FSA.

Q-25. What is the "Dependent Care FSA"?

The Dependent Care FSA is the portion of the Plan that provides for reimbursement of Eligible Day Care Expenses incurred by the Participant. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Day Care Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Q-26. What is the maximum reimbursement amount that I may elect under the Dependent Care FSA?

You may choose any reimbursement amount you desire subject to the maximum annual Dependent Care FSA Reimbursement Amount (and Dependent Care FSA Minimum Reimbursement Amount) described in the Plan Information Appendix. You should be aware that there is an overall statutory maximum on your Dependent Care Reimbursement Amount. This statutory maximum is also described in the Plan Information Appendix.

In addition, the amount of reimbursement that you receive cannot exceed the lesser of your or your spouse's earned income (as defined in Code Section 32). To the extent permitted by applicable law, your spouse will be deemed to have earned income for purposes of the dependent Care FSA of $250 ($500 if you have two or more Qualifying Individuals (as defined in Q-30), for each month that your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Q-27. How are amounts allocated to the Dependent Care FSA withheld from my pay?

When you enroll, you specify the amount of reimbursement for Eligible Day Care Expenses you wish to pay for with Pre-tax Contributions. Thereafter, an equal pro-rata portion of the annual contribution, reduced by any non-elective Employer Contributions (if any) allocated to your Dependent Care FSA sub-account, will be withheld from each paycheck by your Employer.

Q-28. What amounts will be available for reimbursement of Eligible Day Care Expenses at any particular time during the Plan Year?

Under the Dependent Care FSA, you may be reimbursed only up to the amount of your Dependent Care FSA sub-account balance at the time the request for reimbursement is processed.

Q-29. How do I receive reimbursement under the Dependent Care FSA?

When you incur an Eligible Day Care Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party

Administrator. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The provider name;
- The provider contact information;
- The dependent name;
- Service dates (begin and end); and
- A description of the service and
- The expense amount

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Day Care Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Run-Out Period. The Run-Out Period is described in the Plan Information Appendix.

Q-30. What are "Eligible Day Care Expenses"?

You may be reimbursed for work-related dependent day care expenses ("Eligible Day Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

- An individual that you can claim on your federal income tax return as a "Qualifying Child" (as defined in Code Section 152(a)(1)) and who is age 12 or under, or
- A spouse or other tax "Dependent" (as defined generally in Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152; or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only

be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The day care is not provided by a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by the Participant's Spouse or the parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 for further guidance as to what is or is not an Eligible Day Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for Eligible Day Care Expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-31. When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred ***during*** the Plan Year and while a Participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Dependent Care FSA election becomes effective, or after a separation from service.

If the Employer has adopted a Grace Period, you may also be able to use amounts allocated to the Dependent Care FSA that are unused at the end of the Plan Year for expenses incurred during the

Grace Period following the end of the Plan Year. The terms of the Grace Period, if adopted, will be described in the Plan Information Appendix.

Q-32. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount I have allocated to the Dependent Care FSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Day Care Expenses you have incurred and the annual reimbursement amount that you have elected. Except as otherwise set forth in the Plan Information Appendix, any amount allocated to the Dependent Care FSA shall be forfeited by the Participant if it has not been applied by the end of the Run-Out Period to reimburse expenses incurred during the Plan Year. The Run-Out Period is described in the Plan Information Appendix. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

Q-33. What happens if a claim for benefits under the Dependent Care FSA is denied?

If you are denied a benefit under the Dependent Care FSA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-34. What happens to unclaimed Dependent Care FSA reimbursements?

Any Dependent Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Day Care Expense was incurred shall be forfeited.

Q-35. Will I be taxed on the Dependent Care FSA reimbursement I receive?

You will not normally be taxed on your Dependent Care FSA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this Dependent Care FSA and/or another employer's Dependent Care FSA) does not exceed the statutory limits set forth In the Plan Information Appendix below. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-36. If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Day Care Expenses not reimbursed under this Dependent Care FSA may be eligible for the dependent care credit.

THE PLAN INFORMATION APPENDIX TO THE FLEXIBLE SPENDING ACCOUNT PLAN SUMMARY PLAN DESCRIPTION ("SPD")

This Appendix provides information specific to the Fidelity Bank Flexible Spending Account Plan

I. EMPLOYER/PLAN SPONSOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:		Fidelity Bank 100 South Main Street, PO Box 8 Fuquay Varina, NC 27526
2. Employer's federal tax identification number:		56-0132045
3. Adopting Employers participating in the Plan:		
4. Effective Date of the Plan:		1/1/2014
5. Effective Date of Amendment / Restatement (if different from 4):		1/1/2014
6. The initial Plan Year:		1/1/2014 to 12/31/2014
7. All subsequent Plan Years:		2014
8. Name, address, and telephone number of the Plan Administrator:		Laurel LaBonte, HR Director 100 South Main Street, PO Box 8 Fuquay Varina, NC 27526 P: (919) 557-4531
9. Third-Party Administrator:		ADP Benefit Services 2575 Westside Parkway, Suite 500 Alpharetta, GA 30004-3852
10. COBRA Administrator		ADP COBRA Services 2575 Westside Parkway, Suite 500 Alpharetta, GA 30004-3852 P: (800) 526-2720

II. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, and ELECTIONS

(a) The Flexible Spending Account Plan

Each Employee who meets the eligibility requirements noted below in II.(b), II.(c) and II.(d) and who is eligible for coverage or participation under any of the Benefit Plans will be eligible to participate in this Plan on 1/1/2014 ("Eligibility Date").

The Employee's commencement of participation in the Plan is conditioned on the Employee properly completing and submitting a Salary Reduction Agreement as summarized in the SPD. Eligibility for coverage under any given Benefit Plan shall be determined not by this Plan but by the terms of that Benefit Plan.

(b) General Purpose Health FSA.

Each Employee who works 20 hours per week shall be eligible to participate in the Health FSA on 1/1/2014 ("Health FSA Eligibility Date"). An Employee may not participate in both a general purpose Health FSA and a limited purpose Health FSA.

(c) Limited Purpose Health FSA

Each Employee who shall be eligible to participate in the Health FSA on 1/1/2014 ("Health FSA Eligibility Date"). An Employee may not participate in both a limited purpose Health FSA and a general purpose Health FSA.

(d) Dependent Care FSA.

Each Employee who works 20 hours per week shall be eligible to participate in the Dependent Care FSA on 1/1/2014 ("Dependent Care FSA Eligibility Date").

III. BENEFIT PACKAGE OPTION(S) PROVIDED UNDER THE PLAN

The Employer elects to offer to eligible Employees the following Benefit Plan(s) subject to the terms and conditions of the Plan and the terms and conditions of the Benefit Plans. These component Benefit Plan(s) are specifically incorporated herein by reference. The maximum Pre-Tax Contributions a Participant can contribute via the Salary Reduction Agreement is the aggregate cost of the applicable Benefit Plans selected minus any Non-elective Contribution made by the Employer. It is intended that such Pre-Tax Contribution amounts will, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes.

(a) Benefit Package Option(s): The following Benefit Package Option(s) are made available under the Plan to all those eligible Employees who make an appropriate election.

1. Health Care Flexible Spending Account

2. Dependent Care Flexible Spending Account

(b)(1) General Purpose Health Care Reimbursement: Your maximum general purpose Health FSA reimbursement amount is the sum of: (1) the amount of Pre-tax Contributions you elect to make to the general purpose Health FSA Reimbursement Account, not to exceed $2,500.00 plus (2) the amount of any Nonelective Contributions you elect to allocate to the general purpose Health FSA Reimbursement Account. You should note that the current IRS maximum for Pre-Tax Contributions to the general purpose Health FSA Reimbursement Account is $2,500 per Plan Year. The minimum reimbursement amount that may be elected under the general purpose Health FSA is .

(b)(2) Interaction With HRA. See below regarding this general purpose Health FSA's rules with respect to coordination with an HRA:

Does the Employer sponsor an HRA?	No

(b)(3) Limited Purpose Health Care Reimbursement: Your maximum limited purpose Health FSA reimbursement amount is the sum of: (1) the amount of Pre-tax Contributions you elect to make to the limited purpose Health FSA Reimbursement Account, not to exceed plus (2) the amount of any Nonelective Contributions you elect to allocate to the limited purpose Health FSA Reimbursement Account. You should note that the current IRS maximum for Pre-Tax Contributions to the limited purpose Health FSA Reimbursement Account is $2,500 per Plan Year. The minimum reimbursement amount that may be elected under the limited purpose Health FSA is .

(b)(4) Interaction With HRA. See below regarding this limited purpose Health FSA's rules with respect to coordination with an HRA:

Does the Employer sponsor an HRA?	No

(c) Dependent Care Reimbursement. Dependent Care Reimbursement under the Dependent Care FSA shall not exceed the lesser of the amount elected under Plan or per Plan Year (or $2,500 for married filing separate returns), pursuant to the terms of the Dependent Care FSA described in Part II, Appendix "B" of the SPD. The minimum reimbursement amount that may be elected under the Dependent Care FSA is $5,000.00.

IV. QUALIFIED RESERVIST DISTRIBUTIONS

Does this Health FSA include Qualified Reservist Distributions?	No

If this Health FSA offers Qualified Reservist Distributions, you must:

- be a member of a "reserve component" (as defined in section 101 of title 37 of the United States Code), which means a member of the Army National Guard; the Reserve for the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard; Air National Guard of the United States; or the Reserve Corps of the Public Health Service;
- be called or ordered to active military duty for (i) 180 days or more or (ii) for an indefinite period; and
- be a Participant in the Health FSA on the date you are called or ordered to duty.

If you believe you are eligible for a Qualified Reservist Distribution, you must contact the Plan Administrator to request a distribution request form as soon as possible. A request for a Qualified Reservist Distribution must be made in writing on the form provided by the Plan Administrator. You must submit a copy of your order or call to active duty along with your request. Requests for a Qualified Reservist Distribution must be made on or after the date of the order or call to duty but before the last day of the Plan Year (or grace period, if applicable) during which the order or

call to duty occurred. You will receive your Qualified Reservist Distribution within a reasonable period of time, but no later than sixty (60) days after your request has been received.

A Qualified Reservist Distribution will be made based on all salary reduction amounts credited to your Health FSA for the applicable Plan Year that have not been applied to provide Health FSA Reimbursements submitted before the Qualified Reservist Distribution request is submitted. Claims incurred and submitted but not yet reimbursed at the time the Qualified Reservist Distribution request is received will be treated like any other claim submitted for reimbursement under the Health FSA. The Plan Administrator will determine what this amount is on a uniform basis, consistent with applicable law and IRS interpretations. Notwithstanding any other provision of this Plan, an individual who has selected a Qualified Reservist Distribution shall be considered to have made such election as an alternative to COBRA or USERRA coverage

continuation for the Health FSA (except as may otherwise be required by applicable law). If you elect to receive a Qualified Reservist Distribution, you forfeit any right to reimbursement for medical expenses incurred after the date of the Qualified Reservist Distribution request that would otherwise be available under the Plan.

Unlike your reimbursements from your Health FSA for Eligible Medical Expenses, the amount of your Qualified Reservist Distribution is taxed as income and will be reported as income on your W-2.

V. RUN-OUT PERIOD FOR PLAN YEAR EXPENSES

The Employer has established a Run-Out Period for the Plan that follows the end of the Plan Year during which you are allowed to submit reimbursement requests for expenses that were incurred in the prior Plan Year.

(a) The Run-Out Period for active employees is 90 days after the end of the Plan Year.

(b) The Run-Out Period for Participants whose coverage is terminated is 90 days.

VI. CLAIMS AND APPEAL PROCEDURES

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Third Party Administrator*. If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal with the Third Party Administrator no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision.
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their Benefit Plan(s).

VII. GRACE PERIOD

The Employer has established a Grace Period for the Plan that follows the end of the Plan Year during which any amounts unused at the end of the Plan Year may be used to reimburse Eligible Expenses incurred during the Grace Period.

The Grace Period will begin on the first day of the next Plan Year and will end 3/15/2015 (not to exceed two (2) months and fifteen (15) days later)]. For example, for a calendar year plan with a Grace Period of two and a half months, if the Plan Year ends December 31, 2013, the Grace Period begins January 1, 2014 and ends March 15, 2014.

In order to take advantage of the Grace Period, you must be:

- A Participant in the Health FSA and/or Dependent Care FSA (as applicable) on the last day of the Plan Year to which the Grace Period relates, or
- (for Health FSA only) A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the Grace Period relates.

Expenses incurred during a Grace Period must be submitted before the end of the Run-Out Period described in this SPD. This is the same Run-Out Period for expenses incurred during the Plan Year to which the Grace Period relates. Any unused amounts from the end of a Plan Year to which the Grace Period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the Grace Period relates or during the Grace Period will be forfeited if not submitted for reimbursement before the end of the Run-Out Period. The Employer may establish procedures whereby reimbursement for expenses incurred during the Grace Period (to the extent submitted before the end of the Run-Out Period applicable to the prior Plan Year) are reprocessed so that you are able to maximize your annual election amount for the current Plan Year. The procedures will be uniform and nondiscriminatory.

VIII. CARRYOVER PROVISION

The Employer has not established a Carryover Provision for the Health FSA that allows amounts unused at the end of the Plan Year (determined as of the last day of the Run-Out Period for that Plan Year) to be used to reimburse Eligible Medical Expenses incurred during the subsequent Plan Year. Under IRS rules, the maximum carryover amount is $500.

The Employer may choose to transfer any carryover amount from a general purpose Health FSA to a limited purpose Health FSA if doing so would enable a participant to make or receive tax-favored contributions to a Health Savings Account.

IX. ELECTRONIC PAYMENT CARDS

The Employer does not permit Participants to use an electronic payment card to pay for Eligible Expenses at the point of service. If the Employer permits Participants to use an electronic payment card, the following rules apply.

Electronic Payment Card Terms of Usage

You may use the electronic payment card to pay for Health FSA expenses.

You have two reimbursement options under the account(s) identified above. You can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). Alternatively, you may use an electronic payment card ("Electronic Payment Card" or the "Card") provided by the Employer to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc). The following is a summary of how the Electronic Payment Card option works.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

(a) *You must make an election to use the Card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. A Cardholder Agreement will be provided to you. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The Card will be turned off when employment or coverage terminates.* The Card will be turned off when you terminate employment or coverage under the Plan. You may not use the Card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the Card.* As specified in the Cardholder Agreement, you certify during the applicable election period that the amounts in your Health FSA will only be used for Eligible Medical Expenses, that you have not been reimbursed for the expense, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of Card use privileges.

(d) *Reimbursement under the Card is limited to certain merchants.* Use of the Card for Eligible Medical Expenses is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. The Card will be administered in accordance with applicable IRS guidance.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible Medical Expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available under the Health FSA. Every time you swipe the Card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an Eligible Medical Expense, that you have not been reimbursed from any other source and you will not seek reimbursement from another source.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the Card.* You must obtain a third party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the Card:

- Name of person receiving service;
- Date service(s) incurred (e.g. the date the prescription was filled, the date a medical procedure was performed. The date an orthodontia adjustment was performed, etc. This is not necessarily the date that the service was paid for.);
- Name of doctor or provider of service(s) (e.g. the name of the doctor who performed the medical procedure, the store from where the prescription or over-the-counter item was purchased). If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy with the RX number and;
- Nature of expense (e.g., what type of service or treatment was provided); and
- The amount of the expense.

You should retain this receipt for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the Card arrangement, a written third party statement is generally required to be submitted (except as otherwise set forth in the applicable law and/or related guidance). You will receive a letter from the Third Party Administrator that a third party statement is needed. You must provide the third party statement to the Third Party Administrator within 45 days (or such longer period provided in the letter from

the Third Party Administrator) of the request. In accordance with applicable guidance, there may be situations in which the Third Party Administrator does not ask for substantiation related to a Card swipe.

Special Rules for Use of Cards to Purchase Over-the-Counter Drugs or Medicines

If you purchase an over-the-counter drug or medicine with your Card from a merchant that utilizes the inventory information approval system (IIAS) or a vendor that utilizes a merchant code, you must provide the prescription for the drug or medicine to the pharmacist prior to purchase.

If you purchase an over-the-counter drug or medicine with your Card from a merchant that does not utilize the IIAS, you may be required to present to the Third Party Administrator:

- a copy of the prescription; or

- a copy of the receipt that has the RX number and the identity of the individual for whom the prescription was issued.

(g) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Third Party Administrator, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the Card will be turned off and an amount equal to the unsubstantiated expense will be offset against future Eligible Medical Expenses. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder

Agreement) or the remaining unpaid amount may be treated by the Employer as any other bad debt, which will result in additional gross income for you.

(h) *You can use either the Electronic Payment Card or the Traditional Paper Claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the Electronic Payment Card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.