THE FIDELITY BANK LONG TERM DISABILITY PLAN

Amended and Restated
Effective as of January 1, 2012

THE FIDELITY BANK LONG TERM DISABILITY PLAN

The Fidelity Bank (hereinafter referred to as the "Company") hereby amends and restates The Fidelity Bank Long Term Disability Plan (the "Plan"), effective January 1, 2012.

ARTICLE I
ESTABLISHMENT AND PURPOSE OF THE PLAN

1.1 Establishment of Plan. The Company has established the Plan for the exclusive benefit of its employees, employees of certain related businesses, and their respective dependents and beneficiaries, as applicable, to provide certain welfare and fringe benefits to such individuals.

1.2 Plan Document. This document, together with the specific documents (or portions thereof) either (i) set forth in Appendix A, or (ii) the successor documents to such referenced documents, shall constitute the written plan document for this Plan and for the underlying Welfare Benefit provided under the Plan, and each of the separate documents (or portions thereof) referenced in Appendix A are hereby incorporated by reference.

ARTICLE II
DEFINITIONS

The following words and phrases when used with initial capitals herein shall have the following meanings unless the context or Section 6.2 requires otherwise. All other defined terms in this Plan shall have the meanings specified in the documentation with respect to the underlying Welfare Benefit in which they appear.

2.1 Code. "Code" means the Internal Revenue Code of 1986, as amended.

2.2 Contract. "Contract" means any contract, other than a Policy, entered into by the Employer that is being used in conjunction with providing the underlying Welfare Benefit referenced in Appendix A.

2.3 Company. "Company" means The Fidelity Bank and its successors and assigns.

2.4 Employee. "Employee" means any person who is employed by the Employer as a common law employee and who is compensated from the Employer's payroll. Provided, however, the term "Employee" shall not include any independent contractor, contract worker, or any other individual who is not designated as of the initial date of the relationship as a common law employee of the Employer. Any subsequent determination or redetermination that such individual is, was, or may have been a common law employee of the Employer shall not affect the initial treatment of such individual by this Plan as being excluded from "Employee" status and no such individual shall be made retroactively eligible to participate in the Plan. Any such determination or redetermination of such status may only affect the future treatment of that individual with respect to this Plan and only after the Employer has designated that individual as an "Employee."

2.5 Employer. "Employer" means, collectively, (i) the Company, and (ii) any other affiliated or related entity which has adopted this Plan for the benefit of its Employees in a manner satisfactory to such entity and the Company and which is set forth in Appendix B attached hereto, as amended from time to time.

2.6 ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.7 Insurer. "Insurer" means the entity that issues any Policy utilized under the Plan.

2.8 Participant. "Participant" means any individual who is eligible for, and becomes covered with respect to, the Welfare Benefit provided under the Plan.

2.9 Plan. "Plan" means, collectively, this agreement, including all amendments thereto, together with the separate documentation (or portions thereof) with respect to the Welfare Benefit referenced in Appendix A attached hereto that is incorporated by reference. With respect to the Welfare Benefit referenced in Appendix A, the term "Plan" also means the specific documentation (or portions thereof) relating to such underlying Welfare Benefit.

2.10 Plan Administrator. "Plan Administrator means the Company or, except as otherwise set forth in any Policy or Contract incorporated by reference into this Plan, such other entity, person, or committee as may be appointed from time to time to act as Plan Administrator by the Company, pursuant to the terms of Section 6.3.

2.11 Plan Year. "Plan Year" means the Plan's accounting year of twelve months commencing on January 1st of each year and ending the following December 31st.

2.12 Policy. "Policy" means any policy of insurance or health maintenance organization contract which involves the shifting of the risk to an Insurer, health maintenance organization, or other third-party unrelated to the Employer that is being used in conjunction with providing any underlying Welfare Benefit referenced in Appendix A.

2.13 Welfare Benefit. "Welfare Benefit" means the group long term disability benefits provided by this Plan.

ARTICLE III
ELIGIBILITY, PARTICIPATION, AND BENEFITS

3.1 Eligibility and Participation.

(a) The terms and conditions regarding eligibility and participation under the Plan with respect to the Welfare Benefit provided under the Plan, including any applicable enrollment procedures, are set forth in the Plan documentation referenced in Appendix A.

(b) Notwithstanding Section 3.1(a), unless the Plan documentation referenced in Appendix A expressly provides to the contrary, or the provisions of Article VI apply:

(1) Individuals, who at the time eligibility is determined, are not classified as a full-time Employee (*i.e.*, regularly scheduled to work at least twenty (20) hours a week) are not eligible to participate in the Plan;

(2) Any dependent of an individual identified in Section 3.1(b)(1) is not eligible to participate in the Plan; and

(3) Any individual (or dependent thereof) is eligible for coverage under the Plan only if any required contributions by Participants as set forth in Section 4.1 with respect to such coverage have been made for the period for which coverage is claimed or sought.

3.2 Benefits.

(a) The terms and conditions of the benefits provided to Participants under this Plan with respect to the underlying Welfare Benefit are described in the underlying Plan documents, and shall be subject to various limitations and exclusions set forth in the Plan with respect to such Welfare Benefit.

(b) No Participant shall be entitled to any benefits under this Plan except as expressly provided in the Plan with respect to the Welfare Benefit.

ARTICLE IV
CONTRIBUTIONS

4.1 Contributions by Participants.

(a) With respect to the Welfare Benefit provided under the Plan, Participants shall make contributions, if any, in the amounts specified and adjusted from time to time by the Employer for particular groups of Participants. At least annually, the Employer shall provide to individuals eligible to participate in the Plan a schedule of the required contributions, if any, for such Welfare Benefit.

(b) Unless the Plan documentation referenced in Appendix A expressly provides to the contrary or is otherwise impermissible under applicable law, each Participant required to make contributions under this Section 4.1 who is an Employee of the Employer shall authorize payment of his contributions by payroll deduction pursuant to the terms of the cafeteria plan within the meaning of Section 125 of the Code maintained by the Company.

4.2 Contributions by the Employer. The Employer shall provide sufficient funds, in addition to contributions made by Participants, to provide for, directly or indirectly, the Welfare Benefit of this Plan.

ARTICLE V
FUNDING

The Welfare Benefit provided under the Plan shall be funded by the Policy; provided, however, any dividends credited to the Employer under such Policy are reserved by the Employer to the extent that the total of such dividends does not exceed the total of Employer contributions under the policy or contract for such premium year and to such extent such dividends shall not constitute an asset of the Plan. Nothing herein shall be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any particular Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

ARTICLE VI
PLAN ADMINISTRATION AND OPERATION

6.1 Principal Duty. The Plan shall be administered by the Plan Administrator. It shall be the principal duty of the Plan Administrator to determine that the provisions of the Plan are carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative provisions set forth in this Article VI shall govern the administration of the Plan, except to the extent that other administrative provisions set forth in the Plan documentation with respect to the Welfare Benefit (including, but not limited to, any administrative claims and review procedures) differ from the provisions herein.

6.2 Plan Administrator's General Powers, Rights, and Duties. The Plan Administrator shall have full discretionary power to administer the Plan in accordance with its terms and intended meaning, subject to any applicable requirements of law. For this purpose, the Plan Administrator is, as respects the rights and obligations of all parties with an interest in this Plan, given the powers, rights, and duties specifically stated elsewhere in the Plan, and in addition is given, but not limited to, the following powers, rights, and duties:

(a) To determine all questions arising under the Plan, including the power to determine the rights or eligibility of Employees or Participants and any other persons, and the amounts of their contributions or benefits under the Plan;

(b) To make any findings of fact needed in the administration of the Plan;

(c) To interpret and construe the Plan, and to remedy ambiguities, inconsistencies, or omissions in any fashion it deems to be appropriate in its sole judgment (including, but not limited to, interpreting any Plan provision that due to errors, omissions, or delays in drafting does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent);

(d) To make and enforce such rules and regulations as its deems necessary for the proper and efficient administration of the Plan;

(e) To direct payments or distributions from the Plan in accordance with the provisions of the Plan;

(f) To develop such information as may be required by it for tax or other purposes as respects the Plan;

(g) To employ agents, attorneys, accountants, or other persons (who also may be employed by the Employer), and allocate or delegate to them such powers, rights and duties as the Plan Administrator may consider necessary or advisable to properly carry out the administration of the Plan; and

(h) To the extent allowed by law, rely conclusively on any tables, valuations, certificates, opinions, and reports, which are furnished by, or in accordance with the instructions of, the agents, attorneys, accountants, or other persons, employed or engaged by the Plan Administrator.

6.3 Exercise of Authority. To the extent the Plan Administrator has been granted discretionary authority under the Plan, the Plan Administrator's prior exercise of such authority shall not obligate it to exercise its authority in a like fashion thereafter. Moreover, the validity of any findings of fact, interpretation, construction, or decision by the Plan Administrator shall not be given *de novo* review if challenged in court or in any other forum, and shall be upheld unless clearly arbitrary or capricious. Thus, subject to the claims and review procedures set forth in Section 6.6, all actions taken and all determinations made in good faith by the Plan Administrator pursuant to this Article VI shall be final and binding upon all persons claiming any interest in or under the Plan.

6.4 Indemnification of Administrator. The Company agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as a delegate or agent of the Plan Administrator (including any Employee or former Employee who is serving or formerly served as a delegate or agent of the Plan Administrator) against all liabilities, damages, costs, and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is or was in good faith.

6.5 Information Required by Plan Administrator. The Plan Administrator shall obtain such data and information as the Plan Administrator may deem necessary or desirable in order to administer the Plan. The records of the Employer as to an Employee's or Participant's period or periods of employment, termination of employment and the reason therefore, leave of absence, re-employment, and earnings will be conclusive on all persons unless determined by independent agents or delegates of the Plan Administrator to be incorrect. Participants and other persons entitled to benefits under the Plan also shall furnish the Plan Administrator with such evidence, data, or information, as the Plan Administrator considers necessary or desirable to administer the Plan.

6.6 Claims and Review Procedures.

(a) Benefit Determinations. All claims for eligibility to participate or for the payment of benefits under this Plan shall be first made to the Plan Administrator, or to such other person as the Plan Administrator may designate (a "claims administrator"), in such manner and in such form as the Plan Administrator (or claims administrator) may reasonably require. The Plan Administrator (or claims administrator) shall, subject to the review procedures set forth below, have the responsibility and authority to interpret the provisions of the Plan with respect to the underlying benefit involved, to decide the rights of the claimant to the claimed benefit (including, but not limited to, eligibility determinations), to determine the amount of any such benefit, and to inform the claimant of his decision with respect to the claim for benefits. Any Participant or beneficiary (or a duly authorized representative thereof) (collectively, a "claimant") may file a claim for benefits under the Plan to which the claimant believes he is entitled. Upon receipt of a properly documented claim for benefits, the Plan Administrator (or claims administrator) shall inform the claimant of its decision with respect to such claim.

The claimant shall be notified of the Plan's benefit determination within a reasonable period of time (but in no event in excess of the applicable maximum response time) after the claim is received by the Plan Administrator (or claims administrator), unless the claimant has failed to submit sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator (or claims administrator) shall notify the claimant as soon as possible of the specific information necessary to complete the claim. If circumstances beyond the control of the group health plan require an extension of time for processing a claim, then the Plan Administrator (or claims administrator) may be granted such an extension of a specified limited duration, provided the claimant is given notice of such special circumstances and the length of the extension prior to the expiration of the applicable maximum response time. If the claimant is not notified of the determination of his claim for benefits within the applicable maximum response time (including any extensions), then the claim shall be deemed denied as of the last day of such period. For purposes of this Section, the maximum permitted response time for a disability claim is 45 days. Two separate extensions of up to 30 days each are permitted.

(b) Manner and Content of Adverse Benefit Determination Notifications. In the event of a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit provided under the Plan (an "adverse benefit determination"), notice of such adverse benefit determination shall be written (or provided electronically, consistent with the applicable legal standards for electronic notifications) in a manner calculated to be understood by the claimant and shall set forth: (i) the specific reasons for the denial, (ii) references to the specific pertinent Plan provisions, (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as

to why such information is necessary, and (iv) a description of the Plan's claims and claims review procedure and the time limits applicable to such procedure (including the claimant's right to pursue a civil legal action following an adverse benefit determination on review). The following additional rules shall apply: (i) upon request, a claimant shall be provided free of charge with a copy of any rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination, (ii) upon request, a claimant shall be provided free of charge with an explanation applying the terms of the plan to the claimant's medical circumstances if the adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion or limitation, and (iii) in the case of an adverse benefit determination with respect to an urgent care claim, the claimant shall be provided with a description of the expedited review procedures set forth below in Section 6.6(c), and all adverse benefit determination notification information may be provided to the claimant orally if written (or electronic) notification is furnished to the claimant no later than three (3) days after the oral notification.

(c) Review Procedure. After receipt of the notice of an adverse benefit determination (or, if applicable, the date on which an adverse benefit determination is considered to have occurred), the claimant shall have a reasonable opportunity to appeal such adverse benefit determination to a designated named Plan fiduciary for a full and fair review. A claimant (i) may request such a review upon written notice to the designated named Plan fiduciary; (ii) may submit written comments, documents, records, and other information relating to the claim; (iii) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (iv) shall be provided with a review that takes into account all comments, documents, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The following procedures shall apply to the claim under review: (i) a claimant shall have at least 180 days after the date on which the claimant receives a written notice of a denied claim (or, if applicable, the date on which an adverse benefit determination is considered to have occurred) to file a written request with the Plan Administrator for a review of the adverse benefit determination; (ii) such review shall not afford deference to the initial claim denial and shall be conducted by a designated named Plan fiduciary who is neither the individual who made the initial claim denial or is a subordinate of such individual; (iii) with respect to an adverse benefit determination that is based, in whole or in part, on a medical judgment, the named fiduciary conducting the review shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment, provided that such professional was not consulted with respect to the initial claim denial or is a subordinate of any such individual who was so consulted; (iv) a claimant shall be provided with the identification of any medical or vocational experts whose advice was obtained by

the Plan in connection with a claimant's initial claim denial; and (v) in the case of an urgent care claim, a claimant shall be provided with an expedited review process pursuant to which the appeal of an adverse benefit determination may be submitted orally or in writing by a claimant, and all necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

The claimant shall be notified of the Plan's benefit determination on review within a reasonable period of time (but in no event in excess of the applicable maximum response time) after receipt of the claimant's request for review. Under special circumstances, then the designated named Plan fiduciary may be granted an extension (or extensions) of a specified limited duration, provided the claimant is given notice of such special circumstances and the length of the extension prior to the expiration of the applicable maximum response time. If the claimant is not notified of the determination of the review of his claim for benefits within the applicable maximum response time (including any extensions), then the appeal of the claim shall be deemed denied as of the last day of such period. For purposes of the review of appeals of adverse benefit determinations, the maximum response time is 60 days, and the maximum extension of such response time is another 60 days beyond the initial response time.

(d) Manner and Content of Notification of Benefit Determination on Review. In the case of an adverse benefit determination of a claim on review, such adverse benefit determination shall be written (or provided electronically, consistent with the applicable legal standards for electronic notifications) in a manner calculated to be understood by the claimant and shall set forth: (i) the specific reasons for the denial; (ii) references to the specific pertinent Plan provisions; (iii) a statement that the claimant is entitled to receive, upon request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; and (iv) a statement of any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information concerning any such procedures and his right to bring a civil action with respect to the claim. With respect to disability benefits, the following additional rules shall also apply: (i) upon request, a claimant shall be provided free of charge with a copy of any rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination, (ii) upon request, a claimant shall be provided free of charge with an explanation applying the terms of the plan to the claimant's medical circumstances if the adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion or limitation, and (iii) the notification shall include the statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

6.7 Furnishing Information or Providing Other Reports. To the extent required by the Code or ERISA, the Employer shall provide Employees with: (a) a description of the Plan which will satisfy the Summary Plan Description requirements of Title I of ERISA, and (b) any other required information or notices with respect to the Plan. After payment by the Employee of a reasonable charge, which charge may be waived by the Plan Administrator, the Employer shall provide the Employee with a copy of this Plan upon written request by the Employee. The Company or Plan Administrator, as appropriate or as required by law, shall also file with government authorities any reports or returns required.

ARTICLE VII
MISCELLANEOUS

7.1 Amendment and Termination of Plan. The Company, at any time or from time to time, may amend or terminate the Plan in whole or in part, without the consent of any Employee or Participant; provided, however, no such action shall adversely affect any claims that have actually been incurred by a Participant (or beneficiary) that would otherwise be eligible for payment under the Plan, as it is in effect when the expense is incurred. Where an amendment of the Plan requires the consent or approval of any Insurer, such amendment shall be subject to a condition that such consent or approval is obtained. Notice of any amendment or termination shall be given to the Plan Administrator.

7.2 Information to be Furnished. Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan. The Plan, at its own expense, shall have the right and opportunity (i) to have the person of any individual whose injury or sickness is the basis of a claim under the Plan, examined by a physician designated by the Plan Administrator, when and as often as it may reasonably require during the pendency of a claim under the Plan, and (ii) to make an autopsy in case of death, where it is not forbidden by law.

7.3 No Guaranty of Tax Treatment. Neither the Employer nor the Plan Administrator makes any representation, commitment, or guaranty that the value of any coverage and any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any federal or state tax treatment will apply or be available to any Participant.

7.4 Incapacity. If a Participant is, in the judgment of the Plan Administrator, legally, physically, or mentally incapable of personally receiving any payment due under the Plan, the Plan Administrator, in its sole discretion, may direct payments due to such other person or institution who, in the opinion of the Plan Administrator, is then maintaining or having custody of such Participant until claim is made by a duly appointed guardian or

other legal representative of such Participant. Such payment shall constitute a full discharge of liability of the Plan to the extent of such payment.

7.5 Alienation of Interests. Unless the Plan documentation referenced in Appendix A with respect to a given Welfare Benefit expressly provides to the contrary, benefits provided under this Plan may not be assigned or alienated.

7.6 Unclaimed Payments. Unless the Plan documentation referenced in Appendix A with respect to the Welfare Benefit expressly provides to the contrary, checks that are issued by the Plan for benefit payments and are not cashed within 90 days may be voided. A new check will be issued upon request of the party entitled to payment.

7.7 Recovery of Benefits. If a Participant (or beneficiary) receives a benefit payment under the Plan in excess of the benefit payment that should have been made, the Plan or its agent shall have the right to recover such excess from the Participant (or beneficiary). The Plan may, however, at its option, deduct the amount of such excess from any subsequent benefits payable to or for such Participant (or beneficiary).

7.8 Scope of Legal Rights. Except as provided herein, neither the establishment or maintenance of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving any Participant, or other person any legal or equitable right against the Employer or Plan Administrator. Furthermore, the adoption and maintenance of the Plan shall not be deemed to constitute or modify a contract between the Employer and any Employee or Participant, or to be consideration, inducement for, or condition of the performance of services by any person. Nothing contained herein or in any document incorporated herein shall be deemed to give any Employee or Participant the right to continue in the service of the Employer, to interfere with the right of the Employer to discharge any Employee or Participant at any time, or to give the Employer the right to require an Employee or Participant to remain in its service or to interfere with his right to terminate his service at any time.

7.9 Gender and Number. Wherever any words are used herein in the masculine, feminine, or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

7.10 Action by the Employer. Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by an officer of the Employer or person authorized to act on behalf of the Employer by its legally constituted authority.

7.11 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

7.12 Captions. The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

7.13 Governing Law. This Plan is governed by the Code, ERISA, and the regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan with respect to any given Welfare Benefit. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, administered, and enforced according to the laws of the State of North Carolina.

IN WITNESS WHEREOF, this Plan document is hereby executed on ___________________________.

THE FIDELITY BANK
Company

By:_________________________________
Title:_______________________________

ATTEST:

By:_________________________________
Title:_______________________________

Appendix A

WELFARE BENEFITS PROVIDED UNDER PLAN

Effective as of January 1, 2012

The underlying Welfare Benefits maintained by the Employer under this Plan are listed in the first column below, a description of such benefits is listed in the second column below, any associated documents relating to such benefits are listed in the third column below, and the policy number along with the name and address of any insurer providing such benefits are listed in the fourth column below, as follows:

Underlying Welfare Benefit	Welfare Benefits Provided	Associated Documents	Policy Number, Name & Address of Insurer (if applicable)
LTD	Group Long Term	UNUM Life Insurance	ID: 95593 011
	Disability Benefit	Certificate and SPD	

Appendix B

ARTICLE IXPARTICIPATING AFFILIATED OR RELATED EMPLOYERS

Effective as of January 1, 2012

Name and Address of Primary Location	Employer Identification Number	Benefits Provided
NONE		

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