Your Summary Plan Description

Benefits at Fidelity

Fidelity INVESTMENTS®

The Summary Plan Description (SPD) and any applicable Summaries of Material Modification (SMM) contain general information regarding the terms of the benefit plans offered by FMR LLC and its affiliated companies ("Fidelity" or "the Company"). The benefits described in this SPD are available only to eligible Regular Employees, as defined by the plans, of certain Fidelity Companies. The language used in this SPD is not intended to create, nor is it to be construed to create, a contract between Fidelity and any one of its employees or former employees.

In the event that the content of this SPD, or any oral or written representations made by any person regarding a particular plan or plans, conflicts or is inconsistent with the provisions of the applicable plan document(s), the provisions of the applicable plan(s) and/or any related insurance contract(s) are controlling and will govern. Your enrollment in these plans is subject to all limitations of the plans, including any pre-existing condition exclusions, elimination periods, at-work requirements, and hourly eligibility requirements. Fidelity reserves the right to change, suspend, withdraw, amend, modify, or terminate these plans, in whole or in part, at any time.

Please note: This document is an unofficial version of the SPD that includes 2009, 2010, and 2011 SMM. For an official version, please go to netbenefits.fidelity.com > Employer News (to view electronically) or netbenefits.fidelity.com > FMR Profit Sharing > Plan Information and Documents > Plan Literature (to order a paper copy).

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Benefits Overview

The Fidelity Benefits Program

When it comes to benefits, everyone has different needs. From providing medical coverage for you and your family to helping you save for retirement, Fidelity offers a comprehensive benefits program.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, entering into a domestic partnership (as defined on page 5), having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

As a Regular Employee with Fidelity, you can select the benefits that best meet your needs. You then have the opportunity to update your benefit elections each year during the Annual Benefits Enrollment period and at other times, as permitted by the terms of the plans or applicable law.

This SPD provides a description of various features of Fidelity's benefit plans, including when your coverage becomes effective and how each plan works. The SPD is designed to provide you with a general understanding of your benefits and to answer some of the most commonly asked questions. Please read this SPD carefully and review its contents with individuals in your family whom you may be able to cover under Fidelity's benefit plans.

AN OVERVIEW OF YOUR FIDELITY BENEFITS

This SPD describes the key features of a number of benefits that Fidelity makes available to Regular Employees, including:

- **Medical coverage.**
- **Dental coverage.**
- **Flexible Spending Accounts for health care and/or dependent care.**
- **Life Insurance coverage.**
- **Business Travel Accident Insurance coverage.**
- **Disability coverage.**
- **Group Long-Term Care Insurance coverage.**
- **Employee Assistance Program (EAP) coverage.**
- **Tobacco Cessation Program.**
- **The Retirement Program, including the:**
  - **Profit Sharing Plan (features include 401(k), Catch-up, and Company Contributions).**
  - **Retiree Health Reimbursement Plan (RHRP)*.**

Regular Employees regularly scheduled to work 30 or more hours per week are eligible for all the benefits listed above (assuming employment with a Participating Fidelity Company). Regular Employees regularly scheduled to work at least 20 but fewer than 30 hours per week are eligible for all the benefits listed above (assuming employment with a Participating Fidelity Company), except for life insurance and disability coverage. Regular Employees regularly scheduled to work less than 20 hours per week are eligible for Business Travel Accident Insurance coverage. Regular Employees who are regularly scheduled to work at least 20 but fewer than 30 hours per week share in a greater portion of the cost for medical and dental coverage than Regular Employees who are regularly scheduled to work 30 or more hours per week. The annual RHRP credit amount for Regular Employees who are regularly scheduled to work 30 or more hours per week may be greater than the RHRP credit amount for Regular Employees who are regularly scheduled to work at least 20 but fewer than 30 hours per week.

A number of the plans require that you enroll to participate and that you file a claim to receive benefits. Each section of this SPD contains information about how to file a claim for benefits under that particular benefit plan. The *Administrative* section of this SPD describes your legal rights under the plans, including what to do if your claim is denied.

In some circumstances, a plan may require you to provide evidence of insurability (proof of good health). Some HMOs may require you to select a Primary Care Physician (PCP). More information is included in the applicable sections.

***Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.**

Eligibility

Regular Employees regularly scheduled to work 30 or more hours per week are eligible for the following benefits:

- Medical.
- Dental.
- Flexible Spending Accounts for health care and/or dependent care.
- Life Insurance:
  - Core Life Insurance, which includes Employee Life and Dependent Life Insurance.
  - Variable Life Insurance, which includes Variable Basic Life Insurance, Variable Supplemental Life Insurance, and Variable Investment Options.
- Business Travel Accident Insurance.
- Disability:
  - Short-Term Disability (STD).
  - Long-Term Disability (LTD).
  - Supplemental Long-Term Disability.
- Group Long-Term Care Insurance.
- Employee Assistance Program (EAP).
- Tobacco Cessation Program.
- The Retirement Program*, including the:
  - Profit Sharing Plan (features include 401(k), Catch-up, and Company Contributions).
  - Retiree Health Reimbursement Plan (RHRP)**.

Regular Employees regularly scheduled to work at least 20 but fewer than 30 hours per week are eligible for the following benefits:

- Medical.
- Dental.
- Flexible Spending Accounts for health care and/or dependent care.
- Business Travel Accident Insurance.
- Group Long-Term Care Insurance.
- Employee Assistance Program (EAP).
- Tobacco Cessation Program.
- The Retirement Program*, including the:
  - Profit Sharing Plan (features include 401(k), Catch-up, and Company Contributions).
  - Retiree Health Reimbursement Plan (RHRP)**.

Regular Employees regularly scheduled to work less than 20 hours per week are eligible for the following benefit:

- Business Travel Accident Insurance.

*All employees should note that the Plans under the Retirement Program have additional eligibility requirements. For details, refer to the *Profit Sharing Plan* and the *Retiree Health Reimbursement Plan* sections of this SPD.

**Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Who You May Cover

In addition to yourself, you may elect coverage for your Eligible Dependents under the medical and dental plans. Your Eligible Dependents automatically are covered under the EAP, and under the Dependent Life Insurance Plan, provided that you are eligible for life insurance.

If you are eligible for life insurance, your Eligible Dependents are enrolled automatically in the Dependent Life Insurance Plan.

In this case, Eligible Dependents include your legal spouse, your Domestic Partner, any unmarried children age 2 days to 19 years (or to 23 years if your unmarried child is a full-time student who is dependent upon you for care and support), and any other person designated as eligible under applicable state law.

Eligible Dependents include:

- ***For the medical and dental plans:***
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
  - Those for whom coverage is required by a Qualified Medical Child Support Order (QMCSO).
- ***For reimbursement from the Health Care Flexible Spending Account and the Health Care HSA-Compatible Flexible Spending Account:***
  - Your legal spouse who is a member of the opposite sex, as evidenced by a marriage certificate.
  - Your dependent(s), as defined under Section 152 of the Internal Revenue Code, including, but not limited to, your dependent children.
- ***For reimbursement from the Dependent Care Flexible Spending Account:***
  - Your dependent child(ren) younger than age 13, who generally spends at least eight hours per day in your home, and for whom you provide more than one-half of the individual's support.
  - Any other dependent who is physically or mentally disabled and therefore incapable of self-care, who lives in your home for more than one-half of the tax year, for whom you provide more than one-half of the individual's support.
- ***For the dependent life insurance plans:***
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Unmarried dependent children who are at least 2 days old and younger than age 19 (age 23, if your unmarried dependent is a full-time student who is dependent upon you for care and support).
  - Any other person designated as eligible under applicable state law.
- ***For the EAP:***
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
- ***For the Tobacco Cessation Program:***
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Unmarried dependent children age 18 and over.

For purposes of Fidelity's benefit plans, children include:

– Your natural children.

– Legally adopted children (including a child for whom legal adoption proceedings have begun and who has been placed in your home).

– Natural or legally adopted children of your spouse or Domestic Partner (e.g., your stepchildren).

– Children for whom you are a legal guardian.

If You Have a Child with a Disability. You may request to continue medical, dental, EAP, and life insurance coverage for a dependent child with a disability when that child reaches age 26, provided the child is wholly dependent upon you for support because of the disability. You must provide proper notification of your child's incapacity to the applicable Claims Administrator at least 31 days before your child's 26th birthday.

If you are a new hire, newly benefits eligible employee, or are enrolling in the plan as a result of a Change in Status or Special Enrollment Period (collectively "eligibility event") and you have a disabled dependent age 26 or over, the dependent must have been disabled prior to age 26 in order to be eligible for coverage and must be enrolled within 31 days of the eligibility event.

You may be required to provide periodic proof of your child's continued disability at the Claims Administrator's request.

You must notify HR Solutions within 31 days of the date your child no longer is eligible for coverage under the medical and dental plans and the EAP. This occurs at the earliest of the following dates:

- When your child reaches age 26.
- When your child becomes eligible for other employer-sponsored group health plan coverage which is contributed to, in whole or in part, by their employer.

For purposes of the medical, dental, life insurance, tobacco cessation, business travel accident insurance plans and the survivor benefit under the long-term disability plan, a Domestic Partner (including, without limitation, civil union partners) shall mean a person who:

1. Is a same-sex person in a committed, marriage-like relationship with a Fidelity employee (Note: If you or your partner are age 62 or older and eligible for Social Security benefits or Supplemental Security Income (SSI) based on age, a Domestic Partner may be of the opposite sex);
2. Is at least 18 years old, not related to the employee, and not married to any other person;
3. Is not a member of another domestic partnership or civil union with someone else unless the domestic partnership or civil union was terminated, dissolved or adjudged a nullity;
4. Is capable of consenting to the domestic partnership;
5. Shares a common residence with a Fidelity employee; and
6. Has legally formalized the domestic partnership with the Fidelity employee, if the employee lives in a state where such legal means exist, by having either: (i) legally formalized the domestic partnership in the employee's state of residence; or (ii) formalized the domestic partnership in another state that permits non-resident registration. [For example, employees with a same-sex partner in New Hampshire must either enter into a civil union in New Hampshire or register their partner as a Domestic Partner in another state that permits non-resident Domestic Partner registration, such as California.]

For purposes of the EAP and Long-Term Care, a Domestic Partner is a same-sex or opposite-sex person in a marriage-like relationship with a Regular Employee. The Domestic Partner must have reached the age of majority, not be a relative of the Regular Employee and not be married to any other person. The Regular Employee and the Domestic Partner must have been living together for at least one year, with the intent to be life partners, and generally must be economically interdependent.

In addition to the resources available through NetBenefits® and HR Solutions, most of Fidelity's benefit carriers have websites and representatives you can access for information or assistance. See the ***Resources*** chart at the end of this SPD for a complete listing.

NETBENEFITS® AND HR SOLUTIONS—YOUR BENEFITS INFORMATION RESOURCES

NetBenefits®

NetBenefits® provides you with convenient Internet access to information about your benefits from work or home. For example, when you log on to NetBenefits® (netbenefits.fidelity.com), you can:

- Manage your health benefits, including selecting your initial Primary Care Physician (PCP), if applicable.
- Access health resources by linking to third-party websites.
- Manage your retirement plan account(s), including running online statements or requesting paper statements.
- Estimate your pension benefits, if applicable.
- Consult financial educational information and planning tools.
- View and manage your paycheck and personal information.

To access NetBenefits® for the first time, you must establish your personal identification number (PIN).

HR Solutions

To help you get answers and make changes to your benefit elections, Fidelity provides the services of HR Solutions. When you call HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1, you may:

- Enroll in your benefits.
- Make a change to your benefit elections based on a Change in Status (including, but not limited to, marriage, divorce, or the birth or adoption of a child).
- Request plan information and claim forms.

You may call HR Solutions' Voice Response System (VRS) virtually 24 hours a day, 7 days a week. In addition, representatives are available business days from 8:30 A.M. to 8:00 P.M. ET, except New York Stock Exchange holidays.

Enrolling in Your Fidelity Benefits

Once you become eligible, information that you need to enroll in your benefits will be provided—either electronically or mailed to your address of record. Different rules, eligibility requirements, enrollment dates, Beneficiary designations, forms, requirements, and durations of benefits apply to different types of benefits, as outlined below. For more information about a particular benefit, refer to the appropriate section of this SPD.

Who You May Cover

For medical and dental coverage, you may choose from three coverage levels:

- Individual (yourself only).
- Individual plus one dependent (yourself and one Eligible Dependent).
- Family (yourself and two or more Eligible Dependents).

You may select different coverage levels for different benefits. For example, you may choose medical coverage for your entire family and dental coverage for just you.

If Both You and Your Spouse or Domestic Partner Are Employed by Fidelity. You and your spouse or Domestic Partner each may enroll in individual coverage or one spouse or Domestic Partner may choose to enroll as a dependent of the other. You cannot be covered as both a dependent and an employee in the same type of coverage. For example, you cannot select individual medical coverage for yourself and also be covered as your spouse's or Domestic Partner's dependent under the same type of coverage.

Also, your dependent child(ren) may not be covered by both you and your spouse or Domestic Partner under the same type of coverage. For example, you may cover your children for medical, and your spouse or Domestic Partner may cover them for dental, but you and your spouse or Domestic Partner cannot each cover them for medical.

Regular Employees Regularly Scheduled to Work 30 or More Hours per Week

Regular Employees regularly scheduled to work 30 or more hours per week are eligible for the Fidelity benefits outlined in this section.

For Medical, Dental, and Flexible Spending Accounts. You generally may enroll in medical, dental, and Flexible Spending Accounts via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860) and following the enrollment instructions. Please note, however, that if you are electing medical and/or dental coverage for your same-sex spouse, online enrollment via NetBenefits® is not available; you must enroll by calling HR Solutions. You must complete a Declaration of Domestic Partnership form in order to complete enrollment for your Domestic Partner. The form can be found on NetBenefits® (Health & Insurance tab > All Health & Insurance Forms). You must enroll within 31 days of your date of hire.

The elections you make will remain in effect until December 31 of that year, provided that you continue to satisfy the applicable eligibility requirements. With the exception of Supplemental LTD coverage, you may be eligible to change some of your benefit elections during the year only if you experience a Change in Status (as defined on page 10) or qualify for a special enrollment period (as defined on page 11). Otherwise, you only will have the opportunity to enroll or change your benefit elections for the next calendar year during the Annual Benefits Enrollment period.

You will receive a confirmation statement in the mail shortly after you enroll. If you have elected medical coverage under an HMO, you also will receive a PCP designation form. You can complete and return the form to the HMO or you can make your initial PCP election online via NetBenefits®. You must select a PCP for most HMOs to be eligible to receive benefits.

For Short-Term Disability, Core Long-Term Disability, and Core Life Insurance Coverage. Short-Term Disability, Core Long-Term Disability, and Core Life Insurance coverage does not require enrollment. You automatically are covered as of your first day of active work. Your Eligible Dependents automatically are covered under the Dependent Life Insurance Plan as of your first day of active work.

For Supplemental Long-Term Disability (LTD). You will be automatically enrolled in Supplemental Long-Term Disability coverage and may choose to opt out within 31 days of your date of hire.

For Variable Life Insurance Coverage. Minnesota Life, the Claims Administrator of the Variable Life Insurance Plan, will mail an enrollment package to your address of record soon after your date of hire. To enroll, simply follow the instructions included in the package. Be sure to return the completed form to Minnesota Life no later than 60 days from your date of hire. Please note: this deadline is different than the deadline for most of your other Fidelity benefits.

If you do not return the form to Minnesota Life by the deadline, you will be enrolled in Default Basic Life Insurance coverage, which will provide you with Company-reimbursed coverage only. However, you will not have a Beneficiary designation on file (unless you contact Minnesota Life directly and obtain, complete, and return a Beneficiary designation form) and you will not be eligible to contribute additional premium dollars to Fidelity's Variable Insurance Products (VIP) Funds. If you later apply for Variable Supplemental coverage, you will be required to provide evidence of insurability (proof of good health).

You will receive a certificate of insurance shortly after Minnesota Life receives and approves your enrollment form. You can change your elections at any time by contacting Minnesota Life at 888-567-2882 or www.lifebenefits.com. Certain requests for coverage changes may require evidence of insurability.

For Group Long-Term Care Insurance Coverage. John Hancock will mail a personalized information package for the Group Long-Term Care Plan to your address of record shortly after your date of hire. To enroll, simply follow the instructions included in the package. If you enroll within 60 days of your date of hire, you will not be required to provide evidence of insurability (proof of good health). Please note: this deadline is different than the deadline for most of your other Fidelity benefits. Also, you may later apply for Group Long-Term Care coverage, but you will be required to provide evidence of insurability (proof of good health). For additional information, contact John Hancock Life Insurance Company at 888-333-5731 or visit fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit).

As a new eligible Regular Employee who is regularly scheduled to work 30 or more hours per week, you must enroll in your medical, dental, and Flexible Spending benefits within 31 days of your date of hire. If you do not enroll within this 31-day period, you will not be eligible to enroll for the remainder of the calendar year unless you experience a Change in Status (see page 10), a Same-Sex Spouse or Domestic Partner Life Event, or qualify for a special enrollment period (see page 11). As a new eligible Regular Employee who is regularly scheduled to work 30 or more hours per week, you will automatically be enrolled in the Supplemental Long-Term Disability coverage, and premiums will automatically be deducted from your pay unless you opt out within 31 days of your date of hire. There are separate enrollment procedures for Variable Life Insurance and Group Long-Term Care Insurance; refer to the following pages for details.

For Business Travel Accident (BTA) Insurance Coverage. All employees regardless of scheduled hours are covered under the Business Travel Accident (BTA) Insurance Plan. The BTA Insurance Plan does not require enrollment. You are automatically covered the first day you are Actively at Work.

For Employee Assistance Program (EAP) Coverage. The Employee Assistance Program (EAP) does not require enrollment. You and your Eligible Dependents are automatically covered as of your date of hire.

For the Tobacco Cessation Program. You are automatically covered as of your date of hire; however, enrollment is required in order to utilize the program. You may enroll in the Tobacco Cessation Program by calling 866-784-8454 or online at www.quitnow.net/fidelity.

For the Retirement Program Plans. You will receive Profit Sharing Plan enrollment information—either electronically or in the mail—shortly after your date of hire. Upon your date of hire, you will automatically be enrolled in the 401(k) feature of the Profit Sharing Plan. Your Pre-Tax 401(k) deduction will be set at 3 percent of your Eligible Compensation and your investment elections will default to the Freedom K® Fund that correlates to your assumed retirement age (currently age 65) based on your date of birth. See the chart on page 156 for the specific Freedom K® Fund. You may change either election at any time. Additionally, you may enroll in the Catch-up feature, if applicable, under the Profit Sharing Plan at any time via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1. Enrollment in the Company-match and Profit Sharing contribution* features under the Profit Sharing Plan automatically will occur once you satisfy the applicable eligibility criteria. You do not need to enroll in the Retiree Health Reimbursement Plan*.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

As a new eligible Regular Employee regularly scheduled to work 20 or more hours per week, you will be automatically enrolled in the Company's Profit Sharing Plan, and 401(k) Pre-Tax contributions will automatically be deducted each payroll period at a rate of 3 percent.

You may opt out of auto-matic enrollment at any time within 30 days of your date of hire. You may change your deferral percentage and/or investment options at any time.

You may make changes online via NetBenefits® at netbenefits.fidelity.com or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860). For more information, refer to the ***Profit Sharing Plan*** section of this SPD.

Regular Employees Regularly Scheduled to Work at Least 20 but Fewer than 30 Hours per Week

Regular Employees who are regularly scheduled to work at least 20 but fewer than 30 hours per week are eligible for the Fidelity benefits outlined below.

For Medical and Dental coverage, as well as Flexible Spending Accounts. You generally may enroll in medical and dental coverage, as well as the Flexible Spending Accounts via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860) and following the enrollment instructions. Please note, however, that if you are electing medical and/or dental coverage for your same-sex spouse, online enrollment via NetBenefits® is not available; you must enroll by calling HR Solutions. You must complete a Declaration of Domestic Partnership form in order to complete enrollment for your Domestic Partner. The form can be found on NetBenefits® (Health & Insurance tab > All Health & Insurance Forms). You must enroll within 31 days of your date of hire.

The elections you make will remain in effect until December 31 of that year, provided that you continue to satisfy the applicable eligibility requirements. You may be eligible to change some of your benefit elections during the year only if you experience a Change in Status (as defined on page 10) or qualify for a special enrollment period (as defined on page 11). Otherwise, you only will have the opportunity to enroll or change your benefit elections for the next calendar year during the Annual Benefits Enrollment period.

You will receive a confirmation statement in the mail shortly after you enroll. If you have elected medical coverage under an HMO, you also will receive a PCP designation form. You can complete and return the form to the HMO or you can make your initial PCP election online via NetBenefits®. You must select a PCP for most HMOs to be eligible to receive benefits.

For Business Travel Accident (BTA) Insurance Coverage. All employees regardless of scheduled hours are covered under the Business Travel Accident (BTA) Insurance Plan. The BTA Insurance Plan does not require enrollment. You are automatically covered the first day you are Actively at Work.

For Group Long-Term Care Insurance Coverage. John Hancock will mail a personalized information package for the Group Long-Term Care Plan to your address of record shortly after your date of hire. To enroll, simply follow the instructions included in the package. If you enroll within 60 days of your date of hire, you will not be required to provide evidence of insurability (proof of good health). Please note: this deadline is different than the deadline for most of your other Fidelity benefits. Also, you may later apply for Group Long-Term Care coverage, but you will be required to provide evidence of insurability (proof of good health). For additional information, contact John Hancock Life Insurance Company at 888-333-5731 or visit fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit).

For Employee Assistance Program (EAP) Coverage. The Employee Assistance Program (EAP) does not require enrollment. You and your Eligible Dependents are automatically covered as of your date of hire.

For the Tobacco Cessation Program. You are automatically covered as of your date of hire; however, enrollment is required in order to utilize the program. You may enroll in the Tobacco Cessation Program by calling 866-784-8454 or online at www.quitnow.net/fidelity.

For the Retirement Program Plans. You will receive Profit Sharing Plan enrollment information—either electronically or in the mail—shortly after your date of hire. Upon your date of hire, you will automatically be enrolled in the 401(k) feature of the Profit Sharing Plan. Your Pre-Tax 401(k) deduction will be set at 3 percent of your Eligible Compensation and your investment elections will default to the Freedom K® Fund that correlates to your assumed retirement age (currently age 65) based on your date of birth. See the chart on page 156 for the specific Freedom K® Fund. You may change either election at any time. Additionally, you may enroll in the Catch-up feature, if applicable, under the Profit Sharing Plan anytime via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1. Enrollment in the Company-match and Profit Sharing contribution features* under the Profit Sharing Plan automatically will occur once you satisfy the applicable eligibility criteria. You do not need to enroll in the Retiree Health Reimbursement Plan*.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Regular Employees Regularly Scheduled to Work Less than 20 Hours per Week

Regular Employees regularly scheduled to work less than 20 hours per week are eligible for the following benefit:

For Business Travel Accident (BTA) Insurance Coverage. All employees regardless of scheduled hours are covered under the Business Travel Accident (BTA) Insurance Plan. The BTA Insurance Plan does not require enrollment. You are automatically covered as of the first date you are Actively at Work.

Annual Benefits Enrollment Period

You have the opportunity to make changes to your benefit elections for the upcoming Plan Year during the Annual Benefits Enrollment period. You may choose to make changes to your benefits or keep your current benefit elections. Generally, the benefit elections you make will remain in effect for the entire Plan Year unless you experience a Change in Status, a Same-Sex Spouse Life Event, or you qualify for the special enrollment period (described in the following sections) and you change your benefit election(s).

Each year, you will be notified of the Annual Benefits Enrollment procedures, coverage costs, and time frames available to enroll in or change your elections for the upcoming Plan Year. Fidelity may make changes to the plans at any time, so it is important to review your Annual Benefits Enrollment materials carefully when you receive them.

Fidelity will notify you of the Annual Benefits Enrollment period. You may access Annual Benefits Enrollment information, obtain contact information, review plan design changes, and confirm most benefits via NetBenefits®.

To make changes to your benefit elections because of a Change in Status or a Same-Sex Spouse Life Event, you must notify HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of your Change in Status or Same-Sex Spouse or Domestic Partner Life Event. If you do not request a change within 31 days of your Change in Status, you must wait until the next Annual Benefits Enrollment period to make any changes to your benefit elections.

Changes in Status

Outside of the Annual Benefits Enrollment period, federal law provides that you may change certain benefit elections only if you experience a Change in Status, and the change in your benefit election is consistent with your Change in Status. For purposes of Change in Status rules, which are governed by federal law, including the *Defense of Marriage Act of 1996* (DOMA), marriage is defined as a legal union between one man and one woman and spouse refers only to a husband or wife who is a member of the opposite sex. Please refer to the *Same-Sex Spouse and Domestic Partner Life Events* section below for specific information regarding permissible changes to your benefit elections with regard to a same-sex marriage. A Change in Status includes, but is not limited to, the following types of events:

- Changes in your legal marital status, as those terms are defined under federal law (marriage, divorce, death of a spouse, legal separation).
- Changes in the number of your dependents (birth, death, adoption, placement for adoption).
- Employment changes (termination or commencement of your own, your opposite-sex spouse's, or your Eligible Dependent's employment, or your own, your opposite-sex spouse's, or your Eligible Dependent's commencement of or return from an unpaid leave of absence).
- Work schedule changes (reduction or increase in hours by you, your opposite-sex spouse, or your Eligible Dependents).
- Changes in your dependent's eligibility (change in age, marital, student, or disability status).

As mentioned above, any requested change in coverage must be consistent with your Change in Status.

You must notify HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of your Change in Status. If you do not make a change to your benefit elections within 31 days of your Change in Status, you must wait until the next Annual Benefits Enrollment period, or until you experience another Change in Status, to make a change.

The effective date of your change in coverage generally will be the date that your Change in Status occurred; however, in some cases, coverage will extend to the last day of the month following your Change in Status. Any resulting change in the cost of your coverage (for example, from individual to individual plus one) is effective as soon as administratively feasible, generally one to two pay periods, following the date of your requested change in coverage as a result of your Change in Status.

Same-Sex Spouse and Domestic Partner Life Events

Outside of the Annual Benefits Enrollment period, you may add or drop your Same-Sex Spouse or Domestic Partner from your medical and dental coverage if you experience a Same-Sex Spouse or Domestic Partner Life Event and the change if your benefit election is consistent with that event. A Same-Sex Spouse or Domestic Partner Life Event includes:

- Changes in your legal marital status (marriage, divorce death of a Same-Sex Spouse, legal separation).
- Entering into or termination of a domestic partnership.
- Work schedule changes of your Same-Sex Spouse or Domestic Partner that results in eligibility or ineligibility for coverage.
- Employment changes (termination or commencement of your Same-Sex Spouse's or Domestic Partner's employment).

You must notify HR Solution at 800-835-5099 (TDD 888-343-0860) within 31 days of your Same-Sex Spouse or Domestic Partner Life Event. If you do not contact HR Solutions to add or drop you Same-Sex Spouse or Domestic Partner to your coverage within 31 days of your Life Event, you must wait until the next Annual Benefits Enrollment period to make a change. The effective date of your change generally will be the date that your Same-Sex Spouse or Domestic Partner Life Event occurred; however, in some cases, coverage will extend to the last day of the month following your Change in Status. Any resulting change in the cost of your coverage (for example, from individual coverage to individual plus one coverage) is effective as soon as administratively feasible, generally one to two pay periods, following the date of your requested change in coverage following the Same-Sex Spouse or Domestic Partner Life Event.

SPECIAL ENROLLMENT PERIOD FOR GROUP HEALTH COVERAGE

In certain circumstances, you may be eligible to enroll in group health coverage without waiting until the next Annual Benefits Enrollment period, even if you enroll later than 31 days after you become eligible for coverage. For purposes of these special enrollment rights, which are governed by federal law, including the *Defense of Marriage Act of 1996* (DOMA), marriage is defined as a legal union between one man and one woman and spouse refers only to a husband or wife who is a member of the opposite sex. Please refer to the *Special Enrollment Period for Group Health Coverage for Same-Sex Spouses* below for additional information regarding same-sex marriages. You generally may enroll in medical, dental, and Health Care Flexible Spending Account coverage for yourself and your Eligible Dependents if:

- You declined coverage because you had alternative health coverage and that alternative health coverage has been terminated because:
  - The coverage was continuation coverage under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA) and that coverage has been exhausted. (Special enrollment option is not available if COBRA coverage terminates because of failure to pay premiums or for cause.) or
  - You lost eligibility for coverage you had elsewhere (including as a result of legal separation or divorce from an opposite-sex spouse, death, Termination of Employment, reduction in hours, or for reasons other than failure to pay premiums or for cause) or
  - Employer contributions toward the cost of coverage terminated.
- You have gained a dependent (opposite-sex spouse or child) through marriage, birth, adoption, or placement for adoption.

In all cases, you must notify HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of the date when the event described above occurs. Coverage under Fidelity's plan(s) will become effective on the date coverage with your alternative plan ends.

In addition, you may enroll in medical, dental, and Health Care Flexible Spending Account coverage for yourself and your eligible dependents if:

- Your or your eligible dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility.
- You or your eligible dependents become eligible for employment assistance under Medicaid or CHIP coverage

To request special enrollment or obtain more information, you must contact HR Solutions at 800-835-5099, prompt 1, within 60 days of the date of termination or the date you or your eligible dependents are determined to be eligible for assistance.

Special Enrollment Period for Group Health Coverage for Same-Sex Spouses and Domestic Partners

In certain circumstances, you may be eligible to enroll your same-sex spouse or Domestic Partner in medical and dental coverage if:

- You declined coverage for your same-sex spouse or Domestic Partner because he/she had alternative health coverage and that alternative health coverage has been terminated because:
  - The coverage was COBRA or COBRA-like continuation coverage and that coverage has been exhausted. (Special enrollment option is not available if COBRA or COBRA-like coverage terminates because of failure to pay premiums or for cause.) or
  - Your same-sex spouse or Domestic Partner lost eligibility for coverage he/she had elsewhere (including as a result of a legal separation or divorce, death, Termination of Employment, reduction in hours, or for reasons other than failure to pay premiums or for cause) or
  - Employer contributions toward the cost of coverage terminated.
- You have gained a same-sex spouse through marriage.

In all cases, you must notify HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of the date when the event described above occurs. Coverage under Fidelity's plan(s) will become effective on the date coverage with your alternative plan ends.

In addition, you may enroll in medical, dental, and Health Care Flexible Spending Account coverage for yourself and your eligible dependents if:

- Your or your eligible dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility
- You or your eligible dependents become eligible for employment assistance under Medicaid or CHIP coverage

To request special enrollment or obtain more information, you must contact HR Solutions at 800-835-5099, prompt 1, **within 60 days** of the date of termination or the date you or your eligible dependents are determined to be eligible for assistance.

When Coverage Becomes Effective

Medical and Dental coverage for you and your Eligible Dependents, and contributions to the ***Flexible Spending Account(s)***, begin on your date of hire, provided you enroll within 31 days of your date of hire.

Core Life Insurance coverage for you and your Eligible Dependents, and Company-Reimbursed Life Insurance, Short-Term Disability, and Core Long-Term Disability coverage begins on the first day you are Actively at Work.

Variable Basic Life Insurance coverage begins on the first day you are Actively at Work, provided you enroll no later than 60 days after your date of hire.

Variable Supplemental Life Insurance coverage generally begins on the first day of the month after your application has been approved, provided you enroll no later than 60 days after your date of hire.

Business Travel Accident Insurance coverage for all employees begins the first date you are Actively at Work.

Group Long-Term Care Insurance coverage begins on the first of the month following acceptance of your application, provided you enroll within 60 days of your date of hire.

Supplemental Long-Term Disability coverage begins automatically on your date of hire, provided you do not opt out of the coverage within 31 days of your date of hire and you are Actively at Work on your enrollment date.

EAP coverage for you and your Eligible Dependents automatically begins on your date of hire.

Tobacco Cessation Program coverage for you and your Eligible Dependents automatically begins on your date of hire; however, benefits begin when you enroll.

If you do not enroll within the time frames specified, and later decide to elect Supplemental LTD or Variable Supplemental Life Insurance coverage, your coverage will begin on the first day you are Actively at Work after approval of any applicable evidence of insurability (proof of good health) requirements. If you do not enroll within the time frame specified, and later decide to elect Group Long-Term Care Insurance coverage, your coverage will begin on the first of the month following acceptance of your application including evidence of insurability (proof of good health).

Paying for Your Coverage

In most cases, the cost of your coverage is shared by you and Fidelity, with Fidelity paying the majority of the cost. You pay your share of the cost through regular payroll deductions. Your cost is based on a number of factors, including the benefits you select and the level of coverage you choose (for example, individual or family coverage).

When you enroll in Fidelity medical or dental coverage, or elect to contribute to a Flexible Spending Account, your contributions generally are made on a Pre-Tax basis. This means that your share of the cost of your coverage and/or your contributions to a Flexible Spending Account generally are deducted from your salary before federal, Social Security, and, in most cases, state income taxes are withheld. As a result, your taxable income is reduced, thereby saving you money. However, it's important to note that paying for coverage or making contributions on a Pre-Tax basis could slightly reduce future Social Security benefits.

If you elect to enroll your same-sex spouse or Domestic Partner in medical or dental coverage, your share of the cost for medical and/or dental coverage for a same-sex spouse or Domestic Partner is made on an After-Tax basis for federal tax purposes. Your share of the cost for medical and/or dental coverage for a same-sex spouse is made on a Pre-Tax basis for state tax purposes in Massachusetts. State tax treatment of your share of the cost for medical and/or dental coverage for a Domestic Partner varies by state. Employees should consult their tax adviser.

In addition, Fidelity's share of the cost for medical and/or dental coverage for a same-sex spouse or Domestic Partner is includable in your income as additional wages for federal tax purposes, and is referred to as imputed income. The amount of imputed income that is treated as additional wages for federal tax purposes is equal to Fidelity's share of the cost for individual coverage. For state tax purposes, Fidelity's share of the cost for your same-sex spouse or Domestic Partner may be included in income depending on the state in which you work.

Medical Coverage

About Your Medical Coverage

A major concern for most people is access to comprehensive, affordable medical coverage. That's why Fidelity offers most eligible Regular Employees at least three coverage options from which to choose—two Preferred Provider Organizations (PPOs), and, in some locations, a Health Maintenance Organization (HMO). For purposes of this SPD and all references to HMO herein, HMO means an HMO-like self-funded plan.

For information on when you become eligible for coverage, who you may cover, and when coverage becomes effective, see the ***Benefits Overview*** section of this SPD.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

This section of *Benefits at Fidelity* describes the HealthFlex Plan, the Fidelity Health Plan, and provides an overview of Fidelity's HMO options. When you enroll in an HMO, the carrier may send you a detailed description of your coverage, which will include, among other things, a description of coverage for preventive services; limits applicable to obtaining emergency medical care; and preauthorization and utilization review requirements. If the carrier does not send you this information directly, you can access detailed coverage information for the HMO option on NetBenefits®.

Regardless of which medical option you choose, you are covered for a wide range of services, including preventive care, hospitalization, doctor visits, surgery, and emergency care. For the most part, the options differ in:

- How care is delivered.
- How much you pay, both in contributing toward the cost of your premium and when you receive care.
- How claims are paid.
- Primary Care Physician requirements.

The HealthFlex Plan

The HealthFlex Plan, a Preferred Provider Organization (PPO) option, is available to all eligible Regular Employees. UnitedHealthcare is the Claims Administrator of the HealthFlex Plan.

Under the HealthFlex Plan, you have the flexibility to obtain care from any health care provider of your choice. However, you will receive a higher level of coverage when you receive care from a medical provider from the HealthFlex Plan's extensive network of preferred medical providers. You may choose from In-Network and Out-of-Network Coverage *each time* you receive care for Covered Services. No referrals are required to see a specialist (e.g., cardiologist) or other provider who is a member of the network.

With the HealthFlex Plan, in-network Physician office visits generally are covered after a $20 copayment. Other in-network services generally are covered at 90 percent with no copayment up to the annual out-of-pocket maximum. Your preferred provider handles the submission of all claims for you. If you decide to seek treatment for a Covered Service from outside the network you must first pay an annual deductible then the HealthFlex Plan generally will cover 70 percent of the Reasonable and Customary Amount for the Covered Service, up to the annual out-of-pocket maximum. You are responsible for the difference, if any, between the amount an out-of-network provider charges and the Reasonable and Customary Amount, as determined by UnitedHealthcare, even if you have reached the out-of-pocket maximum.

The Fidelity Health Plan

The Fidelity Health Plan, a PPO option, is available to all eligible Regular Employees. The Fidelity Health Plan uses the same network of providers as the HealthFlex Plan and offers comprehensive coverage similar to the HealthFlex Plan. The Fidelity Health Plan's Claims Administrator is Definity Health, a division of UnitedHealthcare that administers high-deductible health plans.

With the Fidelity Health Plan, you pay lower premiums in exchange for a higher health care deductible before the Plan begins to pay benefits for most Covered Services, including non-preventive prescription drugs. In-network preventive care services, and preventive prescription drugs, are covered at 100 percent after the applicable copayment. If you are enrolled in the Fidelity Health Plan, you may also be eligible to establish a Health Savings Account (HSA), which is a tax-advantaged account that can be used to pay for current and future qualified medical expenses. For more information about the Fidelity HSA, please refer to the NetBenefits® Reference Library.

Under the Fidelity Health Plan, you will receive a higher level of coverage when you receive care from an in-network medical provider. You may choose from In-Network and Out-of-Network Coverage *each time* you receive care for Covered Services. No referrals are required to see a specialist or other provider who is a member of the network.

Under the Fidelity Health Plan, in-network preventive care services are covered at 100 percent after a $20 copayment. With the exception of prenatal care, preventive care is not covered out-of-network. In-network non-preventive Covered Services generally are covered at 90 percent after you satisfy the annual deductible, up to the annual out-of-pocket maximum. If you decide to seek treatment for a Covered Service from outside the network, the Fidelity Health Plan will cover 70 percent of the Reasonable and Customary amount for the Covered Service after you satisfy the annual deductible, up to the annual out-of-pocket maximum. You are responsible for the difference, if any, between the amount an out-of-network provider charges and the Reasonable and Customary Amount, as determined by UnitedHealthcare, even if you have reached the out-of-pocket maximum.

Health Maintenance Organizations

Most eligible Regular Employees also have at least one Health Maintenance Organization (HMO) option available in their area. When you enroll in an HMO, you may be required to choose a Physician as your Primary Care Physician (PCP). You may make your PCP selection via NetBenefits® upon your initial enrollment into an HMO and during Annual Benefits Enrollment, or by completing and returning a PCP election form to the HMO. You may change your PCP election by contacting your HMO directly. You may choose a different PCP for each covered family member. Your PCP then handles or arranges for all of your care.

If you enroll in an HMO and subsequently move out of your HMO's service area, you may elect coverage under another coverage option. To enroll in a new coverage option, you must call HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of your move. Otherwise, you must wait until the next Annual Benefits Enrollment period to make a change in coverage, which will become effective January 1 of the following year.

With an HMO, you pay the applicable copayment and then your care generally is covered at 100 percent. Your PCP also handles claims and prenotification for you. It's important to note that HMOs differ from the HealthFlex Plan and the Fidelity Health Plan in that your PCP must provide or coordinate your care, including making referrals to specialists and hospitals, in order for services to be covered. Care obtained outside the HMO network generally is not covered, except in the case of emergencies, as defined by your HMO.

You may request more information about the HMO(s) available in your area from HR Solutions at 800-835-5099 (TDD 888-343-0860). When you enroll in an HMO, you will receive information describing what services are covered, any limitations, and special programs that the HMO may offer.

For an overview of services that the HMOs offer, refer to the charts beginning on page 61. For more information about what a specific HMO covers, refer to the HMO's detailed description of coverage, available by calling the HMO directly.

Your Medical Identification Card

Shortly after you enroll in one of the Fidelity medical coverage options (the HealthFlex Plan, the Fidelity Health Plan, or an HMO), you will receive a medical identification (ID) card directly from the carrier. Your ID card lists the information your health care provider will need when you receive care, as well as the toll-free number you can call when you have questions.

If you experience a Change in Status (including, but not limited to, marriage, divorce, or the birth or adoption of a child) or a Same-Sex Spouse or Domestic Partner Life Event, you must call HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of the event to make a corresponding change to your coverage.

If you do not request a change in coverage during this 31-day period, you must wait until the next Annual Benefits Enrollment period to make any changes to your benefit elections. Benefit changes are effective on the date of your Change in Status or Same-Sex Spouse or Domestic Partner Life Event. For more information about Changes in Status, see the ***Benefits Overview*** section of this SPD.

Be sure to review the ***Flexible Spending Accounts*** section of this SPD. With a Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account, you may be able to save money by using Pre-Tax dollars to reimburse yourself for eligible expenses. You can take advantage of a Flexible Spending Account even if you are not enrolled in Fidelity medical or dental coverage.

Your Medical Coverage Options

Choosing the right medical coverage for you and your family is an important decision. In most Fidelity locations, you have the choice between at least three medical coverage options—the HealthFlex Plan, the Fidelity Health Plan, and an HMO. The options differ mainly in how you access and pay for care, as shown in this chart:

	HEALTHFLEX PLAN	FIDELITY HEALTH PLAN	HMOs
Choice of Physicians	You may see any Physician you choose. The Plan provides greater levels of coverage when you see a network provider, also called a "preferred provider."	You may see any Physician you choose. The Plan provides greater levels of coverage when you see a network provider, also called a "preferred provider."	You may be required to choose a PCP. Your PCP coordinates all of your care. You only may see Physicians in the HMO network.
How the Plan Pays Benefits	**In-network** Generally, most office services are covered at 100% after a $20 copayment. Generally, most other services are covered at 90%, with no copayment up to the annual out-of-pocket maximum. **Out-of-network** You must first satisfy an annual deductible, then the HealthFlex Plan generally pays 70% of the Reasonable and Customary Amount and you generally pay 30% of the Reasonable and Customary Amount, up to the annual out-of-pocket maximum. You also must pay the difference, if any, between the amount an out-of-network provider charges for a Covered Service and the Reasonable and Customary Amount for such Covered Service even if you have reached the annual out-of-pocket maximum. Preventive care is not covered out-of-network.	**In-network** Generally, you pay 100% of the cost of non-preventive Covered Services until you satisfy the annual deductible, then the Fidelity Health Plan generally pays 90% up to the annual out-of-pocket maximum. Preventive care is covered at 100% after a $20 copayment. **Out-of-network** You must first satisfy an annual deductible, then the Fidelity Health Plan generally pays 70% of the Reasonable and Customary Amount and you generally pay 30% of the Reasonable and Customary Amount, up to the annual out-of-pocket maximum. You also must pay the difference, if any, between the amount an out-of-network provider charges for a Covered Service and the Reasonable and Customary Amount for such Covered Service even if you have reached the annual out-of-pocket maximum. Preventive care is not covered out-of-network, with the exception of prenatal visits.	When you receive care from an HMO provider, you generally pay a $20 copayment for office visit services, after which your care generally is covered at 100%. Most other services are covered at 100%. Care outside the HMO network generally is not covered, except in the case of emergencies.
Hospital Prenotification	**In-network** You are not responsible for providing prenotification. **Out-of-network** You are responsible for providing prenotification (within 48 hours after an emergency admission) for all inpatient admissions to UnitedHealthcare directly. Please see page 20 for more information about prenotification procedures.	**In-network** You are not responsible for providing prenotification. **Out-of-network** You are responsible for providing prenotification (within 48 hours after an emergency admission) for all inpatient admissions to UnitedHealthcare directly. Please see page 41 for more information about prenotification procedures.	Your PCP handles and obtains approval from the HMO directly.
Claims	**In-network** No claim forms to file. **Out-of-network** You file claims.	**In-network** No claim forms to file. **Out-of-network** You file claims.	No claim forms to file.

Your Prescription Drug Coverage

When you elect coverage under one of the medical coverage options, it includes prescription drug coverage. The prescription drug coverage is administered by Medco. Your prescription drug card is separate from your medical ID card. There are two ways you can purchase prescriptions—through a retail pharmacy or through the convenient mail-order program. For more information about the prescription drug coverage, refer to the Medco Prescription Drug Benefit Booklet available on NetBenefits (Health & Insurance > Reference Library).

Health Education, Wellness, and Support Resources

Fidelity offers and pays the full cost for the health education, wellness, and support resources that it makes available to Regular Employees and their Eligible Dependents. These resources are available 24 hours a day, 7 days a week.

HealthFlex Plan Coordinated Care Management

Fidelity is committed to providing you with access to quality health care. The programs in this section are designed to help you use your medical coverage under the HealthFlex Plan effectively. All programs are voluntary.

In addition, you may be contacted by a Care Management nurse, who will:

- Explain other types of treatments and the benefits available under your Plan for any alternative care.
- Assist you in planning for admission to and discharge from the hospital.
- Outline the continuing involvement and support provided by the HealthFlex Plan during your hospitalization and after your discharge.

MORE ABOUT CARE MANAGEMENT'S SERVICES

Care Management is designed to:

- Provide you with one-on-one health care information, guidance and support to help you manage your health condition.
- Help coordinate your care with physicians and health care professionals.
- Support you in understanding and following your doctor's treatment plan as well as reviewing your doctor's treatment plan for quality and effectiveness.

To ensure that you receive the right type of care in the most appropriate setting, Care Management is also available to help you:

- Locate a surgeon or Physician to provide a second opinion when surgery is recommended.
- Learn more about alternate treatments or medical resources in your community, for example, home health care, convalescent facilities, ambulatory surgical centers, and hospice care.

You can reach Care Management at 800-331-0265.

Health Dialog

Health Dialog provides access to health information and answers to health-related questions. The service offers support via a confidential telephone line staffed by licensed health care professionals (registered nurses, dietitians, and respiratory therapists) called Health Coaches.

Health Coaches provide support via the phone and can provide additional information through printed materials and videos. Health Coaches can:

- Answer general health and prevention questions.
- Provide information on treatment options based on your needs.
- Offer support for chronic conditions, such as diabetes or asthma.
- Provide guidance on health issues, including back pain, heart disease, breast cancer, and joint pain.
- Work with you to facilitate better communication with your Physician.

To find out if your provider and/or facility is a member of the UnitedHealthcare preferred provider network, visit UnitedHealthcare's website (www.myuhc.com) or call member services at 800-331-0265 for the most current listing.

You, your spouse, Domestic Partner, and adult children age 18 and older who are enrolled as a dependent under a Fidelity employee's medical coverage can reach a Health Coach by calling 888-923-4393.

About the HealthFlex Plan

IMPORTANT TERMS

Being familiar with the following terms will help you understand how you share in the cost of Covered Services under the HealthFlex Plan:

- ***Coinsurance.*** Coinsurance is the percentage that you pay toward the cost of certain Covered Services. For example, the HealthFlex Plan has a 10 percent Coinsurance rate for most in-network care. This means that the HealthFlex Plan pays 90 percent of the cost of the Covered Service and you pay the remaining balance, which generally is 10 percent, up to the annual out-of-pocket maximum. For out-of-network care, the HealthFlex Plan has a 30 percent Coinsurance rate once you satisfy the annual deductible. This means the HealthFlex Plan pays 70 percent of the cost of the Covered Service, based on the Reasonable and Customary Amount (defined below) and you pay the remaining balances, which generally includes 30 percent of the Reasonable and Customary Amount, up to the annual out-of-pocket maximum.
- ***Copayment.*** The copayment is the amount you pay up-front to your in-network health care provider for certain types of Covered Services, such as office visits and exams. In most cases, the copayment amount is $20. Note that copayments for in-network care do not apply toward the annual out-of-pocket maximums. The chart beginning on page 22 includes copayment amounts for certain Covered Services.
- ***Deductible.*** The deductible is the amount you must pay each calendar year for out-of-network Covered Services before the Plan begins to pay benefits. The deductible is ($250) for each covered person, up to ($500) per family per year. Deductibles apply to the annual out-of-pocket maximums.
  - Note that there generally isn't a deductible for in-network care, except for certain Covered Services including those Covered Services noted in *An Overview of the HealthFlex Plan*. The deductible applies to in vitro fertilization both in-network and out-of-network.
- ***Out-of-pocket maximum.*** The HealthFlex Plan places some limits on the amount you spend for care each year. Once you reach the in-network care out-of-pocket maximum, the HealthFlex Plan pays 100 percent for Covered Services for the rest of the year. Once you reach the out-of-network care out-of-pocket maximum, the HealthFlex Plan pays 100 percent of the Reasonable and Customary Amount for Covered Services for the rest of the year. The current in-network care out-of-pocket maximum is $1,000 per individual and $2,000 per family. The current out-of-network care out-of-pocket maximum is $3,000 per individual and $6,000 per family. Certain expenditures do not count toward these maximums, including:
  - Any amount you pay toward the premium for your coverage.
  - Copayments for in-network care.
  - Charges for services the HealthFlex Plan does not cover.
  - Amounts in excess of the Reasonable and Customary Amount (defined below) for the Covered Service.
  - Amounts in excess of HealthFlex Plan limits and maximums.
  - Inpatient and outpatient mental health/substance abuse treatment and bereavement counseling.
- ***Reasonable and Customary Amount*** for Out-of-Network Coverage refers to the prevailing amount for corresponding treatment, services, or supplies for similar medical conditions in your geographic area, as determined by UnitedHealthcare. When determining what amount is Reasonable and Customary, UnitedHealthcare considers the complexity and range of services provided. Therefore, the Reasonable and Customary Amount may be different than the amount charged by an out-of-network provider.

How the HealthFlex Plan Works

HealthFlex Plan In-Network Coverage

You receive the highest level of benefits available under the HealthFlex Plan when you use a preferred provider at an in-network facility. The HealthFlex Plan's network of preferred providers offers an extensive selection of doctors, specialists, hospitals, facilities, and other health care providers from which to choose. These providers have contracted with UnitedHealthcare, the HealthFlex Plan's Claims Administrator, to provide medical services at predetermined rates.

Under the HealthFlex Plan, you are not required to have a Primary Care Physician. In addition, you don't pay a deductible before the HealthFlex Plan begins to pay benefits, and you are not required to file any claim forms for in-network services.

Routine and Preventive Care. When you and your covered family members receive care from a preferred provider at an in-network facility, you are covered for most routine and preventive services, including, but not limited to:

- Age-appropriate routine screenings such as vision and hearing exams.
- Immunizations (including flu shots) and inoculations.
- Laboratory tests for or in connection with a routine Pap smear.
- Routine physical exams.
- Vision and hearing exams.
- Well-child care visits.

When you visit a preferred provider at an in-network facility, preventive care is covered at 100 percent after you pay your $20 copayment.

EXAMPLE

HealthFlex Plan In-Network Coverage Costs

- Pat, an individual HealthFlex Plan participant, has surgery at an in-network hospital.
- The surgery is a Covered Service under the HealthFlex Plan and the cost of the surgery is $10,000.
- The HealthFlex Plan will pay $9,000 (90% of the cost of the Covered Service).
- Pat will pay $1,000 (10% of the cost of the Covered Service).
- If, later in the year, Pat has a second surgery at an in-network hospital, the HealthFlex Plan would pay the total cost of the Covered Service for that surgery, because Pat already paid $1,000 (the in-network out-of-pocket maximum) for the first surgery.

HealthFlex Plan Out-of-Network Coverage

You always can choose to receive care outside of the UnitedHealthcare network of preferred providers. In this case, the amount you pay for Covered Services generally is higher. You must first pay an annual deductible before the HealthFlex Plan begins to pay benefits. Then, the HealthFlex Plan pays 70 percent of the Reasonable and Customary Amount (not necessarily the same as the amount charged by the out-of-network provider) for most eligible services and you pay the remaining balance, which generally is 30 percent of the Reasonable and Customary Amount, up to the annual out-of-pocket maximum.

After you reach the annual out-of-pocket maximum, the HealthFlex Plan pays 100 percent of the Reasonable and Customary Amount for Covered Services, for the rest of the calendar year.

Reasonable and Customary Amount. If your out-of-network provider charges more than the Reasonable and Customary Amount, as determined by UnitedHealthcare, you are responsible for paying the difference between the amount your out-of-network provider charges and the Reasonable and Customary Amount, in addition to your Coinsurance and deductible amounts. Please note that you still are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount for the Covered Service, as determined by UnitedHealthcare, even after you have reached the annual out-of-pocket maximum for out-of-network care.

EXAMPLE

HealthFlex Plan Out-of-Network Coverage Costs

Mary, a HealthFlex Plan participant, has an office visit with an out-of-network provider. The out-of-network provider charges Mary $100 for the visit. UnitedHealthcare determines that the Reasonable and Customary Amount for the office visit is $90. Mary has already satisfied her deductible for the year. Here's how the out-of-network office visit will get paid:

- The HealthFlex Plan will pay $63 (70% of the Reasonable and Customary Amount).
- Mary will pay $27 (30% of the Reasonable and Customary Amount) plus $10 (the difference between the amount the out-of-network provider charged [$100] and the Reasonable and Customary Amount [$90]). **Mary's total is $37**.

If Mary had reached the annual out-of-pocket maximum for out-of-network care at the time of the office visit:

- **The HealthFlex Plan would pay $90** (100% of the Reasonable and Customary Amount).
- **Mary would pay $10** (the difference between the amount the out-of-network provider charged and the Reasonable and Customary Amount).

Routine and Preventive Care. It's important to note that routine and preventive care is *not* covered under the HealthFlex Plan when provided by an out-of-network provider. In addition, when you receive care from an out-of-network provider, you are responsible for filing your own claims (see page 28 for details).

Prenotification for Out-of-Network Inpatient Admissions

If your Physician recommends inpatient hospitalization (other than for a maternity admission covered by the *Newborns' and Mothers' Health Protection Act*), including admission for mental health or substance abuse care, or to a skilled nursing facility or hospice, you *must* follow the review procedures outlined in this section to receive the highest level of benefits available under the HealthFlex Plan.

If you do not follow these prenotification procedures, all inpatient benefits for that admission will be reduced by $500. Your benefits may be further reduced if you receive services that have not been approved, if applicable. These prenotification penalty amounts do not apply toward your annual deductible or out-of-pocket maximum.

To provide prenotification, you must call UnitedHealthcare's Care Management Center at 800-331-0265. You must call at least 48 hours in advance for non-emergency inpatient admissions and no later than 48 hours after emergency admissions to a hospital or other facility.

When you call, be prepared to provide:

- Your employer's name: Fidelity Investments.
- Your group contract number: GA#119174.
- Your name and Social Security number.
- The name of the covered person receiving care.
- Any medical information concerning the hospital stay.
- The attending Physician's name, phone number, and address.

In addition to calling for a non-emergency inpatient admission or an emergency admission, you also must call for:

- ***Lengthened maternity hospital stays.*** For childbirth, you must call for an extension due to complications for either the mother or the child. An extension is any length of time longer than that outlined on page 26.
- ***Rescheduled hospital stays.*** You must call again before you are admitted, even if previously approved. Otherwise, penalties may apply.
- ***Any change in plans.*** You must call before you make any changes (such as transferring between hospitals), unless it is an emergency situation. In emergency situations, you must call no later than 48 hours after the change.

When you call, your case will be reviewed by a staff of medical professionals to ensure that you receive quality care within the proper setting.

Specialty Care

Under the HealthFlex Plan, you always have direct access to specialty care through the preferred provider network. You are eligible for in-network benefits whenever you visit a preferred provider network specialist at an in-network facility. And you always are free to go outside the network for specialist care, receiving benefits at the out-of-network level of coverage.

Emergency Care

You always are covered for *emergency care*, no matter where you are when an emergency occurs. If you need emergency care, you immediately should go to the nearest emergency room. Your benefits are the same whether you use an in-network or out-of-network provider.

An *emergency* is a life- or limb-threatening condition that comes on suddenly. Examples of emergencies include, but are not limited to, acute appendicitis, cardiac arrest, loss of consciousness, and severe bleeding.

In either case, you are covered at 100 percent, after a $100 copayment, for each visit to a hospital emergency room. This copayment is waived if you are admitted to the hospital.

An additional $25 copayment applies to ambulance services. These copayment amounts do not apply toward your annual deductible or out-of-pocket maximums.

An Overview of the HealthFlex Plan

This chart provides an overview of the services covered under the HealthFlex Plan, which is available to all eligible Regular Employees. You also have the option to elect coverage under the Fidelity Health Plan and depending on where you live or work, you also may have the option to elect coverage under an HMO. For an overview of services that the Fidelity Health Plan provides, refer to the chart that begins on page 43 and for an overview of services that the HMOs provide, refer to the charts that begin on page 61.

HEALTHFLEX PLAN		
	In-Network	**Out-of-Network***
General Information		
For More Information	800-331-0265, www.myuhc.com	
Referrals	Not required	
Pre-Existing Conditions	No restrictions	
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.	
Costs		
Annual Deductible**	In most cases, none. However, an in-network deductible applies to certain Covered Services***	$250 per person, $500 per family
Annual Out-of-Pocket Maximum**	$1,000 per person, $2,000 per family	$3,000 per person, $6,000 per family
Lifetime Benefit Maximum	None	None
Covered Services		
Preventive Care *Routine physical exams*	Covered at 100% with no copayment per visit	Not covered
Well-child care visits	Covered at 100% with no copayment per visit	Not covered
Routine mammograms, colonoscopies, and Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment per visit	Not covered
Mammograms for diagnostic purposes	In physician's office: Covered at 100% after $20 copayment In facility: Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Routine Pap smears	Covered at 100% with no copayment per visit	Not covered
Routine vision exams	Covered at 100% with no copayment per visit	Not covered
Routine hearing exams	Covered at 100% with no copayment per visit	Not covered
Diagnostic, Sick or Specialist Office Visits *Non-preventive*	Covered at 100% after $20 copayment per visit	Covered at 70% of Reasonable and Customary* after deductible
Nutritional Counseling (Maximum of 12 visits per calendar year in-network and out-of-network combined) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 100% after $20 copay per visit	Covered at 70% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

**The difference, if any, between the amount an out-of-network provider charges and the Reasonable and Customary Amount does not count toward the annual out-of-pocket maximum for out-of-network care. Copayment amounts do not apply to the annual deductible or out-of-pocket maximums.

***Please refer to the section titled *What the HealthFlex Plan Covers* for a list of Covered Services.

An ambulatory surgical center is a specialized medical facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and that either is licensed in accordance with the applicable regulatory authority or satisfies the requirements listed on page 29.

Be sure to review the ***Flexible Spending Accounts*** section of this SPD. With a Health Care Flexible Spending Account, you may be able to save money by paying for eligible expenses with Pre-Tax dollars. You can take advantage of a Flexible Spending Account even if you are not enrolled in Fidelity medical or dental coverage.

HEALTHFLEX PLAN *(continued)*		
	In-Network	**Out-of-Network***
Inpatient Care (Includes semi-private room and board, intensive care services, laboratory and x-ray services, and doctor's/ surgeon's services)	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible***
Outpatient Care (Includes laboratory tests, diagnostic laboratory and x-ray services, and doctor's/ surgeon's services)	Covered at 90% with no copayment (In Physician's office: covered at 100% after $20 copayment)	Covered at 70% of Reasonable and Customary* after deductible
Outpatient Surgery	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Ambulatory Surgical Center	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Emergency Care** *Emergency room visit*	Covered at 100% after $100 copayment per visit (waived if admitted)	
Ambulance Services	Covered at 100% after $25 copayment per transport	
Urgent Care Center	Covered at 100% after $50 copayment per visit	Covered at 70% of Reasonable and Customary* after deductible
Maternity Care *Prenatal exams*	Covered at 100% with no copayment per visit	Covered at 70% of Reasonable and Customary* after deductible
Hospital and delivery services	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Birthing center services	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Postnatal exams	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Mental Health/ Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient* Bereavement coverage available up to 6 months after the death of an immediate family member, as defined under Fidelity's bereavement policy	Covered at 90% with no copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details	Covered at 70% of Reasonable and Customary* after deductible**
	See page 27 for Substitution of Benefits for Mental Health and Substance Abuse Care	
Outpatient	Covered at 100% after $20 copayment, unlimited visits per calendar year. Prior authorization may be required; contact the carrier for details	Covered at 70% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

**The difference, if any, between the amount an out-of-network provider charges and the Reasonable and Customary Amount does not count toward the annual out-of-pocket maximum for out-of-network care. Copayment amounts do not apply to the annual deductible or out-of-pocket maximums.

***You must call the Care Management Center at 800-331-0265 at least 48 hours *in advance* for all non-emergency inpatient hospital admissions and no later than 48 hours after any emergency admission. If you fail to call in your admission, you will be required to pay a $500 penalty in addition to any other applicable costs for your care.

To find out if you will be covered under the HealthFlex Plan for certain medical care services, call the toll-free customer service number on your medical ID card.

You may want to take advantage of the Health Care Flexible Spending Account to pay for eligible expenses that are not covered by a medical, dental, vision, or other health plan. For more information, see the ***Flexible Spending*** section of this SPD.

HEALTHFLEX PLAN *(continued)*		
	In-Network	**Out-of-Network***
Infertility Coverage Comprehensive Fertility Treatment, including but not limited to: Ovulation Induction Therapy (Unlimited cycles/attempts per member per lifetime) Artificial Insemination (Maximum 6 cycles/attempts per lifetime) Assisted Reproductive Treatment (ART), including but not limited to: In Vitro Fertilization Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT) (Maximum 3 attempts/cycles per member per lifetime for ART for in-network and out-of-network combined) (Prior authorization is required)	In office: Covered at 100% after $20 copayment In facility: Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Hospice Care	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible***
Home Health Care (Maximum 60 visits per calendar year for in-network and out-of-network combined)	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Skilled Nursing Facility (Maximum 100 days per calendar year for in-network and out-of-network combined)	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible**
Chiropractic Care (Up to 20 visits per year for in-network and out-of-network combined) (Massage therapy is not covered)	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible**
Acupuncture (Services must be administered by a licensed acupuncturist) (Up to 20 visits per year for in-network and out-of-network combined)	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Durable Medical Equipment (Including, but not limited to, glucose monitors, crutches, wheelchairs, and respirators) (Prior authorization required for equipment exceeding $750)	Covered at 90% with no copayment	Covered at 70% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

**You must call the Care Management Center at 800-331-0265 at least 48 hours *in advance* for all non-emergency inpatient hospital admissions and no later than 48 hours after any emergency admission. If you fail to call in your admission, you will be required to pay a $500 penalty in addition to any other applicable costs for your care.

***Please refer to the section titled *What the HealthFlex Plan Covers* for a list of Covered Services.

HEALTHFLEX PLAN *(continued)*		
	In-Network	**Out-of-Network***
Feeding Formula Coverage is for specific diagnoses: 1. Specific inborn errors of metabolism (including, but not limited to phenylketonuria – PKU, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia, or to protect the fetus of a pregnant woman with PKU) 2. Malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility (including, but not limited to Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, inherited diseases of amino and/or organic acids 3. Central nervous system/ neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition	Covered 50% with no copayment	Covered at 50% of Reasonable and Customary* after deductible
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/ Occupational Therapy* Limited to 60 visits for PT/OT combined per member per calendar year for in-network and out-of-network combined *Speech Therapy* Limited to 52 visits per member per calendar year for in-network and out-of-network combined	In office: Covered at 100% after $20 copayment per visit In facility: Covered at 90% with no copayment.	Covered at 70% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

HealthFlex Plan Coordinated Care Management

Fidelity is committed to providing you with access to quality health care. The programs in this section are designed to help you use your medical coverage under the HealthFlex Plan effectively. All programs are voluntary.

In addition, you may be contacted by a Care Management nurse, who will:

- Explain other types of treatments and the benefits available under your Plan for any alternative care.
- Assist you in planning for admission to and discharge from the hospital.
- Outline the continuing involvement and support provided by the HealthFlex Plan during your hospitalization and after your discharge.

MORE ABOUT CARE MANAGEMENT'S SERVICES

Care Management is designed to:

- Provide you with one-on-one health care information, guidance, and support to help you manage your health condition.
- Help coordinate your care with physicians and health care professionals.
- Support you in understanding and following your doctor's treatment plan as well as reviewing your doctor's treatment plan for quality and effectiveness.

To ensure that you receive the right type of care in the most appropriate setting, Care Management is also available to help you:

- Locate a surgeon or Physician to provide a second opinion when surgery is recommended.
- Learn more about alternate treatments or medical resources in your community, for example, home health care, convalescent facilities, ambulatory surgical centers, and hospice care.

You can reach the Care Management at 800-331-0265.

Healthy Pregnancy Program

Whether or not this is your first time expecting a child, it's important that you begin your pregnancy with as much quality information as possible. The voluntary Healthy Pregnancy Program provides expectant parents with:

- An educational kit containing information about valuable resources for you and your baby.
- Access to quality information from trained nurses.
- Screenings for high-risk pregnancies.

To enroll, call the Care Management at 800-331-0265.

IMPORTANT INFORMATION ABOUT MATERNITY STAYS

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If a state law provides for a hospital length of stay in connection with childbirth for the mother or newborn child that is greater than 48 hours following a vaginal delivery, or greater than 96 hours following a cesarean section, the state law provision will apply to the extent that state law is applicable.

Complex Illness Support—Impact Program

The HealthFlex Plan's voluntary Impact Program provides assistance when you need help coordinating your medical care. These services can save you time as well as help ensure that you receive the most appropriate care.

When you call Care Management at 800-331-0265, you speak with a nurse who can:

- Provide you with information and alternatives to consider.
- Assist you with discharge planning.
- Make arrangements for home health care services.
- Review information about condition management programs, such as Diabetes, Asthma, Chronic Obstructive Pulmonary Disease, Heart Failure, or Coronary Artery Disease.

In addition, a Care Management Center nurse will follow up with you to provide further assistance and/or information as needed.

Centers of Excellence

Centers of Excellence network facilities are located throughout the country, and are nationally respected organizations chosen because of their high-quality results for certain procedures and diagnoses. Centers of Excellence programs are offered for transplants, cancer, bariatric surgery, congenital heart disease, kidney disease, neonatal care, and infertility treatment.

For example, if you or a covered Eligible Dependent needs a kidney transplant and a hospital in another city is the leader in kidney transplants, the HealthFlex Plan will pay for:

- Coverage in that city for the individual needing the transplant.
- Travel expenses for the patient and one family member.

You will be notified by UnitedHealthcare if you are determined to be a candidate for any of these programs, or you may self-refer by calling 800-331-0265.

Substitution of Benefits for Mental Health and Substance Abuse Care

When you or a covered Eligible Dependent requires mental health or substance abuse care, you may substitute certain types of eligible intermediate outpatient care for inpatient care. This substitution program enables you to receive the appropriate level of treatment for your condition in a cost-effective setting, while expanding your benefits. Your benefits will continue to be paid at the appropriate in- or out-of-network level.

In order to be eligible for substitution of benefits, you or your covered Eligible Dependent must receive preauthorization from United Behavioral Health. **You must contact United Behavioral Health at 800-331-0265 to initiate your substitution of benefits before you have exhausted the number of in- or out-of-network inpatient or outpatient visits available under the HealthFlex Plan.**

When you use substitution of benefits, the outpatient care you receive is counted toward the inpatient care maximum under the HealthFlex Plan (refer to the chart beginning on page 22 for details) for the treatment received as follows:

IF YOU RECEIVE INTERMEDIATE TREATMENT IN THIS SETTING	YOU MAY USE THIS NUMBER OF DAYS/VISITS OF INTERMEDIATE TREATMENT TO EQUAL ONE INPATIENT DAY
Residential Treatment	1.5 days
Day Treatment/Partial Hospital Stay	2 days
Structured Outpatient	5 visits
Outpatient Psychotherapy	6 visits

It's a good idea to keep copies of all claim forms and bills that you submit for reimbursement. Because deductible amounts and other limitations apply separately to each covered person, it's important to keep separate records for each covered person.

Explanation of Benefits (EOB) are available on UnitedHealthcare's website at www.myuhc.com.

How to File a HealthFlex Plan Claim

When you receive care from an in-network provider, you don't have to file any claim forms. Simply show your medical ID card and pay the applicable copayment. Your network provider then bills the HealthFlex Plan directly for its share of the cost of your care. Subsequently, your network provider bills you for your remaining share of the cost of your care (e.g., Coinsurance).

When you receive care from an out-of-network provider, you generally pay for your care up-front and then file a claim for reimbursement for the share of the cost covered by the HealthFlex Plan. Here are the steps to follow:

1. ***Complete the "Employee" section of a HealthFlex Claim Form***, available from HR Solutions—online or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860)—or on NetBenefits®.
2. ***Obtain an itemized bill*** from your provider that includes:
   - The provider's name and Internal Revenue Service (IRS) tax identification number.
   - An itemized description of services performed and the charges for these services.
   - The date of services.
   - A diagnosis.
   - The amount you paid.
3. ***Attach a copy of your itemized bill*** to the claim form and submit both to:

   UnitedHealthcare
   PO Box 740800
   Atlanta, GA 30374-0800

Claims should be submitted no later than 90 days after the date care was received or as soon as possible thereafter. In all cases, your claim must be submitted within 18 months of receiving treatment. Claims submitted more than 18 months after the date of service are not considered valid and will not be paid. If a benefit is incorrectly overpaid, the HealthFlex Plan has the right to request the return of the overpayment and receive it from you.

What the HealthFlex Plan Covers

The HealthFlex Plan covers the services, health supplies, and/or equipment set forth on the following pages that are used to prevent, diagnose, or treat a sickness, injury or symptom ("Covered Health Services") as determined by UnitedHealthcare. In-Network Coverage levels are listed unless otherwise noted.

In order for a service, health supply, or equipment to be a Covered Health Service it must meet each of the following criteria:

- Supported by national medical standards of practice;
- Consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:
  - Well-conducted randomized controlled trials, and
  - Well-conducted cohort studies, and
  - The most cost-effective method and yields a similar outcome to other available alternatives.

Medically necessary means that a medical service or supply is medically appropriate and meets all of the following requirements. It is:

- Necessary to meet the basic health needs of the covered person, and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply, and
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare, and
- Consistent with the diagnosis of the condition, and
- Required for reasons other than the convenience of the covered person or his or her Physician, and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed, or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition, and
    - In a clinically controlled research setting, and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is a medically necessary service, as defined above. The definition of medically necessary used in this SPD relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

- ***Acupuncture services*** rendered by a licensed acupuncturist, covered at 90 percent with no copayment, up to 20 visits per calendar year for both in-network and out-of-network care combined.
- ***Ambulatory surgical center services*** given within 72 hours before or after a surgical procedure, provided they are given in connection with the procedure, covered at 90 percent with no copayment.

  An *ambulatory surgical center* is a specialized medical facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and that either:

  – Is licensed in accordance with the applicable regulatory authority.

  – Where licensing is not required, meets *all* of the following requirements:

    - Is operated under the supervision of a licensed Physician.
    - Provides at least one operating room and one post-anesthesia recovery room.
    - Has immediate access to blood supplies.
    - Is equipped to perform diagnostic tests and x-rays.
    - Provides nursing services.
    - Maintains adequate patient medical records.
- ***Assistant surgeon services***, limited to one-fifth of the amount of covered expenses for the surgeon's charge for the surgery. The assistant surgeon must be a Physician. Services of a surgical assistant are not covered.
- Diagnoses of ***Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.*** Coverage levels will vary on the type of service needed and all benefit limits will apply. Contact UnitedHealthcare at 800-331-0265.
- ***Bereavement counseling*** for the patient's immediate family, as defined under Fidelity's bereavement policy, covered at 90 percent with no deductible for up to 6 months after the patient's death, up to 15 visits per family. Coinsurance amounts you pay do not count toward the HealthFlex Plan out-of-pocket maximum.

- ***Birthing center services***, including room and board, and anesthetics and charges for administering them, as well as other services and supplies, covered at 90 percent with no copayment.

  A *birthing center* is a specialized medical facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that:

  – Is licensed in accordance with the appropriate regulatory authority.

  – Meets *all* of the following requirements:

  - Is operated and equipped in accordance with any applicable state law.
  - Is equipped to perform routine diagnostic and laboratory tests.
  - Has emergency personnel and equipment available.
  - Is operated under the supervision of a Physician or registered nurse.
  - Maintains adequate patient records.
  - Has immediate access to an area hospital.
  - Discharges patients within 24 hours after delivery.

- ***Chiropractic care***, covered at 90 percent with no deductible, up to 20 visits per calendar year for both in-network and out-of network care combined.
- ***Cochlear implants,*** when deemed medically necessary by UnitedHealthcare, covered at 90 percent with no copayment.
- ***Dental care***, limited to charges for or in connection with:

  – The installation of fixed bridgework or full or partial dentures (if needed after an accidental injury to sound, natural teeth).

  – Initial emergency visit to an emergency room or urgent care center when all of the following are true:

  - Treatment is medically necessary because of accidental damage (does not include damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth),
  - Dental services are received from a Physician and
  - Dental damage is severe enough that initial contact with a Physician occurred within 72 hours of the accident.

- ***Durable medical equipment***, covered at 90 percent with no copayment, provided it is:

  – For repeated use and is not a consumable or disposable item.

  – Used primarily for a medical purpose.

  – Appropriate for use in the home.

  In each case, UnitedHealthcare will decide whether to cover the purchase or rental of the equipment. Prior authorization is required for equipment exceeding $750.

- ***Enteral formula***, when it is the sole source of nutrition, is for life-sustaining purposes only, and meets UnitedHealthcare's Care Coordination guidelines. Enteral formula is covered at 50% with no copay.
- Routine ***gynecological examinations***, covered in-network only.
- Routine ***hearing exams***, covered in-network only, at 100 percent after copayment.
- ***Hearing aids,*** covered at 90 percent with no copayment up to $300 per member per calendar year.

Examples of *durable medical equipment* include, but are not limited to:

- Appliances that replace a lost body organ or part, or help an impaired one to function.
- Orthotic devices, such as arm, leg, neck, and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.

- ***Home health care*** that is prescribed, generally in writing, by the covered person's Physician and administered by a home health care agency and that provides for the care and treatment of a covered person's illness or injury in the covered person's home, covered at 90 percent with no copayment.

  A *home health care agency* is an agency or organization that provides a program of home health care and:

  – Is approved by Medicare.

  – Is established and operated in accordance with applicable licensing and other laws.

  The HealthFlex Plan covers home health care for up to 40 visits per calendar year for in-network and out-of-network care combined. Covered Services include:

  – Temporary or part-time nursing care by or supervised by a registered graduate nurse.

  – Temporary or part-time care by a home health aide.

  – Physical therapy.

  – Occupational therapy.

  – Speech therapy.

  Each period of home health care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team counts as one visit.

- ***Hospice care***, for a patient certified by a Physician to be terminally ill with six or fewer months to live, covered at 90 percent with no copayment. Eligible services include:

  – Room and board and other services charged by the hospice.

  – Part-time nursing care by or supervised by a registered graduate nurse.

  – Home health care services.

  – Counseling by a licensed social worker for the patient and the patient's immediate family members who are covered under the HealthFlex Plan.

A *hospice* is an agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided.

- Travel-related ***immunizations***.
- ***Inpatient hospital services***, including semi-private room and board, intensive care services, laboratory and x-ray services, Physician's/surgeon's services, and other services, covered at 90 percent with no copayment.
- ***In vitro fertilization, Gamete Intrafallopian Transfer (GIFT), and Zygote Intrafallopian Transfer (ZIFT)***, to a maximum of six cycles per member per lifetime for in-network and out-of-network care combined, covered at 80 percent after deductible.
- Diagnostic ***mammograms***, covered at 100 percent after copayment.
- Routine ***mammograms***, provided by an in-network provider only, covered at 100 percent after copayment.
- ***Maternity care***, including:

  – Prenatal care performed by an in-network provider only, exams, and tests, covered at 100 percent after copayment for initial visit only. Covered at 90 percent with no copayment thereafter.

  – Hospital and delivery services, covered at 90 percent with no copayment.

  – Postnatal exams, covered at 90 percent with no copayment.

Under federal law, group health plans generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a normal vaginal delivery or fewer than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a stay that does not exceed the above periods. The minimum stay requirements do not apply when the decision to stay for a shorter period of time has been made by the Physician and the mother. If a state law provides for a hospital length of stay in connection with childbirth for the mother or newborn child that is greater than 48 hours following a vaginal delivery, or greater than 96 hours following a cesarean section, the state law provision will apply to the extent that state law is applicable.

- ***Mental health care.*** Inpatient hospitalization in any hospital, up to 60 days per member per calendar year for in-network and out-of-network care combined. Inpatient mental health and substance abuse benefits are also combined. Outpatient care is covered for up to 20 visits per member per calendar year by an in-network provider and up to 10 visits per year by an out-of-network provider. The maximum number of outpatient visits for in-network and out-of-network care combined is 20 visits per calendar year. Outpatient mental health and substance abuse benefits are combined. See page 23 for additional information about mental health care benefits and page 27 for substitution of care options.

- ***Multiple surgical procedures***, where more than one surgical procedure is performed during the same operative session. Coverage is limited to 50 percent for a secondary procedure and 50 percent for any subsequent procedure. Covered expenses for secondary and any other subsequent procedures include those expenses that have not already been covered in relationship to the surgical procedure (e.g., anesthesia or room and board). To determine Covered Services for multiple surgical procedures, contact UnitedHealthcare at 800-331-0265.
- Services of a licensed or certified ***nurse practitioner*** acting within the scope of that license or certification.
- Services for medically necessary ***organ or tissue transplants***. Qualified procedures include:
  - Heart transplants.
  - Lung transplants.
  - Heart/lung transplants.
  - Liver transplants.
  - Kidney transplants.
  - Pancreas transplants.
  - Kidney/pancreas transplants.
  - Bone marrow/stem cell transplants.
  - Other transplant procedures when determined to be medically appropriate.

  Donor charges are covered only if the recipient is covered under the HealthFlex Plan. If the recipient is not covered under the HealthFlex Plan, benefits are not payable for donor charges. Services for donors who are biologically related are covered, regardless of whether the search is in connection with a transplant procedure arranged by a designated facility.

  Covered expenses for services provided in connection with a transplant procedure include:
  - Pre-transplant evaluation for a covered transplant.
  - Organ acquisition and procurement.
  - Hospital and Physician fees.
  - Transplant procedures.
  - Follow-up care for a period of up to one year after the transplant.
  - The search for bone marrow/stem cell from a donor who is not biologically related to the patient. The search must be in connection with a transplant procedure arranged by a designated transplant facility. If a separate charge is made for the bone marrow/stem cell search, a lifetime maximum benefit of $25,000 is payable for all charges made in connection with the search.

  The Care Management Center will assist the patient and family with travel and lodging arrangements. Benefits for travel and lodging expenses are available only if the transplant recipient resides more than 50 miles from the designated transplant facility. Covered expenses include the following:
  - Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
  - Reasonable and necessary expenses for the lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $200 for the patient and companion.
  - If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered. In this case, lodging expenses will be reimbursed up to the $200 per diem rate.

  There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under the HealthFlex Plan in connection with all transplant procedures.

You must call the Care Management Center at 800-331-0265 at least seven business days, or as soon as reasonably possible, before the scheduled date of any of the following:

- A transplant evaluation.
- A donor search.
- The organ procurement/ tissue harvest.
- The transplant procedure.

The Care Management Center also will assist the patient and family with travel and lodging arrangements. For more information, call the Care Management Center.

UnitedHealthcare's Centers of Excellence program can provide valuable assistance if you are a transplant candidate. For more information, refer to page 27.

- ***Nutritional counseling*** when deemed medically necessary by UnitedHealthcare for certain diagnoses only, covered at 100 percent after copayment. Services must be rendered by a registered dietitian in an individual setting. Visit limitations vary based on diagnosis.
- Surgical treatment of ***obesity*** including, but not limited to, gastric bypass, lap bands, etc., received on an inpatient basis subject to the following requirements: You have a minimum Body Mass Index (BMI) of 40; you are over the age of 21; the surgery is performed at a network hospital by a network surgeon; and you were on a 6-month MD supervised diet prior to approval. Travel-related expenses to a network hospital are not covered. Experimental or investigational or unproven services related to the surgical treatment of obesity are not covered.
- ***Oral Surgery/Wisdom Teeth Removal,*** when deemed medically necessary by UnitedHealthcare. Surgery performed in office is covered at 100 percent after copayment. Surgery performed in facility or at an inpatient setting is covered at 90 percent with no copayment.
- ***Orthoptic training*** (eye muscle exercise). Certain training provided by a licensed optometrist or an orthoptic technician is covered. Covered Services are limited to a lifetime maximum of 20 visits for employee or spouse, 30 visits for a dependent child. For a list of Covered Services, contact UnitedHealthcare at 800-331-0265.
- ***Outpatient therapy***, including physical, occupational, and rehabilitative therapy. Services must be provided in a hospital or comprehensive outpatient rehabilitative facility (CORF) or in a provider's office. Covered Services are limited to 30 visits, per calendar year, per therapy for in-network and out-of-network care combined.
- Routine ***physical exams***, covered in-network only, at 100 percent after copayment. **Routine physical exams performed by out-of-network providers are not covered.**
- Diagnoses of ***Pervasive Developmental Disorders,*** included but not limited to: Autistic Spectrum Disorders, Childhood Disintergrative Disorder, Asperger's Syndrome, Rett's Disorder and Pervasive Developmental Disorder not otherwise specified/atypical Autism will no longer be excluded conditions. Coverage levels will vary depending on the type of service needed and all benefit limits will apply. Services provided in schools or other institutions for training are not covered. Expenses and associated expenses for experimental, investigational, or unproven services treatments, devices or pharmacological regimens are excluded.
- ***Post-mastectomy services***, including:
  - Prosthesis.
  - Reconstructive surgery for the affected breast and, if required, additional reconstructive procedures to achieve bilateral breast symmetry.
  - Medical procedures or services related to any post-surgical complications.
- Medically appropriate ***private duty nursing care***, given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).
- ***Reconstructive surgery***, covered at 90 percent for the following:
  - To improve the function of a body part when the malfunction is the direct result of:
    - A birth defect.
    - Sickness.
    - Surgery to treat a sickness or accidental injury.
    - An accidental injury.
  - Breast surgery following a medically appropriate mastectomy, including surgery on the non-affected breast to achieve symmetry. Additional services include breast prosthesis and treatment of physical complications during all stages of the mastectomy, including lymphedemas.
  - The removal of scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.

The *Women's Health and Cancer Rights Act* (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy must provide specified post-mastectomy services. These services must be provided in consultation with the attending Physician and the patient. This coverage may be subject to annual deductibles and Coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable plan in which you choose to enroll.

- ***Second surgical opinions***, including:
  - Consultation with a specialist Physician or specialist surgeon (the surgeon cannot be the one who was originally scheduled to perform the surgery).
  - X-rays, laboratory tests, and other diagnostic procedures needed for the consultation.

  If the second opinion does not confirm the need for surgery, a third opinion also is covered.
- Care in a ***skilled nursing facility*** is covered at 90 percent with no copayment, including charges made for a semi-private room and board and other services and supplies, for up to 100 days per calendar year for in-network and out-of-network care combined.

  A *skilled nursing facility* is a facility approved by Medicare as a skilled nursing facility. If not approved by Medicare, it may be approved if it meets all of the following criteria. It:
  - Is operated in accordance with the applicable licensing and other laws.
  - Is under the full-time supervision of a licensed Physician or registered nurse.
  - Is primarily engaged in providing room and board and continuous 24-hour-a-day skilled nursing care.
  - Maintains a daily record of each patient.

  A facility does not qualify if it is used primarily for:
  - Residential services.
  - Rest.
  - The care of drug abuse or alcoholism.
  - The care of mental disease or disorders.
  - Custodial or educational care.
- Restorative ***speech therapy*** is covered at 100 percent after copayment for up to 30 visits per year for in-network and out-of-network care combined, provided that services are given to restore speech lost or impaired because of:
  - The removal of vocal cords (laryngectomy).
  - Cerebral thrombosis (cerebral vascular accident).
  - Brain damage because of accidental injury or organic brain lesion (aphasia).
  - Infantile autism.
  - Cerebral palsy.
  - A hearing impairment.
  - Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

  Coverage may be available for more than 30 visits if the Claims Administrator, after review of the participant's medical condition, determines that additional visits are necessary and medically appropriate.

The *Women's Health and Cancer Rights Act* (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy must provide specified post-mastectomy services. These services must be provided in consultation with the attending Physician and the patient. This coverage may be subject to annual deductibles and Coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable plan in which you choose to enroll.

- ***Substance abuse treatment.*** Inpatient hospitalization in any hospital, up to 60 days per member per calendar year for in-network and out-of-network care combined. Inpatient substance abuse and mental health benefits are also combined. Outpatient care is covered for up to 20 visits per member per calendar year by an in-network provider and up to 10 visits per year by an out-of-network provider. The maximum number of outpatient visits for in-network and out-of-network care combined is 20 visits per calendar year. Outpatient substance abuse and mental health benefits are combined. See page 23 for additional information about substance abuse treatment benefits and page 27 for substitution of care options.
- ***Temporomandibular Joint Surgery,*** when deemed medically necessary by UnitedHealthcare. Surgery is covered at 90 percent with no copayment. Treatment and appliances are not covered.
- Routine ***vision exams***, covered in-network only at 100 percent after copayment.
- ***Well-child care visits***, covered in-network only at 100 percent after copayment.

What the HealthFlex Plan Does Not Cover

While the HealthFlex Plan provides coverage for many services, there are some services that are not covered, even if your Physician or professional provider approves or recommends them. Services that are not covered include, but are not limited to, the following:

- Testing and treatment of ***Attention Deficit Disorder (ADD and ADHD), learning disabilities, and developmental delays.***
- Charges incurred ***before the effective date of your coverage*** or your Eligible Dependents' coverage (including newborns).
- ***Birthing/lamaze classes.***
- ***Chelation therapy***, except to treat heavy metal poisoning.
- Charges for the ***completion of claim forms.***
- ***Cosmetic or reconstructive surgery***, except to the extent reconstructive surgery is covered after a mastectomy or as specified in the "What the HealthFlex Plan Covers" section under "Reconstructive Surgery."
- ***Custodial care***, meaning services and supplies that meet one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living rather than to provide medical treatment.
  - Care that can be provided safely and adequately by persons who do not have the technical skills of a covered health care professional.

  Custodial care is not covered regardless of:
  - Who recommends, provides, or directs the care.
  - Where the care is provided.
  - Whether the patient or another caregiver can be or is being trained to care for himself or herself.
- Emergency ***dental care*** for:
  - Dental services provided by a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."
  - Dental services provided after the initial emergency care visit (as defined in "What the HealthFlex Plan Covers" section under "Dental Care") or follow-up care that is dental in nature.
- Diagnosis by and/or treatment with ***ecological or environmental medicine***.
- ***Education, training, and bed and board***, including those services provided while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the development of activities of daily living, a place for the aged, or a nursing home.
- Expenses incurred by an ***Eligible Dependent***, if the Eligible Dependent is covered as an employee for the same services under the HealthFlex Plan.
- ***Elective vision correction eye surgery***. These surgeries include, but are not limited to, Radial keratotomy (RK), Photorefractive keratectomy (PRK), Automated lamellar keratoplasty (ALK), and Laser in situ keratomileusis (LASIK).
- Expenses and associated expenses incurred for services and supplies for ***experimental, investigational, or unproven services, treatments, devices, and/or pharmacological regimens***, except for services that are otherwise experimental, investigational, or unproven that are deemed to be covered transplant services. The fact that an experimental, investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition.

Experimental, investigational, or unproven services are medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be:

- **Not approved by the U.S. FDA to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the use, or**
- **Subject to review and approval by any institutional review board for the proposed use, or**
- **The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, or**
- **Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.**

To find out if you will be covered under the HealthFlex Plan for certain medical care services, call the toll-free customer service number on your medical ID card.

You may want to take advantage of the Health Care Flexible Spending Account to pay for eligible expenses that are not covered by a medical, dental, vision, or other health plan. For more information, see the ***Flexible Spending*** section of this SPD.

- ***Eyeglasses, contact lenses, cochlear implants, and hearing aids,*** unless needed because of an accidental injury.
- ***Herbal medicine, holistic, or homeopathic care,*** including drugs.
- Charges ***in excess of the Reasonable and Customary Amount*** for a treatment or procedure.
- Charges incurred for ***services performed internationally***, except for emergencies.
- Charges associated with certain ***in vitro procedures***, such as fees for an egg donor, assisted hatching, specimen preservation, and cryopreservation of sperm and egg.
- ***Investigational or experimental procedures*** that are not treatments of an illness, injury, or disease, or are only a means of circumventing a condition.
- ***Maintenance procedures***. Any type of physical therapy, service, or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, as determined by UnitedHealthcare, and that is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- ***Membership costs for health clubs***, weight-loss clinics, and similar programs.
- Charges for ***missed appointments.***
- Charges that would ***not have been made*** in the absence of coverage by the HealthFlex Plan.
- Services or supplies that are ***not covered health services and/or not medically necessary***, including any confinement or treatment given in connection with a service or supply that is not a covered health service.
- Medical exams or tests ***not needed to treat an injury, sickness, or pregnancy***, including genetic screenings, except as specifically named in the HealthFlex Plan.
- Charges by any facility that provides ***nursing home or long-term care services***.
- ***Occupational injury or sickness***, meaning one that is covered (or claimed to be covered) by a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered by the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatments ***ordered by a court*** in connection with legal proceedings unless such examinations or treatments otherwise qualify as Covered Services under the HealthFlex Plan.
- Charges that are ***paid by another plan.***
- ***Pastoral counseling***.

- ***Personal convenience or comfort items***, including, but not limited to, TVs, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs.
- ***Private duty nursing services*** while confined in a facility.
- Services ***provided by a member of your immediate family*** (or by a business in which a member of your immediate family has an interest), a person who lives in your home, a volunteer, or persons who do not normally charge for their services.
- Services for, or related to, the ***removal of an organ or tissue from a person for transplantation into another person***, unless the transplant recipient is covered by the HealthFlex Plan and is undergoing a covered transplant.
- ***Reversal of sterilization procedures***, or in vitro, Zygote Intrafallopian Transfer (ZIFT) and Gamete Intrafallopian Transfer (GIFT) procedures after a reversal of sterilization.
- ***Sensitivity training***, education training, therapy, or treatment for an educational requirement.
- ***Sex-change surgery***.
- Charges for ***shoe orthotics*** are generally not covered.
- ***Special foods***, food supplements, liquid diets, diet plans, or any related products. Food of any kind, even if specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Enteral formula may be covered when it is the sole source of nutrition, is for life-sustaining purposes only, and meets UnitedHealthcare's Care Coordination guidelines.
- ***Standby services*** required by a Physician.
- Care of or treatment to the ***teeth, gums, or supporting structures***, including, but not limited to, periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak.
- ***Telephone consultations***.
- Appliances, including, but not limited to, splints, study models, bite plates, tens units, panoramic x-rays, and ultrasounds for ***temporomandibular joint (TMJ) dysfunction***.
- Treatment for ***tobacco dependency***.
- Charges for treatment in a ***U.S. governmental or agency hospital***.
- Charges due to an injury or sickness caused by ***war***, declared or undeclared, or international armed conflict.
- ***Weight reduction or control***, unless there is a diagnosis of morbid obesity.
- ***Wigs or toupees*** (except for hair loss resulting from treatment of a malignancy or permanent loss of hair from an accidental injury or medical condition up to a limit of $350 per calendar year), hair transplants, hair weaving, or any drug if such drug is used in conjunction with baldness.

When Your Coverage under the HealthFlex Plan Ends

Your coverage under the HealthFlex Plan ends on the earliest of the following:

- The last day of the month in which your employment with Fidelity ends.
- The date the HealthFlex Plan is terminated.
- The last day of the month in which you stop sharing in the cost of your coverage.
- The date of your death.
- The last day of the month in which you and/or your covered Eligible Dependents no longer satisfy the eligibility requirements under the HealthFlex Plan.

In some circumstances, you and your covered Eligible Dependents may be able to continue coverage for a limited time under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA). For more information, see page 177 in the ***Administrative*** section of this SPD.

While same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the Medical Plans. See page 179 for more information.

YOUR RIGHTS UNDER HIPAA

The *Health Insurance Portability and Accountability Act* (HIPAA) was enacted to make it easier for you and your family members to have continued health plan coverage when changing from one employer to another.

If Your Coverage or Your Employment Ends. If your coverage under a group health plan ends or your employment terminates, the group health plan will provide you and your covered Eligible Dependents with a written "certificate of creditable coverage." This certificate can be used to demonstrate that you have had coverage under a group health plan and that you may be eligible to reduce or eliminate any pre-existing condition limitations imposed by your new group health plan. Be sure to keep this certificate when you receive it. (Because none of Fidelity's medical plans has a pre-existing condition limitation, you are not required to provide a certificate from your previous employer when enrolling in a Fidelity medical plan.)

About the Fidelity Health Plan

To find out if your provider and/or facility is a member of the UnitedHealthcare preferred provider network, visit UnitedHealthcare's website (www.myuhc.com) or call member services at 877-240-4016 for the most current listing.

Health Savings Account
If you are enrolled in the Fidelity Health Plan you may also be eligible to establish a Health Savings Account (HSA). An HSA is a tax-advantaged account that can be used to pay for current and future qualified medical expenses.

For more information about the Fidelity HSA, refer to the NetBenefits® Reference Library.

IMPORTANT TERMS

Being familiar with the following terms will help you understand how you share in the cost of Covered Services under the Fidelity Health Plan:

- ***Coinsurance.*** Coinsurance is the percentage that you pay toward the cost of certain Covered Services. For example, the Fidelity Health Plan has a 10 percent Coinsurance rate for most in-network care, once you satisfy the annual deductible. This means that the Fidelity Health Plan pays 90 percent of the cost of the Covered Service and you pay the remaining balance, which generally is 10 percent, once you satisfy the annual deductible, up to the annual out-of-pocket maximum. For out-of-network care, the Fidelity Health Plan has a 30 percent Coinsurance rate once you satisfy the annual deductible. This means the Fidelity Health Plan pays 70 percent of the cost of the Covered Service, based on the Reasonable and Customary Amount (defined below) and you pay the remaining balances, which generally includes 30 percent of the Reasonable and Customary Amount, up to the annual out-of-pocket maximum.
- ***Copayment.*** The copayment is the amount you pay up-front to your in-network health care provider for preventive care Covered Services. In most cases, the copayment amount is $20. The chart beginning on page 43 includes copayment amounts for preventive care Covered Services.
- ***Deductible.*** The deductible is the amount you must pay each calendar year for non-preventive Covered Services before the Plan begins to pay benefits.
  - The annual deductible for non-preventive in-network Covered Services is $1,500 per individual and $3,000 per individual +1 or family. Preventive care and preventive prescription drug copays do not apply toward the deductible. The out-of-network deductible is $3,000 per individual and $6,000 per individual +1 or family.
- ***Out-of-pocket maximum.*** The Fidelity Health Plan places some limits on the amount you spend for care each year. Once you reach the in-network care out-of-pocket maximum, the Fidelity Health Plan pays 100 percent for Covered Services for the rest of the year. Once you reach the out-of-network care out-of-pocket maximum, the Fidelity Health Plan pays 100 percent of the Reasonable and Customary Amount for Covered Services for the rest of the year. The current in-network care out-of-pocket maximum is $2,000 per individual and $4,000 per family. The current out-of-network care out-of-pocket maximum is $4,000 per individual and $8,000 per family. Deductibles, preventive care copays, and preventive prescription drug copays apply to the annual out-of-pocket maximums. Certain expenditures do not count toward these maximums, including:
  - Any amount you pay toward the premium for your coverage.
  - Charges for services the Fidelity Health Plan does not cover.
  - Amounts in excess of the Reasonable and Customary Amount (defined below) for the Covered Service.
  - Amounts in excess of Fidelity Health Plan limits and maximums.
  - Inpatient and outpatient mental health/substance abuse treatment and bereavement counseling.
- ***Reasonable and Customary Amount*** for Out-of-Network Coverage refers to the prevailing amount for corresponding treatment, services, or supplies for similar medical conditions in your geographic area, as determined by UnitedHealthcare. When determining what amount is Reasonable and Customary, UnitedHealthcare considers the complexity and range of services provided. Therefore, the Reasonable and Customary Amount may be different than the amount charged by an out-of-network provider.

How the Fidelity Health Plan Works

Fidelity Health Plan In-Network Coverage

You receive the highest level of benefits available under the Fidelity Health Plan when you use a preferred provider at an in-network facility. The network of preferred providers offers an extensive selection of doctors, specialists, hospitals, facilities, and other health care providers from which to choose. These providers have contracted with UnitedHealthcare to provide medical services at predetermined rates.

You do not need a Primary Care Physician, nor are you required to obtain a referral to see a specialist (e.g., cardiologist) or other provider who is a member of the network. When you obtain services from an in-network provider, you are not required to file any claim forms. Your preferred provider handles the submission of all claims for you.

How the Annual Deductible Applies to In-Network Coverage. The Fidelity Health Plan requires you to satisfy an annual deductible ($1,500 individual, $3,000 individual +1 or family) before you can receive benefits for non-preventive Covered Services you receive in-network. Then, the Plan pays 90 percent of the total cost of Covered Services, up to the annual out-of-pocket maximum. The annual in-network care out-of-pocket maximum is $2,000 per individual, $4,000 per individual +1 or family. Preventive care and preventive prescription drug copayments do not apply toward your annual deductible, but they do count toward the out-of-pocket maximum.

Routine and Preventive Care. You and your covered family members are always covered at 100 percent after a $20 copayment for covered routine and preventive care services that you receive from a preferred provider at an in-network facility. With the exception of prenatal care, preventive care is not covered out-of-network. See page 44 for information about Out-of-Network Coverage for prenatal care.

Covered preventive care services include, but are not limited to:

- Age-appropriate routine screenings such as vision and hearing exams.
- Certain preventive prescription drugs (covered at 100 percent after appropriate copay of $10, $20, or $40).
- Immunizations (including flu shots) and inoculations.
- Laboratory tests for or in connection with a routine pap smear.
- Routine physical exams.
- Well-child care visits.

Preventive care services are covered at 100 percent, after a $20 copayment, only when they are performed for preventive reasons. Any service that is provided as part of a diagnostic or treatment plan is subject to the annual deductible and Coinsurance. See page 55 for a list of services that are covered as preventive care under the Fidelity Health Plan.

Health Care HSA-Compatible Flexible Spending Account

Fidelity Health Plan participants who have established a Health Savings Account may also want to consider enrolling in the ***Health Care HSA-Compatible Flexible Spending Account***. With this Account, you may be able to save money by paying for eligible expenses with Pre-Tax dollars. These expenses include eligible dental and vision expenses (as defined by the IRS) and preventive care copays that aren't covered by another health plan.

Medical expenses (other than the preventive care copays) that are generally reimbursable under the Health Care Flexible Spending Account are not reimbursable under the Health Care HSA-Compatible Flexible Spending Account. Review the ***Flexible Spending Accounts*** section of this SPD for complete details.

EXAMPLE

Fidelity Health Plan In-Network Coverage Costs

Peter, an individual Fidelity Health Plan participant, has surgery at an in-network hospital. The surgery is a Covered Service under the Fidelity Health Plan and the cost of the surgery is $10,000. After Peter satisfies his in-network annual deductible of $1,500, the Fidelity Health Plan will pay 90 percent of the Covered Service cost. Once Peter reaches the in-network care out-of-pocket maximum of $2,000, the Fidelity Health Plan will pay 100 percent of the remaining cost of the Covered Service.
Here's how it works:

PLAN PROVISION	COVERED EXPENSE	PETER PAYS	PLAN PAYS
Annual Deductible Is Satisfied	First $1,500	$1,500	$0
Coinsurance Applies	Next $5,000	$500 (10%)	$4,500 (90%)
Out-of-Pocket Maximum Is Reached	Last $3,500	$0	$3,500 (100%)
Total	**$10,000**	**$2,000**	**$8,000**

Fidelity Health Plan Out-of-Network Coverage

You always can choose to receive care outside of the UnitedHealthcare network of preferred providers. In this case, the amount you pay for Covered Services generally is higher. When you receive care from an out-of-network provider, you are responsible for filing your own claims (see page 48 for details).

How the Annual Deductible Applies to Out-of-Network Coverage. You are required to pay an out-of-network annual deductible ($3,000 per individual, $6,000 per individual +1 or family) before the Fidelity Health Plan begins to pay benefits. Then, the Fidelity Health Plan pays 70 percent of the Reasonable and Customary Amount (not necessarily the same as the amount charged by the out-of-network provider) for most Covered Services and you pay the remaining balance, which generally is 30 percent of the Reasonable and Customary Amount, up to the annual out-of-network care out-of-pocket maximum. The annual out-of-network care out-of-pocket maximum is $4,000 per individual, $8,000 per individual +1 or family.

Reasonable and Customary Amount. If your out-of-network provider charges more than the Reasonable and Customary Amount, as determined by UnitedHealthcare, you are responsible for paying the difference between the amount your out-of-network provider charges and the Reasonable and Customary Amount, in addition to your Coinsurance and deductible amounts. Please note that you still are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount for the Covered Service, as determined by UnitedHealthcare, even after you have reached the annual out-of-pocket maximum for out-of-network care.

Routine and Preventive Care. It's important to note that routine and preventive care is not covered under the Fidelity Health Plan when provided by an out-of-network provider, except for prenatal visits. Out-of-network prenatal care is subject to the out-of-network deductible and Coinsurance, as well as Reasonable and Customary guidelines. You are responsible for 100 percent of the costs above the Reasonable and Customary Amount.

EXAMPLE

Fidelity Health Plan Out-of-Network Coverage Costs

Helen, an individual Fidelity Health Plan participant, has an office visit with an out-of-network provider. The out-of-network provider charges Helen $100 for the visit. UnitedHealthcare determines that the Reasonable and Customary Amount for the office visit is $90. Helen has already satisfied her out-of-network deductible of $3,000 for the year. Here's how the out-of-network office visit will get paid.

- The Fidelity Health Plan will pay $63 (70% of the Reasonable and Customary Amount).
- Helen will pay $27 (30% of the Reasonable and Customary Amount) *plus* $10 (the difference between the amount the out-of-network provider charged [$100] and the Reasonable and Customary Amount [$90]). **Helen's total is $37.**

If Helen had reached the annual out-of-pocket maximum for out-of-network care at the time of the office visit:

- **The Fidelity Health Plan would pay $90** (100% of the Reasonable and Customary Amount).
- **Helen would pay $10** (the difference between the amount the out-of-network provider charged and the Reasonable and Customary Amount).

Prenotification for Out-of-Network Inpatient Admissions

If your Physician recommends inpatient hospitalization (other than for a maternity admission covered by the *Newborns' and Mothers' Health Protection Act*), including admission for mental health or substance abuse care, or to a skilled nursing facility or hospice, you must follow the review procedures outlined in this section to receive the highest level of benefits available under the Fidelity Health Plan.

If you do not follow these prenotification procedures, all inpatient benefits for that admission will be reduced by $500. Your benefits may be further reduced if you receive services that have not been approved, if applicable. These prenotification penalty amounts do not apply toward your annual deductible or out-of-pocket maximum.

To provide prenotification, you must call UnitedHealthcare's Care Management Center at 877-240-4016. You must call at least 48 hours in advance for non-emergency inpatient admissions and no later than 48 hours after emergency admissions to a hospital or other facility.

When you call, be prepared to provide:

- Your employer's name: Fidelity Investments.
- Your group contract number: GA#119174.
- Your name and Social Security number.
- The name of the covered person receiving care.
- Any medical information concerning the hospital stay.
- The attending Physician's name, phone number, and address.

In addition to calling for a non-emergency inpatient admission or an emergency admission, you also must call for:

- ***Lengthened maternity hospital stays.*** For childbirth, you must call for an extension due to complications for either the mother or the child. An extension is any length of time longer than that outlined on page 47.
- ***Rescheduled hospital stays.*** You must call again before you are admitted, even if previously approved. Otherwise, penalties may apply.
- ***Any change in plans.*** You must call before you make any changes (such as transferring between hospitals), unless it is an emergency situation. In emergency situations, you must call no later than 48 hours after the change.

When you call, your case will be reviewed by a staff of medical professionals to ensure that you receive quality care within the proper setting.

Specialty Care

Under the Fidelity Health Plan, you always have direct access to specialty care through the preferred provider network. You are eligible for in-network benefits whenever you visit a preferred provider network specialist at an in-network facility. And you always are free to go outside the network for specialist care, receiving benefits at the out-of-network level of coverage.

Emergency Care

You always are covered for emergency care, no matter where you are when an emergency occurs. If you need emergency care, you immediately should go to the nearest emergency room. Your benefits are the same whether you use an in-network or out-of-network provider.

An *emergency* is a life- or limb-threatening condition that comes on suddenly. Examples of emergencies include, but are not limited to, acute appendicitis, cardiac arrest, loss of consciousness, and severe bleeding.

Once you reach your annual deductible, you are covered for emergency care at 90 percent whether in-network or out-of-network. You are responsible for charges above the Reasonable and Customary Amount for out-of-network emergency care.

An Overview of the Fidelity Health Plan

This chart provides an overview of the services covered under the Fidelity Health Plan, which is available to all eligible Regular Employees. You also have the option to elect coverage under the HealthFlex Plan and depending on where you live or work, you also may have the option to elect coverage under an HMO. For an overview of services that the HealthFlex Plan provides, refer to the chart that begins on page 22 and for an overview of services that the HMOs provide, refer to the charts that begin on page 61.

FIDELITY HEALTH PLAN		
	In-Network	**Out-of-Network***
General Information		
For More Information	877-240-4016, www.myuhc.com	
Referrals	Not required	
Pre-Existing Conditions	No restrictions	
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.	
Costs		
Annual Deductible**	$1,500 per individual, $3,000 per individual +1 or family *Note that the annual deductible also applies to all non-preventive prescription drugs*	$3,000 per individual, $6,000 per individual +1 or family *Note that the annual deductible also applies to all non-preventive prescription drugs*
Annual Out-of-Pocket Maximum**	$2,000 per individual, $4,000 per individual +1 or family	$4,000 per individual, $8,000 per individual +1 or family
Lifetime Benefit Maximum	None	None
Covered Services		
Preventive Care *Routine physical exams*	Covered at 100% with no copayment per visit	Not covered
Well-child care visits	Covered at 100% with no copayment per visit	Not covered
Routine mammograms, colonoscopies, Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment per visit	Not covered
Mammograms for diagnostic purposes	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Routine Pap smears	Covered at 100% with no copayment per visit	Not covered
Routine vision exams	Covered at 100% with no copayment per visit	Not covered
Routine hearing exams	Covered at 100% with no copayment per visit	Not covered
Diagnostic, Sick, or Specialist Physician Office Visits *Non-preventive*	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Nutritional Counseling (Includes (Maximum of 12 visits per calendar year) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible**
Inpatient Care (Includes semi-private room and board, intensive care services, laboratory and x-ray services, and doctor's/ surgeon's services)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible**
Outpatient Care (Includes laboratory tests, diagnostic laboratory and x-ray services, and doctor's/ surgeon's services)	Covered at 90% after deductible (As preventive care in Physician's office: covered at 100% after a $20 copayment)	Covered at 70% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

**The difference, if any, between the amount an out-of-network provider charges and the Reasonable and Customary Amount does not count toward the annual out-of-pocket maximum for out-of-network care. Copayment amounts do not apply to the annual deductible, but do apply to out-of-pocket maximums.

An *ambulatory surgical center* is a specialized medical facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and that either is licensed in accordance with the applicable regulatory authority or satisfies the requirements listed on page 49.

FIDELITY HEALTH PLAN *(continued)*		
	In-Network	**Out-of-Network***
Outpatient Surgery	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Ambulatory Surgical Center	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Emergency Care** *Emergency room visit*	Covered at 90% after deductible	
Ambulance Services	Covered at 90% after deductible	
Urgent Care Center	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Maternity Care *Prenatal exams*	Covered at 100% with no copayment	Covered at 70% of Reasonable and Customary* after deductible
Hospital and delivery Services	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible***
Birthing center services	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Postnatal exams	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Mental Health/ Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient* Bereavement coverage available up to 6 months after the death of an immediate family member, as defined under Fidelity's bereavement policy.	Covered at 90% after deductible, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details.	Covered at 70% of Reasonable and Customary* after deductible***
	See page 48 for Substitution of Benefits for Mental Health and Substance Abuse Care	
Outpatient	Covered at 90% after deductible, unlimited visits per calendar year. Prior authorization may be required; contact the carrier for details.	Covered at 70% of Reasonable and Customary* after deductible
Infertility Coverage Comprehensive Fertility Treatment, including but not limited to: Ovulation Induction Therapy (unlimited cycles/attempts per member per lifetime) Artificial Insemination (maximum 6 cycles/ attempts per lifetime) Assisted Reproductive Treatment (ART), including but not limited to: In Vitro Fertilization Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT) (Maximum 3 attempts/ cycles per member per lifetime for ART for in-network and out-of-network combined) (Prior authorization is required)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Hospice Care	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible**

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

**The difference, if any, between the amount an out-of-network provider charges and the Reasonable and Customary Amount does not count toward the annual out-of-pocket maximum for out-of-network care. Copayment amounts do not apply to the annual deductible, but do apply to out-of-pocket maximums.

***You must call the Care Management Center at 877-240-4016 at least 48 hours *in advance* for all nonemergency inpatient hospital admissions and no later than 48 hours after any emergency admission. If you fail to call in your admission, you will be required to pay a $500 penalty in addition to any other applicable costs for your care.

FIDELITY HEALTH PLAN *(continued)*		
	In-Network	**Out-of-Network***
Home Health Care (Maximum 60 visits per calendar year for in-network and out-of-network combined)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Skilled Nursing Facility (Maximum 100 days per calendar year for in-network and out-of-network combined)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible**
Chiropractic Care (Up to 20 visits per year for in-network and out-of-network combined) (Massage therapy is not covered)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Acupuncture (Services must be administered by a licensed acupuncturist) (Up to 20 visits per year for in-network and out-of-network combined)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Durable Medical Equipment (Including, but not limited to, glucose monitors, crutches, wheelchairs, and respirators) (Prior authorization required for equipment exceeding $750)	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible
Feeding Formula Coverage is for specific diagnoses: 1. Specific inborn errors of metabolism (including, but not limited to phenylketonuria – PKU, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia, or to protect the fetus of a pregnant woman with PKU) 2. Malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility (including, but not limited to Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, inherited diseases of amino and/or organic acids 3. Central nervous system/ neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition	Covered at 50% after deductible	Covered at 50% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

**You must call the Care Management Center at 877-240-4016 at least 48 hours *in advance* for all non-emergency inpatient hospital admissions and no later than 48 hours after any emergency admission. If you fail to call in your admission, you will be required to pay a $500 penalty in addition to any other applicable costs for your care.

Be sure to review the ***Flexible Spending Accounts*** section. With a Health Care HSA-Compatible Flexible Spending Account, you may be able to save money by paying for eligible expenses with Pre-Tax dollars. You can take advantage of a Flexible Spending Account even if you are not enrolled in Fidelity medical or dental coverage.

An *emergency* is a life- or limb-threatening condition that comes on suddenly. Examples of emergencies include, but are not limited to, acute appendicitis, cardiac arrest, loss of consciousness, and severe bleeding.

FIDELITY HEALTH PLAN *(continued)*		
	In-Network	**Out-of-Network***
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/ Occupational Therapy* Limited to 60 visits per member for PT/OT combined per member per calendar year for in-network and out-of-network combined *Speech Therapy* Limited to 52 visits per member per calendar year for in-network and out-of-network combined. Must be medically necessary	Covered at 90% after deductible	Covered at 70% of Reasonable and Customary* after deductible

*Coverage based on Reasonable and Customary Amount. You are responsible for paying the difference, if any, between the amount your out-of-network provider charges and the Reasonable and Customary Amount.

Fidelity Health Plan Coordinated Care Management

Fidelity is committed to providing you with access to quality health care. The programs in this section are designed to help you use your medical coverage under the Fidelity Health Plan effectively. All programs are voluntary.

In addition, you may be contacted by a Care Management nurse, who will:

- Explain other types of treatments and the benefits available under your Plan for any alternative care.
- Assist you in planning for admission to and discharge from the hospital.
- Outline the continuing involvement and support provided by the Fidelity Health Plan during your hospitalization and after your discharge.

MORE ABOUT CARE MANAGEMENT'S SERVICES

Care Management is designed to:

- Provide you with one-on-one health care information, guidance, and support to help you manage your health condition.
- Help coordinate your care with physicians and health care professionals.
- Support you in understanding and following your doctor's treatment plan as well as reviewing your doctor's treatment plan for quality and effectiveness.

To ensure that you receive the right type of care in the most appropriate setting, Care Management is also available to help you:

- Locate a surgeon or Physician to provide a second opinion when surgery is recommended.
- Learn more about alternate treatments or medical resources in your community, for example, home health care, convalescent facilities, ambulatory surgical centers, and hospice care.

You can reach the Care Management Center at 877-240-4016.

Healthy Pregnancy Program

Whether or not this is your first time expecting a child, it's important that you begin your pregnancy with as much quality information as possible. The voluntary Healthy Pregnancy Program provides expectant parents with:

- An educational kit containing information about valuable resources for you and your baby.
- Access to quality information from trained nurses.
- Screenings for high-risk pregnancies.

To enroll, call Care Management at 877-240-4016.

IMPORTANT INFORMATION ABOUT MATERNITY STAYS

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If a state law provides for a hospital length of stay in connection with childbirth for the mother or newborn child that is greater than 48 hours following a vaginal delivery, or greater than 96 hours following a cesarean section, the state law provision will apply to the extent that state law is applicable.

Complex Illness Support—Impact Program

The Fidelity Health Plan's voluntary Impact Program provides assistance when you need help coordinating your medical care. These services can save you time as well as help ensure that you receive the most appropriate care.

When you call Care Management at 877-240-4016, you speak with a nurse who can:

- Provide you with information and alternatives to consider.
- Assist you with discharge planning.
- Make arrangements for home health care services.
- Review information about condition management programs, such as Diabetes, Asthma, Chronic Obstructive Pulmonary Disease, Heart Failure, or Coronary Artery Disease.

In addition, a Care Management nurse will follow up with you to provide further assistance and/or information as needed.

Centers of Excellence

Centers of Excellence network facilities are located throughout the country, and are nationally respected organizations chosen because of their high-quality results for certain procedures and diagnoses. Centers of Excellence programs are offered for transplants, cancer, bariatric surgery, congenital heart disease, kidney disease, neonatal care, and infertility treatment.

For example, if you or a covered Eligible Dependent needs a kidney transplant and a hospital in another city is the leader in kidney transplants, the Fidelity Health Plan will pay for:

- Coverage in that city for the individual needing the transplant.
- Travel expenses for the patient and one family member.

You will be notified by UnitedHealthcare if you are determined to be a candidate for any of these programs, or you may self-refer by calling 877-240-4016.

Substitution of Benefits for Mental Health and Substance Abuse Care

When you or a covered Eligible Dependent requires mental health or substance abuse care, you may substitute certain types of eligible intermediate outpatient care for inpatient care. This substitution program enables you to receive the appropriate level of treatment for your condition in a cost-effective setting, while expanding your benefits. Your benefits will continue to be paid at the appropriate in- or out-of-network level.

In order to be eligible for substitution of benefits, you or your covered Eligible Dependent must receive preauthorization from United Behavioral Health. **You must contact United Behavioral Health at 877-240-4016 to initiate your substitution of benefits before you have exhausted the number of in- or out-of-network inpatient or outpatient visits available under the Fidelity Health Plan.**

When you use substitution of benefits, the outpatient care you receive is counted toward the inpatient care maximum under Fidelity Health Plan (refer to the chart beginning on page 43 for details) for the treatment received as follows:

IF YOU RECEIVE INTERMEDIATE TREATMENT IN THIS SETTING	YOU MAY USE THIS NUMBER OF DAYS/VISITS OF INTERMEDIATE TREATMENT TO EQUAL ONE INPATIENT DAY
Residential Treatment	1.5 days
Day Treatment/Partial Hospital Stay	2 days
Structured Outpatient	5 visits
Outpatient Psychotherapy	6 visits

How to File a Fidelity Health Plan Claim

It's important to review your Health Statement from UnitedHealthcare prior to paying your provider bill. When you use an in-network provider, your Health Statement will always reflect the amount you should pay based on the discounted rate between UnitedHealthcare and your provider.

Health Statements are available on UnitedHealthcare's website at www.myuhc.com.

When you receive care from an in-network provider, you don't have to file any claim forms. Simply show your medical ID card to your medical provider. For preventive care services, you will need to pay the applicable copayment at the time you receive services.

Your network provider will notify UnitedHealthcare that care has been provided. You then receive a Health Statement from UnitedHealthcare at your home address. The Health Statement describes how much of the expense you pay and how much the Fidelity Health Plan pays. Subsequently, your network provider will bill you for your share of the cost of your care.

When you receive care from an out-of-network provider, you generally pay for your care up-front and then file a claim for reimbursement for the share of the cost covered by the Fidelity Health Plan. Here are the steps to follow:

1. ***Complete the "Employee" section of a Fidelity Health Plan Claim Form***, available from HR Solutions—online or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860)—or on NetBenefits®.
2. ***Obtain an itemized bill*** from your provider that includes:

– The provider's name and Internal Revenue Service (IRS) tax identification number.

– An itemized description of services performed and the charges for these services.

– The date of services.

– A diagnosis.

– The amount you paid.

3. ***Attach a copy of your itemized bill*** to the claim form and submit both to:

UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800

Claims should be submitted no later than 90 days after the date care was received or as soon as possible thereafter. In all cases, your claim must be submitted within 18 months of receiving treatment. Claims submitted more than 18 months after the date of service are not considered valid and will not be paid. If a benefit is incorrectly overpaid, the Fidelity Health Plan has the right to request the return of the overpayment and receive it from you.

What the Fidelity Health Plan Covers

The Fidelity Health Plan covers the services, health supplies, and/or equipment set forth on the following pages that are used to prevent, diagnose, or treat a sickness, injury, or symptom ("Covered Health Services") as determined by UnitedHealthcare. In-Network Coverage levels are listed unless otherwise noted.

To find out if you will be covered under the Fidelity Health Plan for certain medical care services, call the toll-free customer service number on your medical ID card.

You may want to take advantage of the Health Care HSA-Compatible Flexible Spending Account to pay for eligible expenses that are not covered by a dental, vision, or other health plan. For more information, see the ***Flexible Spending*** section of this SPD.

Medically necessary means that a medical service or supply is medically appropriate and meets all of the following requirements. It is:

- Necessary to meet the basic health needs of the covered person, and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply, and
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare, and
- Consistent with the diagnosis of the condition, and
- Required for reasons other than the convenience of the covered person or his or her Physician, and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed, or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition, and
    - In a clinically controlled research setting, and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is a medically necessary service, as defined above. The definition of medically necessary used in this SPD relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

In order for a service, health supply, or equipment to be a Covered Health Service it must meet each of the following criteria:

- Supported by national medical standards of practice;
- Consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:
  - Well-conducted randomized controlled trials, and
  - Well-conducted cohort studies, and
  - The most cost-effective method and yields a similar outcome to other available alternatives.
- ***Acupuncture services*** rendered by a licensed acupuncturist, covered at 90% after the deductible, up to 20 visits per calendar year for both in-network and out-of-network care combined.
- ***Ambulatory surgical center services*** given within 72 hours before or after a surgical procedure, provided they are given in connection with the procedure, covered at 90 percent after deductible.

An ambulatory surgical center is a specialized medical facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and that either:

– Is licensed in accordance with the applicable regulatory authority.

– Where licensing is not required, meets *all* of the following requirements:

- Is operated under the supervision of a licensed Physician.
- Provides at least one operating room and one post-anesthesia recovery room.
- Has immediate access to blood supplies.
- Is equipped to perform diagnostic tests and x-rays.
- Provides nursing services.
- Maintains adequate patient medical records.

- ***Assistant surgeon services***, limited to one-fifth of the amount of covered expenses for the surgeon's charge for the surgery. The assistant surgeon must be a Physician. Services of a surgical assistant are not covered.
- Diagnoses of ***Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.*** Coverage levels will vary on the type of service needed and all benefit limits will apply. Contact UnitedHealthcare at 877-240-4016 for more information on coverage.
- ***Bereavement counseling*** for the patient's immediate family, as defined under Fidelity's bereavement policy, covered at 90 percent after deductible for up to 6 months after the patient's death, up to 15 visits per family. Coinsurance amounts you pay do not count toward the Fidelity Health Plan out-of-pocket maximum.
- ***Birthing center services***, including room and board, and anesthetics and charges for administering them, as well as other services and supplies, covered at 90 percent after deductible.

  A birthing center is a specialized medical facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that:

  – Is licensed in accordance with the appropriate regulatory authority.

  – Meets *all* of the following requirements:

  - Is operated and equipped in accordance with any applicable state law.
  - Is equipped to perform routine diagnostic and laboratory tests.
  - Has emergency personnel and equipment available.
  - Is operated under the supervision of a Physician or registered nurse.
  - Maintains adequate patient records.
  - Has immediate access to an area hospital.
  - Discharges patients within 24 hours after delivery.

- ***Chiropractic care***, covered at 90% after the deductible, up to 20 visits per calendar year for both in-network and out-of network care combined.
- ***Cochlear implants,*** when deemed medically necessary by UnitedHealthcare, covered at 90 percent after deductible.
- ***Dental care***, covered at 90 percent after deductible and limited to charges for or in connection with:

  – The installation of fixed bridgework or full or partial dentures (if needed after an accidental injury to sound, natural teeth).

  – Initial emergency visit to an emergency room or urgent care center when all of the following are true:

  - Treatment is medically necessary because of accidental damage (does not include damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth),
  - Dental services are received from a Physician and
  - Dental damage is severe enough that initial contact with a Physician occurred within 72 hours of the accident.

- ***Durable medical equipment***, covered at 90 percent after deductible, provided it is:
  - For repeated use and is not a consumable or disposable item.
  - Used primarily for a medical purpose.
  - Appropriate for use in the home.

  In each case, UnitedHealthcare will decide whether to cover the purchase or rental of the equipment. Prior authorization is required for equipment exceeding $750.

Examples of *durable medical equipment* include but are not limited to:

- Appliances that replace a lost body organ or part, or help an impaired one to function.
- Orthotic devices, such as arm, leg, neck, and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.

- ***Enteral formula***, when it is the sole source of nutrition, is for life-sustaining purposes only, and meets UnitedHealthcare's Care Coordination guidelines. Enteral formula is covered at 50% after the deductible.
- Routine ***gynecological examinations***, covered in-network only.
- Routine ***hearing exams***, covered in-network only, at 100 percent after copayment.
- ***Hearing aids,*** covered at 90 percent after deductible up to $300 per member per calendar year.
- ***Home health care*** that is prescribed, generally in writing, by the covered person's Physician and administered by a home health care agency and that provides for the care and treatment of a covered person's illness or injury in the covered person's home, covered at 90 percent after deductible.

  A *home health care agency* is an agency or organization that provides a program of home health care and:
  - Is approved by Medicare.
  - Is established and operated in accordance with applicable licensing and other laws.

  The Fidelity Health Plan covers home health care for up to 40 visits per calendar year for in-network and out-of-network care combined. Covered Services include:
  - Temporary or part-time nursing care by or supervised by a registered graduate nurse.
  - Temporary or part-time care by a home health aide.
  - Physical therapy.
  - Occupational therapy.
  - Speech therapy.

  Each period of home health care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team counts as one visit.
- ***Hospice care***, for a patient certified by a Physician to be terminally ill with six or fewer months to live, covered at 90 percent after deductible. Eligible services include:
  - Room and board and other services charged by the hospice.
  - Part-time nursing care by or supervised by a registered graduate nurse.
  - Home health care services.
  - Counseling by a licensed social worker for the patient and the patient's immediate family members who are covered under the Fidelity Health Plan.

A *hospice* is an agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided.

- Travel-related ***immunizations***, covered at 90 percent after deductible.
- ***Inpatient hospital services***, including semi-private room and board, intensive care services, laboratory and x-ray services, Physician's/surgeon's services, and other services, covered at 90 percent after deductible.
- ***In vitro fertilization, Gamete Intrafallopian Transfer (GIFT), and Zygote Intrafallopian Transfer (ZIFT)***, to a maximum of six cycles per member per lifetime for in-network and out-of-network care combined, covered at 90 percent after deductible.
- Diagnostic ***mammograms***, covered at 90 percent after deductible.
- Routine ***mammograms***, performed by an in-network provider, covered at 100 percent after copayment.

Under federal law, group health plans generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a normal vaginal delivery or fewer than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a stay that does not exceed the above periods. The minimum stay requirements do not apply when the decision to stay for a shorter period of time has been made by the Physician and the mother. If a state law provides for a hospital length of stay in connection with childbirth for the mother or newborn child that is greater than 48 hours following a vaginal delivery, or greater than 96 hours following a cesarean section, the state law provision will apply to the extent that state law is applicable.

- ***Maternity care***, including:
  - Prenatal care, exams, and tests, covered at 100 percent after copayment for initial visit only. Covered at 100 percent with no copayment thereafter.
  - Hospital and delivery services, covered at 90 percent after deductible.
  - Postnatal exams, covered at 90 percent after deductible.
- ***Mental health care.*** Inpatient hospitalization in any hospital, up to 60 days per member per calendar year for in-network and out-of-network care combined. Inpatient mental health and substance abuse benefits are also combined. Outpatient care is covered for up to 20 visits per member per calendar year by an in-network provider and up to 10 visits per year by an out-of-network provider. The maximum number of outpatient visits for in-network and out-of-network care combined is 20 visits per calendar year. Outpatient mental health and substance abuse benefits are combined. See page 44 for additional information about mental health care benefits and page 48 for substitution of care options.
- ***Multiple surgical procedures***, where more than one surgical procedure is performed during the same operative session. Coverage is limited to 50 percent for a secondary procedure and 50 percent for any subsequent procedure. Covered expenses for secondary and any other subsequent procedures include those expenses that have not already been covered in relationship to the surgical procedure (e.g., anesthesia or room and board). To determine Covered Services for multiple surgical procedures, contact UnitedHealthcare at 877-240-4016.
- Services of a licensed or certified ***nurse practitioner*** acting within the scope of that license or certification.
- Services for medically necessary ***organ or tissue transplants***. Qualified procedures include:
  - Heart transplants.
  - Lung transplants.
  - Heart/lung transplants.
  - Liver transplants.
  - Kidney transplants.
  - Pancreas transplants.
  - Kidney/pancreas transplants.
  - Bone marrow/stem cell transplants.
  - Other transplant procedures when determined to be medically appropriate.

  Donor charges are covered only if the recipient is covered under the Fidelity Health Plan. If the recipient is not covered under the Fidelity Health Plan, benefits are not payable for donor charges. Services for donors who are biologically related are covered, regardless of whether the search is in connection with a transplant procedure arranged by a designated facility.

  Covered expenses for services provided in connection with a transplant procedure include:
  - Pre-transplant evaluation for a covered transplant.
  - Organ acquisition and procurement.
  - Hospital and Physician fees.
  - Transplant procedures.
  - Follow-up care for a period of up to one year after the transplant.
  - The search for bone marrow/stem cell from a donor who is not biologically related to the patient. The search must be in connection with a transplant procedure arranged by a designated transplant facility. If a separate charge is made for the bone marrow/stem cell search, a lifetime maximum benefit of $25,000 is payable for all charges made in connection with the search.

The Care Management Center will assist the patient and family with travel and lodging arrangements. Benefits for travel and lodging expenses are available only if the transplant recipient resides more than 50 miles from the designated transplant facility. Covered expenses include the following:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
- Reasonable and necessary expenses for the lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $200 for the patient and companion.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered. In this case, lodging expenses will be reimbursed up to the $200 per diem rate.

There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under the Fidelity Health Plan in connection with all transplant procedures.

You must call the Care Management Center at 877-240-4016 at least seven business days, or as soon as reasonably possible, before the scheduled date of any of the following:

- A transplant evaluation.
- A donor search.
- The organ procurement/ tissue harvest.
- The transplant procedure.

The Care Management Center also will assist the patient and family with travel and lodging arrangements. For more information, call the Care Management Center.

UnitedHealthcare's Centers of Excellence program can provide valuable assistance if you are a transplant candidate. For more information, refer to page 47.

- ***Nutritional counseling*** when deemed medically necessary by UnitedHealthcare for certain diagnoses only, covered at 90 percent after deductible. Services must be rendered by a registered dietitian in an individual setting. Visit limitations vary based on diagnosis.
- Surgical treatment of ***obesity*** including, but not limited to, gastric bypass, lap bands, etc., received on an inpatient basis subject to the following requirements: You have a minimum Body Mass Index (BMI) of 40; you are over the age of 21; the surgery is performed at a network hospital by a network surgeon; and you were on a 6-month MD supervised diet prior to approval. Travel-related expenses to a network hospital are not covered. Experimental or investigational or unproven services related to the surgical treatment of obesity are not covered.
- ***Oral Surgery/Wisdom Teeth Removal,*** when deemed medically necessary by UnitedHealthcare, covered at 90 percent after deductible.
- ***Orthoptic training*** (eye muscle exercise). Certain training provided by a licensed optometrist or an orthoptic technician is covered. Covered Services are limited to a lifetime maximum of 20 visits for employee or spouse, 30 visits for a dependent child. For a list of Covered Services, contact UnitedHealthcare at 877-240-4016.
- ***Outpatient therapy***, including physical, occupational, and rehabilitative therapy. Services must be provided in a hospital or comprehensive outpatient rehabilitative facility (CORF) or in a provider's office. Covered Services are limited to 30 visits, per calendar year, per therapy for in-network and out-of-network care combined.
- Diagnoses of ***Pervasive Developmental Disorders***, included but not limited to: Autistic Spectrum Disorders, Childhood Disintergrative Disorder, Asperger's Syndrome, Rett's Disorder and Pervasive Developmental Disorder not otherwise specified/atypical Autism will no longer be excluded conditions under the plan. Coverage levels will vary depending on the type of service needed and all benefit limits will apply. Services provided in schools or other institutions for training are not covered. Expenses and associated expenses for experimental, investigational, or unproven services treatments, devices or pharmacological regimens are excluded. Contact UnitedHealthcare at 877-240-4016 for more information on coverage.
- Routine ***physical exams***, covered in-network only, at 100 percent after copayment. **Routine physical exams performed by out-of-network providers are not covered.**
- ***Post-mastectomy services***, including:
  - Prosthesis.
  - Reconstructive surgery for the affected breast and, if required, additional reconstructive procedures to achieve bilateral breast symmetry.
  - Medical procedures or services related to any post-surgical complications.
- Medically appropriate ***private duty nursing care***, given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

The *Women's Health and Cancer Rights Act* (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy must provide specified post-mastectomy services. These services must be provided in consultation with the attending Physician and the patient. This coverage may be subject to annual deductibles and Coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable plan in which you choose to enroll.

- ***Reconstructive surgery***, covered at 90 percent after deductible for the following:
  - To improve the function of a body part when the malfunction is the direct result of:
    - A birth defect.
    - Sickness.
    - Surgery to treat a sickness or accidental injury.
    - An accidental injury.
  - Breast surgery following a medically appropriate mastectomy, including surgery on the non-affected breast to achieve symmetry. Additional services include breast prosthesis and treatment of physical complications during all stages of the mastectomy, including lymphedemas.
  - The removal of scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.
- ***Second surgical opinions***, including:
  - Consultation with a specialist Physician or specialist surgeon (the surgeon cannot be the one who was originally scheduled to perform the surgery).
  - X-rays, laboratory tests, and other diagnostic procedures needed for the consultation.

  If the second opinion does not confirm the need for surgery, a third opinion also is covered.
- Care in a ***skilled nursing facility***, including charges made for a semi-private room and board and other services and supplies, for up to 100 days per calendar year for in-network and out-of-network care combined, covered at 90 percent after deductible.

  A *skilled nursing facility* is a facility approved by Medicare as a skilled nursing facility. If not approved by Medicare, it may be approved if it meets all of the following criteria. It:
  - Is operated in accordance with applicable licensing and other laws.
  - Is under the full-time supervision of a licensed Physician or registered nurse.
  - Is primarily engaged in providing room and board and continuous, 24-hour-a-day, skilled nursing care.
  - Maintains a daily record of each patient.

  A facility does not qualify if it is used primarily for:
  - Residential services.
  - Rest.
  - The care of drug abuse or alcoholism.
  - The care of mental disease or disorders.
  - Custodial or educational care.
- Restorative ***speech therapy*** is covered at 90 percent after deductible for up to 30 visits per year for in-network and out-of-network care combined, provided that services are given to restore speech lost or impaired because of:
  - The removal of vocal cords (laryngectomy).
  - Cerebral thrombosis (cerebral vascular accident).
  - Brain damage because of accidental injury or organic brain lesion (aphasia).
  - Infantile autism.
  - Cerebral palsy.
  - A hearing impairment.
  - Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

  Coverage may be available for more than 30 visits if the Claims Administrator, after review of the participant's medical condition, determines that additional visits are necessary and medically appropriate.

- ***Substance abuse treatment.*** Inpatient hospitalization in any hospital, up to 60 days per member per calendar year for in-network and out-of-network care combined. Inpatient substance abuse and mental health benefits are also combined. Outpatient care is covered for up to 20 visits per member per calendar year by an in-network provider and up to 10 visits per year by an out-of-network provider. The maximum number of outpatient visits for in-network and out-of-network care combined is 20 visits per calendar year. Outpatient substance abuse and mental health benefits are combined. See page 44 for additional information about substance abuse treatment benefits and substitution of care options on page 48.
- ***Temporomandibular Joint Surgery,*** when deemed medically necessary by UnitedHealthcare. Surgery is covered at 90 percent after deductible. Treatment and appliances are not covered.
- Routine ***vision exams***, covered in-network only, at 100 percent after copayment.
- ***Well-child care visits***, covered in-network only, at 100 percent after copayment.

Fidelity Health Plan Preventive Care Covered Services

Routine preventive care services under the Fidelity Health Plan are typically covered at 100 percent after a $20 copayment when you use in-network Physicians. Preventive care services are typically not covered when you use out-of-network Physicians. **Listed services are covered as preventive only when performed as preventive care by your Physician. Any services provided as part of a diagnostic or treatment plan are subject to the applicable deductible and Coinsurance.**

To determine if a service is covered as preventive care under the Fidelity Health Plan, contact UnitedHealthcare at 877-240-4016.

- Annual ***adult routine office visit and exam***.
- ***Immunizations*** (age appropriate), including annual flu shot:
  - DTaP or DTP
  - H. influenzae type B (Hib)
  - Hepatitis A
  - Hepatitis B
  - Influenza
  - Inactivated polio (IPV)
  - Meningococcus
  - MMR
  - Pneumococcal conjugate vaccine
  - Rubella serology or vaccination history
  - Tetanus-diphtheria (Td)
  - Varicella
  - Zoster (Shingles), covered at age 60 and older
- ***Labs, pathology, chest x-ray, and EKG***.
- Annual ***pap smear and pelvic exam***.
- ***Prenatal visits***.
- ***Screenings*** (age appropriate):
  - Blood pressure
  - Bone density test
  - C-reactive protein test
  - CBC
  - Chlamydia
  - Cholesterol—total blood cholesterol and high density lipoprotein cholesterol (HDL-C) screening
  - Clinical breast exam

Keep in mind that these services are covered as preventive care only when performed as preventive care by an in-network Physician.

Preventive care copayments under the Fidelity Health Plan apply toward your annual out-of-pocket maximum, but not toward your annual deductible.

If you are a Fidelity Health Plan participant and enrolled in a Health Savings Account, you may want to consider enrolling in the Health Care HSA-Compatible Flexible Spending Account.

Through this Account, you can set aside Pre-Tax money to pay for eligible dental and vision expenses, as well as preventive care medical and prescription drug copayments. See the ***Flexible Spending*** section of this SPD for details.

  - Colonoscopy
  - Cytological
  - Depression—all adults in clinical practices with adequate diagnostic and treatment capabilities
  - Digital rectal exam
  - Double contract barium enema
  - Fecal occult blood test
  - Glucose
  - Hearing
  - Height/weight
  - Hemoglobinopathy (including sickle-cell anemia)
  - Hereditary and metabolic
  - Lipoproteins
  - Mammogram
  - PKU level
  - Problem drinking screening—all adolescents and adults
  - Prostate specific antigen test
  - Rubella serology or vaccination history
  - Serum lead
  - Sigmoidoscopy
  - Thyroid (T4 and/or TSH)
  - Triglycerides
  - Tuberculin tests
  - Type 2 diabetes—screening in adults with hypertension, hyperlipidemia, or obesity
  - Urinalysis
  - Vision
- *Screenings for pregnant women*:
  - Blood pressure
  - Chlamydia
  - Chronic villus sampling—CVS (pregnancy under 13 weeks) or amniocentesis (pregnancy 15–18 weeks)
  - D(Rh) typing, antibody
  - Hemoglobin and hematocrit
  - Hemoglobinopathy
  - Hepatitis B surface antigen
  - HIV
  - Problem or risk drinking assessment
  - RPR/VDRL
  - Rubella serology or vaccination history
- *Well-baby visits*.
- *Well-child visits*.

What the Fidelity Health Plan Does Not Cover

While the Fidelity Health Plan provides coverage for many services, there are some services that are not covered, *even* if your Physician or professional provider approves or recommends them. Services that are not covered include, but are not limited to, the following:

- Testing and treatment of ***Attention Deficit Disorder (ADD and ADHD), learning disabilities, and developmental delays***.
- Charges incurred ***before the effective date of your coverage*** or your Eligible Dependents' coverage (including newborns).
- ***Birthing/lamaze classes.***
- ***Chelation therapy***, except to treat heavy metal poisoning.
- Charges for the ***completion of claim forms***.
- ***Cosmetic or reconstructive surgery***, except to the extent reconstructive surgery is covered after a mastectomy or as specified in the "What the Fidelity Health Plan Covers" section under "Reconstructive Surgery."
- ***Custodial care***, meaning services and supplies that meet one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living rather than to provide medical treatment.
  - Care that can be provided safely and adequately by persons who do not have the technical skills of a covered health care professional.

  Custodial care is not covered regardless of:
  - Who recommends, provides, or directs the care.
  - Where the care is provided.
  - Whether the patient or another caregiver can be or is being trained to care for himself or herself.
- Emergency ***dental care*** for:
  - Dental services provided by a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."
  - Dental services provided after the initial emergency care visit (as defined in "What the Fidelity Health Plan Covers" section under "Dental Care") or follow-up care that is dental in nature.
- Diagnosis by and/or treatment with ***ecological or environmental medicine***.
- ***Education, training, and bed and board***, including those services provided while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the development of activities of daily living, a place for the aged, or a nursing home.
- Expenses incurred by an ***Eligible Dependent***, if the Eligible Dependent is covered as an employee for the same services under the Fidelity Health Plan.
- ***Elective vision correction eye surgery***. These surgeries include, but are not limited to, Radial keratotomy (RK), Photorefractive keratectomy (PRK), Automated lamellar keratoplasty (ALK), and Laser in situ keratomileusis (LASIK).
- Expenses and associated expenses incurred for services and supplies for ***experimental, investigational, or unproven services, treatments, devices, and/or pharmacological regimens***, except for services that are otherwise experimental, investigational, or unproven that are deemed to be covered transplant services. The fact that an experimental, investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition.

Experimental, investigational, or unproven services are medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be:

- **Not approved by the U.S. FDA to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the use, or**
- **Subject to review and approval by any institutional review board for the proposed use, or**
- **The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, or**
- **Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.**

To find out if you will be covered under the Fidelity Health Plan for certain medical care services, call the toll-free customer service number on your medical ID card.

You may want to take advantage of the Health Care HSA-Compatible Flexible Spending Account to pay for eligible expenses that are not covered by a dental, vision, or other health plan. For more information, see the ***Flexible Spending*** section of this SPD.

- ***Eyeglasses, contact lenses, cochlear implants, and hearing aids***, unless needed because of an accidental injury.
- ***Herbal medicine, holistic, or homeopathic care***, including drugs.
- Charges ***in excess of the Reasonable and Customary Amount*** for a treatment or procedure.
- Charges incurred for ***services performed internationally***, except for emergencies.
- Charges associated with certain ***in vitro procedures***, such as fees for an egg donor, assisted hatching, specimen preservation, and cryopreservation of sperm and egg.
- ***Investigational or experimental procedures*** that are not treatments of an illness, injury, or disease, or are only a means of circumventing a condition.
- ***Maintenance procedures***. Any type of physical therapy, service, or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, as determined by UnitedHealthcare, and that is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- ***Membership costs for health clubs***, weight-loss clinics, and similar programs.
- Charges for ***missed appointments***.
- Charges that would ***not have been made*** in the absence of coverage by the Fidelity Health Plan.
- Services or supplies that are ***not covered health services and/or not medically necessary***, including any confinement or treatment given in connection with a service or supply that is not a covered health service.
- Medical exams or tests ***not needed to treat an injury, sickness, or pregnancy***, including genetic screenings, except as specifically named in the Fidelity Health Plan.
- Charges by any facility that provides ***nursing home or long-term care services***.
- ***Occupational injury or sickness***, meaning one that is covered (or claimed to be covered) by a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered by the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatments ***ordered by a court*** in connection with legal proceedings unless such examinations or treatments otherwise qualify as Covered Services under the Fidelity Health Plan.
- Charges that are ***paid by another plan***.
- ***Pastoral counseling***.

- ***Personal convenience or comfort items***, including, but not limited to, TVs, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs.
- ***Private duty nursing services*** while confined in a facility.
- Services ***provided by a member of your immediate family*** (or by a business in which a member of your immediate family has an interest), a person who lives in your home, a volunteer, or persons who do not normally charge for their services.
- Services for, or related to, the ***removal of an organ or tissue from a person for transplantation into another person***, unless the transplant recipient is covered by the Fidelity Health Plan and is undergoing a covered transplant.
- ***Reversal of sterilization procedures***, or in vitro, Zygote Intrafallopian Transfer (ZIFT) and Gamete Intrafallopian Transfer (GIFT) procedures after a reversal of sterilization.
- ***Sensitivity training***, education training, therapy, or treatment for an educational requirement.
- ***Sex-change surgery***.
- Charges for the ***shoe orthotics*** are generally not covered.
- ***Special foods***, food supplements, liquid diets, diet plans, or any related products. Food of any kind, even if specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Enteral formula may be covered when it is the sole source of nutrition, is for life-sustaining purposes only, and meets UnitedHealthcare's Care Coordination guidelines.
- ***Standby services*** required by a Physician.
- Care of or treatment to the ***teeth, gums, or supporting structures***, including, but not limited to, periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak.
- ***Telephone consultations***.
- Appliances including, but not limited to, splints, study models, bite plates, tens units, panoramic x-rays, and ultrasounds for ***temporomandibular joint (TMJ) dysfunction***.
- Treatment for ***tobacco dependency***.
- Charges for treatment in a ***U.S. governmental or agency hospital***.
- Charges due to an injury or sickness caused by ***war***, declared or undeclared, or international armed conflict.
- ***Weight reduction or control***, unless there is a diagnosis of morbid obesity.
- ***Wigs or toupees*** (except for hair loss resulting from treatment of a malignancy or permanent loss of hair from an accidental injury or medical condition up to a limit of $350 per calendar year), hair transplants, hair weaving, or any drug if such drug is used in conjunction with baldness.

When Your Coverage under the Fidelity Health Plan Ends

Your coverage under the Fidelity Health Plan ends on the earliest of the following:

- The last day of the month in which your employment with Fidelity ends.
- The date the Fidelity Health Plan is terminated.
- The last day of the month in which you stop sharing in the cost of your coverage.
- The date of your death.
- The last day of the month in which you and/or your covered Eligible Dependents no longer satisfy the eligibility requirements under the Fidelity Health Plan.

In some circumstances, you and your covered Eligible Dependents may be able to continue coverage for a limited time under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA). For more information, see page 177 in the ***Administrative*** section of this SPD.

While same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the Medical Plans. See page 179 for more information.

YOUR RIGHTS UNDER HIPAA

The *Health Insurance Portability and Accountability Act* (HIPAA) was enacted to make it easier for you and your family members to have continued health plan coverage when changing from one employer to another.

If Your Coverage or Your Employment Ends. If your coverage under a group health plan ends or your employment terminates, the group health plan will provide you and your covered Eligible Dependents with a written "certificate of creditable coverage." This certificate can be used to demonstrate that you have had coverage under a group health plan and that you may be eligible to reduce or eliminate any pre-existing condition limitations imposed by your new group health plan. Be sure to keep this certificate when you receive it. (Because none of Fidelity's medical plans has a pre-existing condition limitation, you are not required to provide a certificate from your previous employer when enrolling in a Fidelity medical plan.)

An Overview of Fidelity's HMO Options

If you are enrolled in an HMO, you may be required to choose a Primary Care Physician (PCP), the network doctor who coordinates your care. A *specialist* is defined by the HMOs as a doctor who provides medical care in a medical specialty not practiced by a PCP. Care from a specialist generally is not covered unless the covered person first obtains a referral from his or her PCP.

Depending on where you live or work, you may be eligible to elect medical coverage under a Health Maintenance Organization (HMO). HMOs generally provide comprehensive medical coverage for a range of medical care, including:

- Routine checkups and immunizations.
- Maternity and pediatric care.
- Inpatient hospital and Physician services.
- Surgical services.
- X-rays and laboratory tests.
- Specialized care, such as ophthalmology, cardiology, gynecology, and urology.

Please note, some HMOs have out-of-pocket maximums. These HMOs place some limits on the amount you spend for care each year. Once you reach the out-of-pocket maximum, these HMOs generally pay 100 percent for Covered Services for the rest of the year.

The following charts provide a brief overview of the HMOs that Fidelity offers. For more information about what a specific HMO covers, refer to that HMO's separate detailed description of coverage. To request additional information, contact the HMO directly.

Harvard Pilgrim Health Care

The Harvard Pilgrim Health Care's service area includes certain parts of Maine, New Hampshire, Rhode Island, and Massachusetts. Please contact the HMO for information regarding accessing care in your service area.

HARVARD PILGRIM HEALTH CARE	
General Information	
For More Information	888-333-HPHC (4742), www.harvardpilgrim.org
Referrals	Required from Primary Care Physician (PCP)
Pre-Existing Conditions	No restrictions
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.)
Costs	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$2,000 per individual, $4,000 per family
Lifetime Maximum	None
Covered Services	
Preventive Care *Routine physical exams*	Covered at 100% with no copayment per visit
Well-child care visits	Covered at 100% with no copayment
Routine mammograms, colonoscopies, Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment
Routine Pap smears	Covered at 100% with no copayment
Routine vision exams	Covered at 100% with no copayment
Routine hearing exams	Covered at 100% with no copayment
Diagnostic, Sick, or Specialist Office Visits *Non-preventive*	Covered at 100% after $20 copayment
Inpatient Care (Includes semi-private room and board, surgery, hospital care, coronary care, intensive care, and physician's and surgeon's services)	Covered at 100% with no copayment
Outpatient Care (Includes anesthesia services, chemotherapy, laboratory tests and x-rays, physician's and surgeon's services, and radiation therapy)	Covered at 100% with no copayment (In physician's office: covered at 100% after $20 copayment)
Emergency Care *Emergency room visit*	Covered at 100% after $100 copayment per visit (waived if admitted)
Maternity Care *Prenatal exams*	Covered at 100% with no copayment
Hospital and delivery services	Covered at 100% with no copayment
Postnatal exams	Covered at 100% with no copayment
Mental Health/Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient*	Covered at 100% with no copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details
Outpatient	Covered at 100% after $20 copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details

Copayment. The copayment is the amount you pay up-front to your in-network health care provider for certain types of services, such as office visits and exams. In most cases, the copayment amount is $20.

HARVARD PILGRIM HEALTH CARE *(continued)*	
Chiropractic Care (Up to 20 visits per year)	Covered at 100% after $20 copayment
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/Occupational Therapy* Limited to 60 visits for PT/OT combined per member per calendar year *Speech Therapy* Limited to 52 visits per member per calendar year Must be medically necessary	Covered at 100% after $20 copayment
Nutritional Counseling (Maximum of 12 visits per calendar year) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 100% after $20 copayment
Acupuncture (Services must be rendered by a licensed acupuncturist) (Up to 20 visits per year)	Covered at 100% after $20 copayment

SelectHealth

You may elect this HMO if you live in the service area in Utah.

SELECTHEALTH	
General Information	
For More Information	800-538-5038, www.selecthealth.org
Referrals	Not required
Pre-Existing Conditions	No restrictions
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
Costs	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$1,000 per individual, $3,000 per family
Lifetime Maximum	None
Covered Services	
Preventive Care *Routine physical exams*	Covered at 100% with no copayment
Well-child care visits	Covered at 100% with no copayment
Routine mammograms, colonoscopies, Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment
Routine Pap smears	Covered at 100% with no copayment
Routine vision exams	Covered at 100% with no copayment
Routine hearing exams	Covered at 100% with no copayment
Diagnostic, Sick, or Specialist Office Visits *Non-preventive*	Covered at 100% after $20 copayment
Inpatient Care (Includes ambulance services, semi-private room, physician services, and anesthesia)	Covered at 100% with no copayment
Outpatient Care (Includes laboratory and x-ray services)	Covered at 100% with no copayment (In physician's office: covered at 100% after $20 copayment)
Emergency Care *Emergency room visit*	Participating Facility: Covered at 100% after $100 copayment Non-Participating Facility: Covered at 100% after $150 copayment (waived if admitted)
Maternity Care *Prenatal exams*	Covered at 100% with no copayment
Hospital and delivery services	Covered at 100% with no copayment
Postnatal exams	Covered at 100% with no copayment
Mental Health/Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient*	Covered at 100% with no copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details
Outpatient	Covered at 100% after $20 copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details

Copayment. The copayment is the amount you pay up-front to your in-network health care provider for certain types of services, such as office visits and exams. In most cases, the copayment amount is $20.

SELECTHEALTH *(continued)*	
Chiropractic Care (Up to 20 visits per year)	Covered at 100% after $20 copayment
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/Occupational Therapy* Limited to 60 visits for PT/OT combined per member per calendar year *Speech Therapy* Limited to 52 visits per member per calendar year Must be medically necessary	Covered at 100% after $20 copayment
Nutritional Counseling (Maximum of 12 visits per calendar year) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 100% after $20 copayment
Acupuncture (Services must be rendered by a licensed acupuncturist) (Up to 20 visits per year)	Covered at 100% after $20 copayment

Humana

You may elect this HMO if you live within the service area in Indiana, Kentucky, or Ohio.

HUMANA	
General Information	
For More Information	888-357-6767, www.humana.com
Referrals	Not required
Pre-Existing Conditions	No restrictions
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
Costs	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$1,500 per individual, $3,000 per family
Lifetime Maximum	None
Covered Services	
Preventive Care *Routine physical exams*	Covered at 100% with no copayment
Well-child care visits	Covered at 100% with no copayment
Routine mammograms, colonoscopies, Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment
Routine Pap smears	Covered at 100% with no copayment
Routine vision exams	Covered at 100% with no copayment
Routine hearing exams	Covered at 100% with no copayment
Diagnostic, Sick, or Specialist Office Visits *Non-preventive*	Covered at 100% after $20 copayment
Inpatient Care (Includes semi-private room, physician's and surgeon's services, and therapeutic services)	Covered at 100% with no copayment (Prior authorization required)
Outpatient Care (Includes immunizations, diagnostic x-rays and laboratory tests, and initial emergency dental care)	Covered at 100% with no copayment (In physician's office: covered at 100% after $20 copayment) Initial emergency dental care requires $75 emergency room copayment if performed at a hospital
Emergency Care *Emergency room visit*	Covered at 100% after $100 copayment per visit (waived if admitted)
Maternity Care *Prenatal exams*	Covered at 100% with no copayment
Hospital and delivery services	Covered at 100% with no copayment
Postnatal exams	Covered at 100% with no copayment
Mental Health/Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient*	Covered at 100% with no copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details
Outpatient	Covered at 100% after $20 copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details

Copayment. The copayment is the amount you pay up-front to your in-network health care provider for certain types of services, such as office visits and exams. In most cases, the copayment amount is $20.

HUMANA *(continued)*	
Chiropractic Care (Up to 20 visits per year)	Covered at 100% after $20 copayment
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/Occupational Therapy* Limited to 60 visits for PT/OT combined per member per calendar year *Speech Therapy* Limited to 52 visits per member per calendar year Must be medically necessary	Covered at 100% after $20 copayment
Nutritional Counseling (Maximum of 12 visits per calendar year) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 100% after $20 copayment
Acupuncture (Services must be rendered by a licensed acupuncturist) (Up to 20 visits per year)	Covered at 100% after $20 copayment

Aetna Health Inc. and Aetna of North Texas*

(CT, NJ, NY, PA, TX)

You may elect this HMO if you live in the service area in Connecticut, New Jersey, New York, Pennsylvania, or Texas.

AETNA HEALTH INC. AND AETNA OF NORTH TEXAS*	
General Information	
For More Information	800-238-6291, www.aetna.com
Referrals	Required from Primary Care Physician (PCP)
Pre-Existing Conditions	No restrictions
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
Costs	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$1,500 per individual, $3,000 per family
Lifetime Maximum	None
Covered Services	
Preventive Care *Routine physical exams*	Covered at 100% with no copayment
Well-child care visits	Covered at 100% with no copayment
Routine mammograms, colonoscopies, Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment
Routine Pap smears	Covered at 100% with no copayment
Routine vision exams	Covered at 100% with no copayment
Routine hearing exams	Covered at 100% with no copayment
Diagnostic, Sick, or Specialist Office Visits *Non-preventive*	Covered at 100% after $20 copayment
Inpatient Care (Including semi-private room, intensive/cardiac care, surgery, physical and rehabilitative therapy)	Covered at 100% with no copayment
Outpatient Care (Including outpatient surgery, diagnostic x-rays and laboratory tests, radiation therapy, inhalation therapy, and chemotherapy)	Covered at 100% with no copayment (In physician's office: covered at 100% after $20 copayment)
Emergency Care *Emergency room visit*	Covered at 100% after $100 copayment per visit (waived if admitted)
Maternity Care *Prenatal exams*	Covered at 100% with no copayment
Hospital and delivery services	Covered at 100% with no copayment
Postnatal exams	Covered at 100% with no copayment
Mental Health/Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient*	Covered at 100% with no copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details
Outpatient	Covered at 100% after $20 copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details

*For Aetna, there are slight variations by state. Please contact Aetna for details.

Copayment. The copayment is the amount you pay up-front to your in-network health care provider for certain types of services, such as office visits and exams. In most cases, the copayment amount is $20.

AETNA HEALTH INC. AND AETNA OF NORTH TEXAS* *(continued)*	
Chiropractic Care (Up to 20 visits per year)	Covered at 100% after $20 copayment
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/Occupational Therapy* Limited to 60 visits for PT/OT combined per member per calendar year *Speech Therapy* Limited to 52 visits per member per calendar year Must be medically necessary	Covered at 100% after $20 copayment
Nutritional Counseling (Maximum of 12 visits per calendar year) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 100% after $20 copayment per visit
Acupuncture (Services must be rendered by a licensed acupuncturist) (Up to 20 visits per year)	Covered at 100% after $20 copayment per visit

*For Aetna, there are slight variations by state. Please contact Aetna for details.

CIGNA HealthCare of North Carolina, Inc.

You may elect this Open Access Plus In-Network (OAPIN) if you live in the service area in North Carolina.

CIGNA HEALTHCARE OF NORTH CAROLINA, INC.	
General Information	
For More Information	800-CIGNA24, www.cigna.com
Referrals	Not Required
Pre-Existing Conditions	No restrictions
Dependent Coverage	Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
Costs	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$1,000 per individual, $2,000 per family
Lifetime Maximum	None
Covered Services	
Preventive Care *Routine physical exams*	Covered at 100% with no copayment
Well-child care visits	Covered at 100% with no copayment
Routine mammograms, colonoscopies, Prostate Specific Antigen (PSA) tests	Covered at 100% with no copayment
Routine Pap smears	Covered at 100% with no copayment
Routine vision exams	Covered at 100% with no copayment
Routine hearing exams	Covered at 100% with no copayment
Diagnostic, Sick, or Specialist Office Visits *Non-preventive*	Covered at 100% after $20 copayment
Inpatient Care (Limited to semi-private room and board, special care units, physician and surgeon's services)	Covered at 100% with no copayment
Outpatient Care (Includes anesthesia services, laboratory tests and x-rays, physician's and surgeon's services, and radiation therapy)	Covered at 100% with no copayment (In physician's office: covered at 100% after $20 copayment)
Emergency Care *Emergency room visit*	Covered at 100% after $100 copayment per visit (waived if admitted)
Maternity Care *Prenatal exams*	Covered at 100% with no copayment
Hospital and delivery services	Covered at 100% with no copayment
Postnatal exams	Covered at 100% with no copayment
Mental Health/Substance Abuse/ Bereavement Counseling – combined benefits *Inpatient*	Covered at 100% with no copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details
Outpatient	Covered at 100% after $20 copayment, unlimited days per calendar year. Prior authorization may be required; contact the carrier for details

Copayment. The copayment is the amount you pay up-front to your in-network health care provider for certain types of services, such as office visits and exams. In most cases, the copayment amount is $20.

CIGNA HEALTHCARE OF NORTH CAROLINA, INC. *(continued)*	
Chiropractic Care (Up to 20 visits per year)	Covered at 100% after $20 copayment
Outpatient Therapy: including physical therapy (PT), occupational therapy (OT), and speech therapy (ST) *Physical Therapy/Occupational Therapy* Limited to 60 visits for PT/OT combined per member per calendar year *Speech Therapy* Limited to 52 visits per member per calendar year Must be medically necessary	Covered at 100% after $20 copayment
Nutritional Counseling (Maximum of 12 days per calendar year) Must be medically necessary and must be rendered by a Registered Dietitian	Covered at 100% after $20 copayment
Acupuncture (Services must be rendered by a licensed acupuncturist) (Up to 20 days per year)	Covered at 100% after $20 copayment

When Your Coverage under an HMO Plan Ends

Your HMO coverage ends on the earliest of the following:

- The last day of the month in which your employment with Fidelity ends.
- The date the applicable HMO coverage is terminated.
- The last day of the month in which you stop sharing in the cost of your coverage.
- The date of your death.
- The last day of the month in which you and/or your covered Eligible Dependents no longer satisfy the eligibility requirements under the applicable HMO Plan.

In some circumstances, you and your covered Eligible Dependents may be able to continue coverage for a limited time under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA). For more information, see page 177 in the ***Administrative*** section of this SPD.

While same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the Medical Plans. See page 179 for more information.

YOUR RIGHTS UNDER HIPAA

The *Health Insurance Portability and Accountability Act* (HIPAA) was enacted to make it easier for you and your family members to have continued health plan coverage when changing from one employer to another.

If Your Coverage or Your Employment Ends. If your coverage under a group health plan ends or your employment terminates, the group health plan will provide you and your covered Eligible Dependents with a written "certificate of creditable coverage." This certificate can be used to demonstrate that you have had coverage under a group health plan and that you may be eligible to reduce or eliminate any pre-existing condition limitations imposed by your new group health plan. Be sure to keep this certificate when you receive it. (Because none of Fidelity's medical plans has a pre-existing condition limitation, you are not required to provide a certificate from your previous employer when enrolling in a Fidelity medical plan.)

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Dental Coverage

About Your Dental Coverage

Regular dental care is important to your overall health. That's why Fidelity offers a comprehensive dental plan to you and your eligible family members. In addition to routine examinations and cleanings, the FMR LLC Group Dental Insurance Plan covers a range of other dental services, including basic, major restorative, and orthodontic treatment.

How the Dental Plan Works

For information on when you become eligible for coverage, who you may cover, and when coverage becomes effective, see the ***Benefits Overview*** section of this SPD.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

Under the FMR LLC Group Dental Insurance Plan, you may visit the dentist of your choice. However, you may reduce your out-of-pocket expenses by using a Preferred Dental Provider (PDP). The Dental Plan provides you and your covered Eligible Dependents with the following levels of dental care:

- ***Preventive treatment,**** such as oral examinations, cleanings, bitewing, full mouth and panorex x-rays, and fluoride treatments. Preventive treatment is covered at 100 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount, as determined by MetLife, the Claims Administrator of the Dental Plan. There is no deductible for preventive treatment. However, coverage for preventive treatment is subject to the Calendar-Year Maximum.
- ***Basic treatment,**** such as extractions, fillings, surgery, and general anesthesia, as well as endodontic and periodontic treatments. Once you have met the annual deductible, basic treatment is covered at 80 percent of either the cost of the service provided by a PDP or of the Reasonable and Customary Amount, subject to the Calendar-Year Maximum.
- ***Major restorative treatment,**** such as installation of crowns, bridgework, implants, and dentures. Once you have met the annual deductible, major restorative treatment is covered at 60 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount, subject to the Calendar-Year Maximum.
- ***Orthodontic treatment,*** such as diagnosis and treatment for aligning and straightening the teeth. Orthodontic treatment is covered at 60 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount, up to a lifetime maximum of $2,500.

For more detailed information on Covered Services, see "What the Dental Plan Covers" on page 78.

*Some treatments are subject to certain frequency and age limitations. See "What the Dental Plan Covers" beginning on page 78 for more details.

Preferred Dental Provider (PDP) Feature

The Dental Plan offers an optional preferred dental provider (PDP) feature that enables you and your covered Eligible Dependents to take advantage of negotiated rates with select dentists. For more detailed information, to determine if your dentist is a PDP, or to locate a PDP in your area, visit MetLife's website at mybenefits.metlife.com or call MetLife at 888-660-1046.

EXAMPLE

Possible PDP Savings

Jen, a Dental Plan participant, received a porcelain crown. Her dentist is a PDP and the cost of the procedure, as negotiated by MetLife, is $655. Under the Dental Plan:

- Jen has already met the annual deductible.
- Because Jen's dentist is a PDP, this procedure, as a major restorative treatment, is covered at 60 percent of the negotiated cost.
- The Dental Plan will pay $393 (60 percent of the negotiated cost ($655)).
- Jen will pay $262 (40 percent of the negotiated cost ($655)).

Bob, a Dental Plan participant, received a porcelain crown. His dentist is not a PDP and the cost of the procedure is $1,200. Under the Dental Plan:

- Bob has already met the annual deductible.
- The Reasonable and Customary Amount for this procedure, as determined by MetLife, is $1,000.
- This procedure, as a major restorative treatment, is covered at 60 percent of the Reasonable and Customary Amount.
- The Dental Plan will pay $600 (60 percent of Reasonable and Customary Amount ($1,000)).
- Bob will pay $600:
  - $400 (40 percent of the Reasonable and Customary Amount ($1,000)), plus
  - $200 (the difference between the actual cost of the procedure ($1,200) and the Reasonable and Customary Amount ($1,000)).

By using a PDP, Jen paid $338 less than Bob for the same procedure.

IMPORTANT TERMS

The FMR LLC Group Dental Insurance Plan has deductibles, Coinsurance, and maximums for certain services. Understanding these terms will help you understand how your dental coverage works.

- ***Calendar-Year Maximum.*** The Calendar-Year Maximum is the limit on how much the Dental Plan will pay for care in any calendar year. The Calendar-Year Maximum is $2,000 per covered person for preventive, basic, and major restorative treatment combined. There is a separate lifetime maximum of $2,500 per covered person for orthodontic treatment.
- ***Coinsurance.*** Coinsurance refers to the percentage of the cost for Covered Services that you are responsible for paying after the Dental Plan pays for Covered Services, based on either the cost of the service provided by a PDP or the Reasonable and Customary Amount. The Coinsurance amount is based on the type of dental treatment you receive. Because preventive services are covered at 100 percent (based on either the cost of the service provided by a PDP or the Reasonable and Customary Amount, as described below), there is no Coinsurance. The Coinsurance for basic treatment is 20 percent because the Dental Plan pays for 80 percent of Covered Services, based on either the cost of the service provided by a PDP or the Reasonable and Customary Amount. The Coinsurance for major restorative treatment and orthodontic treatment is 40 percent because the Dental Plan pays for 60 percent of Covered Services, based on either the cost of the service provided by a PDP or the Reasonable and Customary Amount.
- ***Deductible.*** The deductible is the amount of eligible charges you must pay each calendar year before the Dental Plan begins to pay benefits. The deductible is $50 per person, up to a maximum of $150 per family per year. The deductible does not apply to preventive or orthodontic treatment.
- ***Reasonable and Customary Amount.*** The Dental Plan pays claims based on the Reasonable and Customary Amount if you receive services from a dentist who is not a PDP. The Reasonable and Customary Amount is considered the prevailing cost for that service, treatment, or supply for similar dental conditions in your geographic area, as determined by MetLife, the Claims Administrator of the Dental Plan. The Dental Plan does not cover charges in excess of the Reasonable and Customary Amount. If your dentist is not a PDP and she or he charges more than the Reasonable and Customary Amount for a Covered Service or treatment, you are responsible for paying the difference between the amount your dentist charges and the Reasonable and Customary Amount, in addition to any deductible or Coinsurance.

If you experience a Change in Status (including, but not limited to, marriage, divorce, or the birth or adoption of a child) or a Same-Sex Spouse or Domestic Partner Life Event, you must call HR Solutions at 800-835-5099 (TDD 888-343-0860) within 31 days of the event to make a corresponding change to your coverage.

If you do not request a change in coverage during this 31-day period, you must wait until the next Annual Benefits Enrollment period to make any changes to your benefit elections. Benefit changes are effective on the date of your Change in Status or Same-Sex Spouse or Domestic Partner Life Event. For more information about Changes in Status, see the ***Benefits Overview*** section of this SPD.

When You Have a Question

If you need information about dental coverage, you may call MetLife toll-free at 888-660-1046 or visit MetLife's website at mybenefits.metlife.com.

Consider a PDP

The optional PDP feature enables employees to take advantage of negotiated rates with select dentists. Call MetLife toll-free at 888-660-1046 or visit MetLife's website at mybenefits.metlife.com for details.

As shown in this chart, the Dental Plan provides coverage for a wide variety of dental services. For more details about Covered Services, see "What the Dental Plan Covers" on page 78.

DENTAL BENEFITS AT A GLANCE

Calendar-Year Deductible (excludes orthodontic)	$50 per covered person, $150 per family	
Calendar-Year Maximum	$2,000 per covered person	
Orthodontic Lifetime Maximum	$2,500 per covered person	
Level of Care	**Includes**	**Coverage***
Preventive Treatment**	• Oral exams • Routine cleanings • Bitewing x-rays† • Panorex x-rays† • Full-mouth x-rays† • Emergency palliative treatment • Sealants (for molars only) • Fluoride treatments • Space maintainers	Covered at 100% of either the cost of the service provided by a PDP or the Reasonable and Customary Amount* with no deductible †Full mouth x-rays are covered at 100% of Reasonable and Customary Amount with no deductible; full mouth (including Panorex) covered once every 60 months; bitewings once per calendar year for adults, twice per calendar year for children up to age 19
Basic Treatment**	• Fillings (amalgam or composite) • Oral surgery • Periodontal treatment • Endodontics • Extractions • General anesthesia • Diagnostic laboratory tests • Repair of bridgework or dentures • Other x-rays	Covered at 80% of either the cost of the service provided by a PDP or the Reasonable and Customary Amount* after deductible
Major Restorative Treatment**	• Crowns and bridgework • Dentures • Implants • Inlays and onlays • Post and Core Buildups	Covered at 60% of either the cost of the service provided by a PDP or the Reasonable and Customary Amount* after deductible
	• Occlusal Guards	Covered at 60% of either the cost provided by a PDP or the Reasonable and Customary Amount after you have met the annual deductible, up to the calendar year maximum
	• Temporomandibular joint dysfunction (TMJ) services	Treatment and Appliances for TMJ will be covered at 60% of either the cost provided by a PDP or the Reasonable and Customary Amount after you have met the annual deductible, up to the calendar year maximum with the exception of TMJ surgery. Note: TMJ surgery will be covered under Fidelity's medical plans subject to applicable limits and copays.
Orthodontic Treatment	• Examinations • Diagnostic procedures • Appliances	Covered at 60% of either the cost of the service provided by a PDP or the Reasonable and Customary Amount*, subject to the orthodontic lifetime maximum.

*Coverage for services provided by a dentist who is not a PDP is based on the Reasonable and Customary Amount for a particular service or procedure, as determined by MetLife, the Claims Administrator of the Dental Plan.

**Some treatments are subject to certain frequency and age limitations. See "What the Dental Plan Covers" beginning on page 78 for more details.

Predetermination of Benefits

When you ask your dentist to submit a treatment plan, you find out up-front how much the Dental Plan will pay for that treatment. You also have the opportunity to learn about alternative treatment methods that may meet your needs.

If your dentist recommends that you or a covered Eligible Dependent receive treatment that is expected to cost more than $300, you may wish to have your dentist file a treatment plan with the Claims Administrator, MetLife, in advance. A *treatment plan* is a written description of the patient's condition, and includes x-rays, the proposed form of treatment, and the estimated treatment cost.

Based on the treatment plan submitted by your dentist, MetLife advises you and your dentist of the portion(s) of your treatment that will be covered under the Dental Plan. Any predetermination of benefits made by MetLife is valid for one year. Actual payment will not be made until the dental work has been completed and you have submitted the claim (see below for information on how to file a dental claim). In some cases MetLife may recommend an alternative treatment method, as described below. If the treatment received differs from that outlined in the treatment plan, payment will be made for the appropriate lower cost treatment that meets generally accepted professional standards.

Alternative Benefits. For many dental conditions, there may be more than one acceptable course of treatment. As part of the predetermination process, MetLife's dental consultants may suggest one or more alternative treatment methods that meet professional dental standards. In this case, you still may choose the original treatment proposed by your dentist. However, the Dental Plan will cover only the cost of the less expensive treatment method. You are responsible for paying any difference, in addition to any deductible, Coinsurance, or other charges that may apply.

How to File a Dental Claim

You may obtain a claim form from HR Solutions—online or by calling 800-835-5099 (TDD 888-343-0860)—or on NetBenefits®.

The form is also available from MetLife's website (mybenefits.metlife.com), or by calling MetLife at 888-660-1046.

Generally, your dentist will submit your claim directly to MetLife and you will not need to obtain a claim form. If you do need to file a claim for dental treatment, follow these steps:

1. ***Obtain a dental claim form,*** available from HR Solutions—online or by calling 800-835-5099 (TDD 888-343-0860)—or on NetBenefits®. The form is also available on MetLife's website at mybenefits.metlife.com or by calling MetLife at 888-660-1046.
2. ***Complete and sign your section of the form.***
3. ***Give the form to your dentist to complete*** and sign the remaining sections.
4. ***Submit the completed claim form*** to MetLife at the address on the form.

In some cases, before approving or denying a claim, MetLife may request additional information, such as:

- A complete dental chart showing prior work performed.
- Itemized bills.
- Laboratory or hospital reports.
- Casts, molds, or study models.
- Other evidence of the condition or treatment of the teeth or mouth.

Your claim should be filed within one year of the date on which you receive the dental service or Appliance. *Claims submitted more than one year after the date of service will not be paid.*

All benefits are paid directly to you unless you specify on the claim form to have benefits paid to your dentist. You will receive an explanation of benefits (EOB) as notice of payment. If the total cost for treatment exceeds the benefits allowed under the Dental Plan, you will be responsible for paying the difference, *in addition* to any deductible or Coinsurance.

Payment of Claims for Orthodontic Treatment. Benefits for orthodontic treatment are paid in equal, monthly installments. Benefits for orthodontic treatment beginning on or after July 1, 2003, are paid on a quarterly basis. Payments begin on the date treatment begins and continue for the duration of the proposed treatment period. If orthodontic treatment begins prior to when dental coverage becomes effective you will be eligible to receive up to $2,500 per covered person for treatments that started prior to the effective date of your dental coverage. This will count against your $2,500 lifetime maximum per covered person. If a separate charge is made for the installation of initial Appliances, benefits for this service will be paid immediately and benefits for the balance of the treatment will be paid in equal installments.

What the Dental Plan Covers

The Dental Plan covers a wide variety of services, up to the Reasonable and Customary Amount, and subject to any applicable maximums. Covered Services include the following:

Preventive Treatment

(Covered at 100 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount, with no deductible, up to the Calendar-Year Maximum.)

- ***Cleanings,*** two per calendar year.
- ***Emergency Palliative treatment***.
- ***Oral examinations,*** two per calendar year.
- ***Sealants*** for molar teeth, once every 36 months per tooth, up to age 19.
- ***Space maintainers*** for missing primary teeth, up to age 19.
- ***Topical fluoride treatment,*** once per calendar year, up to age 19.
- ***X-rays,*** full-mouth and panorex, once every 36 months; bitewings, twice per calendar year up to age 19 and once per calendar year age 19 and above.

Basic Treatment

(Covered at 80 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount after you have met the annual deductible, up to the Calendar-Year Maximum.)

- Treatment for ***accidental injury*** to teeth for services that are within the basic treatment category (an initial emergency care visit may be covered under your medical plan).
- General ***anesthesia***.
- ***Consultation*** by the attending dentist, excluding orthodontia, two per calendar year.
- ***Diagnostic x-ray and laboratory procedures.***
- ***Endodontic treatment,*** including root canal therapy, once per tooth per 24 months.
- Simple ***extractions***.
- ***Fillings***.
- Administration and cost of ***injected drugs*** prescribed by a dentist.
- ***Oral surgery***.
- ***Periodontic treatment.***
  - Scaling and root planing once per quadrant per 24 months.
  - Surgery once per quadrant (same service) per 36 months.
  - Preventive periodontal maintenance after active treatment, up to four times per year in combination with adult cleanings.
- ***Relining, rebasing, or repairing existing bridgework or dentures,*** in some cases, as determined as necessary by MetLife, once per 36 months.

Major Restorative Treatment

(Covered at 60 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount after you have met the annual deductible, up to the Calendar-Year Maximum.)

- Treatment for ***accidental injury*** to teeth for services that are within the major restorative treatment category (an initial emergency care visit may be covered under your medical plan).
- ***Crowns, inlays, and onlays***, including gold and porcelain veneer fillings where other material is not suitable.

- ***Creation of bridgework and dentures***.
- Partial or full ***dentures***.
- ***Implants***.
- ***Installation of bridgework or dentures***.
- ***Occlusal guards***.
- ***Post and core buildups***.
- ***Replacement of existing crowns, inlays, and onlays***, once every 5 years.
- ***Replacement of existing removable denture or fixed bridgework***, once every 5 years, if needed because the existing denture or bridgework is no longer serviceable, as determined as necessary by MetLife.
- Treatment and Appliances for ***temporomandibular joint dysfunction (TMJ)*** with the exception of TMJ surgery.

Special provisions apply for payment of claims for orthodontic treatment. See page 77 for details.

Orthodontic Treatment

(Covered at 60 percent of either the cost of the service provided by a PDP or the Reasonable and Customary Amount, up to a lifetime maximum of $2,500 per covered person.)

- Fixed or removable ***Appliances*** for tooth guidance or to control harmful habits.
- ***Diagnostic procedures***, including exams, x-rays, diagnostic casts, and other diagnostic services.
- ***Formal retention***, including full-banded treatment.
- ***Preliminary examinations***, including x-rays and any proposed treatment plan.

What the Dental Plan Does Not Cover

While the Dental Plan covers a variety of services, some services are not covered, even if your dentist approves or recommends them. Services that the Dental Plan does not cover include, but are not limited to, the following:

- Charges for ***advice given by telephone*** or other means of telecommunication.
- ***Athletic mouthguards***.
- Services that treat the results of ***attrition***.
- Dental expenses incurred ***before the effective date of coverage.*** Please see page 77 for specific information on payment of expenses for orthodontic treatment.
- Charges for a ***broken or missed appointment or completion of claim forms***.
- ***Cosmetic surgery or treatment***, unless such treatment is for accidental injuries and begins no later than 90 days after the accident.
- ***Dental expenses that are covered by any governmental health insurance plan*** if, at the time these expenses are incurred, you are eligible to enroll in or are insured by the governmental plan.
- ***Dietary planning***.
- ***Experimental, investigational, or unproven*** treatment or procedures.
- Services that ***increase vertical dimension***.
- Expenses incurred as a result of ***insurrection, war, or service in the armed forces of any country***.
- Services ***not dentally necessary*** as determined by the Claims Administrator.
- ***Oral hygiene instruction*** or training in preventive dental care.
- Dental treatment ***received from a dental or medical department*** maintained by an employer, an association, or a labor union.

Experimental, investigational, or unproven services are those types of dental procedures or services not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, nor are they demonstrated through prevailing peer-review dental literature to be safe and effective for treating or diagnosing the condition for which their use is proposed.

- The ***replacement of an existing Appliance*** (fixed bridgework, or removable partial or complete dentures) that has been lost, mislaid, or stolen, or if the existing Appliance is less than five years old.
- ***Temporary Appliances***.
- Surgery for ***temporomandibular joint dysfunction (TMJ)***.
- Examinations required by a ***third party*** (for example, employment, school activity, or camp).
- Expenses in connection with a Physician's or dentist's ***time spent traveling*** or for transportation costs.

When Dental Coverage Ends

Your coverage under the Dental Plan ends on the earliest of the following dates:

- The last day of the month in which your employment with Fidelity ends.
- The date the Dental Plan is terminated.
- The last day of the month in which you stop sharing in the cost of your coverage.
- The date of your death.
- The last day of the month you and/or your covered Eligible Dependents no longer satisfy the eligibility requirements under the Dental Plan.

In some circumstances, you and your covered Eligible Dependents may be able to continue coverage for a limited time under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA). For more information, see page 177 in the ***Administrative*** section of this SPD.

While same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the Medical Plans. See page 179 for more information.

YOUR RIGHTS UNDER HIPAA

The *Health Insurance Portability and Accountability Act* (HIPAA) was enacted to make it easier for you and your family members to have continued health plan coverage when changing from one employer to another.

If Your Coverage or Your Employment Ends. If your coverage under a group health plan ends or your employment terminates, the group health plan will provide you and your covered Eligible Dependents with a written "certificate of creditable coverage." This certificate can be used to demonstrate that you have had coverage under a group health plan and that you may be eligible to reduce or eliminate any pre-existing condition limitations imposed by your new group health plan. Be sure to keep this certificate when you receive it. (Because none of Fidelity's group health plans has a pre-existing condition limitation, you are not required to provide a certificate from your previous employer when enrolling in a Fidelity group health plan.)

Flexible Spending Accounts

About the Flexible Spending Accounts

Fidelity offers you the opportunity to participate in the Flexible Spending Accounts which are governed by Sections 125 (health care) and 129 (dependent care) of the Internal Revenue Code of 1986, as amended. With these accounts, you can reduce your taxable income by making Pre-Tax contributions to the Flexible Spending Account(s) and later using that Pre-Tax money to reimburse yourself for eligible expenses.

For information on when you become eligible for coverage, who you may cover, and when coverage becomes effective, see the ***Benefits Overview*** section of this SPD.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

Fidelity offers three Flexible Spending Accounts:

- ***Dependent Care Flexible Spending Account*** – can be used to pay for eligible child or elder care expenses so that you (and your opposite-sex spouse, if you are married) can work or attend school.
- ***Health Care Flexible Spending Account*** – can be used to pay for eligible expenses that are not otherwise covered by a medical, dental, vision, or other group health plan.
- ***Health Care HSA-Compatible Flexible Spending Account*** – can be used to pay for eligible dental and vision expenses, and preventive care copayments. It is important to note that medical expenses (other than the preventive care copayments) that are generally reimbursable under the Health Care Flexible Spending Account, are not reimbursable under this account.

When you participate in the Flexible Spending Accounts, you contribute money to an account in your name each pay period on a *Pre-Tax basis*—before federal and Social Security, as well as most state and local taxes, are withheld from your pay. The money in your Flexible Spending Account(s) is then used to reimburse you after you incur and pay for eligible expenses.

You are eligible to enroll in the Flexible Spending Accounts when you are first hired. Otherwise, you will have the opportunity to enroll during the Annual Benefits Enrollment period. You also may enroll during the year if you experience a Change in Status (see page 83).

WageWorks administers the Flexible Spending Accounts for Fidelity.

How Flexible Spending Accounts Work

Participation in the Flexible Spending Accounts is optional. When you enroll in the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account and/or the Dependent Care Flexible Spending Account, you elect to participate for the full calendar year (or the remainder of the calendar year if you first become eligible to enroll during the year). The amount you elect to contribute to your account(s) is then deducted from your paycheck in equal amounts throughout the year and credited to an account in your name.

Flexible Spending Accounts do not earn interest during the year. If you elect to participate in the Health Care Flexible Spending Account or the Health Care HSA-Compatible Flexible Spending Account and a Dependent Care Flexible Spending Account, you cannot transfer money between the two accounts.

Each type of account has specific guidelines regarding which expenses are eligible for reimbursement. Note that not all expenses that you may incur are eligible for reimbursement. (For additional information on eligible Health Care Flexible Spending Account expenses, see page 85; for eligible Health Care HSA-Compatible Flexible Spending Account expenses, see page 89; for eligible Dependent Care Flexible Spending Account expenses, see page 90.)

To be eligible for reimbursement, expenses must be incurred and paid for during the same calendar year in which you made contributions to the Flexible Spending Account(s).

Amount You May Contribute to Your Flexible Spending Account(s)

You decide how much you want to contribute to your Flexible Spending Account(s) by estimating how much you expect your eligible out-of-pocket expenses will be for the upcoming calendar year (or for the remainder of the calendar year if you become eligible to enroll during the year). With the health care and dependent care Flexible Spending Accounts, there are minimum and maximum amounts you may contribute each year.

FLEXIBLE SPENDING ACCOUNT	ANNUAL MINIMUM	ANNUAL MAXIMUM
Health Care Flexible Spending Account	$100	$5,000
Health Care Flexible Spending Account Limited	$100	$5,000
Dependent Care Flexible Spending Account	$100	$5,000*

*See the section below for limitations on Dependent Care Flexible Spending Account contributions.

You have until March 31 of the next year to submit claims for reimbursement for eligible expenses incurred during the calendar year in which you made the contributions. Otherwise, Internal Revenue Code regulations require that any money left in your Flexible Spending Account(s) after that date be forfeited. That's why it's important to estimate your expenses carefully before signing up for any of the Flexible Spending Accounts.

Setting aside part of your pay into a Flexible Spending Account does not affect the value of salary-related benefits, such as your life insurance coverage or disability benefits. Please note, however, that your future Social Security benefits may be reduced if you make contributions to the Flexible Spending Accounts because Social Security taxes are not withheld from any Pre-Tax contributions.

If You Are Newly Hired or Eligible to Enroll During the Calendar Year Due to a Change in Status.
The maximum amount you may contribute to the Flexible Spending Account(s) will be prorated. For example, if your employment with Fidelity begins on July 1 (halfway through the year), the maximum amount you generally would be eligible to contribute would be $2,500 (one-half the annual maximum) to the Health Care Flexible Spending Account or to the Health Care HSA-Compatible Flexible Spending Account, and $2,500 to the Dependent Care Flexible Spending Account (unless you are married and filing separate tax returns, in which case the maximum amount you would be eligible to contribute to a Dependent Care Flexible Spending Account would be $1,250).

Limitations on Dependent Care Flexible Spending Account Contributions

Current tax regulations limit the amount you may contribute to a Dependent Care Flexible Spending Account in certain circumstances, including if:

- You are married and you and your opposite-sex spouse file separate tax returns. In this case, your annual maximum is limited to $2,500.
- You or your opposite-sex spouse has earned income for the year that is less than $5,000. In this case, your contribution amount cannot exceed the income of the individual who earns less than $5,000.
- Your opposite-sex spouse is a full-time student for at least five months during the calendar year or is disabled. In this case, your opposite-sex spouse's income is assumed to be:
  - $250 per month (an annual limit of $3,000), if you have one person for whom you incur eligible dependent care expenses.
  - $500 per month, if you have two or more persons for whom you incur eligible dependent care expenses.
- You or your opposite-sex spouse already has participated or currently is participating in another employer's dependent care plan during the same calendar year. In this case, the combined total of your and your opposite-sex spouse's contributions cannot exceed $5,000.
- You are a highly compensated employee, as defined under the Internal Revenue Code. In this case, your contributions may be limited to ensure that the Dependent Care Flexible Spending Account passes the nondiscrimination testing rule. Fidelity will notify you if your contributions will be affected.

Making Changes to Your Flexible Spending Account(s)

Other than during the Annual Benefits Enrollment period, federal law provides that you may make a change to your Flexible Spending Account(s) only if you experience a Change in Status, including, but not limited to, a change in marital status (as those terms are defined under federal law) or a change in the number of your dependents, only if your election is consistent with your Change in Status. If you experience a Change in Status, it may be permissible for you to begin making contributions to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account or the Dependent Care Flexible Spending Account, or you may elect to stop making contributions to the Health Care Flexible Spending

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

For more information about Changes in Status, refer to the ***Benefits Overview*** section of this SPD.

Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account. However, your election must be consistent with your Change in Status. In addition, it may be permissible for you to elect to increase or decrease the amount you contribute to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account provided that such election is consistent with your Change in Status. For more information about what events are considered a Change in Status under federal law, please refer to the Change in Status section of this SPD on page 10.

To start, stop, or change any contributions that you make to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account, you must call HR Solutions at 800-835-5099 (TDD 888-343-0860) and finalize your change **within 31 days of your Change in Status.** Otherwise, you must wait until the next Annual Benefits Enrollment period. The effective date of your change to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account will be the date that your Change in Status occurred. However, your actual payroll deductions will begin or stop, as the case may be, as soon as administratively feasible following your Change in Status.

If you start making contributions to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account during the year because of a Change in Status, your participation in that Flexible Spending Account starts as of the date that the Change in Status occurs. This means that you cannot request reimbursement for expenses that you incur before your Change in Status occurs.

If you increase the amount you contribute to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account because of a Change in Status, you cannot request reimbursement for expenses that you incurred prior to such increase if, at the time you incurred such expense, the maximum amount available to you under the Flexible Spending Account is less than the amount of the expense.

If you stop making contributions to the Dependent Care Flexible Spending Account because of a Change in Status, you may only submit claims for reimbursement for expenses incurred prior to the date of the Change in Status. If you stop making contributions to the Health Care Flexible Spending Account or the Health Care HSA-Compatible Flexible Spending Account because of a Change in Status, you may only submit claims for reimbursement for expenses incurred on or before the last day of the month in which the Change in Status occurred.

Changes made during the Annual Benefits Enrollment period are effective the next January 1. You will be notified during the Annual Benefits Enrollment period whether your Flexible Spending Account(s) election(s) will carry over to the following year or not if you do not actively make a change.

Key Restrictions

While the Flexible Spending Accounts can save you money on your taxes, you should be aware of certain restrictions before you enroll in the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, or the Dependent Care Flexible Spending Account:

- ***If you do not incur enough eligible expenses during a calendar year to use all the contributions you made to your Flexible Spending Account(s), the Internal Revenue Code requires you to forfeit any balance in your Flexible Spending Account(s).*** You cannot receive a refund, carry balances over to pay for expenses that you may incur in the next calendar year, or transfer money from one Flexible Spending Account to another.
- ***You have until March 31 of the next year to submit claims for reimbursement for eligible expenses incurred during the calendar year during which you made the contributions.*** Any money left in your Flexible Spending Account(s) after that date will be forfeited.
- ***Once you sign up for a Flexible Spending Account, you cannot change your contributions during the year unless you experience a Change in Status,*** including, but not limited to, marriage, divorce, or the birth or adoption of a child. See page 83 for more information.

- ***You cannot deduct expenses on your federal income tax return that are the same as those for which you received reimbursement under a Flexible Spending Account.*** You are encouraged to consider participation in the Flexible Spending Accounts carefully and, if appropriate, consult a financial or tax adviser before making a decision about what best fits your personal situation.
- ***The aggregate amount you may contribute to a Dependent Care Flexible Spending Account cannot exceed $5,000 per year*** if you participate in another employer's plan in the same year, or if your opposite-sex spouse also participates in a dependent care account through his or her employer and you file a joint federal tax return.
- ***You cannot request reimbursement from any increased contributions you make following a Change in Status for expenses that you incurred before the Change in Status.*** If you elect to increase your contributions mid-year due to a Change in Status, you cannot request reimbursement out of the increased contributions for expenses incurred prior to the date of the Change in Status.

EXAMPLE

How You Save with Flexible Spending Accounts

In years when you elect to make contributions to the Health Care Flexible Spending Account, the Health Care HSA-Compatible Flexible Spending Account, and/or the Dependent Care Flexible Spending Account, you set up an account to reimburse yourself for eligible expenses you incur during the year using Pre-Tax dollars.

For example, if you earn $40,000 per year, you could save $600 in federal taxes by contributing $2,500 to a Dependent Care Flexible Spending Account and $1,500 to the Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account. (*Based on a family with four exemptions, married, filing jointly, and using 2008 tax rates. In most states, you also would save on state income taxes.*)

Any advice contained herein is not intended or written to be used, and cannot be used, for the purposes of: (a) avoiding penalties under the Internal Revenue Code; or (b) promoting, marketing, or recommending to another party any transaction or matter addressed herein.

Health Care Flexible Spending Account

You may use the Health Care Flexible Spending Account to pay for eligible health care expenses that are not otherwise covered by a medical, dental, vision, or other health plan. Expenses must be incurred by you, your opposite-sex spouse, or your Eligible Dependents.

Please note that if you enroll in the Health Care Flexible Spending Account, you are not eligible to establish an HSA.

For detailed guidelines on what constitutes an eligible health care expense under the Health Care Flexible Spending Account, contact the IRS on the Internet (www.irs.gov) or by phone at 800-829-3676. You may also contact WageWorks at 877-924-3967.

Eligible Expenses under the Health Care Flexible Spending Account

Eligible expenses recognized by the IRS include, but are not limited to, the following:

- ***Acupuncture***.
- ***Ambulance***.
- ***Braces and other orthodontia*** for medical reasons.
- ***Braille books and magazines***, limited to the difference between the cost of the Braille items and the cost for regular items.
- Special ***car controls*** for the disabled.
- ***Chiropractic expenses*** in excess of medical plan limits.
- Cost for services by ***Christian Science practitioners***.
- ***Contact lenses and supplies***, such as saline and cleaning solution.
- Plan ***copayment fees, deductibles, and Coinsurance amounts***.

- ***Dental examinations***.
- Treatment for ***drug abuse or alcoholism***, including meals and lodging if necessary for the treatment.
- ***Eyeglasses***, including lenses, frames, and exams.
- ***Eye surgery***, including RK, LASIK, ALK, etc.
- Purchase of a ***guide dog*** for an individual who is blind.
- ***Hearing expenses***, including examinations, hearing aids, and batteries required to operate a hearing aid.
- ***Hospitalization charges*** in excess of the Reasonable and Customary Amount, including private room coverage.
- ***Laboratory fees***.
- Costs for ***medical services*** provided by Physicians, surgeons, specialists, or other medical practitioners.
- ***Medicine*** or other drugs prescribed by a doctor, including dietary supplements, birth control pills, and medicines. See page 87 for information about over-the-counter medicines and drugs.
- Expenses for medical care in a ***nursing home***.
- ***Nursing services***, when provided by a registered nurse or licensed practical nurse for medical care.
- Services by an ***optometrist***.
- ***Orthopedic shoes***.
- ***Oxygen or oxygen equipment*** to relieve breathing problems caused by a medical condition.
- ***Psychiatrist/psychologist fees***.
- Purchase or rental of ***special medical equipment***, such as wheelchairs and crutches, if the primary purpose is medical care.
- Tuition fees for a ***special school for a learning-disabled child*** who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, when recommended by a doctor. Tutoring fees for a teacher who is specially trained and qualified to work with children with severe learning disabilities also are eligible when recommended by a doctor.
- ***Sterilization fees***.
- ***Surgery***, including experimental procedures.
- Special ***telephones*** for the deaf.
- Audio-display ***televisions*** for the deaf.
- Medical expenses for ***therapy***, such as speech, occupational, physical, or cardiac, received as medical treatment.
- ***Vaccinations***.
- ***Weight-loss programs*** as a treatment for a specific disease or ailment, including obesity, diagnosed by a Physician.

EXPENSES FOR OVER-THE-COUNTER (OTC) MEDICINES AND DRUGS

Expenses for over-the-counter (OTC) medicines and drugs that are used for medical care as defined under IRC section 213(d) are only considered eligible for reimbursement under the Health Care Flexible Spending Accounts if they are purchased with a prescription.

There are two categories of OTC medicines and drugs; those that are primarily used for medical care (such as aspirin and antacid) and those that may have a dual purpose, that is, those that could be used for both medical and non-medical purposes (such as vitamins and herbs). To receive a reimbursement for an eligible OTC medicine or drug expense, your doctor must write you a prescription for the medication/drug and you must complete a Health Care Account Pay Me Back claim form available from HR Solutions Online and submit it to WageWorks along with a copy of the prescription from your doctor, a receipt that lists the name of the OTC medicine or drug, the date of the purchase, and the cost of the item. For dual purpose OTC medicines and drugs you must include a letter from your physician with your request for reimbursement. The letter must cite the specific medical condition being treated and indicate that the OTC medicine or drug will treat or alleviate the medical condition. Please note, amounts paid for items that are merely beneficial to your or your spouse or dependents' general health are not eligible for reimbursement (such as vitamins or dietary supplements). For more information about whether a particular OTC medicine or drug is considered eligible for reimbursement under the Health Care Flexible Spending Account, please call WageWorks (877-924-3967) or access the Internal Revenue Service website at www.irs.gov. To find out what documentation is required for a particular reimbursement, please contact WageWorks.

Ineligible Expenses under the Health Care Flexible Spending Account

In general, health care expenses that do not qualify as medical deductions for federal income tax purposes are not eligible for reimbursement under the Health Care Flexible Spending Account. Examples of ineligible expenses include, but are not limited to, the following:

- ***Automobile insurance premiums***, including any portion of the premium providing medical coverage for persons injured because of an accident in or with the covered individual's vehicle.
- ***Bottled water***.
- ***Braces and other orthodontia*** for Cosmetic reasons.
- ***Cosmetic surgery***, except to correct a congenital abnormality, bodily injury, or disfiguring disease.
- ***Cosmetics***, such as toiletries and toothpaste.
- Any expense ***covered by a health care plan***.
- ***Custodial care*** in an institution.
- ***Dancing or swimming lessons, or any other instructional therapy***, even when recommended by a qualified Physician for health improvement.
- ***Dietary Supplements*** when taken for general health purposes.
- Expenses that are ***filed on a federal tax return*** for a tax credit or for which a deduction is taken.
- ***Funeral and burial expenses***.
- Expenditures for the ***general health*** of an individual, including expenses related to exercise, fitness, nutrition, recreation, vacation, or membership in a spa or health club.
- ***Hair removal*** (electrolysis).
- ***Hair transplants***.
- ***Household and domestic help***, even if recommended by a qualified Physician because of an individual's inability to perform physical housework.
- Any expenses incurred in connection with an ***illegal operation or treatment***.
- Charges by a ***licensed practical nurse*** who cares for your normal, healthy, newborn child.

For detailed guidelines on what constitutes an eligible health care expense under the Health Care Flexible Spending Account, contact the IRS on the Internet (www.irs.gov) or by phone at 800-829-3676. You may also contact WageWorks at 877-924-3967.

- ***Life insurance premiums*** or premiums for policies taken to provide repayment for loss of earnings or accidental loss of life, limb, sight, etc.
- ***Maternity clothes***, diaper services, etc.
- ***Meals and lodging*** while away from home for medical treatment.
- ***Medical insurance premiums***, including premiums for employer-provided medical and dental coverage and for contact lens insurance.
- Costs for sending a child with behavioral or disciplinary problems to a ***special school*** for benefits the child may receive from the course of study and disciplinary methods.
- ***Transportation expenses*** to and from work, even if a physical condition requires a special means of transportation.
- ***Vacation or travel***, when taken for general health purposes, improvement of morale, or to relieve physical or mental discomfort.
- ***Vitamins***, when taken for general health purposes.
- ***Weight-loss programs***, if the primary purpose is to improve health and appearance.

THE WAGEWORKS HEALTH CARE CARD

A Special Feature for the Health Care Flexible Spending Account

The WageWorks Health Care Visa Card (the Card) makes funds immediately available so you can pay for eligible medical expenses. You can also use your Card at qualified general merchandise stores (e.g., supermarkets, etc.) to pay for eligible over-the-counter (OTC) items. To qualify, the merchant must have an IRS-approved system that can automatically verify the eligibility of items at checkout. While many of your Card transactions will be automatically verified, you are still required to hold onto your receipts for tax purposes. For a list of qualified merchants, please visit www.sigis.com. If you use the Card at a health care provider or independent pharmacy that does not have an IRS-approved system, you will be required to submit your receipt for verification.

Please note that the WageWorks Health Care Card is not available for the Health Care HSA-Compatible Flexible Spending Account or the Dependent Care Flexible Spending Account.

Health Care HSA-Compatible Flexible Spending Account

You may use the Health Care HSA-Compatible Flexible Spending Account to pay for eligible dental and vision expenses (as defined by the IRS), and preventive care copayments that are not otherwise covered by a vision, dental, or other health plan. Expenses must be incurred by you, your opposite-sex spouse, or your Eligible Dependents.

It's important to note that medical expenses (other than the preventive care copays) that are generally reimbursable under the Health Care Flexible Spending Account are not reimbursable under the Health Care HSA-Compatible Flexible Spending Account.

Please note, enrollment in the Health Care HSA-Compatible Flexible Spending Account will not impact your eligibility to establish an HSA.

Eligible Expenses under the Health Care HSA-Compatible Flexible Spending Account

Eligible expenses recognized by the IRS include, but are not limited to, the following expenses:

- ***Preventive care copayments (including copayments for preventive care prescription drugs)***.
- ***Dental expenses, including but not limited to:***
  - Cleanings
  - Crowns
  - Dental implants, if medically necessary (non-cosmetic)
  - Dentures
  - Examinations
  - Fillings
  - Root canals and bridges
  - X-rays
- ***Vision care expenses, including but not limited to:***
  - ***Braille books and magazines***, limited to the difference between the cost of the Braille items and the cost for regular items.
  - ***Contact lenses and supplies***, such as saline and cleaning solution.
  - ***Eyeglasses***, including lenses, frames, and exams.
  - Purchase of a ***guide dog*** for an individual who is blind.
  - ***Eye surgery***, including RK, LASIK, ALK, etc.

For more information about eligible expenses under the Health Care HSA-Compatible Flexible Spending Account, contact WageWorks at 877-924-3967.

Ineligible Health Care HSA-Compatible Flexible Spending Account Expenses

In general, eligible dental and vision care expenses, and preventive care copayments, are the only expenses eligible for reimbursement under the Health Care HSA-Compatible Flexible Spending Account. Medical expenses (other than preventive care copayments) that are generally reimbursable under the Health Care Flexible Spending Account are not eligible under the Health Care HSA-Compatible Flexible Spending Account. Cosmetic services, whether dental or vision related, are not eligible for reimbursement.

AUTOMATIC HEALTH PLAN CLAIM

A Special Feature for the Health Care HSA-Compatible Flexible Spending Account

If you are enrolled in the Health Care HSA-Compatible Flexible Spending Account, you automatically will be enrolled in the Automatic Health Plan Claim feature. Here's how it works.

Any preventive prescription drug copayments and dental expenses under the Fidelity Health Plan and/or the Dental Plan that are not covered, or are covered only in part, are forwarded automatically to WageWorks. Expenses that are eligible for reimbursement under the Health Care HSA-Compatible Flexible Spending Account are automatically reimbursed to you via check or through direct deposit to your bank of choice. To set up direct deposit, log on to your account at www.wageworks.com or call WageWorks at 877-924-3967.

The minimum reimbursement amount is $5.00, unless the reimbursement will exhaust the account.

Please note that the Automatic Health Plan Claim feature is not available for the Health Care Flexible Spending Account.

Dependent Care Flexible Spending Account

You may use the Dependent Care Flexible Spending Account to reimburse yourself for the care of your Eligible Dependents. *Eligible Dependents* include your dependent children younger than age 13 and any other dependent who is physically or mentally disabled and therefore incapable of self-care, has an annual income of less than $3,400, who lives in your home for more than one-half of the tax year, and you provide more than one-half of the individual's support.

Dependent care services may be provided in or outside of your home. Expenses must be those that you pay so that you (and your opposite-sex spouse, if you are married) can work. If you are married, this means that both you and your opposite-sex spouse generally must be gainfully employed. However, if your opposite-sex spouse is a full-time student or disabled, the "gainfully employed" requirement is considered met. If you are a divorced parent with custody of your children, you may be eligible to use the Dependent Care Flexible Spending Account even if you don't claim your children on your tax return.

For detailed guidelines on what constitutes an eligible dependent care expense, contact the IRS on the Internet (www.irs.gov) or by phone at 800-829-3676 and request a copy of Publication 503, *Child and Dependent Care Expenses*.

Eligible Dependent Care Expenses

You may use the Dependent Care Flexible Spending Account to reimburse yourself for a variety of eligible dependent care expenses (incurred and paid for in the calendar year), including, but not limited to, the following:

- Expenses for ***after-school programs***.
- Expenses for a ***licensed dependent care center*** that cares for six or more unrelated individuals.
- The full amount paid to a ***nursery school***, even when the school provides lunch and educational services.
- Amounts paid to a ***relative*** who provides dependent care services, provided that the relative is not also your or your opposite-sex spouse's:
  - Dependent for whom a personal exemption deduction is allowed for federal income tax purposes.
  - Child or stepchild who is younger than age 19 at the end of the calendar year.
- Amounts paid for ***services performed outside the home*** for the care of your dependent or disabled opposite-sex spouse.
- Expenses for a ***summer day camp***, if the main purpose of sending your child is to allow you and your opposite-sex spouse to remain gainfully employed.
- Amounts paid to an ***unlicensed dependent care provider, baby sitter, or nurse*** who cares for fewer than six individuals.

Ineligible Dependent Care Expenses

Certain expenses are not eligible for reimbursement under the Dependent Care Flexible Spending Account. Examples of ineligible expenses include, but are not limited to, the following:

- ***Baby-sitting expenses*** related to your or your opposite-sex spouse's non-work activities.
- Care in a ***convalescent nursing home***.
- ***Custodial care*** for a dependent who resides outside your home.
- The cost of ***food, clothing, and education***.
- ***Overnight camp***.
- Services ***provided by one dependent*** to care for another.
- Expenses that are reimbursed from a health care reimbursement account or for which a dependent care ***tax credit*** is taken.
- ***Transportation*** between your home and the place where dependent care services are provided.
- Dependent care that allows you or your opposite-sex spouse to do ***volunteer work***.

How to File a Claim for Reimbursement

Claim forms are available from HR Solutions online or log on to your account at www.wageworks.com.

The following payment options are available:

Health Care Flexible Spending Account

- ***Health Care Card –*** Use your Card at the point of service to pay for eligible expenses. In most instances, your Card transaction will be automatically verified at checkout, which means you will not have to submit a receipt to WageWorks after the transaction. Note: you are required to keep each receipt for tax purposes, and in the event it is needed for verification.
- ***Pay Me Back Claim –*** After you have incurred and paid for eligible expenses, complete a Pay Me Back Claim Form, available on HR Solutions online or log on to your account at www.wageworks.com. Submit the completed claim form, together with the appropriate receipts and documentation, to:

  Claims Administrator
  P.O. Box 14053
  Lexington, KY 40512

  You can also fax the completed claim form, together with the appropriate receipts and documentation to: WageWorks at 877-353-9236.
- ***Pay My Provider –*** If you don't pay at the point of service and later receive a bill from your provider, you can send a payment directly from your account using the Pay My Provider feature on www.wageworks.com.

Health Care HSA-Compatible Flexible Spending Account

- ***Automatic Health Plan Claim –*** If you are enrolled in the Health Care HSA-Compatible Flexible Spending Account, you automatically will be enrolled in this feature. See page 89.
- ***Pay Me Back Claim –*** After you have incurred and paid for eligible expenses, complete a Pay Me Back Claim Form, available on HR Solutions online or log on to your account at www.wageworks.com. Submit the completed claim form, together with the appropriate receipts and documentation, to:

  Claims Administrator
  P.O. Box 14053
  Lexington, KY 40512

  You can also fax the completed claim form, together with the appropriate receipts and documentation to: WageWorks at 877-353-9236.
- ***Pay My Provider –*** If you don't pay at the point of service and later receive a bill from your provider, you can send a payment directly from your account using the Pay My Provider feature on www.wageworks.com.

Dependent Care Flexible Spending Account

- ***Pay Me Back Claim –*** After you have incurred and paid for eligible expenses, complete a Pay Me Back Claim Form, available on HR Solutions online or log on to your account at www.wageworks.com. Submit the completed claim form, together with the appropriate receipts and documentation, to:

  Claims Administrator
  P.O. Box 14053
  Lexington, KY 40512

  You can also fax the completed claim form, together with the appropriate receipts and documentation to: WageWorks at 877-353-9236.
- ***Pay My Provider –*** If you don't pay at the point of service and later receive a bill from your provider, you can send a payment directly from your account using the Pay My Provider feature.

Note: You must submit a minimum of $5.00 in eligible expenses in order for a reimbursement to be made. If you submit a request for less than $5.00, you will not receive a reimbursement until the amount of your requests equals at least $5.00, unless it is your final request for reimbursement for the year.

For questions on the payment options available and how to use them, contact WageWorks at 877-924-3967.

In addition, the following guidelines apply to reimbursement requests:

- ***Health Care Flexible Spending Account/Health Care HSA-Compatible Flexible Spending Account.*** Your annual election amount is available as of the first day you are enrolled in the plan. Throughout the Plan Year you may request reimbursement up to your annual election amount or up to your account's remaining balance. A copy of the explanation of benefits (EOB) or an itemized bill from your provider must be submitted with your claim form.
- ***Dependent Care Flexible Spending Account.*** You may be reimbursed only up to the current balance in your Dependent Care Flexible Spending Account. If you submit a request that exceeds your current Dependent Care Flexible Spending Account balance, you will be reimbursed when the funds become available in your Dependent Care Flexible Spending Account.

When you participate in a Flexible Spending Account, you must make contributions to your Flexible Spending Account and use the balance in your Flexible Spending Account for eligible expenses incurred in the same calendar year. You have until March 31 of the following year to submit a claim for reimbursement for expenses incurred during the year in which you made the contributions.

Any expenses for which you are reimbursed under your Flexible Spending Account(s) cannot also be claimed as itemized deductions or as a tax credit on your federal income tax return. You are encouraged to consider your participation carefully and, if appropriate, consult your tax or financial adviser to determine what is best for your personal financial situation.

You have until March 31 of the next year to submit claims for reimbursement for eligible expenses incurred during the calendar year. *Internal Revenue Code regulations require that any money in your Flexible Spending Account(s) that you do not use for eligible expenses incurred during the Plan Year will be forfeited.*

Your Flexible Spending Account Statement. You can go to www.wageworks.com to track the status of your claim or to check your balances at any time.

Important Information about Taxes

Health Care Expenses

If you decide to reimburse yourself for eligible expenses under the Health Care Flexible Spending Account or the Health Care HSA-Compatible Flexible Spending Account, you cannot deduct those same expenses on your federal income tax return. Current Internal Revenue Code regulations only allow you to deduct those expenses that exceed 7½ percent of your adjusted gross income.

Dependent Care Expenses

Under current Internal Revenue Code regulations, you may be able to take a dependent care tax credit when you file your taxes. The maximum credit is $3,000 for one dependent and $6,000 for two or more dependents.

If you choose to reimburse yourself on a Pre-Tax basis under the Dependent Care Flexible Spending Account, those reimbursed expenses may reduce the amount of the federal dependent care tax credit that may be available to you. You should consult with a financial or tax adviser to determine what best fits your personal situation.

When Your Contributions End

Your Pre-Tax contributions to your Flexible Spending Account(s) generally will end as of the last payroll period prior to the date that:

- Your employment ends.
- You retire.
- You no longer satisfy eligibility requirements.
- You die.
- The Flexible Spending Account is terminated.

You may continue to request reimbursement from your Health Care Flexible Spending Account or your Health Care HSA-Compatible Flexible Spending Account, for expenses incurred on or before the last day of the month in which your contributions end. You may continue to request reimbursement from your Dependent Care Flexible Spending Account for expenses incurred on or before the date of the event that causes your contributions to end. However, all such requests must be made before March 31 of the next year.

In some circumstances, you and/or your opposite-sex spouse or your Eligible Dependents may be able to continue making contributions to the Health Care Flexible Spending Account or the Health Care HSA-Compatible Flexible Spending Account, on an After-Tax basis, but only for the year during which you experience a COBRA Qualifying Event. For more information, see page 177 in the ***Administrative*** section of this SPD.

YOUR RIGHTS UNDER HIPAA

The *Health Insurance Portability and Accountability Act* (HIPAA) was enacted to make it easier for you and your family members to have continued health plan coverage when changing from one employer to another.

If Your Coverage or Your Employment Ends. If your coverage under a group health plan ends or your employment terminates, the group health plan will provide you and your covered Eligible Dependents with a written "certificate of creditable coverage." This certificate can be used to demonstrate that you have had coverage under a group health plan and that you may be eligible to reduce or eliminate any pre-existing condition limitations imposed by your new group health plan. Be sure to keep this certificate when you receive it. (Because none of Fidelity's group health plans has a pre-existing condition limitation, you are not required to provide a certificate from your previous employer when enrolling in a Fidelity group health plan.)

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Life and Accident Insurance Coverage

About Your Life and Accident Insurance Coverage

Life insurance offers important protection from the unexpected. That's why Fidelity automatically provides Regular Employees who are regularly scheduled to work 30 or more hours per week with Company-paid Core Life Insurance, which includes Employee Life Insurance and Dependent Life Insurance. Additionally, all Regular Employees who travel on Company business are automatically covered under Business Travel Accident (BTA) Insurance regardless of their regularly scheduled hours.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

- Employee Life automatically provides you with $50,000 of coverage.
- Dependent Life automatically provides your spouse or Domestic Partner with $20,000 of coverage and each Eligible Dependent child, and any other person designated as eligible under applicable state law, with $10,000 of coverage.

In addition, Fidelity offers Variable Life Insurance, which has three components:

- Variable Basic is life insurance coverage for which Fidelity reimburses you.
- Variable Supplemental is voluntary life insurance coverage for which you pay the full cost.
- Variable Investment Options allow you to contribute additional premium dollars to Fidelity's Variable Insurance Products (VIP) Funds.

For all employees, BTA insurance automatically covers you in the event of certain accidental injuries or death while you are traveling on Company business.

A Summary of Fidelity's Life and Accident Insurance Plans

Below is an overview of the life and accident insurance plans.

PLAN	COVERAGE AMOUNT
Core Life Insurance	
• Employee Life Insurance	$50,000
• Dependent Life Insurance	
– Spouse	$20,000
– Domestic Partner	$20,000
– Each Eligible Dependent	$10,000
BTA Insurance	
• For accidental loss of life	Five times your annualized Base Salary, or Benefits Base, rounded up to the next $1,000, up to a maximum of $2 million
• For certain accidental injury(ies)	Varies based on your injury(ies)
Variable Life Insurance	
• Variable Basic	Fidelity reimburses you for the cost of coverage equal to 4x your annualized Base Salary, or Benefits Base, up to a maximum of $250,000
• Variable Supplemental	You may purchase additional coverage for yourself, in increments of your annualized Base Salary, or Benefits Base (from 1x to 15x), up to $3 million (Variable Basic and Variable Supplemental combined)
• Variable Investment Options	You may choose to invest in Fidelity VIP Funds on an After-Tax basis, up to Internal Revenue Code (IRC) limits. Earnings are Tax-Deferred and, in many cases, income-tax free

Employee Life Insurance Plan

Under the Fidelity Employee Life Insurance Plan, Regular Employees who are regularly scheduled to work 30 or more hours per week automatically receive life insurance coverage of $50,000. Fidelity pays the full cost of this coverage.

Coverage is effective as of the first day you are Actively at Work. If you are not Actively at Work on the date coverage is scheduled to begin, your coverage becomes effective on the first day you return to active employment.

Living Needs Benefit

If you are terminally ill and have been diagnosed by a licensed Physician as having 12 or fewer months to live, you may elect to have as much as 50 percent, up to a maximum of $25,000, of your Employee Life Insurance benefit paid to you in one lump sum payment. If you elect this option, the remainder of your Employee Life Insurance benefit will be payable to your Beneficiary upon your death. For more information, call HR Solutions at 800-835-5099 (TDD 888-343-0860).

Dependent Life Insurance Plan

For Regular Employees who are regularly scheduled to work 30 or more hours per week, the Fidelity Dependent Life Insurance Plan provides coverage for your Eligible Dependents at no cost to you. *Eligible Dependents* refers to:

- Your legal spouse, as evidenced by a marriage certificate.
- Your Domestic Partner.
- Your unmarried dependent children who are at least 2 days old and younger than age 19 (age 23, if your unmarried dependent is a full-time student who is dependent upon you for care and support).
- Any other person designated as eligible under applicable state law.

Coverage for your Eligible Dependents becomes effective on the same date as your Employee Life Insurance coverage. If you and your spouse or Domestic Partner are both Regular Employees and both of you are eligible for life insurance coverage, your dependent children are covered by the employee with the longer period of continuous service with Fidelity. If one of you leaves Fidelity, your dependent children automatically are covered by the other spouse or Domestic Partner.

The coverage amount for each Eligible Dependent is a fixed amount:

- *Spouse or Domestic Partner:* $20,000.
- *Each other Eligible Dependent:* $10,000.

Benefits are not payable if your dependent's death occurs while he or she is a full-time member of the armed forces. You automatically are the Beneficiary under the Dependent Life Insurance Plan.

Business Travel Accident (BTA) Insurance Plan

The Fidelity BTA Insurance Plan provides protection for certain accidental injuries or death when you travel on Company business.

All Regular Employees who travel on Company business, regardless of scheduled hours, are eligible for BTA Insurance coverage.

With the Fidelity Business Travel Accident (BTA) Insurance Plan, Regular Employees, regardless of scheduled hours, are covered in the event of accidental death, or an injury that results in the loss of limb(s), sight, speech, or hearing, while traveling on Company business. You also may be eligible for additional benefits under the BTA Insurance Plan, as described in this section.

BTA insurance coverage becomes effective the first day you are Actively at Work. Fidelity pays the full cost of this coverage. Benefits under the BTA Insurance Plan are in addition to any benefits that may be payable under the Employee Life Insurance Plan and/or the Variable Life Insurance Plan.

Coverage amount/principal sum. Your coverage amount or principal sum, in the event of your death while traveling on Company business, is five times your annualized Base Salary or Benefits Base (rounded up to the next $1,000), up to a maximum of $2.5 million.

Business Travel Policies and Programs

Fidelity has policies and programs related to business travel. Prior to making any travel plans, you should review the *Fidelity Investments Corporate Business Expense Policy*, which you can find on Fidelity's intranet on the Corporate Accounts Payable page.

Fidelity also offers certain emergency travel services through International SOS, which are designed to help with personal, travel, security, and legal issues you may encounter when you are away from home. For more information on this program, visit Fidelity Travel Security's intranet site at travelsecurity.fmr.com.

Accidental Death and Dismemberment Benefits

If you experience an accident while traveling on Company business that results in any of the following covered losses within 365 days from the date of the covered accident, benefits are payable as shown in this chart:

	IF WHILE TRAVELING ON FIDELITY BUSINESS YOU ACCIDENTALLY LOSE:	COVERAGE AMOUNT
1.	Thumb and index finger of the same hand; four fingers of the same hand; uniplegia (total paralysis of one lower limb or one upper limb)	25% of your coverage amount
2.	One hand; one foot; sight of one eye; speech; hearing in both ears	50% of your coverage amount
3.	Paraplegia (total paralysis of both upper limbs or lower limbs)	50% of your coverage amount
4.	Hemiplegia (total paralysis of the upper and lower limbs on one side of the body)	75% of your coverage amount
5.	Any combination of two or more items listed in #2 above; quadriplegia (total paralysis of both upper and lower limbs)	100% of your coverage amount
6.	Your life	100% of your coverage amount

How Loss Is Defined

- Loss of a hand or foot means complete severance at or above the wrist or ankle joint.
- Loss of sight, speech, or hearing means the total, permanent, and irrecoverable loss of sight in one eye, audible communication, or hearing in both ears.
- Loss of a thumb or finger means the complete severance through or above the joints between the finger and the hand.
- Paralysis means the total loss of use. A doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

The BTA Insurance Plan also covers losses:

- Due to exposure to the elements as a result of the forced landing, stranding, sinking, or wrecking of a vehicle in which you were traveling.
- If the vehicle in which you were traveling disappears, sinks, is stranded, or wrecked and your body has not been found within one year of the covered accident you will be presumed dead.

When Coverage Begins and Ends

Coverage begins when you leave your home, regular place of work, or other location on business travel, whichever is later. Additionally, you may be eligible for BTA insurance coverage up to the 7 days prior to your business travel if you are traveling for personal reasons immediately before your covered business trip begins.

Coverage ends the date you return home, return to your place of work, or at the end of the seventh personal vacation day immediately following your business travel. Business travel does not include your normal commute between your home and your regular place of work.

Personal travel coverage. If while you are traveling on Company business you also travel for personal reasons, the BTA Insurance Plan will cover you for a total of 7 days immediately prior to, during, or immediately following your Company business travel.

For example, if you decide to extend a business trip for an additional 10 days of personal travel, you will be covered under the BTA Insurance Plan through the end of the seventh personal day.

If your personal travel occurs *immediately before* a covered business trip, your BTA Insurance coverage begins at the start of your trip, lasts for up to 7 days prior to the start of your Company business travel, ceases for any personal days in excess of seven, and then continues during the period you are traveling on Company business.

If you take side trips that are incidental to business *during* your Company business travel, you will be covered under the BTA Insurance Plan only for the first 7 days of your personal travel. If you have more than seven personal days during your Company business travel, any personal days in excess of the first 7 days are not covered under the BTA Insurance Plan.

Please note that the BTA Insurance Plan does not cover your family members who may be traveling with you.

How Coverage Works

To be eligible for BTA benefits, your loss must occur both:

- As the direct result of the accident and
- Within 365 days of the date of the accident.

In the event of your death, benefits are paid to your Beneficiary (see page 107). Otherwise, benefits are payable to you.

If you suffer more than one loss in any one covered accident, the maximum amount payable for all losses combined is 100 percent of your coverage amount under the BTA Insurance Plan. The maximum amount payable for all claims (including death) for all Fidelity employees resulting from any one accident is $25 million. If the total claims exceed this amount, all claims will be reduced proportionately.

Emergency Medical Evacuation Benefit

If you are traveling on Company business at least 100 miles away from your home and suffer a Medical Emergency that requires emergency medical evacuation, the BTA Insurance Plan will cover you for up to $100,000 for expenses incurred for your medical evacuation subject to certification by the treating Physician and other usual and customary limitations.

Medical Emergency means a condition caused by an injury or sickness that manifests itself by symptoms of sufficient severity that a reasonable person would expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

An emergency medical evacuation includes your immediate transportation from the site of the medical emergency to the nearest hospital or medical facility as well as your transportation home to obtain further medical treatment in a hospital or medical facility or to recover. An emergency medical evacuation also includes medically necessary medical treatment, medical services, and supplies received in connection with such transportation.

Repatriation Benefit

In the event of your death while traveling outside of your home country while on Company business, the BTA Insurance Plan will pay up to a maximum benefit of $50,000 to prepare and ensure your return to your home country.

Benefits also are available for some of the expenses incurred by a family member or a Fidelity employee to accompany the body back to your home.

Coma Benefit

Coverage is also available in the event you lapse into a coma within 31 days of a covered accident and remain in a coma for at least 31 days. The benefit amount you may be eligible to receive is equal to 1 percent of the coverage amount for each month that you remain comatose, for up to 11 months. If after 11 months you still remain in a coma, you will receive 100 percent of the coverage amount, paid as a lump-sum benefit.

After the initial 31 days of the coma, the BTA Insurance Plan Claims Administrator may require proof that you remain comatose. This proof may include, but is not limited to, requiring an independent medical examination at the Claims Administrator's expense.

Seatbelt and Air Bag Benefits

If you die or suffer a loss in a car accident while traveling on Company business while protected by an air bag and/or wearing a seatbelt, you may be eligible to receive additional benefits, as follows:

- ***If you were wearing a seatbelt,*** the Plan will pay an additional 10 percent of the coverage amount (up to $50,000).
- ***If you were in a seat with a functioning air bag that was deployed,*** the Plan will pay an additional 10 percent of the coverage amount (up to $25,000).

To receive these additional benefits, verification that you had used the seatbelt correctly at the time of the covered accident and that the air bag properly inflated upon impact is required. If verification is either unavailable or impossible, then a default benefit will be paid in the amount of $2,000.

These additional benefits are not available if you were traveling while in motor vehicles used in mass or public transit.

Special Adaptation Benefit

In the event you incur a disability directly caused by a covered accident, you may be eligible for additional special housing or vehicle adaptation benefits equal to an additional 10 percent of the coverage amount (up to $25,000).

Adjustment Benefit. Coverage (up to $5,000 per occurrence after $250 deductible) is available for the actual charges incurred by an insured's immediate family "Adjustment Expense Benefits," if he or she is receiving Disability Benefits under the policy. These benefits are subject to any deductibles and limits. Benefits are payable directly to Immediate Family members for:

- ***travel,*** limited to travel to and from the location where the Insured is receiving treatment in a Hospital or Rehabilitation Facility.
- ***lodging*** in connection with a trip to visit the Insured in a Hospital or Rehabilitation Facility.
- ***training*** of the Insured's Immediate Family member to perform rehabilitative or custodial functions necessary to the Insured's care.
- ***Usual and Customary charges*** for counseling Immediate Family members to deal with the Insured's loss.
- ***loss of earnings*** by an Immediate Family member necessitated by the Insured's Injury. Benefits will not be paid for more than 12 weeks of lost earnings.

"Rehabilitation Facility" means a legally operating institution or part of an institution that has a transfer agreement with one or more Hospitals and that is:

- Primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation inpatient care.
- Duly licensed by the appropriate government agency to provide such services.
- Required to be accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities.

A Rehabilitation Facility does not include institutions that provide only minimal care, custodial care, care for the terminally ill, part-time care, or services or facilities for drug abuse or alcoholism. "Usual and Customary Charge" means the average amount charged by most providers for treatment, service, or supplies in the geographic area where the treatment, service, or supply is provided.

Felonious Assault Benefit. Coverage is available if a Covered Person dies as the result of an Injury that occurs as a direct result of a Felonious Assault. A person other than another person covered by the Policy, a Covered Person's Immediate Family Member, or household member must inflict the assault.

- 10% of the Covered Person's Principal Sum up to a Maximum Benefit of $25,000

"Felonious Assault" means an act of physical violence against a person covered by this Policy. "Immediate Family Member" means a Covered Person's parent, sister, brother, spouse, Domestic Partner, or children.

Counseling and Rehabilitation Benefits

If you experience a covered loss while traveling on Company business, you are eligible for up to 10 mental health counseling sessions (up to $150 per session) to help you cope with the loss.

Additionally, if you experienced a covered loss and your doctor prescribes your participation in a rehabilitation program, you may be eligible for rehabilitation benefits in the amount of an additional 10 percent of your covered amount (up to $25,000). The Rehabilitation Benefit covers the cost of the facility providing the rehabilitation program as well as travel expenses incurred by immediate family members who travel to and from the location at which you are participating in the rehabilitation program. For benefits to be payable, you must submit actual receipts with the claim.

Rehabilitation program means a specialized, intensive program for rehabilitation or assimilation at an accredited medical facility specializing in research, surgery, and training of persons with accidental dismemberment covered losses.

See **Accidental Death and Dismemberment Benefits** for a list of reimbursements that are covered losses.

Rehabilitation benefits end the earlier of the date you complete the rehabilitation program or the date of your death.

Disability Benefit

If you are considered to be Permanently Totally Disabled solely as a direct result of a covered accident while traveling on Company business, you may be eligible for a Disability Benefit in the amount of 100 percent of your coverage amount. To be eligible for the Disability Benefit, you must first satisfy a 52-week waiting period and provide satisfactory proof of your permanent total disability to the Claims Administrator.

Permanently Totally Disabled means that you are Totally Disabled and are expected to remain so for the rest of your life, as certified by a doctor.

Total Disability means that as a direct result of an injury caused by a covered accident:

- If employed, you cannot do any work for which you are, or may become qualified by reason of education, experience, or training
- If not employed, you cannot perform the normal and customary activities of a healthy person of like age and sex.

The BTA Disability Benefit is in addition to any other benefits you may be eligible to receive under the BTA Insurance Plan.

Age Reduction Schedule. The Disability Benefit coverage amount is reduced as you get older. On the date of the covered accident, if you are:

- ***Age 70–74,*** your disability benefit is reduced to 50 percent of the coverage amount that would otherwise be payable.
- ***Age 75 or older,*** your disability benefit is reduced to 25 percent of the coverage amount that would otherwise be payable.

What the BTA Insurance Plan Does Not Cover

The BTA Insurance Plan does not cover certain losses or injuries. These include, but are not limited to, losses and injuries that occur or are caused:

- By ***bacterial infection or viral infection***, a bacterial infection is caused by an accidental cut, wound, or accidental ingestion of contaminated food.
- While ***commuting*** to and from work.
- By ***disease, sickness, bodily or mental infirmity*** of any kind.
- While engaged in ***illegal activity,*** including the commission of or attempt to commit a felony or assault.
- By ***intentionally self-inflicted injuries***, including suicide or attempted suicide.
- By ***medical or surgical infection*** for the treatment of a bacterial or viral infection.
- While ***piloting or serving as a crewmember*** of any aircraft.
- While ***riding in any aircraft except as a fare-paying passenger*** on a regularly scheduled or charter airline or aircraft that is owned or leased by Fidelity Investments.
- By ***service in the armed forces*** of any country.
- While ***traveling in any aircraft*** being used for aerial navigation, aerial photography, or other purposes of exploration or inspection.
- While ***traveling on vacation***, except for the 7 days of covered personal vacation taken immediately before, during, or immediately after your business travel.
- By ***war or act of war*** within the United States or your home country, whether declared or undeclared.

Variable Life Insurance Plan

Variable Life Insurance is a way for eligible Regular Employees to purchase additional life insurance coverage and invest additional premiums in mutual fund options that offer certain tax advantages.

When you become eligible and enroll in Variable Life Insurance, you must name a Beneficiary(ies) for all your life insurance coverage (Employee Life, BTA, and Variable Life). Your Beneficiary is the person to whom benefits are payable in the event of your death. For more information, refer to page 107.

The deadline for enrolling in the Variable Life Insurance Plan is 60 days after your date of hire. It's important to note that this deadline is different than the enrollment deadline for most of your other Fidelity benefits.

Under the Variable Life Insurance Plan, Fidelity reimburses Regular Employees who are regularly scheduled to work 30 or more hours per week for the cost of Variable Basic life insurance coverage and makes additional life insurance coverage available at group rates. Eligible Regular Employees also may take advantage of Variable Investment Options, in which you may make contributions (invest additional premiums) through After-Tax payroll deductions.

The Variable Life Insurance Plan has three components:

- ***Variable Basic*** coverage is equal to 4 times your annualized Base Salary, or Benefits Base, up to a maximum of $250,000. All coverage amounts are rounded up to the next $1,000, if not already a multiple thereof. Fidelity reimburses you for the cost of Variable Basic coverage through additions to your paychecks. These payments are equal to, or offset, your actual cost. However, the payments are considered taxable income, meaning you pay the taxes on the reimbursement amount.
- ***Variable Supplemental*** coverage allows you to purchase additional coverage in increments of your annualized Base Salary, or Benefits Base (from 1 to 15 times). The maximum coverage amount for Variable Basic and Variable Supplemental combined is the lesser of 19 times your annualized Base Salary, or Benefits Base, or $3 million.
- ***Variable Investment Options*** allow you to invest in the available Fidelity VIP Funds, up to IRC limits. Because the Variable Investment Options are part of a life insurance contract, you enjoy certain tax advantages (see page 107). Plus, many benefits paid to your Beneficiary are income-tax free.

While Variable Life Insurance coverage is issued through a group contract, each employee is issued his or her own individual certificate of coverage.

The coverage is portable, meaning if you terminate your employment with Fidelity or are no longer eligible to participate in the Variable Life Insurance Plan because of a reduction in regularly scheduled hours to fewer than 30 per week, you may continue your Variable Life Insurance Coverage and Variable Investment Options. Unless you call to cancel your coverage, Minnesota Life will automatically continue your coverage and will bill you directly for the premiums.

Enrolling in Variable Life Insurance

If you are a Regular Employee who is regularly scheduled to work 30 or more hours per week, you will receive a personalized enrollment package from Minnesota Life in the mail, shortly after you are hired. This package contains everything you need to enroll, including instructions to help you complete your application using an online enrollment tool. You may elect to enroll in Variable Basic only, in Variable Basic and Variable Supplemental, or decline coverage entirely (see "Declining Variable Life Insurance" on page 105). When you enroll, you also may elect to participate in the Variable Investment Options. For information about naming your Beneficiary, see page 107.

Provided you enroll within 60 days of the date you are first eligible, you are guaranteed coverage, up to a maximum of $1 million for Variable Basic and Variable Supplemental combined, subject to the Variable Life Insurance Plan limits, without providing evidence of insurability (proof of good health).

If you apply for a total coverage amount of more than $1 million, you will be required to provide evidence of insurability (proof of good health). First, you will be asked to answer a brief medical questionnaire. Depending on your answers to the brief questionnaire, you may be asked to complete a more detailed medical questionnaire. Some individuals also may be required to have a paramedical examination, which is paid for by Minnesota Life. If your application is approved, Minnesota Life will mail an individual certificate to your address of record.

If your application for coverage of more than $1 million is declined for medical reasons and you enrolled by the deadline, you will become insured for the largest multiple of your annualized Base Salary, or Benefits Base, equal to or less than $1 million, subject to the Variable Life Insurance Plan limits, unless you are age 65 or older (see the "Age Reduction Schedule" on page 105).

Default Basic Coverage. If you do not return your Variable Life Insurance application form by the enrollment deadline (in other words, if you neither elect nor decline coverage), you automatically will receive Default Basic Life Insurance coverage. Default Basic Life Insurance coverage provides you with the same amount of coverage as the Variable Basic coverage amount. However, your Beneficiary designation will not be on file (unless you contact Minnesota Life directly and obtain, complete, and return a Beneficiary designation form) and you will not be eligible to invest in Fidelity's VIP Funds through the Variable Investment Options until you complete your application.

If you receive Default Basic coverage and later apply for Variable Supplemental coverage, you will be required to provide evidence of insurability (proof of good health).

When Variable Life Insurance Coverage Becomes Effective. If you are a Regular Employee who is regularly scheduled to work 30 or more hours per week, you automatically are provided with coverage equal to the amount of Variable Basic coverage (see page 102) as of the first day you are Actively at Work. Please note, if your regularly scheduled hours are reduced to less than 30 hours per week, you may only continue coverage by submitting payments directly to Minnesota Life. This Initial Basic Life Insurance coverage continues until the earliest of the dates that:

- You become enrolled under Variable Basic coverage.
- You receive Default Basic coverage (as described above).
- You return your application form electing to decline coverage.

When You Have A Question

If you need information about your Variable Life Insurance coverage, you may call Minnesota Life at 888-567-2882 weekdays between 8:00 A.M. and 7:00 P.M. ET or visit Minnesota Life's website (www.lifebenefits.com).

If you are a Regular Employee, regularly scheduled to work 30 or more hours per week, you will be asked to name a Beneficiary for your life insurance coverage, soon after you are hired. It is your responsibility to keep your Beneficiary designation up to date. For more information, see "Naming Your Beneficiary" on page 107.

If you return your application within 60 days of the date you are first eligible, your Initial Basic coverage will become Variable Basic coverage without interruption in coverage. Variable Supplemental coverage, and any participation in the Variable Investment Options, generally becomes effective on the first day of the month after your application has been approved. Variable Supplemental coverage amounts of more than what is guaranteed generally will become effective after the evidence of insurability (proof of good health) has been approved.

If you do not return an application form naming a Beneficiary, any death benefit will be paid to your spouse or Domestic Partner if living. If you do not have a spouse or Domestic Partner at the time of your death and have not named a Beneficiary, the payment will be made to your estate. For information about naming your Beneficiary, see page 107.

Enrolling in the Variable Investment Options

You may enroll in the Variable Investment Options at any time provided that you are enrolled in Variable Basic coverage.

If you have Default Basic coverage, you will not be eligible to invest in the Fidelity VIP Funds through the Variable Investment Options until you complete and submit your Variable Life Insurance application form to Minnesota Life.

Your cost for Variable Supplemental Life Insurance is based on your current age and current coverage amount.

Your Cost for Variable Life Insurance

Fidelity reimburses you for the cost of your Default Basic or Variable Basic coverage. You pay the full cost of Variable Supplemental coverage through After-Tax payroll deductions.

The cost of your Variable Supplemental Life Insurance is based on your current age and coverage amount. This means that your cost for coverage may change throughout the year.

All administrative fees and state premium taxes already are included in the rates. The funds in your Variable Investment Options are subject to a Mortality and Expense (M&E) risk charge of one-quarter of 1 percent (0.0025). The M&E risk charge is deducted automatically from your Variable Investment Options.

Changes to Your Variable Life Insurance

Changes in your Base Salary or Benefits Base are reported to Minnesota Life throughout the year. These changes in your salary will be used to recalculate your Variable Basic and Variable Supplemental coverage. All increases in coverage resulting from a salary increase are guaranteed, up to the Variable Life Insurance Plan maximum. If you experience a reduction of coverage equal to one times or more of your annualized Base Salary, or Benefits Base due to a salary decrease, you may be given an opportunity to buy back the coverage up to the Variable Life Insurance Plan maximums without having to provide evidence of insurability. Your premium rate also will change based on your age and your new coverage amount.

REQUESTING CHANGES TO YOUR VARIABLE SUPPLEMENTAL COVERAGE

Following certain life events—including marriage, divorce, or the birth or adoption of a child—you may want to ask yourself whether your life insurance needs have changed. You can make changes to your Variable Supplemental coverage at any time. An increase of 1 times your annualized Base Salary, or Benefits Base, is guaranteed, up to a resulting amount of $1 million (for Variable Basic and Variable Supplemental combined), subject to the Variable Life Insurance Plan limits, if you apply within 31 days of the Change in Status and you previously have not been declined coverage under the Variable Life Insurance Plan for medical reasons.

For any other request to increase your Variable Supplemental coverage, whether during the year or during the Annual Benefits Enrollment period, you will be required to provide evidence of insurability (proof of good health). Coverage increases are subject to approval by Minnesota Life. Once the change is approved, you will receive confirmation from Minnesota Life.

Age Reduction Schedule

Your Initial Basic, Default Basic, or Variable Basic coverage amount is reduced as you grow older according to the following schedule:

WHEN YOU REACH AGE	COVERAGE AMOUNT
65	65% of your total, original coverage
70	50% of your total, original coverage
75	25% of your total, original coverage

If you experience this reduction of coverage, you may maintain your current coverage level by buying back any lost Initial Basic, Default Basic, or Variable Basic coverage and paying for it through Variable Supplemental—or After-Tax—deductions. This allows you to maintain your Initial Basic, Default Basic, or Variable Basic coverage level without having to provide evidence of insurability.

If You Have a Question about Your Variable Investment Options Account

If you have a question, contact Minnesota Life at 888-567-2882 weekdays between 8:00 A.M. and 7:00 P.M. ET, or visit Minnesota Life's website (www.lifebenefits.com) and use the *Managing Your Account* tool.

Declining Variable Life Insurance Coverage

When you are first hired, you may decline Variable Life Insurance coverage. In this case, you will receive a one-time payment from Fidelity equal to what would have been the cost of one year's Variable Basic coverage. Reimbursement is made in December of the year in which you decline coverage. Because this reimbursement is considered taxable income, regular payroll taxes are withheld.

To decline coverage, you must indicate that you do not want any coverage by contacting Minnesota Life within 60 days of the date you are first eligible. If you do not call Minnesota Life at 888-567-2882 by the deadline, you automatically will be enrolled in Default Basic coverage and you will have no Beneficiary designation on file (unless you contact Minnesota Life directly and obtain, complete, and return a Beneficiary designation form).

If, at a later date, you wish to enroll in Variable Life Insurance, you may do so, but you will be required to provide evidence of insurability (proof of good health).

How the Variable Investment Options Work

Your Investment Amount. If you are enrolled in Variable Basic coverage and you elect to participate in the Variable Investment Options, you may invest any amount you wish, up to certain limits imposed under the Internal Revenue Code (IRC). The limits are based on your age and the amount of your Variable Life Insurance (Basic and Supplemental combined).

The amount you choose to contribute to the Variable Investment Options is deducted from your paycheck on an After-Tax basis. You may change the amount of your payroll deduction by calling Minnesota Life at 888-567-2882 or via Minnesota Life's website, www.lifebenefits.com. Any request to change the amount of your payroll deduction must be received on or before the 20th of the month (or the last business day before the 20th if the 20th falls on a weekend day or a New York Stock Exchange holiday) for the change to become effective during the first payroll period of the following month.

In addition, you may make lump-sum contributions to your Variable Investment Options at any time, subject to IRC limitations. To do so, send a check for the amount you wish to invest, together with investment instructions including your name, Social Security number, and insurance certificate number to:

Minnesota Life Insurance Company
Group Insurance Division
Attn: B2-4256
400 Robert Street North
St. Paul, MN 55101–2098

You can change the amount of your future Variable Investment Options deductions by going to Minnesota Life's website (www.lifebenefits.com) and using the *Managing Your Account* tool. To use this feature, you will need a personal identification number (PIN), which is provided in your personalized enrollment instructions.

Electronic Statements and Prospectuses

You can elect to receive electronic statements and Prospectuses from Minnesota Life. To request electronic statements and Prospectuses, contact Minnesota Life at www.lifebenefits.com or call 888-567-2882.

Your Variable Investment Options. Your enrollment materials include Prospectuses for the available Fidelity Variable Insurance Products (VIP) Funds and for the Variable Life Insurance product (Variable Group Universal Life). The Prospectuses provide important information about each VIP Fund portfolio, including its investments, its past performance, and the risks associated with investing in that fund.

When you first enroll in the Variable Investment Options, you choose how to invest your contributions among the available Fidelity VIP Funds. These investments are made with After-Tax payroll deductions. You may invest each contribution in any combination of the funds, with a minimum of 10 percent in any fund. Because your Variable Investment Option account builds up cash value (see page 105) you will need to elect a Variable Investment Option at the time you enroll, even if you do not participate in the Variable Investment Options.

You may update how your future deductions are invested at any time by calling Minnesota Life at 888-567-2882 or by visiting its website, www.lifebenefits.com.

Information about the Fidelity VIP Funds, including fund Prospectuses, is available by logging on to Minnesota Life's website or by calling Minnesota Life. The Prospectuses provide valuable information about each portfolio and any applicable fees.

As with any investment, it is important to understand that the value of your Variable Investment Options may fluctuate and may ultimately be more or less than the amount you originally invested. You are encouraged to read all investment information carefully, including the Prospectuses, and to consult with your tax or financial adviser before making any investment decisions.

Your Account Statements. After the close of each quarter, you will receive a statement from Minnesota Life showing the value of your Variable Investment Options on that date and the investments you have selected. If you have questions about your Variable Investment Options account, you should call Minnesota Life or visit its website.

With the Variable Investment Options, you may access your money for any reason through convenient loans and withdrawals, subject to certain conditions.

For information about all available Fidelity VIP funds, visit Minnesota Life's website (www.lifebenefits.com) or call 888-567-2882.

Accessing the Money in Your Variable Investment Options. You may take a loan or make a withdrawal from your Variable Investment Options for any reason, subject to the following conditions:

- ***Loans*** may be taken at any time, once you begin to participate in the Variable Investment Options. You may borrow up to 90 percent of the value in your Variable Investment Options. The minimum loan amount is $100. You may have more than one outstanding loan at a time. However, the total of all outstanding loans and interest thereon cannot exceed the sum of 90 percent of the value in your Variable Investment Options plus any accrued policy loan interest.

  You are charged an annual interest rate of 8 percent on any loan you take, but Minnesota Life credits you with 6 percent on the borrowed amount, making the net rate for your loan equal to 2 percent, assuming you pay the interest and do not add it to your loan balance. While your loan is outstanding, the amount you borrowed is removed from your Variable Investment Options and placed in a collateral account. You may repay all or part of your loan at any time by sending a check to:

  Minnesota Life Insurance Company
  Group Insurance Division
  Attn: B2-4256
  400 Robert Street North
  St. Paul, MN 55101–2098

  When you have an outstanding loan, the interest is due at the end of each month. If you do not pay the interest on the loan when due, the interest will be added to your outstanding loan balance, and you will be paying interest on interest.

- ***Withdrawals*** may be made at any time. The minimum amount you may withdraw is $100. The maximum is 100 percent of the value of your Variable Investment Options, less any outstanding loans and accrued interest. You may take a withdrawal at any time, once you begin contributing to your Variable Investment Options. There is no charge for making a withdrawal.

Keep in mind that loans and withdrawals will reduce your insurance certificate's cash value, which decreases your overall death benefit.

Important Information about Taxes. Because your Variable Investment Options are part of a life insurance contract, your investments accrue earnings on a Tax-Deferred basis. In addition, some or all of your earnings may be withdrawn free from income taxes. This means that you do not pay any income taxes on your investment earnings until you withdraw an amount that exceeds your cost basis. Your cost basis consists of the premium you pay for Variable Life Insurance (Basic and Supplemental) and the money you invest. Your enrollment materials will show your estimated tax-exempt investment opportunity, which is based on your income, the amount you contribute to your Variable Investment Options, and the amount of coverage you have elected.

Accelerated Death Benefit

If you are terminally ill (meaning you have been diagnosed by a licensed Physician as having 12 or fewer months to live), you may elect to take all or part of your death benefit in a lump sum, up to a maximum of $1 million. This may result in no benefit being available for your Beneficiary upon your death. For more information, call Minnesota Life at 888-567-2882.

Waiver of Premium

If you become totally disabled, as determined by Minnesota Life, before age 60, you may not have to pay certain premiums and Minnesota Life will pay the cost of certain insurance charges for your coverage until the earliest of the following dates:

- You reach age 95.
- You are no longer considered totally disabled, as determined by Minnesota Life.
- You surrender your certificate.

If you become disabled and wish to apply for waiver of premium, you must file a waiver of premium claim with Minnesota Life. You must file your claim within one year of the date you became disabled. If approved, only the cost of insurance is waived.

Your Variable Investment Options will not be affected by waiver of premium, and you still may make additional contributions to your Variable Investment Options.

What Variable Life Insurance Does Not Cover

Certain losses are not covered by the Variable Life Insurance Plan. You should review the terms of your individual certificate for more information on those exclusions.

Naming Your Beneficiary

If you are a Regular Employee, regardless of scheduled hours for BTA, or a Regular Employee who is regularly scheduled to work 30 or more hours per week, for Employee Life and Variable Life, you will be asked, soon after you are hired, to name a Beneficiary(ies)—the person(s) who will receive benefits under the Employee Life, BTA, and Variable Life Insurance Plans in the event of your death. How you name your Beneficiary(ies) and who you contact is determined by whether you enroll in Variable Life Insurance:

- ***If you enroll in Variable Life Insurance***, complete the *Beneficiary Designation* portion of the application form or designate your Beneficiary on Minnesota Life's website (www.lifebenefits.com). Unless you request otherwise, the Beneficiary you name also will be your Beneficiary for your Employee Life and BTA Insurance.
- ***If you are enrolled in Default Basic Life Insurance***, you must name your Beneficiary by completing a Default Basic Life Insurance application form, which is available by logging on to Minnesota Life's website or by calling 888-567-2882.
- ***If you decline Variable Life Insurance or are not eligible for Variable Life Insurance***, you must complete a Core Employee Life Insurance and a BTA Insurance Beneficiary Designation Form, which are available by calling HR Solutions at 800-835-5099 (TDD 888-343-0860).

You may want to update your Variable Life Insurance Beneficiary designation if you marry or have or adopt a child. You may change your Beneficiary at any time on Minnesota Life's website (www.lifebenefits.com) or by calling 888-567-2882.

HR Solutions has a dedicated "Survivor Services Unit." It provides survivors with a primary contact for benefits-related questions and paperwork assistance. To contact the Survivor Services Unit, please call HR Solutions and ask to be transferred to a Survivor Services Unit representative.

If you wish to name different Beneficiaries for your Core Employee Life, Variable Life, and BTA Insurance, you still must complete the *Beneficiary Designation* portion of the Variable Life Insurance application form. In addition, you must also complete a separate Beneficiary form for *Core Employee Life Insurance* and *BTA Insurance*, which are available by calling HR Solutions at 800-835-5099 (TDD 888-343-0860).

You may name more than one Beneficiary. In this case, you must specify how you want your Beneficiaries to share the benefit. Otherwise, it will be divided equally among them. You also may name *contingent* Beneficiaries, who will receive benefits only if your primary Beneficiary(ies) predeceases you.

If you wish to name a minor (a person younger than age 18) as a Beneficiary, it's important to note that benefits cannot be paid directly to that person. You may wish to make separate provisions for the handling of any such benefit payments.

If an insured dies and his/her designated Beneficiary is not of legal age (18 in most states) there are two options:

1) ***Letters of Guardianship*** – Minnesota Life would be able to issue payment to the court-appointed guardian of the minor Beneficiary's estate/property. In order to do so, Minnesota Life would require Certified Letters of Guardianship showing the individual appointed by the court as the legal guardian of the minor Beneficiary's estate/property. Minnesota Life would then issue payment to that individual on behalf of the minor Beneficiary.
2) ***Hold Proceeds at Interest*** – Minnesota Life to hold the proceeds at interest until the minor reaches legal age based on the state in which the minor lives. Once the Beneficiary reaches legal age, Minnesota Life would then be able to issue the proceeds directly to him or her.

If you do not name a Beneficiary or if your Beneficiary predeceases you, benefits are payable to your spouse or Domestic Partner if living. If you do not have a spouse or Domestic Partner at the time of your death, the payment will be made to your estate.

For the BTA Insurance Plan, if you do not name a Beneficiary or if your Beneficiary predeceases you, benefits are payable in equal shares to the first surviving class of the following: spouse/Domestic Partner; children; parents; brothers and sisters. If there are no survivors in any of these classes, the benefits are payable to your estate. If the insured is a minor, benefits are payable to a parent, guardian, or other person supporting the minor.

You automatically are the Beneficiary of any benefit paid by the Dependent Life Insurance Plan.

How to File a Claim

Employee Life, Dependent Life, and Variable Life Insurance

You or your Beneficiary must call HR Solutions at 800-835-5099 (TDD 888-343-0860) to file a claim. HR Solutions will then send the required forms. To receive a benefit, these forms must be completed and returned to the Claims Administrator. To ensure that you or your Beneficiary receives benefits promptly, it's important to call as soon as possible after the loss occurs.

BTA Insurance

You or your Beneficiary must notify the Claims Administrator (listed in the ***Administrative*** section on page 197) in writing within 90 days of the date of the accident or death (if notice cannot be given within that time, it must be given as soon as reasonably possible). The written notice should clearly identify you and the Policy Number (ADD N01029411). Within 15 days of receiving the written notice, the Claims Administrator will send out the required claims form for filing proof of loss.

When Your Life and Accident Insurance Coverage Ends

Employee Life Insurance

Your Employee Life coverage ends on the earliest of the following dates:

- 31 days after the date on which your employment with Fidelity ends.
- The date the Employee Life Insurance Plan is terminated.
- The date of your death.
- 31 days after the date on which you no longer satisfy the eligibility requirements under the Employee Life Insurance Plan.

Dependent Life Insurance

Your spouse or Domestic Partner, and/or other Eligible Dependents' coverage ends on the earliest of the following dates:

- 31 days after the date on which your employment with Fidelity ends.
- The date the Dependent Life Insurance Plan is terminated.
- 31 days after the date of your death.
- 31 days after the date on which you no longer satisfy the eligibility requirements under the Employee Life Insurance Plan.
- 31 days after the date that your spouse or Domestic Partner no longer satisfies the definition of Eligible Dependent under the Dependent Life Insurance Plan.
- The date that your child or any other person designated as eligible under applicable state law no longer satisfies the definition of Eligible Dependent under the Dependent Life Insurance Plan.

BTA Insurance

Your BTA coverage ends on the earliest of the following dates:

- The date on which your employment with Fidelity ends.
- The date the BTA Insurance Plan is terminated.
- The date of your death.
- The date on which you no longer satisfy the eligibility requirements under the BTA Insurance Plan.

Variable Life Insurance

Your Variable Life coverage ends on the earliest of the following dates:

- The date on which your employment with Fidelity ends.
- The date the Variable Life Insurance Plan is terminated.
- The last day of the month in which you stop sharing in the cost of your coverage, if applicable.
- The date of your death.
- The date on which you no longer satisfy the eligibility requirements under the Variable Life Insurance Plan.

Converting to an Individual Policy

Employee Life and Dependent Life Insurance

If your coverage ends because your employment with Fidelity ends or your regularly scheduled hours are reduced to fewer than 30 per week, you may convert your Employee Life Insurance coverage, and your spouse or Domestic Partner and Eligible Dependents' Dependent Life Insurance coverage, to individual policies. In the event that your spouse, child, or any other person designated as eligible under applicable state law ceases to satisfy the definition of an Eligible Dependent under the Dependent Life Insurance Plan, he or she also may convert to an individual policy.

In all cases, the maximum amount of coverage that may be converted is the coverage in effect at the time of the event which caused the loss of coverage. Once you convert to an individual policy, you will pay the cost of your premium directly to MetLife, the Employee and Dependent Life Insurance carrier.

To convert all or part of your own or your spouse or other Eligible Dependents' coverage to an individual policy, you must complete and submit the conversion application(s) directly to MetLife within 60 days of the date of the event that caused the loss of coverage. For more information about converting coverage and to request conversion application(s), call HR Solutions at 800-835-5099 (TDD 888-343-0860).

BTA Insurance

If your coverage ends because your employment with Fidelity ends, there is no conversion option for BTA insurance.

Continuing Your Variable Life Insurance

You may continue your Variable Life Insurance coverage, including your Variable Investment Options (if you have at least $10 in your Variable Investment Options), when your employment with Fidelity ends or when you no longer satisfy the eligibility requirements under the Variable Life Insurance Plan. There is no charge to continue your coverage. However, the cost for your coverage will be higher than the cost for active Fidelity employees.

Unless you contact Minnesota Life directly within 60 days of the date of termination or loss of eligibility to cancel your coverage, Minnesota Life will bill you directly for the cost of your coverage, and you will pay your premiums directly to Minnesota Life. If you do not pay your premiums and do not provide a written request for termination, the cost of insurance will be deducted from your contract's cash value, if any. You may set up a payment schedule to pay your premium monthly, quarterly, semi-annually, or annually. You may pay Minnesota Life directly via check or bank draft.

Disability Coverage

About Disability Coverage

The loss of income because of a disabling injury or sickness can be financially devastating. That's why Fidelity provides Regular Employees who are regularly scheduled to work 30 or more hours per week with coverage under the Short-Term and Group Long-Term Disability Plans.

The Short-Term Disability (STD) Plan provides eligible Regular Employees with coverage in the event a non-work-related injury, sickness, or pregnancy prevents you from working. Your STD benefit may be reduced by other benefits you may be eligible to receive (see page 115). The Group Long-Term Disability (LTD) Plan, which is comprised of Core coverage and optional Supplemental coverage, provides coverage for work-related and non-work-related sicknesses and injuries after you have been disabled for 180 days. Your LTD benefit may be reduced by other benefits you or your family member(s) may be eligible to receive (see page 118).

Only Regular Employees who are regularly scheduled to work 30 or more hours per week are eligible for Fidelity's STD and LTD Plans.

If you are a Regular Employee regularly scheduled to work 30 or more hours per week, you automatically are covered under the STD Plan and you automatically have Core coverage under the LTD Plan as of the first day you are Actively at Work. If you are not Actively at Work on the date your coverage is scheduled to begin, your coverage becomes effective on the first day you return to active employment. Fidelity pays the full cost of your coverage under the STD Plan and of your Core coverage under the LTD Plan. You also are eligible to purchase Supplemental LTD coverage to provide additional benefits if you become disabled and your claim for LTD benefits is approved. All newly eligible employees automatically are enrolled in the Supplemental LTD coverage and premiums automatically are deducted from your pay on an After-Tax basis. Should you choose not to participate in the Supplemental LTD coverage, you must opt out of the coverage within 31 days of your date of eligibility by calling HR Solutions at 800-835-5099 or by logging on to NetBenefits®.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

If you elect to maintain your Supplemental LTD coverage, it will be effective as of the first day you are Actively at Work. If you are not Actively at Work on the date your coverage is scheduled to begin, your coverage becomes effective on the first day you return to active employment. If you opt out of coverage when you first become eligible and elect Supplemental LTD coverage at a later date, you will be required to provide evidence of insurability. Your coverage will become effective once evidence of insurability has been approved.

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

AN OVERVIEW OF YOUR DISABILITY COVERAGE

- ***STD Coverage.*** All Regular Employees who are regularly scheduled to work 30 or more hours per week automatically are covered under the STD Plan. With STD coverage, you may apply for STD benefits for up to 180 days when you are unable to work because of a non-work-related disability. Your STD benefit amount is based on the length of your disability and your years of service.
- ***Group LTD Coverage.*** Regular Employees who are regularly scheduled to work 30 or more hours per week also are eligible for:
  - ***Core LTD Coverage.*** Eligible Regular Employees automatically receive Core LTD coverage. Core LTD coverage enables you to apply for LTD benefits after you have been disabled for 180 days. You are eligible to receive 60 percent of your Base Salary or Benefits Base up to a maximum benefit amount of $20,000 per month for approved benefit claims. The minimum monthly benefit is $100.
  - ***Supplemental LTD Coverage.*** Eligible Regular Employees may purchase Supplemental LTD coverage that enables you to apply for Supplemental LTD benefits equal to 10 percent of your Base Salary or Benefits Base and 70 percent of your Eligible Bonus (or a total income replacement of 70 percent per month for Core and Supplemental LTD combined). The maximum Supplemental LTD benefit amount for approved benefit claims is $10,000 per month (or $30,000 per month for Core and Supplemental LTD combined). Because you pay for Supplemental LTD coverage on an After-Tax basis, any Supplemental LTD benefits you receive are not considered taxable income.

You will receive more information about Supplemental LTD coverage, including eligibility requirements when you are hired and during the Annual Benefits Enrollment period. All newly eligible and newly hired employees are automatically enrolled in the coverage and must opt out if they do not want the coverage. It's important to note that if you decline Supplemental LTD coverage when you are first eligible and then enroll at a later date, you will be required to provide evidence of insurability (proof of good health).

IMPORTANT TERMS

- ***Concurrent disability*** means that if you are out on an approved disability leave and receiving disability benefits, and another disabling condition occurs that would qualify for benefits, you will be deemed disabled for the length of time that you are unable to work as a result of either disability. If you recover from one disability and remain disabled from the other disability, you will continue to receive benefits.
- ***Disability*** means during the elimination period and for the next 24 months, you will be considered to be disabled if you are unable to perform the material duties of your regular job solely as a result of an accidental injury, sickness, mental illness, substance abuse, or pregnancy; and under the LTD Plan, you are unable to earn 80% or more of your indexed predisability earnings from working in your regular job. After that, for the next 24 months to be considered disabled, you also must be prevented from performing the material duties of your regular occupation; and unable to earn 80% or more of your indexed predisability earnings from working in your regular occupation under the LTD Plan. Thereafter, you will be considered to be disabled only if you are unable to perform one or more of the material duties of any occupation for which you are qualified by education, training, or experience; and unable to earn 60% or more of your indexed predisability earnings under the LTD Plan. To be eligible to receive disability benefits, you must be under a Physician's continuous care.
- ***Eligible Bonus*** means quarterly, semiannual, and annual bonuses (excluding annual nonexempt gifts) averaged over the past two years. If two years of bonus history is not available, Eligible Bonus will be based on the available history. Sales and commission bonuses are not covered in the bonus coverage. For Benefits Base employees, eligible sales and commissions bonuses are factored into your insurance base rate.
- ***Elimination period*** means the period of time that you must be disabled before disability benefits become payable.
- ***Good Cause*** means a medical or psychological reason substantially preventing participation in a rehabilitation plan or modified work arrangement designed to enable the employee to return to work. Satisfactory proof of good cause must be provided to the insurance company. Good cause shall not include child care/family care issues.
- ***Indexed predisability earnings*** means your predisability earnings (defined below) adjusted annually against the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), up to a maximum of 10 percent. The first adjustment takes effect on your disability anniversary date after 12 consecutive monthly benefit payments. After the first adjustment, your predisability earnings will be increased by additional adjustments each year on your disability anniversary date.
- ***Optimum Ability***
  1) For the first 48 months that benefits are payable, the greatest extent of work the employee is able to do in his or her regular occupation;
  2) After 48 months, the greatest extent of work the employee is able to do in any occupation based on education, training, or experience.

  The employee's ability to work is based on the following:
  1) Medical evidence submitted by the employee;
  2) Consultation with the employee's Physician; and
  3) Evaluation of the employee's ability to work by not more than three independent experts if required by the insurance company.
- ***Predisability earnings*** means your Base Salary or Benefits Base (and Eligible Bonus if you are enrolled in the Supplemental LTD Plan) in effect on the last day you were Actively at Work before becoming disabled.
- ***Pre-existing condition*** means any injury, sickness, or pregnancy for which you incurred expenses, consulted with or received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of disability insurance coverage.

How Short-Term Disability Coverage Works

The Short-Term Disability (STD) Plan provides you with coverage for the first 180 days of a non-work-related disability. Generally, if your claim for STD benefits is approved, you are eligible to receive STD benefits after you have been absent from work for eight consecutive calendar days as the result of a non-work-related sickness, injury, or pregnancy. These eight consecutive calendar days are considered the elimination period and are the first eight days of the 180-day STD period. During this initial eight-day period, you may be paid in accordance with Fidelity's sick day policy (see HR Solutions for details).

For more information about how your sick time and STD benefits are paid, visit or call HR Solutions.

Approved STD benefits begin after you have been disabled for eight consecutive calendar days. You may use any of your available sick time to be paid during this eight-day period.

In order to be eligible to receive benefits under the STD Plan, you must be an active Regular Employee and not be on an unpaid leave of absence (except approved family care and military leaves of absence) when your disability begins, and you must be under a Physician's continuous care. Upon your return to work, you must provide a written report from your Physician that verifies your fitness for duty. If you are unable to return to work when originally scheduled, you must provide additional medical documentation and notify your supervisor or manager of your continued absence due to your disability.

Periodically, CIGNA Group Insurance, the STD Plan's Claims Administrator, may request that a Physician of its choice conduct an independent medical examination at no cost to you. Failure to cooperate with such a request may result in the loss of STD benefits.

Recurrent Disabilities. If you return to work and then become disabled again for the *same reason* within 30 days of your return to work, you will be treated as having a recurrent disability and you will not have to satisfy another elimination period before you may resume receiving STD benefits. If you experience a recurrent disability, this subsequent disability period will be combined with your initial disability period and will count toward the 180-day maximum for STD benefits. In addition, if you experience a recurrent disability, you must notify CIGNA Group Insurance at 800-982-4888 to reopen your STD claim.

Concurrent Disabilities. If you are out on an approved disability leave and are receiving STD benefits, *and another disabling condition occurs that would qualify for benefits*, you will be eligible for STD benefits for the length of time that you are unable to work as a result of either disability. If you recover from one disability and remain disabled from the other disability, you will continue to receive STD benefits up to a maximum of 172 days from the date of the first disability.

Your STD Benefit Amount

The amount of your STD benefit is based on your years of service and the length of your disability, as shown in this chart:

YEARS OF SERVICE*	STD BENEFIT AMOUNT**
Less than one	100% for the first 60 days*** 80% for the next 60 days 60% for the next 60 days
One or more	100% for the first 60 days*** 80% for the next 120 days

*A Year of Service is a 12-month period based on your most recent date of hire.

**Benefits are calculated based on your Base Salary or Benefits Base at the time your disability begins.

***The first eight consecutive calendar days are considered the elimination period and are the first eight days of the 180-day STD period. During this initial eight-day period, you may be paid in accordance with Fidelity's sick day policy (see HR Solutions for details).

Your disability leave may be covered under the Family and Medical Leave Act. For more information, refer to the Family and Medical Leave Act policy on HR Solutions Online or contact an HR Solutions Representative.

Residual STD Benefits

Residual STD benefits are designed to provide a monthly benefit if you are disabled but able to perform a part of your job. *Residual disability* means that you are prevented by disability from doing all essential duties of your own occupation on a full-time basis, except that:

- You are performing at least one of the essential duties of your own occupation on a part-time basis
- You are under the continuous care of a Physician, and
- You are currently earning more than 20 percent, but no more than 80 percent, of your indexed predisability earnings as a result of the same injury or sickness that caused the disability.

You may be eligible for residual STD benefits during the eight-day elimination period. Your residual STD benefit plus your current monthly earnings will equal 100 percent of your predisability earnings, regardless of your years of service, as long as you are:

- Working the full agreed-upon schedule for your new work assignment, and
- Approved for residual disability benefits by CIGNA Group Insurance.

For the 172-day period following the end of the elimination period, your benefits will be calculated as follows:

Your monthly predisability earnings ***minus*** your current monthly earnings ***equals*** your monthly residual STD benefit.

EXAMPLE: CALCULATING RESIDUAL STD BENEFITS

Jane is an eligible Regular Employee whose predisability earnings are $3,000 per month. Before becoming disabled, she had been an eligible Regular Employee for one and a half years. She has been on an approved disability leave and receiving STD benefits for 70 days.

After 70 days, Jane is able to perform one of the functions of her job, earning $1,000 per month. Since her monthly predisability earnings were $3,000, once she is approved for the residual STD benefit, she will be eligible to receive a $2,000 per month residual STD benefit.

Jane's monthly predisability earnings	$3,000
minus	–
Jane's current monthly earnings	$1,000
equals	
Jane's monthly residual STD benefit, once approved	$2,000

Applying for STD Benefits

To file a claim for STD benefits, call CIGNA Group Insurance at 800-982-4888.

To apply for STD benefits, call CIGNA Group Insurance at 800-982-4888. To avoid a delay in receiving STD benefits, it's important that you notify CIGNA Group Insurance of your disability as soon as you know you will be out of work. If your Physician does not provide CIGNA Group Insurance with applicable supporting medical documentation, STD benefits are not payable.

If your claim is approved, all STD benefit payments are made directly to you based on Fidelity's regular payroll schedule. STD payments are not made until your STD claim has been approved. Tax withholdings and the following deductions will be taken from your STD payments, as applicable:

- Medical, Dental, Variable Life Insurance, and Group Long-Term Care Insurance coverage.
- Health Care Flexible Spending Account and Health Care HSA-Compatible Flexible Spending Account contributions.
- Profit Sharing Plan loan repayments.
- 401(k) and Catch-up contributions.

All other deductions will cease.

Other Income or Benefits

Your STD benefit may be reduced by other income or benefits you may be eligible to receive from other sources, including, but not limited to:

- Disability payments (periodic or in a lump sum) from a no-fault automobile insurance plan.
- State Disability Insurance benefits.

It's important to note that your STD benefits may be reduced by other income or benefits that you receive or for which you may be eligible, *regardless of whether you apply for those benefits*. That's why it's important to apply for any benefits that you may be eligible for as soon as possible.

If a benefit from any other source of income is paid retroactively, the amount of the retroactive payment may reduce the STD benefits you already have received or may be eligible to receive. In other words, your STD benefits may be reduced by these amounts.

What the STD Plan Does Not Cover

The STD Plan does not cover any disabilities caused by or contributed to by:

- Participation in the ***commission of an assault or felony or the attempt to commit an assault or a felony***.
- ***War or any act of war***, declared or undeclared.
- Any ***work-related injury***.
- An ***intentionally self-inflicted injury***.

When STD Benefits End

STD benefit payments end on the earliest of the dates that you:

- Cease to be disabled, as determined by CIGNA Group Insurance, pursuant to the terms of the STD Plan.
- Reach the maximum duration of STD leave (180 days).
- Fail to provide proof of your continued disability, as requested by CIGNA Group Insurance.
- Refuse to allow a medical examination, as requested by CIGNA Group Insurance.
- Fail to be under the continuous care of a Physician.
- Do not follow your Physician's recommended treatment plan.
- Die.

When STD Coverage Ends

Your coverage under the STD Plan ends on the earliest of the following:

- The last day of your employment with Fidelity.
- The date the STD Plan is terminated.
- The date of your death.
- The date you no longer satisfy the eligibility requirements under the STD Plan.

Supplemental LTD Coverage

Regular Employees who are regularly scheduled to work 30 or more hours per week will be automatically enrolled in Supplemental LTD coverage. You may choose to opt out of this coverage within 31 days of your date of eligibility by logging on to NetBenefits® or calling HR Solutions. If you remain enrolled and pay premiums for this coverage, your monthly LTD benefit will increase from 60 percent to 70 percent of your Base Salary or Benefits Base and 70 percent of Eligible Bonus up to a maximum of $30,000 per month for Core and Supplemental LTD coverage combined. Because you pay for Supplemental LTD coverage on an After-Tax basis, any Supplemental LTD benefits you receive are not considered taxable income.

How Long-Term Disability Coverage Works

Fidelity's Group Long-Term Disability (LTD) Plan, which is comprised of Core coverage and optional Supplemental coverage, provides disability coverage after you have been disabled for 180 days. The 180-day period is considered the elimination period for LTD purposes. As with the STD Plan, you must be under a Physician's continuous care while you are disabled to be eligible for LTD benefits.

During the elimination period and for the next 24 months, you will be considered to be disabled if you are unable to perform the material duties of your regular job solely as a result of an accidental injury or sickness, and you are unable to earn 80% or more of your indexed predisability earnings from working in your regular job. After that, for the next 24 months to be considered disabled, you also must be prevented from performing the material duties of your regular occupation and unable to earn 80% or more of your indexed predisability earnings from working in your regular occupation. Thereafter, you will be considered to be disabled only if you are unable to perform one or more of the material duties of any occupation for which you are qualified by education, training, or experience and unable to earn 60% or more of your indexed predisability earnings.

You may be asked to provide proof of your continued disability. CIGNA Group Insurance (benefits are underwritten by Life Insurance of North America, a CIGNA Company), the LTD Plan's insurance carrier and Claims Administrator, reserves the right to periodically request that a Physician of its choice conduct an independent medical examination at no cost to you. Failure to cooperate with such a request may result in a loss of LTD benefits.

Recurrent Disabilities. If you return to work and then become disabled again for the *same or a related reason* within six months of your return to work, you will be treated as having a recurrent disability and you will not have to satisfy another (180-day) elimination period before you may resume receiving LTD benefits. You must notify CIGNA Group Insurance at 800-982-4888 to reopen your LTD claim. If you experience a recurrent disability, you will be treated as having a single period of disability. If your disability is due to *an unrelated sickness or injury,* or if you experience a recurrence of your disability after you have been back to work for six months or longer, you must first apply for STD benefits. In this case, you will be eligible to apply for LTD benefits once you satisfy the 180-day elimination period and the new disability will be subject to a new maximum duration of benefits. (Please refer to page 119 to determine your maximum duration of benefits.)

Concurrent Disabilities. If you are out on an approved LTD leave and are receiving disability benefits, and *another disabling condition occurs that would qualify for benefits,* you will be eligible for LTD benefits for the length of time that you are disabled, as defined under the LTD Plan, as a result of either disability. If you recover from one disability and remain disabled from the other disability, you will continue to receive LTD benefits.

A Word about Workers' Compensation

Workers' compensation provides benefits for disabilities that are work related. If you are eligible to receive workers' compensation benefits and those benefits are less than the benefit from the LTD Plan, the LTD Plan will pay you the difference, up to the LTD Plan maximum.

To ensure that you receive any benefit to which you are entitled, you must report any work-related injury or sickness to your supervisor or manager immediately.

Your Core and Supplemental LTD Benefit Amount

Once you have completed the 180-day elimination period, Core coverage under the LTD Plan provides LTD benefits equal to 60 percent of your Base Salary or Benefits Base, less other income (see page 118), up to a maximum benefit of $20,000 per month. The minimum LTD benefit is $100 per month. If you are enrolled in the optional Supplemental LTD coverage and your claim for LTD benefits is approved, you will receive an additional 10 percent of your Base Salary or Benefits Base; in addition to 70 percent of your Eligible Bonus less other income, up to a maximum benefit of $12,000 per month. The maximum monthly benefit amount you can receive for the Core and Supplemental LTD coverage combined is $32,000.

Return to Work Incentive

The LTD benefit has a return to work incentive provision, which allows you to keep receiving your LTD benefit while attempting to return to work in a limited/reduced capacity at Fidelity. During any month you are able to return to work in a partial capacity and receive wages from Fidelity for work performed (disability earnings), your LTD benefits will be calculated as follows.

Your monthly LTD benefit will be calculated as follows during the first 24 months disability benefits are payable and you have disability earnings:

1. Add your before tax monthly coverage benefit (gross disability benefit) and disability earnings.
2. Compare the sum from 1. to your indexed predisability earnings.
3. If the sum from 1. exceeds 100% of your indexed predisability earnings, then subtract your indexed predisability earnings from the sum in 1.
4. Your gross disability benefit will be reduced by the difference from 3., as well as by other income or benefits and the calculation for optimum ability.
5. If the sum from 1. does not exceed 100% of your indexed predisability earnings, your gross disability benefit will be reduced by other income or benefits and the calculation for optimum ability.

After disability benefits are payable for 24 months, the monthly benefit payable is the gross disability benefit reduced by other income or benefits, the calculation for optimum ability, and 50% of disability earnings.

No disability benefits will be paid, and insurance will end if CIGNA Group Insurance determines you are able to work under a modified work arrangement and you refuse to do so without good cause.

EXAMPLE: CALCULATING THE RETURN TO WORK INCENTIVE BENEFIT

Mark is an eligible Regular Employee whose predisability earnings are $2,150 per month. He stops working because of a disability. After Mark satisfies the 180-day elimination period, he receives a monthly gross Core LTD benefit of $1,290 per month ($2,150 x 60 percent). After receiving LTD benefits for three months, Mark returns to work at Fidelity on a reduced-work-schedule basis, earning $1,000 per month, for a period of nine months.

Step 1:	Mark's monthly gross Core LTD benefit	$1,290
	plus	+
	Mark's current monthly disability earnings	$1,000
		$2,290

Because the sum above exceeds Mark's predisability earnings, then:

Step 2:	The total from Step 1	$2,290
	minus	–
	Mark's predisability monthly earnings	$2,150
		$140
Step 3:	Mark's monthly gross Core LTD benefit	$1,290
	minus	–
	The total from Step 2	$140
	equals	
Mark's adjusted LTD benefit		$1,150

In this example, Mark will now be receiving a total of $2,150 in monthly income, between his adjusted LTD benefit, and his Fidelity earnings, which equals 100% of his predisability earnings.

Indexed predisability earnings. After you have been disabled for 12 consecutive months, your predisability earnings will be recalculated to include a cost-of-living increase based on the CPI-W, up to a maximum of 10 percent, provided that you continue to satisfy the definition of disability. The first adjustment takes effect on your disability anniversary date after 12 monthly benefit payments, provided that you are receiving LTD benefits at the time the adjustment is made.

Applying for LTD Benefits

Once you are approved for STD benefits for a non-work-related injury or sickness, you automatically will receive LTD claim forms midway through your STD claim from CIGNA Group Insurance.

If you have filed a workers' compensation claim and your disability will extend beyond 180 days, you must request your LTD claim forms from CIGNA Group Insurance by calling 800-982-4888. To be eligible, you must be a Regular Employee who is regularly scheduled to work 30 or more hours per week and you must call CIGNA Group Insurance no later than 90 days after you begin receiving workers' compensation benefits.

Other Income or Benefits

Your LTD benefit is reduced by any other income or benefits you or your family member(s) are eligible to receive from other sources as a result of your disability, including, but not limited to:

- Any amounts received (or assumed to be received) by you or your dependents under:
  - the Canada and Quebec Pension Plans;
  - the Railroad Retirement Act;
  - any local, state, provincial, or federal government disability or retirement plan or law payable for injury or sickness provided as a result of employment with Fidelity;
  - any sick leave or salary continuation plan of Fidelity;
  - any work loss provision in mandatory "No-Fault" auto insurance.
- Any Social Security disability or retirement benefits you receive (or are assumed to receive) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive) because of his or her entitlement to such benefits.
- Any Retirement Plan benefits funded by Fidelity. "Retirement Plan" means any pension plan funded by Fidelity. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, Individual Retirement Account, or 401(k) plan.
- Any proceeds payable under any franchise or group insurance or similar plan, but excluding the Individual Disability Income Plan (IDIP) offered to employees through Fidelity. If other insurance applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, CIGNA Group Insurance will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
- Any amounts received (or assumed to be received) by you or your dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for injury or sickness arising out of work with Fidelity, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
- Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
- Any disability benefit payments you may be eligible to receive under the Fidelity Business Travel Accident Plan.

It's important to note that your LTD benefits will be reduced by any other benefits for which you or your family member(s) (as defined by the Social Security Administration) are eligible, *regardless of whether you or your family member(s) apply for those benefits*. That's why it's important to apply for any benefits that you or your family member(s) are eligible for as soon as possible.

If a benefit from any other source of income is paid retroactively, the amount of the retroactive payment will reduce the LTD benefits you already have received or are eligible to receive. In other words, your LTD benefits will be reduced by these amounts.

Once you begin to receive LTD benefits, your LTD benefit amount will not be reduced by any increase in Social Security benefits or other cost-of-living adjustments.

A WORD ABOUT SOCIAL SECURITY AND STATE DISABILITY BENEFITS

In addition to the STD and LTD benefits outlined in this SPD, you also may be eligible for other types of disability benefits, as described below.

Social Security Disability Income (SSDI) Benefits. When you apply for LTD benefits, the Claims Administrator will assist you with filing for SSDI benefits.

State Disability Benefits. If you work in New York, Rhode Island, California, New Jersey, Hawaii, or Puerto Rico you also may be eligible for state disability benefits. You are responsible for applying for these benefits in accordance with the rules governing the state in which you work. For more information, contact your state disability office.

Pre-Existing Conditions

If you have a pre-existing condition, you generally are not eligible to receive benefits for any disability related to that condition until you have been covered under the LTD Plan for 12 months, unless you have been treatment free for a continuous period of 3 months while covered. A pre-existing condition is any injury or sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

Maximum Benefit Duration

The longest period of time that you will be eligible to receive LTD benefits for any one period of disability is based on your age when your disability begins, provided that you continue to satisfy the eligibility requirements of the LTD Policy.

AGE WHEN DISABILITY BEGINS	DURATION OF LTD BENEFITS
Younger than 63	To normal retirement age* or 42 months, if greater
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and older	12 months

*Normal retirement age means the Social Security Normal Retirement Age in effect on the policy effective date.

Disabilities Due to Mental Illness and Substance Abuse. You are eligible to receive LTD benefits for a lifetime maximum of 24 months for all disabilities due to mental or nervous conditions (including but not limited to: anxiety disorders, delusional (paranoid) disorders, depressive disorders, eating disorders, mental illness), alcoholism, drug addiction or abuse, chemical dependency, somatoform disorders, or psychosomatic illness. If you are confined in a hospital, your LTD benefits may be extended beyond this 24-month period for the length of your hospital stay, provided your hospital stay lasted more than 14 consecutive days and started before reaching your lifetime maximum benefit.

Survivor Benefit

The LTD Plan provides an additional benefit to your survivor if you die while receiving LTD benefits. Benefits will be paid to your spouse, or Domestic Partner if there is no spouse. If you do not have a spouse or Domestic Partner, benefits will be paid in equal shares to your surviving children. If you do not have a spouse or Domestic Partner or any children, benefits will be paid to your estate.

Your survivor(s) will receive a one-time payment equal to three times your monthly LTD benefit at the time of your death.

What the LTD Plan Does Not Cover

The LTD Plan does not cover disabilities caused by or contributed to by:

- ***Suicide, attempted suicide, or self-inflicted injury*** while sane or insane.
- ***War or any act of war***, declared or undeclared.
- ***Active participation in a riot.***
- ***Commission of a felony.***
- The ***revocation, restriction, or non-renewal of an Employee's license, permit or certification*** necessary to perform the duties of his or her occupation unless due solely to injury or sickness otherwise covered by the policy.
- Certain ***pre-existing conditions*** (for information on when this limitation applies, see the previous page).
- ***Any period of Disability during which the employee is incarcerated in a penal or corrections institution.***

When LTD Benefits End

LTD disability benefit payments end on the earliest of the dates that you:

- Cease to be disabled, as determined by CIGNA Group Insurance, pursuant to the terms of the LTD Plan.
- Reach the maximum duration of benefits (see the "Maximum Benefit Duration" chart on the previous page).
- Fail to provide proof of your continued disability, as requested by CIGNA Group Insurance.
- Refuse to allow a medical examination, as requested by CIGNA Group Insurance.
- Refuse a rehabilitation program or a reasonable alternative offered by Fidelity.
- Fail to be under the continuous care of a Physician.
- Do not follow your Physician's recommended treatment plan.
- Die.
- Have earnings that exceed certain thresholds while receiving LTD benefits.

When LTD Coverage Ends

Your coverage under the LTD Plan ends on the earliest of the following:

- The date your employment ends.
- The date you no longer satisfy the eligibility requirements of the LTD Plan.
- The date on which you are covered by another plan.
- The date of your death.
- The date the LTD Plan is terminated.

LTD Conversion Option. You may apply to convert your LTD coverage to an individual policy paid for by you, if all of the following apply:

- Your employment ends for a reason other than your retirement or you no longer continue to meet the eligibility requirements of the Plan.
- You are not eligible for similar benefit coverage with another group plan.
- You have been covered for at least 12 consecutive months.
- You are not prevented by disability from performing the duties of your occupation.
- You are not age 70 or older.
- The group policy has not terminated.

If you meet these criteria, you are eligible to apply for coverage under an individual policy. You must submit your conversion application to CIGNA Group Insurance within 31 days of the date your employment with Fidelity ends without providing medical or other evidence of insurability. If you apply for coverage later than 31 days, but within 62 days of the event, you will be required to provide evidence of insurability.

For information about converting your coverage or to request a conversion application, call HR Solutions at 800-835-5099.

Other Important Information about Short-Term Disability and Long-Term Disability Coverage

Taxable Disability Benefits

Under current tax regulations, benefit payments you receive from disability coverage paid for by Fidelity may be subject to federal, FICA, and state income taxes at the time payments are made. Currently, benefits from any disability coverage you pay for, such as Supplemental LTD coverage, are not taxable. Taxes are withheld automatically from all STD benefit payments. You are encouraged to consult a tax adviser for additional information.

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Group Long-Term Care Insurance

About Group Long-Term Care Insurance

To help you preserve and protect your financial resources during a long-term chronic illness or injury, Fidelity offers eligible Regular Employees and their eligible family members Group Long-Term Care Insurance, underwritten by John Hancock Life Insurance Company (John Hancock), Boston, MA 02117.

Group Long-Term Care Insurance provides benefits for certain types of care that Medicare or other medical plans do not fully cover. In addition to conventional nursing home care, the Group Long-Term Care Insurance Plan covers services received in your own home and in other types of care facilities. At the time you enroll, you select the coverage amount that best meets your needs.

You pay the cost for Group Long-Term Care Insurance coverage. The cost of your premiums depends on your age when your application is received, your state of residence, and on the coverage options you elect.

Group Long-Term Care Insurance is issued through a group contract. But, if you and your spouse or Domestic Partner enroll in Group Long-Term Care coverage, each one of you will receive your own insurance certificate. The coverage is portable, which means that if your employment with Fidelity terminates, or you no longer are eligible for coverage under the Group Long-Term Care Insurance Plan because of a reduction in regularly scheduled hours to fewer than 20 per week, you may continue your Group Long-Term Care Insurance policy by paying your premiums directly to John Hancock, the insurance carrier and Claims Administrator.

For purposes of the Group Long-Term Care Insurance Plan, Domestic Partner means a same-sex or opposite-sex person in a marriage-like relationship with an eligible Regular Employee. The Domestic Partner must have reached the age of majority, not be a relative of the eligible Regular Employee, and not be married to any other person. The eligible Regular Employee and the Domestic Partner must have been living together for at least one year, with the intent to be life partners, and generally must be economically interdependent.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

Eligibility

You are eligible to apply for coverage under the Group Long-Term Care Insurance Plan if you are a Regular Employee who is regularly scheduled to work 20 or more hours per week. You also must be Actively at Work in order to be eligible to apply for coverage. *Actively at Work* means you are an active employee and not on a leave of absence performing your regular duties of your job. If you are not Actively at Work on the date you otherwise would first become eligible, you may be eligible to apply for coverage on the first day you return to active employment.

In addition, your eligible family members also may apply for coverage, even if you do not apply. *Eligible family members* under the Group Long-Term Care Insurance Plan include your:

- Legal spouse/Domestic Partner and surviving legal spouse (age 18 or older at the time coverage is issued).
- Parents, parents-in-law, step-parents, step-parents-in-law.
- Grandparents, grandparents-in-law, step-grandparents, and step-grandparents-in-law.

You and your eligible family members must reside within the United States (50 states and District of Columbia) on the date your application is received and on the date your coverage under the Group Long-Term Care Insurance Plan becomes effective.

Your Long-Term Care Benefit Amount

Daily Maximum Benefit

To give you flexibility in selecting the coverage that's right for you, when you apply for Group Long-Term Care Insurance you will choose from four Daily Maximum Benefit (DMB) options. For information on DMB options, visit the Group Long-Term Care website for Fidelity employees at fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit), or call John Hancock at 888-333-5731. The *DMB* is the maximum amount of benefits available on a daily basis, for all Covered Services. Each DMB option also has a corresponding Lifetime Maximum Benefit (LMB). The *LMB* is the maximum amount of benefits you can receive for Covered Services while you have Group Long-Term Care Insurance coverage. In other words, the LMB is a pool of money against which your Group Long-Term Care benefits are drawn.

Reduced Paid-Up Benefit

At the time you enroll, you also may elect a Reduced Paid-Up Benefit (nonforfeiture benefit) feature for an additional cost. The *Reduced Paid-Up Benefit* feature allows you to stop making premium payments after three or more years of premium payments and retain a reduced level of benefit. If you exercise the Reduced Paid-Up Benefit feature and go into Reduced Paid-Up status, you will keep the full DMB amount you elected but your LMB amount will be reduced. Your reduced LMB will equal the greater of 30 times your DMB, or the sum of premiums paid in.

Inflation Options

The Group Long-Term Care Insurance Plan also offers a choice between two inflation protection options that allow your Group Long-Term Care coverage to remain meaningful over time: the Automatic Benefit Increase (ABI) and the Future Purchase Option Provision.

- ***Automatic Benefit Increase (ABI) Option.*** At the time you enroll, you may elect the ABI option for an additional cost. If you select the ABI option, each year on the policy anniversary, your DMB automatically will increase at an annual rate of 5 percent compounded, with no annual increase in premium. Inflation adjustments will end if you elect to go into Reduced Paid-Up status. If you do not elect the ABI option, the Future Purchase Option Provision (described below) automatically will be included in your coverage.
- ***Future Purchase Option Provision.*** If you do not elect the ABI option, in most cases, you will be offered the opportunity to purchase additional amounts of coverage every three years to keep up with inflation. The additional amount of coverage will reflect a benefit increase of at least 5 percent, compounded annually, for the applicable period.

You may accept or decline any inflation adjustment coverage when it is offered. Once you decline an inflation adjustment, you cannot change your mind about that offering. However, you will be eligible to accept future increases. You and your eligible family members may each make a separate decision about accepting an inflation adjustment.

Please note, however, that an inflation adjustment is not available for the following reasons: if your attained age on the increase effective date is 85 or older; if you have been certified for benefits in the six months prior to the increase effective date; or if your Group Long-Term Care Insurance coverage is in Reduced Paid-Up status. (If you are a resident of Connecticut, Delaware, or Kansas, this provision varies slightly. Contact John Hancock at 888-333-5731 for more information.)

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

In addition to conventional nursing home coverage, Group Long-Term Care covers services received in your own home and in other types of care facilities.

When You Have a Question

If you need more information about Group Long-Term Care Insurance, you may call John Hancock at 888-333-5731 (TDD 800-255-1808). Representatives are available Monday through Friday (8:30 A.M. to 6:30 P.M. ET). Or visit the Group Long-Term Care website at fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit).

Enrolling for Coverage

Shortly after you are hired, you will receive an informational package from John Hancock. At that time, you may enroll in Group Long-Term Care Insurance coverage online at the Group Long-Term Care website for Fidelity employees at fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit). To enroll, you will need to use your Corporate ID to access your personal information and complete an application. Enrollment kits for yourself or your eligible family members also are available upon request. Each eligible family member who wants to enroll will need to complete an application, which you can obtain on the website or by calling John Hancock at 888-333-5731 and requesting an enrollment kit.

Provided that you enroll within 60 days of your date of hire, you do not need to provide evidence of insurability (proof of good health) when you apply for Group Long-Term Care Insurance coverage. Your application will be accepted regardless of your current state of health.

If your eligible spouse or Domestic Partner applies within the same 60-day period, he or she will have simplified underwriting and only will need to answer five health questions during the enrollment process.* All other applicants must provide evidence of insurability (proof of good health) when applying at any time.

Evidence of Insurability. Before completing the standard application, including the Statement of Health, your eligible family members (or you, if you're applying later than 60 days after you first became eligible) may want to know if they have a condition that automatically will prevent them from obtaining Group Long-Term Care Insurance coverage. For this reason, a self-screening questionnaire has been included on John Hancock's Group Long-Term Care website for Fidelity employees and in the enrollment forms.* If your eligible family member (or you) *answers "yes" to any of the questions* on the questionnaire, it is unlikely he or she will satisfy the good health requirement. If he or she (or you) *answers "no" to all of the questions*, you should continue to complete the entire application, including the Statement of Health.

No physical examination is required to apply for Group Long-Term Care Insurance coverage. However, John Hancock may request a statement from your Physician. The underwriting evaluation also may include a personal interview. Both the statement from your Physician and the personal interview are completed at no cost to you.

*The simplified application and self-screening questionnaire are not available for use in Kansas or Washington. Any resident of Kansas or Washington (other than a newly hired eligible Regular Employee or newly eligible Regular Employee applying within 60 days) must complete a standard application, including the Statement of Health, when applying at any time.

When Coverage Becomes Effective

- ***If you are an eligible Regular Employee who applies within 60 days of your date of hire,*** your Group Long-Term Care Insurance coverage generally will be effective on the first of the month following the date your application has been accepted by John Hancock.
- ***If you are an eligible Regular Employee who applies within 60 days of the date on which you first become eligible,*** your Group Long-Term Care Insurance coverage generally will be effective on the first of the month following the date your application has been accepted by John Hancock.
- ***If you are an eligible Regular Employee who applies more than 60 days after your date of hire or more than 60 days after you first become eligible,*** your Group Long-Term Care Insurance coverage generally will become effective on the first of the month following the date your application has been approved by John Hancock.
- ***If you are an eligible family member,*** your Group Long-Term Care Insurance coverage will become effective on the first of the month following the date your application is approved.
- ***If you are an eligible Regular Employee who is not Actively at Work*** on the date your Group Long-Term Care Insurance coverage otherwise would become effective, your Group Long-Term Care Insurance coverage will become effective on the first of the month following your return to active employment.

- *If you are an eligible family member and you are disabled,* as defined by John Hancock, on the date your Group Long-Term Care Insurance coverage otherwise would become effective, your coverage will become effective on the first of the month following the date you are no longer disabled, provided you are still eligible.

Calculating Your Cost for Group Long-Term Care Coverage

Your cost for Group Long-Term Care coverage is based on your issue age, the benefit options you elect, and your state of residence.

If both you and your spouse or Domestic Partner are covered under Group Long-Term Care Insurance, you will pay two age-based costs—one for you, based on your issue age when your coverage begins, and one for your spouse or Domestic Partner, based on his or her age when his or her coverage begins.

The cost for Group Long-Term Care coverage depends on your age and your state of residence, as well as the level of benefits you select when you enroll—for example, the greater the Daily Maximum Benefit (DMB) benefit you select, the higher your premiums will be.

John Hancock's Group Long-Term Care Insurance website for Fidelity employees and the enrollment kit both contain rate sheets for the four available DMB choices. Once you have made your DMB coverage choice, find the premium that corresponds with your issue age. Your *issue age* is your attained age on the date your application is received by John Hancock. Your premiums also will be higher if you elect the Reduced Paid-Up or Automatic Benefit Inflation Protection options.

If you are offered and accept the future periodic inflation adjustment (see page 125), the cost for this additional benefit amount will be based on your issue age at the time the increase becomes effective. The cost of your original Group Long-Term Care Insurance coverage amount will not change as a result of this offering.

Premiums will not increase because of age, illness, or the use of long-term care benefits. Premiums will be adjusted only if they are changed for an entire group or class. You and your eligible family members are responsible for the full cost of Group Long-Term Care Insurance coverage. There is no employer contribution toward the premium for Group Long-Term Care Insurance.

If you would like help calculating your cost for Group Long-Term Care Insurance coverage, contact a John Hancock Long-Term Care service consultant at 888-333-5731, Monday through Friday from 8:00 A.M. to 6:30 P.M. ET.

Paying Your Premiums. Your premiums, as well as those of your enrolled spouse or Domestic Partner, will be deducted from your paycheck on an After-Tax basis. All other participants will have the option of paying premiums directly to John Hancock or through automatic withdrawal from a bank account.

Applying for Group Long-Term Care Benefits

It's important that you or a family member call John Hancock as soon as you think long-term care services will be needed. You can contact a John Hancock patient advocate at 888-333-5731 (TDD 800-255-1808).

As soon as you think you will need long-term care benefits, you or your family member should contact John Hancock at 888-333-5731. When you call, you will be assigned a John Hancock patient advocate. Before you can receive Group Long-Term Care benefits, the patient advocate must certify that, due to a covered condition as defined by John Hancock, you are dependent in at least two of six Significant Activities of Daily Living (SADL), or that you are cognitively impaired. (See descriptions on page 128.) In either case, you must first complete the qualification period before you can begin receiving Group Long-Term Care benefits.

JOHN HANCOCK PATIENT ADVOCATES

John Hancock patient advocates are registered nurses who are knowledgeable in the field of long-term care. They will work with you and your family to find the care that's appropriate for you and to help you use your long-term care benefits wisely. Your John Hancock patient advocate will:

- **Determine whether you satisfy the requirements for benefit certification (Significant Activities of Daily Living or cognitive impairment).**
- **Assess your long-term care needs.**
- **Research long-term care resources for you and your family.**

You are never required to follow the patient advocate's recommendation. However, to receive reimbursement, the services you receive must be covered under the Group Long-Term Care Insurance coverage.

Significant Activities of Daily Living (SADL) Dependence

You are considered dependent in a Significant Activity of Daily Living (SADL) if you need substantial assistance from another person to perform the SADL due to loss of functional capacity that is expected to continue for at least 90 days. The six SADLs are:

- Bathing
- Dressing
- Eating
- Toileting
- Maintaining continence
- Transferring from bed to chair

The John Hancock patient advocate will consider your physical and cognitive abilities to perform these activities independently and without supervision or help from another person. For example, if you are unable to bathe or eat without substantial assistance from another person and that assistance is expected to be needed for at least 90 days, you will be considered to be dependent in these two SADLs.

Cognitive Impairment

You are considered to be *cognitively impaired* if you have a deterioration or loss of intellectual capacity due to an organic brain disorder that requires you to need substantial supervision for the protection of yourself or others. Alzheimer's disease is an example of an organic brain disorder.

When You Have a Question

If you need more information about Group Long-Term Care Insurance, you may call John Hancock at 888-333-5731 (TDD 800-255-1808). Representatives are available Monday through Friday (8:30 A.M. to 6:30 P.M. ET). Or visit the Group Long-Term Care website at fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit).

Qualification Period

The *qualification period* is the period of time you must wait before you can begin receiving Group Long-Term Care benefits. The qualification period is 90 days, and it starts on the day you are certified for Group Long-Term Care benefits (e.g., the day the John Hancock patient advocate determines that you are dependent in two or more SADLs or are cognitively impaired). You must remain certified during the entire 90-day qualification period, but you don't have to receive long-term care services or be hospitalized during the 90-day qualification period.

Once you satisfy these requirements, your Group Long-Term Care Insurance coverage will pay benefits for covered charges you incur *after* the 90-day qualification period, provided you remain certified.

Multiple Periods of Long-Term Care

During your lifetime, you may require more than one period of long-term care. For each new period, you must receive certification and fulfill a separate 90-day qualification period. However, if less than 180 days has elapsed between the end of one period of long-term care and the beginning of the next, no new qualification period will be required.

Group Long-Term Care benefits paid during all periods of long-term care will count toward the Lifetime Maximum Benefit you have chosen.

Receiving Benefits under the Group Long-Term Care Plan

Benefits will be paid to you or your legal representative. You may also request benefits to be paid directly to the provider of service.

Additional Plan Features

Return of Premium at Death

A Return of Premium at Death benefit is included in your Group Long-Term Care Insurance coverage. The Return of Premium at Death benefit will pay to your estate a portion of the premiums you paid, less any benefits paid or payable, should you die prior to age 70 while you have Group Long-Term Care Insurance coverage that is not in reduced paid-up status. You are not eligible to receive the Return of Premium at Death benefit if you are age 70 or older or if coverage is in reduced paid-up status at the time of your death.

The portion of the premium (less any benefits paid or payable) that is payable under the Return of Premium at Death benefit is based on your age at the time of death as shown below:

AGE	PERCENTAGE OF PREMIUM
65 and younger	100%
66	80%
67	60%
68	40%
69	20%
70 and older	0%

The Return of Premium at Death benefit is not available to residents of Arkansas or Washington. There is no Return of Premium at Death if coverage is in reduced paid-up status.

Waiver of Premium

Your premium payments will be waived once you are certified for Group Long-Term Care benefits by a John Hancock patient advocate, complete the 90-day qualification period, and incur at least 30 days of covered expenses for services other than informal care. The premium waiver will continue as long as you remain certified.

Bed Reservation Benefit

Your Group Long-Term Care Insurance coverage will continue to pay nursing home or alternate care facility benefits for up to 14 days if you are hospitalized while receiving Group Long-Term Care Insurance benefits.

Alternate Plan of Care

An alternate plan of care can be established by mutual agreement between you and John Hancock if the patient advocate identifies alternatives to the current care plan that are both appropriate and cost-effective. The alternate plan may provide benefits for services or supplies not otherwise included in your Group Long-Term Care Insurance coverage. Any benefits paid under an alternate plan of care will reduce your Lifetime Maximum Benefit.

International Benefits

Group Long-Term Care benefits for qualified claims are payable if you are residing in the following countries:

- Australia
- Canada
- England
- France
- Germany
- Greece
- Hong Kong
- Ireland
- Israel
- Italy
- Lebanon
- Malaysia
- Netherlands
- New Zealand
- Scotland
- Sweden

A flat daily amount equal to 60 percent of the nursing home Daily Maximum Benefit (DMB) will be paid for each day you are qualified for Group Long-Term Care benefits after the qualification period requirement is met. Some limitations and plan modifications will apply. *International benefits are not available to applicants residing in Connecticut.*

HIPAA'S IMPACT ON GROUP LONG-TERM CARE INSURANCE COVERAGE

The *Health Insurance Portability and Accountability Act* (HIPAA) was signed into law in August 1996. An important provision in this law is to treat qualified long-term care insurance premiums up to specified amounts as medical expenses for federal income tax purposes. The benefits you receive are generally not considered taxable income. The policy under which your Group Long-Term Care Insurance coverage is provided is intended to be a qualified long-term care insurance contract under this law. In the future, if changes to your Group Long-Term Care Insurance coverage are required to maintain the qualified status of your Group Long-Term Care Insurance, you will be given the opportunity to have your coverage amended so that you may continue to enjoy the qualified status of your Group Long-Term Care Insurance coverage.

When You Have a Question

If you need more information about Group Long-Term Care Insurance, you may call John Hancock at 888-333-5731 (TDD 800-255-1808). Representatives are available Monday through Friday (8:30 A.M. to 6:30 P.M. ET). Or visit the Group Long-Term Care website at fidelitygroup.jhancock.com (User name: fidelity; password: mybenefit).

What Is Covered under Your Group Long-Term Care Insurance Coverage

Your Group Long-Term Care coverage provides you with the choice and flexibility to receive the long-term care you need, whether in a qualified nursing home, alternate care facility for the cognitively impaired, adult day care center, or in your own home. A brief description of each follows:

- ***Nursing home*** care includes skilled, intermediate, and custodial care, and must be provided in a qualified nursing facility.
- ***Alternate care facility*** is a facility or a distinctly separate part of a facility that is engaged primarily in providing ongoing care and related services to at least five unrelated inpatients and meets all of the standards set forth in the Certificate of Insurance.
- ***Adult day care services*** include a range of medical and support services provided by a qualified adult day care center.
- ***Home health care services*** include:
  - Care provided by a registered nurse, licensed practical nurse, or licensed vocational nurse.
  - Assistance with personal care activities from a qualified home health aide.
  - Physical, respiratory, occupational, or speech therapy provided by a licensed therapist.
  - Nutrition counseling provided by or under the supervision of a qualified home health agency.
  - Services provided by a medical social worker, Physician's assistant, or registered nurse in evaluating the need for and development of a home health care plan.
- ***Informal care services***—provided by a caregiver including a family member or someone who ordinarily lives in your home—include:
  - Assistance with activities of daily living, such as bathing or dressing.
  - Personal supervision for the protection of a cognitively impaired insured person.
  - Maintenance of the home environment, including shopping, menu planning, meal preparation, and light housekeeping.

What Is Not Covered under Your Group Long-Term Care Insurance Coverage

- A service or supply furnished primarily to ***beautify***.
- Home health care or adult day ***care provided by a person who ordinarily resides in the insured's home***.
- ***Care or treatment provided outside the United States*** (50 states and the District of Columbia). (Reduced benefits are available for qualified claimants residing in certain foreign countries. See International Benefits on the previous page.)
- A service or supply for which a ***charge would not have been made in the absence of insurance***.
- Care specifically provided for ***detoxification of or rehabilitation for alcoholism or drug abuse***.
- Conditions caused by committing or attempting to commit a ***felony, engaging in an illegal occupation, or participating in a riot or insurrection***.

- ***Intentionally self-inflicted injuries.***
- Charges to the extent a benefit is payable under ***Medicare***, or would be payable under Medicare but for the Coinsurance and deductible provisions of Medicare.
- ***Mental or emotional disorders*** without demonstrable organic disease. This includes, but is not limited to, neurosis, psychoneurosis, psychopathy, and psychosis. This exclusion does not apply to Alzheimer's disease and other organically caused brain disorders.
- ***A service or supply furnished by or covered as a benefit under a program of any government*** or its subdivisions or agencies, except as otherwise required by law and except:
  - A program established by the federal government for its employees.
  - Medicaid (any state medical assistance program under *Title XIX of the Social Security Act* as amended from time to time).
  - Medicare.
- Conditions caused as result of ***war, whether declared or not, any act of war, or service in the armed forces or auxiliary units of any country.***

Note that these exclusions may not apply in all states and may vary depending on the state in which you live. The Certificate of Insurance you receive once you are approved for Group Long-Term Care Insurance coverage will outline the exact exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance originally was issued will apply.

Long-term care providers must meet the qualifications specified in the Certificate of Insurance that will be issued to you when you become approved for coverage, and services and supplies must be provided in accordance with a plan of care prescribed by a licensed health care practitioner.

Coordination of Benefits

If you or a covered family member receive long-term care services that are covered under another plan in which you are enrolled, such as group medical coverage, your Group Long-Term Care Insurance coverage will be coordinated with the benefits under that other plan. This is called *coordination of benefits*. In this case, benefits under your Group Long-Term Care Insurance coverage may be reduced or eliminated to prevent duplication of benefits payable under another plan. For more information about coordination of benefits under your Group Long-Term Care Insurance, contact John Hancock at 888-333-5731.

When Group Long-Term Care Benefits End

If you or a covered family member receive long-term care services that are Group Long-Term Care, benefit eligibility will end on the earliest of the dates that you:

- Cease to be certified (i.e., dependent in at least two Significant Activities of Daily Living or cognitively impaired).
- Reach the Lifetime Maximum Benefit amount.
- Die.

When Group Long-Term Care Insurance Coverage Ends

Your Group Long-Term Care Insurance coverage ends on the earliest of the following:

- The date you fail to pay a required premium when due.
- The date of your death.
- The date you fail to pay premiums directly to John Hancock following the date you no longer satisfy the eligibility requirements under the Group Long-Term Care Insurance Plan.
- The date you reach the Lifetime Maximum Benefit amount.

Continuing Coverage

If you reduce your hours to less than 20 per week, retire, or leave Fidelity, you may continue your coverage (as well as that of your insured family members) at the same premium rate paid by active Fidelity employees. If you wish to continue your coverage, you will pay your premiums directly to John Hancock. John Hancock automatically will set you up on direct billing about 4–6 weeks after you retire or leave Fidelity.

Fidelity maintains records for active employees only. Terminated employees' and eligible family members' records are maintained by John Hancock.

Employee Assistance Program

About Your Employee Assistance Program Coverage

To help you and your family with a variety of personal and work-related concerns, difficulties, and problems you may experience, Fidelity offers all eligible Regular Employees who are regularly scheduled to work 20 or more hours per week the services under the Employee Assistance Program (EAP).

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

You automatically are covered under the EAP on your date of hire. There is no enrollment process. You may use the EAP services regardless of the medical coverage option you select, if any. The EAP is provided at no cost to you and your Eligible Dependents. This voluntary, professional and confidential counseling, resource, and referral service is designed to help you and your Eligible Dependents with a variety of concerns, such as:

- Adjustments to life transitions
- Adoption Assistance and referrals
- Alcohol and Substance Abuse
- Career Concerns
- Child Care
- Elder Care
- Emotional Difficulties
- Family Conflicts
- Grief and Loss
- Legal Issues
- Mental Health Concerns
- Parenting
- Relationship Issues
- Stress and Anxiety

Fidelity has arranged for these services to be provided by CIGNA Behavioral Health, an EAP provider that specializes in behavioral health care services. CIGNA Behavioral Health clinicians are available to assist you and your Eligible Dependents 24 hours a day, 365 days a year. The EAP offers assistance and resources to help balance work and life demands. The EAP also provides you and each of your Eligible Dependents with up to three in-person counseling sessions per each different presenting problem, with a CIGNA Behavioral Health clinician at no cost to you and your Eligible Dependents throughout each calendar year. If additional counseling services are needed, coverage may be available under your medical coverage (see the ***Medical*** section of this SPD).

How the Employee Assistance Program Works

HOW THE EAP CAN HELP

The EAP is a resource for any personal or work-related concerns you or your Eligible Dependent(s) may have.

- ***Toll-Free at 877-675-3760 (TTY 800-855-2880).*** The EAP's toll-free number is available 24 hours a day, 365 days a year, for times of crisis or when you may want to talk about the concerns and problems you may be facing, or when you are seeking resources to help you balance work/life demands.
- ***Face-to-Face Sessions.*** You and each of your Eligible Dependents are eligible for up to three in-person sessions throughout each calendar year, per each different presenting problem, with a clinician who will assess your situation, make a referral, or provide counseling. To access these services, you or your Eligible Dependent must call the EAP or access the EAP website to get a referral and authorization.
- ***Referrals for Ongoing Assistance.*** Whenever possible, the CIGNA Behavioral Health clinician will attempt to refer you to a clinician who is a member of both the CIGNA Behavioral Health network as well as a provider in the network under your medical coverage. By doing so, you may be able to continue counseling after your EAP benefits are exhausted without interrupting your care. However, there is no guarantee that CIGNA Behavioral Health will be able to refer you to in-network providers or have an extensive list of in-network providers for all of Fidelity's medical plan options.
- ***Confidentiality.*** Any communication you may have with an EAP professional or clinician remains between you and the CIGNA Behavioral Health professional or clinician, within the limits of the law. The EAP program is managed by CIGNA Behavioral Health, an independent organization staffed by clinicians who adhere to the strict confidentiality requirements of their profession.

  No information will be shared with anyone else, unless you give written permission to the CIGNA Behavioral Health clinician to do so. Your use of EAP services is confidential, except in cases of mandatory referrals (see page 136) or when the EAP clinician has reason to believe that an individual poses an imminent risk of serious harm to him/herself or others, or poses a threat to public safety. Fidelity supports the EAP policy of complete confidentiality.
- ***Qualified Clinicians.*** All EAP clinicians are professionally trained health providers, including clinically licensed or certified social workers, Ph.D. Psychologists, or related Master's degree-level professionals.
- ***Resources and referrals for work/life demands.*** The EAP offers assistance for a range of work/life needs. Resources and referrals are available for child care, elder care, adoption assistance, education and college search, summer camps, special needs, legal consultation, and other work/life needs.
- ***Online Resources and Tools.*** The EAP offers self-assessments, articles, provider search and online authorization for face-to-face EAP counseling sessions, and access to work/life resources through www.cignabehavioral.com, using the Employer ID: fidelity to log on. This site is secure and maintained by CIGNA Behavioral Health.

Calling the EAP

When you or your Eligible Dependents need to talk to someone about a personal or work-related problem or concern, you may call the EAP confidentially and toll-free at 877-675-3760 (TTY 800-855-2880) anytime, day or night. Your call will be answered by a clinician, who may help you by:

- ***Responding to a mental health or substance abuse*** emergency.
- ***Evaluating your problem or concern.***
- ***Providing telephone counseling,*** if appropriate.
- ***Referring you directly to an EAP clinician*** in CIGNA Behavioral Health's nationwide provider network so you can begin your face-to-face visits. When possible, CIGNA Behavioral Health will try to match you with a clinician who also is a member of the provider network under your medical coverage, if applicable. If your situation is not appropriate for referral to an EAP clinician, the CIGNA Behavioral Health telephone clinician will refer you to your medical provider for treatment.
- ***Locating, qualifying, and referring you to a local clinician*** who may not be in CIGNA Behavioral Health's network, if this is necessary for therapeutic reasons. For example, this may apply to employees who are geographically limited by a choice of providers.

Calling the EAP

Confidential counseling services are available 24 hours a day, 365 days a year toll-free at 877-675-3760 (TTY 800-855-2880).

Telephonic Consultation

When you call the toll-free telephone line, CIGNA Behavioral Health offers access to EAP clinicians for telephonic consultation, crisis calls, and assistance. This is available on an unlimited basis throughout the calendar year.

Face-to-Face Visits with an EAP Clinician

In addition to the toll-free telephone line, the EAP also provides you and each of your Eligible Dependents with the ability to have up to three face-to-face visits per calendar year, per each different presenting problem, with a CIGNA Behavioral Health clinician. This is available at no charge while you are employed by Fidelity.

- ***You can use these visits to begin treatment*** with a clinician in CIGNA Behavioral Health's provider network and transition to a clinician under your medical coverage, if the CIGNA Behavioral Health clinician is not a member of the provider network under your medical coverage, if appropriate. In this case, your CIGNA Behavioral Health clinician can assist you with the transfer.
- If you give your permission, and depending on the severity of your case, ***you also may receive follow-up care on referral effectiveness*** to determine if you have received services in accordance with your treatment plan. CIGNA Behavioral Health will contact you to ensure you have received, and are satisfied with, the required services for which you were assessed.

Confidentiality

Any communication you may have during the EAP session remains between you and the CIGNA Behavioral Health clinician. The EAP is managed by CIGNA Behavioral Health, an independent organization staffed by clinicians who adhere to the strict confidentiality requirements of their profession. No information will be shared with anyone else, unless you give written permission to the CIGNA Behavioral Health clinician to do so. Your use of EAP services is confidential, except in cases of mandatory referrals (see below) or when the EAP clinician has reason to believe that an individual poses an imminent risk of serious harm to him/herself or others, or poses a threat to public safety. Fidelity supports the EAP policy of complete confidentiality.

Mandatory Referrals

In certain situations in which a personal issue may be affecting an employee's job performance, attendance, or other job-related activities, a manager may refer an employee to the EAP through HR Solutions under a mandatory referral.

HR Solutions will notify CIGNA Behavioral Health of their intention to make a mandatory employee referral. This will alert CIGNA Behavioral Health to expect the employee's call and to identify it as a formal referral. Early in this process, the employee will receive a Release of Information Form which is to be completed and forwarded to CIGNA Behavioral Health. By signing the release form, the employee consents to CIGNA Behavioral Health notifying the designated HR Solutions contact or manager with follow-up information confirming:

- The employee called by the deadline.
- The employee completed the initial evaluation.
- The employee is following through with recommendations rendered by the evaluation agent or agency.
- The employee was compliant with recommended treatment.

Specific details on treatment are not disclosed.

Paying for Your EAP Coverage

Calls to the toll-free telephone line are free of charge to you and your Eligible Dependents while you are employed by Fidelity. There is no limit to the number of calls you may make. Additionally, up to three face-to-face visits throughout each calendar year, per each different presenting problem, with a clinician in CIGNA Behavioral Health's provider network are available to you and each of your Eligible Dependents at no cost while you are employed by Fidelity. Once your EAP benefits are exhausted, CIGNA Behavioral Health may refer you to your medical coverage or to other professional services, if necessary. Continued treatment beyond the three face-to-face visits is your financial responsibility and may be coordinated with your medical coverage while you are employed by the Company, to the extent possible.

When Your Employee Assistance Program Coverage Ends

EAP coverage for you and your Eligible Dependents ends on the earliest of the following:

- The last day of the month in which your employment with Fidelity ends.
- The date the EAP is terminated.
- The date you no longer meet the eligibility requirements under the EAP.
- The end of the month in which you die.

In some circumstances, you and your Eligible Dependents may be able to continue coverage for a limited time under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA). For more information, see page 177 of the ***Administrative*** section of this SPD. If you elect COBRA, please note that you will have to pay a monthly COBRA premium for EAP coverage.

While same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the Employee Assistance Program. See page 179 for more information.

YOUR RIGHTS UNDER HIPAA

The *Health Insurance Portability and Accountability Act* (HIPAA) was enacted to make it easier for you and your family members to have continued health plan coverage when changing from one employer to another.

If Your Coverage or Your Employment Ends. If your coverage under a group health plan ends or your employment terminates, the group health plan will provide you and your covered Eligible Dependents with a written "certificate of creditable coverage." This certificate can be used to demonstrate that you have had coverage under a group health plan and that you may be eligible to reduce or eliminate any pre-existing condition limitations imposed by your new group health plan. Be sure to keep this certificate when you receive it. (Because none of Fidelity's group health plans has a pre-existing condition limitation, you are not required to provide a certificate from your previous employer when enrolling in a Fidelity group health plan.)

You can access CIGNA Behavioral Health's website directly at www.cignabehavioral.com (Employer ID: fidelity) or from HR Solutions Online.

Calling the EAP

Confidential counseling services are available 24 hours a day, 365 days a year toll-free at 877-675-3760 (TTY 800-855-2880).

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Tobacco Cessation Program

About Your Tobacco Cessation Program Coverage

To help you and your family with decision support assistance and recommendations for nicotine replacement therapies, Fidelity offers all eligible Regular Employees who are regularly scheduled to work 20 or more hours per week services under the Tobacco Cessation Program.

Eligibility and Enrollment

You are eligible to enroll in the Tobacco Cessation Program on your date of hire. In addition, your Eligible Dependents age 18 and older also may enroll in the program. The Tobacco Cessation Program is provided at no cost to you and is available regardless of the medical coverage option you select, if any. Fidelity has arranged for these services to be provided through the Quit For Life® Program.

This voluntary program is designed to help individuals quit using all forms of tobacco, including cigarettes, pipes, cigars, and smokeless products such as chewing tobacco.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

How the Tobacco Cessation Program Works

- To participate in the Tobacco Cessation Program, you need to enroll in the program by calling 866-784-8454 from 8 A.M. to 3 A.M. ET 7 days per week or enroll online at www.quitnow.net/fidelity.
- Once you join the program, a Quit Coach® will work with you to develop a personalized quit plan. The Quit Coaches will also determine whether nicotine patches, gum, or medication will be helpful for you during the quit process based on your tobacco history, prior quit attempts, and criteria developed by the Quit For Life Program. Patches or gum will be mailed directly to your home at no cost to you.
- A Quit Coach will make a series of outbound coaching calls to you, at your convenience, to support you in quitting. In addition, you and your Eligible Dependents are encouraged to make an unlimited number of calls to a Quit Coach for ongoing support.
- You will receive a self-paced printed Quit Guide to help you implement a personal quit plan.
- Once you enroll in the program, and provide an email address, you will receive a welcome email with a password to Web Coach®, the Quit For Life interactive website. With Web Coach, you can track your progress and further track your personalized quit plan, interact with others who are trying to quit, and obtain advice from Quit Coach Moderators on the discussion forums. The Quit For Life Program believes peer support is a key factor in success. Providing an email address is completely optional; however, if you do, you will also receive coaching emails between calls with tips on quitting and reminders to help you stay on track.
- Quit Coaches will typically complete your series of outbound coaching calls within two to six months, depending on how quickly you move through the process of quitting. However, the Quit Coaches will help you establish your new tobacco-free lifestyle and provide you with ongoing support for up to twelve months after you enroll. In addition, six months after you join the program you will be asked whether or not you've quit tobacco. If you haven't quit, or if you relapse after quitting or need additional coaching, a Quit Coach will provide you with additional support to help you get back on track.

Confidentiality

Any communication between you and your Quit Coach during your Tobacco Cessation treatment sessions remains between you and the Quit Coach unless required by law to be disclosed. The Quit For Life Tobacco Cessation Program is staffed by employees who adhere to the strict confidentiality requirements of their profession. General information regarding your enrollment in the program may be shared with Fidelity, for administrative purposes (e.g., to award health incentive points); but specific information regarding your treatment sessions and discussions with your Quit Coach will not be shared unless you give written permission to the Quit Coach to do so.

Paying for Your Tobacco Cessation Program Coverage

Fidelity currently pays the full cost for this program for eligible employees and their Eligible Dependents. Calls to the telephone line are toll-free to you and your Eligible Dependents. The program lasts 12 months from the date you enroll in the program.

When Your Tobacco Cessation Program Coverage Ends

Coverage for you and your Eligible Dependents ends:

- Twelve months following your enrollment.

You can access the Quit For Life website directly at www.quitnow.net/fidelity or from HR Solutions Online.

Calling the Tobacco Cessation Program

Tips and resources for quitting tobacco use can be found by contacting the Quit For Life Program at 866-784-8454 (TTY 877-777-6534).

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Retirement Program Overview

ABOUT YOUR RETIREMENT PROGRAM COVERAGE

A Look at Your Total Retirement Picture

About Your Retirement Program Coverage

Financial security in retirement is a concern that most people share. That's why Fidelity offers the Retirement Program. Through two separate plans—the Profit Sharing Plan, which includes a 401(k) feature, and the Retiree Health Reimbursement Plan*—the Retirement Program can help you achieve financial security in retirement.

This section provides a brief description of each of the plans under the Retirement Program. For more details, refer to the appropriate section for each plan in this SPD.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

To learn more about how Social Security works, visit the Social Security Administration's website (www.ssa.gov). To learn more about your benefits under the Profit Sharing Plan and the Retiree Health Reimbursement Plan, log on to NetBenefits®.

A LOOK AT YOUR TOTAL RETIREMENT PICTURE

While the Retirement Program can provide a significant portion of your retirement income, the program is designed to work in combination with other sources of retirement income—such as personal savings and investments, and benefits from Social Security. Together, these plans are intended to help you build a financially secure future. To develop a financial strategy for retirement, you'll need to estimate income from all sources and determine if there will be any gaps. If you are nearing retirement, you may want to consider the Fidelity Retirement Income Advantage℠ program where you can use online tools or speak to an income-planning expert to develop an income plan for retirement.

Social Security. Both you and Fidelity contribute to Social Security. Your contribution is deducted from your paycheck each pay period, up to an annual maximum. Fidelity contributes an equal amount on your behalf.

For a booklet that explains how to determine your Social Security benefits or for an estimate of your Social Security benefits, contact your local Social Security office or call the Social Security Administration at 800-772-1213. It's a good idea to request a statement of your earnings from Social Security every year to review for accuracy.

Profit Sharing Plan. Once you become eligible, Fidelity makes Company-matching contributions on certain amounts that you contribute to the 401(k) feature under the Profit Sharing Plan, as well as an annual Profit Sharing contribution* to your Profit Sharing account. Employer contributions are subject to the availability of sufficient Company profits and cash flow. For more information about your potential benefits under the Profit Sharing Plan, log on to NetBenefits®. With NetBenefits®, you can view your Profit Sharing Plan account balance and account history, the historical performance of each investment option, run online account statements, or request to receive a quarterly paper statement.

In addition, you can evaluate your retirement savings strategy with online planning tools, including Fidelity Retirement Income Planner and Portfolio Review. With Portfolio Review, you can obtain information about how to allocate your assets and develop an investment strategy for your retirement goals. Fidelity Retirement Income Planner can assist you in evaluating your retirement income needs and developing a retirement income plan.

Retiree Health Reimbursement Plan (RHRP)*. The RHRP is designed to reimburse you for eligible expenses, including health insurance premiums that you incur in retirement. Fidelity will make an annual RHRP credit for each eligible employee who satisfies the eligibility requirements.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Profit Sharing Plan

About the Profit Sharing Plan

Preparing for retirement is an important part of financial planning. With Profit Sharing and 401(k) features, the FMR LLC Profit Sharing Plan, a component of the Fidelity Retirement Program, is designed to help you save for retirement.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

Generally, if you are a Regular Employee of a Participating Fidelity Company who is regularly scheduled to work 20 or more hours per week, you automatically will be enrolled in the 401(k) feature under the Profit Sharing Plan at a Pre-Tax contribution rate of 3 percent of your Eligible Compensation. Pre-Tax contributions are deducted before income taxes (but not Social Security and Medicare taxes) are withheld. You also have the option of designating all or a portion of your contributions as Roth 401(k) contributions. Roth contributions are made on a After-Tax basis and qualified distributions of Roth 401(k) contributions are not includable in income. Please refer to page 165 of this document for more information about qualified distributions.

Once you meet certain eligibility requirements (see "Eligibility and Participation" below), Fidelity supplements your savings by:

- Matching your 401(k) contributions dollar-for-dollar, up to 7 percent of your Eligible Compensation, each payroll period.*
- Making an annual Profit Sharing contribution of up to 10 percent of your Eligible Compensation.*

The money you contribute to the Profit Sharing Plan is directed to a Profit Sharing Plan account in your name each payroll period. You are always *Vested* in, or have a nonforfeitable right to receive, all of the money you contribute to your Profit Sharing Plan account, as well as any investment earnings on that money. Over time, you become Vested in, or attain a nonforfeitable right to receive, any money that Fidelity contributes on your behalf, as well as any related earnings.

Provided you remain an active employee, you may access the money in your Profit Sharing Plan account through loans, subject to certain conditions. In addition, there are circumstances under which you may take hardship withdrawals from your Profit Sharing Plan account while you still are employed by the Company. Finally, your Profit Sharing Plan account is portable, which means you may take the Vested portion of the money in your Profit Sharing Plan account with you if you leave Fidelity.

*It is important to note that the Company-matching and annual Profit Sharing contributions are subject to the availability of sufficient Company profits and cash flow. In addition, both are subject to annual Internal Revenue Code (IRC) limitations on contributions. Also, Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

How the Profit Sharing Plan Works

Eligibility and Participation

The Profit Sharing Plan offers Regular Employees of Participating Fidelity Companies who are regularly scheduled to work 20 or more hours per week a 401(k) feature, a Profit Sharing contribution* feature, a Company-matching contribution feature, a Catch-up feature, and a Rollover feature. Participation in the 401(k) and Catch-up features is voluntary. However, all eligible employees automatically are enrolled in the 401(k) feature of the Profit Sharing Plan on a Pre-Tax basis at a contribution rate of 3 percent of Eligible Compensation as of their date of hire. Should an employee choose not to participate in the 401(k) feature or elect to designate all or a portion of his/her contributions as Roth 401(k) contributions, he/she must call HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1 or log on to NetBenefits® within 30 days of their date of hire. Employees can also choose not to participate in the 401(k) feature of the Profit Sharing Plan or elect to designate all or a portion of their contributions as Roth 401(k) contributions at any time.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

If you are regularly scheduled to work fewer than 20 hours per week, you automatically will become enrolled in the 401(k) feature on the first of the month coinciding with or following your completion of 12 months of employment during which you are credited with at least 1,000 hours of service. (For this purpose, the first 12-month period is measured from your hire date. Thereafter, the 12-month period coincides with the Plan Year, which is the calendar year, beginning with the Plan Year in which your first employment anniversary occurs.)

Your 401(k) contributions will be deducted from your pay as soon as administratively feasible after you are enrolled. You are eligible to make a Catch-up contribution election if you are age 50 or older, or will turn 50, during the calendar year.

Although the default contribution rate upon enrollment is 3 percent on a Pre-Tax basis, you can elect to contribute at a greater rate, up to 20 percent of your Eligible Compensation, to the Profit Sharing Plan on a Pre-Tax and/or Roth basis combined. However, your total 401(k) contributions cannot exceed the Internal Revenue Code (IRC) maximum annual limit which is $16,500 for 2010. Pre-Tax and Roth contributions are maintained separately under the plan.

Generally, if eligible, you may make a Catch-up contribution election to contribute between 1 percent and 80 percent of your Eligible Compensation to the Profit Sharing Plan on a Pre-Tax and/or Roth basis, up to the IRC maximum annual limit which is $5,500 for 2010. This amount is indexed periodically for inflation in $500 increments.

Assuming you are enrolled when you have satisfied the eligibility requirements for participation in the 401(k) feature, you may continue to participate in the 401(k) feature under the Profit Sharing Plan (and receive the Company-matching contributions, if eligible) even if you later reduce your hours to fewer than 20 per week. You may also continue to make Catch-up contributions, if eligible.

You are eligible to participate in the Company-matching and Profit Sharing contribution* features beginning on the first of the month coinciding with or following your completion of 12 consecutive months of service during which you have been credited with at least 1,000 hours of service. Generally, you are credited with an hour of service for each hour for which you are entitled to be paid by Fidelity, including both working hours and paid non-working hours such as vacation, holidays, sick days, severance, and the like. Please note, however, that you will only be credited once for any hour of service for which you worked and also received holiday, sick, overtime, or other such pay. During any single period of absence from work, you generally cannot be credited with more than 501 hours of service.

Once you satisfy the eligibility requirements, Fidelity will match your 401(k) contributions dollar-for-dollar, up to the first 7 percent of your Eligible Compensation, each payroll period. Generally, Company-matching contributions are made with the same frequency as your 401(k) contributions, subject to sufficient Company profits and cash flow.

Ongoing Profit Sharing Contribution* Eligibility Requirements. Each year, to be eligible to receive the Profit Sharing contribution, you must:

- Be actively employed by Fidelity on the last business day of the Plan Year. Employees on an approved leave of absence are considered actively employed. Former employees receiving severance pay or vacation pay following termination are not considered actively employed;
- Have been employed as an eligible Regular Employee for at least some portion of the Plan Year by a Participating Fidelity Company that has elected to participate in the Profit Sharing feature; and
- Be credited with at least 1,000 hours of service during the Plan Year.

These Profit Sharing contribution eligibility requirements do not apply in the year that you retire or die. *Retire* means you leave Fidelity after you:

- Reach age 65.
- Reach age 55 with 5 Years of Vesting Service (see page 152).

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Eligible Compensation

Under the Profit Sharing Plan, Eligible Compensation is your Base Salary, plus overtime and regular performance bonus(es), if applicable. If you participate in a compensation plan in which variable compensation may comprise a significant portion of your annualized earnings, your Eligible Compensation is your Benefits Base, which is equal to your Base Salary, plus 75 percent of your variable compensation (as both are paid throughout the calendar year). Certain payments, such as sign-on bonuses and relocation bonuses are not considered Eligible Compensation under the Profit Sharing Plan.

If you leave to perform military service and return within certain time limits, the *Uniformed Services Employment and Reemployment Rights Act* (USERRA) may provide you with certain rights under the Profit Sharing Plan. For more information about your rights under USERRA, refer to the ***Administrative*** section of this SPD or call HR Solutions at 800-835-5099 (TDD 888-343-0860).

WHEN YOU BECOME ELIGIBLE TO PARTICIPATE IN THE COMPANY-MATCHING CONTRIBUTION AND PROFIT SHARING CONTRIBUTION* FEATURES

If you were hired on April 1, 2008 and have been credited with 1,000 hours of service between April 1, 2008 and March 31, 2009, you will be eligible to participate in the Company-matching contribution and Profit Sharing contribution features as of April 1, 2009. Further, if you are credited with at least 1,000 hours of service during 2009 and are employed by a Participating Fidelity Company as of December 31, 2009, you may be eligible to receive a Profit Sharing contribution for the 2009 Plan Year. This annual contribution generally would be posted to your Profit Sharing Plan account in January 2010. Please note that any Profit Sharing contribution you receive for the 2009 Plan Year would be based on the Eligible Compensation you earned between April 1, 2009 and December 31, 2009.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

NETBENEFITS®—YOUR ACCOUNT MANAGEMENT RESOURCE

You may take advantage of NetBenefits® to help you manage your Profit Sharing Plan account. When you log on to netbenefits.fidelity.com, you can:

- **Change your deductions in the 401(k) feature under the Profit Sharing Plan.**
- **Check your current Profit Sharing Plan account balance, contribution rates, and investment elections.**
- **Run an online account statement or request to receive quarterly paper statements.**
- **Exchange balances among investment options.**
- **Change your investment elections for your future contributions.**
- **Request information about the Profit Sharing Plan's investment options, including Prospectuses.**
- **Model a hypothetical loan from your Profit Sharing Plan account.**

You also may take advantage of HR Solutions' Voice Response System (VRS), which is available virtually 24 hours a day, 7 days a week by calling 800-835-5099 (TDD 888-343-0860), prompt 1. Representatives also can assist you business days from 8:30 A.M. to 8:00 P.M. ET, except New York Stock Exchange holidays.

Annual Increase Program

Effective January 1, 2007, newly hired employees, rehired employees, and Veritude transfers who satisfy certain eligibility requirements will be automatically enrolled in the Annual Increase Program at a rate of 1 percent. This means that the deferral rate for your 401(k) contributions will automatically increase by 1 percent each year beginning with the first payroll period in July. However, if you are hired between January 1 and July 1 of a calendar year, your annual increase will not be effective until July of the following calendar year. You may opt out of the Annual Increase Program at any time.

Enrolling in the Profit Sharing Plan

If you are eligible to participate in the 401(k) feature, you automatically will be enrolled at a Pre-Tax contribution rate of 3 percent. For additional enrollment information, contact HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1. You can also log on to NetBenefits® or call HR Solutions to:

- ***Activate your personal identification number (PIN),*** which you then can use to access information from NetBenefits® or the VRS.
- ***Select the amount (percentage of your Eligible Compensation, from 3 percent to 20 percent)*** you want to contribute each payroll period on a Pre-Tax and/or Roth basis. Please note that should you not take action, the default Pre-Tax contribution rate of 3 percent will apply immediately.
- ***Choose the investment option(s) in which you want to invest*** your own and Company-matching contributions, once eligible. You may invest the contributions to your Profit Sharing Plan account in increments of 1 percent. Please note that should you not take action, your contributions will automatically be invested in the default investment option, the Fidelity Freedom K® Fund that is targeted to your assumed retirement age (currently age 65) based on your date of birth. See the chart on page 156 for the specific Freedom K® Fund.

You are automatically enrolled in the 401(k) feature under the Profit Sharing Plan. You are also automatically enrolled in the Company-match and Profit Sharing* features once you meet the applicable eligibility requirements.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Your 401(k) contributions will begin as soon as administratively practicable, depending on your pay frequency and the time you make the deferral election if you opt to increase your 401(k) contributions above the 3 percent deferral rate. You automatically are enrolled in the Company-matching and Profit Sharing contribution* features under the Profit Sharing Plan once you meet the initial eligibility requirements.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for a Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Naming Your Beneficiary. When you first enroll in the Profit Sharing Plan, you will need to name your Beneficiary(ies)—the person(s) to whom your Vested Profit Sharing Plan account balance is payable in the event of your death. You must complete a *Beneficiary Designation Form* and return it to the address listed on the form.

It is your responsibility to keep your Beneficiary information up to date. You may want to consider changing your Beneficiary when you experience a Change in Status (including, but not limited to, marriage, divorce, or the birth or adoption of a child). You may obtain a *Beneficiary Designation Form* from HR Solutions – online or by calling 800-835-5099 (TDD 888-343-0860) – or on NetBenefits®.

For purposes of the Retirement Program, you are considered to be married only if you have a spouse who is a member of the opposite sex, in accordance with how the terms "marriage" and "spouse" are defined under the Defense of Marriage Act of 1996.

If you are not married, you may name anyone you choose as your Beneficiary. If you are married and wish to name someone other than your spouse as your Beneficiary, federal law requires that your spouse provide Notarized consent. Federal law also requires your spouse to provide Notarized consent if you choose to name a primary Beneficiary in addition to your spouse. For example, you need Notarized spousal consent if you want to leave half of your Vested Profit Sharing Plan account balance to your spouse and half to a second person.

If your designated Beneficiary predeceases you and you have not named a new Beneficiary, benefits will be paid in accordance with the terms of the Profit Sharing Plan to your (in the following order):

- Surviving spouse.
- Surviving issue, by right of representation.
- Estate.

You may change your Beneficiary at any time. If you are married, your spouse must provide Notarized consent to your change in Beneficiary.

Contributions to Your Profit Sharing Plan Account

401(k) Contributions. Generally, you may contribute between 3 percent and 20 percent of your Eligible Compensation to the 401(k) feature under the Profit Sharing Plan, up to certain IRC limitations, as indexed periodically (see page 147). In addition, 401(k) contributions may be limited for certain highly paid employees. You will be notified if these restrictions apply to you.

It's important to note that the Internal Revenue Code (IRC) limits the amount of compensation that can be taken into account in allocating contributions to the Profit Sharing Plan. For 2010, this compensation limit is $245,000.

In addition, the IRC limits the amount of 401(k) contributions that you may make during any calendar year (see page 147). For 2010, the maximum amount is $16,500. This limit applies to all 401(k) plans in which you participate in one calendar year, even if the plans are sponsored by different employers.

Exceeding this IRC limit results in adverse tax consequences. If you worked for multiple employers during the Plan Year and you wish to request a distribution of the excess 401(k) contributions from the Profit Sharing Plan, you must notify HR Solutions at P.O. Box 770003, Cincinnati, OH 45277-0065 in writing no later than March 1 of the year following the calendar year in which the excess occurred.

The tax law periodically indexes each of these limits for inflation, subject to rounding rules.

You can elect to make 401(k) contributions on a Pre-Tax and/or or Roth basis. When you save on a Pre-Tax basis, your contributions are made to the Profit Sharing Plan before federal and, in most cases, state and local income taxes are withheld. However, the contributions will be subject to Social Security and Medicare taxes. If you elect to make Roth 401(k) contributions, such contributions are made on an After-Tax basis, meaning your deductions are taken from your pay after all payroll taxes have been deducted from your pay.

Catch-up Contributions. Once eligible, you generally may make a Catch-up contribution election to contribute between 1 percent and 80 percent of your Eligible Compensation. You can elect to make Catch-up contributions on a Pre-Tax and/or Roth basis. Catch-up contributions are not eligible for Company match.

THE BENEFIT OF PRE-TAX SAVINGS

When you make Pre-Tax contributions to the Profit Sharing Plan, it actually costs you less to save the same amount of money than saving on an After-Tax basis through another savings vehicle, such as a traditional savings account. For example, suppose you are single, your pay is $40,000 per year (this example assumes that pay and Eligible Compensation are equal), and you decide to save 10 percent of your pay, or $4,000, under the Profit Sharing Plan. By saving under the Profit Sharing Plan with Pre-Tax dollars instead of through a traditional savings account with After-Tax dollars, you lower your taxable income and save money. Here's how:

	You Save 10% on a Pre-Tax Basis under the Profit Sharing Plan	You Save 10% on an After-Tax Basis through a Traditional Savings Account
Your Pay	$40,000	$40,000
You contribute 10% to the Profit Sharing Plan on a Pre-Tax Basis	– $4,000	0
Your Taxable Pay	$36,000	$40,000
Income Taxes/Withholding	– $9,000	– $10,000
You Put 10% into a Traditional Savings Account	0	– $4,000
Your Take-Home Pay	$27,000	$26,000
Your Take-Home Pay Increases by:	**$1,000**	

This hypothetical example is for illustrative purposes only. It shows the potential impact on take-home pay assuming a Pre-Tax or After-Tax annual contribution of $4,000 based solely on an assumed 25% federal income tax withholding rate. Actual taxes and take-home pay will depend on your individual tax situation. No other payroll deductions are taken into account.

You may change, or stop making 401(k) contributions and Catch-up contributions, if applicable, to your Profit Sharing Plan account at any time. Simply log on to NetBenefits® or call HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1. Changes to your 401(k) contribution or Catch-up contribution percentage will be made as soon as administratively practicable, depending on your pay frequency and the time you make the change.

You must meet certain eligibility requirements to participate in the Company-matching and Profit Sharing contribution features. See page 147 for details.

Company-Matching Contributions.* Once you are eligible, Fidelity will match your 401(k) contributions dollar-for-dollar, up to 7 percent of your Eligible Compensation, each payroll period. This means that for each dollar you contribute, Fidelity contributes $1 to your Profit Sharing Plan account, up to 7 percent of your Eligible Compensation for that payroll period. Fidelity does not match Catch-up contributions.

Profit Sharing Contributions.* If you meet the ongoing eligibility requirements, Fidelity will make an annual Profit Sharing contribution to your Profit Sharing Plan account. The amount of the Profit Sharing contribution will be up to 10 percent of your Eligible Compensation.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

SAVING MORE WITH LESS

This hypothetical example shows how the 401(k) and Company-matching contribution features under the Profit Sharing Plan can help you save more with less, especially when compared with saving through a traditional savings account:

	Pre-Tax Savings	After-Tax Savings
Your Annual Pay*	$40,000	$40,000
You Contribute 8% of Your Eligible Compensation each payroll period	$3,200	$3,200
Fidelity's 7% Company-matching Contribution (if eligible) each payroll period	$2,800	$0
Total	$6,000	$3,200

As you can see in this hypothetical example, saving $3,200 under the 401(k) feature of the Profit Sharing Plan means Fidelity makes another contribution of $2,800 to your account, for a total of $6,000. And that's before any tax advantages available under the Profit Sharing Plan and any earnings you may gain through the investment options your choose.

*This example assumes that all of your pay is Eligible Compensation.

You become *Vested* in (or have a nonforfeitable right to receive) Profit Sharing* and Company-matching contributions, plus applicable earnings on those contributions, over time, based on your Years of Vesting Service. For details, see page 152.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Note that only compensation earned after you are eligible to participate in the Profit Sharing feature under the Profit Sharing Plan will be treated as Eligible Compensation. For example, if you became eligible to participate in the Profit Sharing feature under the Profit Sharing Plan on July 1, 2008, only Eligible Compensation earned between July 1, 2008 and December 31, 2008, will be included for purposes of calculating your Profit Sharing contribution* for the 2008 Plan Year.

Each year, you will be reminded to select the investment option(s) into which you want to invest the Profit Sharing contribution* that Fidelity makes to your Profit Sharing Plan account (see page 155 for more information on the Plan's investment options).

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

IMPORTANT INFORMATION IF YOU WERE A PROFIT SHARING PLAN PARTICIPANT BEFORE JANUARY 1, 2002

Fidelity previously sponsored a Retirement Savings Plan. On December 31, 2001, if you had a balance in the Retirement Savings Plan, it was transferred to the Profit Sharing Plan. Retirement Savings Plan contributions continue to be held in a Retirement Savings feature under the Profit Sharing Plan.

If you completed one or more hours of service after December 31, 2001, your balance under the Retirement Savings feature is subject to the same Vesting provisions as under the Profit Sharing Plan. For more information, contact HR Solutions at 800-835-5099 (TDD 888-343-0860).

IMPORTANT INFORMATION IF YOU WERE A PROFIT SHARING PLAN PARTICIPANT BEFORE MARCH 1, 1998

If you participated in the Profit Sharing Plan before March 1, 1998, you were eligible to contribute up to 10 percent of your Eligible Compensation to the Profit Sharing Plan on an After-Tax basis. This option was discontinued when Fidelity amended the Profit Sharing Plan and increased the amount you could contribute on a Pre-Tax basis.

Any After-Tax contributions you made to the Profit Sharing Plan are accounted for separately under the Profit Sharing Plan. You always are 100 percent Vested in your After-Tax contributions, including any related investment earnings.

If you receive a distribution from an Eligible Employer Plan that is eligible to be rolled over, you may be able to defer taxes and penalties by making a Rollover contribution to the Profit Sharing Plan. If the distribution check is payable to you, you must make your Rollover contribution no later than 60 days after receiving your distribution. All Rollover contributions are subject to IRC regulations and Profit Sharing Plan provisions. You should consult your tax adviser to ensure that you satisfy all of the requirements for a Tax-Deferred rollover.

You may obtain a 401(k) *Rollover Account Application* from HR Solutions—online or by calling 800-835-5099 (TDD 888-343-0860)—or on NetBenefits®.

How Hours of Service Are Determined

When calculating your hours of service under the Retirement Program, Fidelity credits hours based on the date on which a payment for a pay period is made. For example, if a pay period begins on Monday, December 19, ends on Saturday, December 31 and is paid in January, all hours worked during that pay period will be credited in January of the new calendar year rather than in December of the previous calendar year. It is important that you take this into consideration if you are regularly scheduled to work fewer than 30 hours per week, considering reducing your hours, or taking a leave of absence.

If you are regularly scheduled to work 30 or more hours per pay period, you are credited with 190 hours of service for each month in which you work at least one hour. If you are regularly scheduled to work fewer than 30 hours per week, the number of hours of service you are credited with equals the actual number of hours you work.

IMPORTANT INFORMATION IF YOU WERE A PROFIT SHARING PLAN PARTICIPANT BEFORE JULY 1, 1990

Fidelity previously sponsored a Thrift Plan, which was replaced by the 401(k) feature under the Profit Sharing Plan. If you participated in the Thrift Plan, your balance under the Thrift Plan was transferred to the Profit Sharing Plan. Your After-Tax contributions to the Thrift Plan now are held in the After-Tax feature under the Profit Sharing Plan. Thrift Plan-matching contributions continue to be held in a separate Thrift feature under the Profit Sharing Plan.

Your balance under the Thrift feature is subject to the same Vesting and withdrawal provisions as under the Profit Sharing Plan. For more information, contact HR Solutions at 800-835-5099 (TDD 888-343-0860).

Rollover Contributions. In certain circumstances, you also may make a Tax-Deferred Rollover contribution to your Profit Sharing Plan account. Your Rollover contribution must be from an Eligible Employer Plan or a traditional Individual Retirement Account (IRA).

An Eligible Employer Plan includes a plan qualified under section 401(a) of the Internal Revenue Code, including a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan, and money purchase plan; a section 403(a) annuity plan; a section 403(b) tax-sheltered annuity; and an eligible section 457(b) plan maintained by a governmental employer.

You may make a Rollover contribution to the Profit Sharing Plan even if you are not enrolled in the 401(k) feature, provided you meet the applicable eligibility requirements. In other words, you may make a Rollover contribution to the Profit Sharing Plan if you are a Regular Employee who is regularly scheduled to work 20 or more hours per week for a Participating Fidelity Company even if you are not contributing to the Plan. Rollover contributions are not eligible for Company-matching contributions.

To make a Rollover contribution, request a *401(k) Rollover Account Application* on NetBenefits® or call HR Solutions at 800-835-5099 (TDD 888-343-0860). Return the completed application and the rollover check to the address on the application. When you make a Rollover contribution, you also must complete a *Beneficiary Designation Form*, unless one is already on file for your Profit Sharing Plan account.

Becoming Vested in Your Profit Sharing Plan Account

You always are fully Vested in (or have a nonforfeitable right to receive) the value of your 401(k) contributions to the Profit Sharing Plan, including any investment earnings on those contributions. You also are always fully Vested in any Rollover or Catch-up contribution(s) you may make to the Profit Sharing Plan, plus any investment earnings on your Rollover or Catch-up contribution(s).

As outlined in this chart, you become Vested in the Company-matching and Profit Sharing contributions*, plus any earnings on those contributions, over time, based on your Years of Vesting Service.

YEARS OF VESTING SERVICE	VESTED PERCENTAGE OF COMPANY-MATCHING AND PROFIT SHARING CONTRIBUTIONS, AS WELL AS RELATED EARNINGS
1	0%
2	20%
3	40%
4	60%
5	100%

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

For example, if you have 4 Years of Vesting Service, you are 60 percent Vested in your Company-matching and Profit Sharing contributions*, as well as any earnings on those contributions. Once you reach 5 Years of Vesting Service, you will have a nonforfeitable right to receive 100 percent of Fidelity's contributions and any related earnings thereon.

A Year of Service is a calendar year in which you are credited with at least 1,000 hours of service. If you are regularly scheduled to work 30 or more hours per week, you are credited with 190 hours of service for each month in which you work at least one hour. If you are regularly scheduled to work fewer than 30 hours per week, the number of hours of service you are credited with equals the actual number of hours you work.

A Year of Vesting Service is a Year of Service that is taken into account for purposes of determining Vesting under the Profit Sharing Plan.

If your employment with Fidelity terminated prior to January 1, 2002, all Company contributions are subject to the Vesting schedule that was in place at the time of your separation.

You automatically become fully Vested when you reach normal retirement age (age 65), when you become disabled as defined under the terms of the Profit Sharing Plan, or in the event of your death, provided that your employment did not terminate prior to the event. For more information, see "Receiving Payment" beginning on page 162.

If you were employed by certain Capital Companies, Fidelity International Ltd. (FIL), or Fidelity Investments Canada Limited (FICL) and are hired by or transfer to Fidelity: If you are hired by or transfer from a Capital Company, including those with a non-Fidelity administered payroll vendor, FIL, or FICL, you generally may be credited for your prior service with that Company for purposes of eligibility and Vesting under the Retirement Program. Contact HR Solutions at 800-835-5099 (TDD 888-343-0860) and provide your work history. HR Solutions will work with Employee Benefits to research your request.

One-Year Break in Service means any calendar year in which you are credited with fewer than 501 hours of service.

If You Leave and Are Rehired

Participation in the Profit Sharing Plan if You Leave and Are Rehired

If you were a participant in the Profit Sharing Plan and you were at least partially Vested in your Company-matching and Profit Sharing contributions before you left, you are eligible to participate in all the Profit Sharing Plan features (401(k), Catch-up, Rollover, Company-matching, and Profit Sharing*, provided that you meet ongoing eligibility requirements) upon your return. All of your Years of Service will be taken into account in determining the Vested portion of your Profit Sharing Plan account.

If you were a participant in the Profit Sharing Plan but were not at least partially Vested in your Company-matching and Profit Sharing contributions when you left, you are eligible to participate in all Profit Sharing Plan features (401(k), Catch-up, Rollover, Company-matching, and Profit Sharing*, provided that you meet ongoing eligibility requirements) upon your return. Your Years of Service will be taken into account in determining the Vested portion of your Profit Sharing Plan account provided you did not incur five consecutive One-Year Breaks in Service. A One-Year Break in Service is any calendar year in which you are credited with less than 501 hours of service.

If you were not a participant in the Profit Sharing Plan before you left but had worked 12 consecutive months in which you were credited with at least 1,000 hours of service, you will be eligible to participate in all Profit Sharing Plan features (401(k), Catch-up, Rollover, Company-matching, and Profit Sharing*, provided that you meet ongoing eligibility requirements) upon your return. Your Years of Service will be taken into account in determining the Vested portion of your Profit Sharing Plan account provided you did not incur five consecutive One-Year Breaks in Service. A One-Year Break in Service is any calendar year in which you are credited with less than 501 hours of service.

If none of these categories applies, you will be treated as a new employee when you return.

Please note: All rehires automatically will be enrolled in the 401(k) feature of the Profit Sharing Plan at a Pre-Tax contribution rate of 3 percent and their previous elections will be reinstated unless a different contribution rate or new investment instructions (as applicable) are specified by the rehire.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

One-Year Break in Service means any calendar year in which you are credited with fewer than 501 hours of service.

Your Profit Sharing Plan Account Balance if You Leave, Take a Distribution, and Are Rehired
The chart below outlines the effect on your Profit Sharing Plan account balance if you leave, take a distribution, and are rehired:

YEARS OF VESTING SERVICE	LESS THAN 5 CONSECUTIVE ONE-YEAR BREAKS IN SERVICE	5 OR MORE CONSECUTIVE ONE-YEAR BREAKS IN SERVICE
5 years or more	No forfeiture of your Profit Sharing Plan account balance because you are 100% Vested; you may withdraw 100% of your Profit Sharing Plan account balance when you leave.	No forfeiture of your Profit Sharing Plan account balance because you are 100% Vested; you may withdraw 100% of your Profit Sharing Plan account balance when you leave.
Less than 5 years	When you take a distribution from your Profit Sharing Plan account, the portion of your Profit Sharing Plan account balance that is not Vested will be subject to forfeiture. When you return prior to incurring five consecutive One-Year Breaks in Service, the amount subject to forfeiture will be restored to your Profit Sharing Plan account, with earnings calculated using the Fidelity Retirement Money Market Portfolio rate. The restored amount is deposited into the investment option(s) on record at the time of the distribution.	When you take a distribution from your Profit Sharing Plan account, the portion of your Profit Sharing Plan account balance that is not Vested will be subject to forfeiture. When you return after incurring five consecutive One-Year Breaks in Service, the portion of your Profit Sharing Plan account balance that is not Vested is forfeited permanently.

Your Profit Sharing Plan Account Balance if You Leave, Defer Your Distribution, and Are Rehired
The chart below outlines the effect on your Profit Sharing Plan account balance if you leave, defer your distribution, and are rehired:

YEARS OF VESTING SERVICE	LESS THAN 5 CONSECUTIVE ONE-YEAR BREAKS IN SERVICE	5 OR MORE CONSECUTIVE ONE-YEAR BREAKS IN SERVICE
5 years or more	No forfeiture of your Profit Sharing Plan account balance because you are 100% Vested; 100% of your balance remains in your Profit Sharing Plan account until you take a distribution.	No forfeiture of your Profit Sharing Plan account balance because you are 100% Vested; 100% of your balance remains in your Profit Sharing Plan account until you take a distribution.
Less than 5 years	The Vested balance and the portion of your balance that is not Vested remains in your Profit Sharing Plan account.	Your Vested balance remains in your account, but the portion of your Profit Sharing Plan account balance that is not Vested is forfeited permanently when you incur five or more consecutive One-Year Breaks in Service.

Forfeitures may be used to restore those partially Vested amounts subject to forfeiture when participants are rehired prior to incurring five consecutive One-Year Breaks in Service or to offset Company contributions to the Profit Sharing Plan.

Years of Vesting Service under the Profit Sharing Plan if You Leave and Are Rehired
If you leave Fidelity and are rehired, you may be eligible to have your prior Years of Service taken into account, along with any Year(s) of Service you may earn after your rehire date, in calculating Years of Vesting Service. The chart below outlines when and how you will receive credit for your prior Years of Service.

YEARS OF VESTING SERVICE	LESS THAN 5 CONSECUTIVE ONE-YEAR BREAKS IN SERVICE	5 OR MORE CONSECUTIVE ONE-YEAR BREAKS IN SERVICE
5 years or more	All of your prior Years of Service will be taken into account, along with any Year(s) of Service you may earn after your date of rehire, in determining the Vested portion of your Profit Sharing Plan account balance attributable to Company contributions.	All of your prior Years of Service will be taken into account, along with any Year(s) of Service you may earn after your date of rehire, in determining the Vested portion of your Profit Sharing Plan account balance attributable to Company contributions.
At least 2 years, but less than 5 years	All of your prior Years of Service will be taken into account, along with any Year(s) of Service you may earn after your date of rehire, in determining the Vested portion of your Profit Sharing Plan account balance attributable to Company contributions.	All of your prior Years of Service will be taken into account, along with any Year(s) of Service you may earn after your date of rehire, but only for determining the Vested portion of your Profit Sharing Plan account balance attributable to Company contributions made on or after your date of rehire.*
Less than 2 years	All of your prior Year(s) of Service will be taken into account, along with any subsequent Year(s) of Service you may earn after your date of rehire, in determining the Vested portion of your Profit Sharing Plan account balance attributable to Company contributions.	None of your prior Years of Service will be taken into account for if you did not have a Vested balance at the time you left. Only the Year(s) of Service you may earn after your date of rehire will be used in determining the Vested portion of your Profit Sharing account balance attributable to Company contributions made on or after your date of rehire.

*Once you incur five or more consecutive One-Year Breaks in Service, Year(s) of Service that you may earn after your date of rehire will not be taken into account in determining the Vested portion of your Profit Sharing Plan account balance attributable to Company contributions before you incurred the first One-Year Break in Service.

Investing the Money in Your Profit Sharing Plan Account

Under the Profit Sharing Plan, you can decide how to invest your contributions, as well as the contributions Fidelity makes on your behalf, by choosing from more than 170 Fidelity investment options.

Shortly after you are hired, you will receive Profit Sharing Plan enrollment information. It will provide more detailed information about the Profit Sharing Plan's investment options including the *Choosing Your Investments* brochure.

The Profit Sharing Plan is intended to be a participant-directed plan, as described under Section 404(c) of the *Employee Retirement Income Security Act of 1974*, as amended (ERISA), and in the Department of Labor regulations governing section 404(c) plans. This means that the fiduciaries of the Profit Sharing Plan (those who are responsible for operating the Profit Sharing Plan) ordinarily are relieved of liability for any losses that are the direct and necessary result of investment instructions given by you.

You are encouraged to familiarize yourself with the investment goals, risk level, and any applicable administrative fees of each option before making any investment decisions. You may request information about the available investment options, including fund Prospectuses and the *Choosing Your Investments* brochure, via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860).

For more information about the investments available under the Profit Sharing Plan and to learn about the risks associated with these investment options, read the *Choosing Your Investments* brochure. The brochure is included in the Profit Sharing Plan enrollment information and is available on NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1.

You may change or stop making 401(k) contributions to your Profit Sharing Plan account; make a change to your investments; or learn the current value of your Profit Sharing Plan account via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1.

Risk means the likelihood that the value of your investment may go up or down. High-risk investments may fluctuate more over the short term but can offer higher returns over longer periods of time.

For more information about the investment options available under the Profit Sharing Plan and to learn about the risks associated with these investment options, read the *Choosing Your Investments* brochure. The brochure is included in the Profit Sharing Plan enrollment information and is available on NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860).

Your 401(k), Catch-up, Rollover, and Company-Matching Contributions. You may select investment options for your 401(k) contributions in the 401(k) feature under the Profit Sharing Plan. You may invest the contributions to your Profit Sharing Plan account in increments of 1 percent. (See page 149 for information on enrolling in the 401(k) feature under the Profit Sharing Plan.) Once you are eligible for Company-matching contributions or make a Catch-up contribution election, your 401(k) contribution investment elections apply to your Company-matching contributions and Catch-up contributions. Please note, if you do not select the investment option(s) for your contributions, your contributions will be invested in the default investment option under the Profit Sharing Plan. Currently, the default investment option is the Fidelity Freedom K® Fund that is targeted to your assumed retirement age (currently age 65) period based on your date of birth. See the chart below for the specific Freedom K® Fund.

If you elect to make a Rollover contribution to the Profit Sharing Plan, you will be required to select investment options for your Rollover contributions. If you do not select the investment option(s) for your Rollover contributions, or if percentage(s) allocated to the investment option(s) that you select does not equal 100 percent, your Rollover contributions will be invested in the default investment option under the Profit Sharing Plan. Currently, the default investment option is the Fidelity Freedom K® Fund that is targeted to your assumed retirement age (currently age 65) based on your date of birth. See the chart below for the specific Freedom K® Fund.

Profit Sharing Contributions.* Each year, you will have the opportunity to select the investment options into which you wish to invest the Profit Sharing contribution Fidelity makes to your Profit Sharing Plan account. You may invest the Profit Sharing contribution in increments of 1 percent. If you do not change your investment election from the previous year, your Profit Sharing contribution will be invested based on your most current investment election. Or, if you never have selected an investment option, the default investment option into which your Profit Sharing contribution will be invested is the Fidelity Freedom K® Fund that is targeted to your assumed retirement age (currently age 65) based on your date of birth. See the chart below for the specific Freedom K® Fund.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

IF YOUR BIRTH DATE IS BETWEEN	FUND NAME	TARGET RETIREMENT YEARS
01/01/1900 – 12/31/1932	Fidelity Freedom K® Income Fund	Retired before 1997
01/01/1933 – 12/31/1937	Fidelity Freedom K® 2000 Fund	Retired before 2002
01/01/1938 – 12/31/1942	Fidelity Freedom K® 2005 Fund	Retired before 2007
01/01/1943 – 12/31/1947	Fidelity Freedom K® 2010 Fund	2008 – 2012
01/01/1948 – 12/31/1952	Fidelity Freedom K® 2015 Fund	2013 – 2017
01/01/1953 – 12/31/1957	Fidelity Freedom K® 2020 Fund	2018 – 2022
01/01/1958 – 12/31/1962	Fidelity Freedom K® 2025 Fund	2023 – 2027
01/01/1963 – 12/31/1967	Fidelity Freedom K® 2030 Fund	2028 – 2032
01/01/1968 – 12/31/1972	Fidelity Freedom K® 2035 Fund	2033 – 2037
01/01/1973 – 12/31/1977	Fidelity Freedom K® 2040 Fund	2038 – 2042
01/01/1978 – 12/31/1982	Fidelity Freedom K® 2045 Fund	2043 – 2047
01/01/1983 and beyond	Fidelity Freedom K® 2050 Fund	2048 – 2052

Freedom K® Funds are retirement target date funds that assume a person will retire in the year indicated in the fund's name. The Freedom K® Fund chosen as the default for a participant is based on the assumption that the participant will retire at age 65.

The earnings and losses of the investments you select determine the value of your Profit Sharing Plan account. The Profit Sharing Plan is intended to be a participant-directed plan, as described in Section 404(c) of the *Employee Retirement Income Security Act of 1974*, as amended (ERISA), and is subject to Department of Labor regulations under that section. Federal law provides that the Plan Administrator of the Profit Sharing Plan (and any other fiduciaries of the Profit Sharing Plan) may be relieved of liability for any losses that are the direct and necessary result of the investment instructions given by a participant or Beneficiary. In other words, you assume responsibility for the investment decisions you make with respect to your Profit Sharing Plan account.

Making a Change to Future 401(k) Contributions. You may change the amount you contribute and how you invest future contributions as described below:

- You may increase or decrease your 401(k) deferral percentage for future contributions at any time. Deferral changes will be made as soon as administratively practicable, depending on your pay frequency and the time you make the deferral election.
- You may redirect the investment allocation of your future 401(k) deferrals to any of the available investment options at any time. Please note, your 401(k) investment allocation applies to your Company-matching and Catch-up contributions as well.

Making a Change to Your Catch-up Contributions. You may increase or decrease your Catch-up deferral percentage for future contributions at any time. Deferral changes will be made as soon as administratively practicable, depending on your pay frequency and the time you make the deferral election.

Making Exchanges within Your Profit Sharing Plan Account. You may make investment exchanges within your existing Profit Sharing Plan account balance—whether a certain dollar amount, share amount, or percentage of your balance—four times per year. During each transaction, there is no limit on the number of investment options from which or into which you may exchange your balance, as long as the amount you exchange is at least $250 per investment option. If your balance in an investment option is less than $250, you must exchange the entire balance to a different investment option.

In addition, you may make investment exchanges within your existing Profit Sharing Plan account balance:

- A fifth time at any time during the year, provided you exchange part or all of your balance into a money market fund.
- Once in any quarter into the investment option(s) of your choice, even if you already have taken advantage of the five opportunities to exchange your existing balance as listed above.
- Any time a new investment option is added to the Profit Sharing Plan's offering.

For example, if you make investment exchanges within your existing Profit Sharing Plan account balance five times during the first two quarters of the year (four times into the investment options of your choice and a fifth time into a money market fund), you still may exchange your existing Profit Sharing Plan account balance one time in each of the last two quarters.

You may make a change to your investments via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1. Requests made in writing or in person, whether at an investor center or elsewhere, cannot be honored.

Transaction requests confirmed after the New York Stock Exchange closes, or on weekends or holidays, will receive the next business day's closing price. Select Portfolios will receive the next available hourly price. Note that administrative fees may apply to some transactions, as described in the investment option's Prospectus, if applicable. In addition, Fidelity reserves the right to modify or withdraw the exchange privilege for any investment option.

Profit Sharing Plan Statement

If you are a participant in the Profit Sharing Plan, you may elect to receive a quarterly paper statement regarding your Profit Sharing Plan account balance at your address of record or you may generate an online Profit Sharing Plan account statement on NetBenefits®.

You should note that you will receive an annual paper statement in January of each year, regardless of whether or not you have elected to receive a quarterly paper statement. You will also receive an annual notice reminding you that you can retrieve an annual statement online at NetBenefits®.

Your Profit Sharing Plan Account Statement. Unless you elect to receive a quarterly paper statement, you can generate online Profit Sharing Plan account statements on NetBenefits® and customize your Profit Sharing Plan account statement to reflect any date range within the past 24 months. If you would like to receive a quarterly statement at your address of record, you must make an election via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860). However, if you elect to receive a quarterly paper statement, you will not be able to access or generate an online Profit Sharing Plan account statement. Instead, you will receive a statement at the close of each calendar quarter that shows the value of your Profit Sharing Plan account on that date. Regardless of whether you generate online Profit Sharing Plan account statements or you have elected to receive quarterly paper statements, you can learn the current value of your Profit Sharing Plan account at any time via NetBenefits® or by calling HR Solutions at 800-835-5099 (TDD 888-343-0860) because your Profit Sharing Plan account is valued every business day. An annual paper statement will be mailed to all participants, regardless of their election.

Accessing the Money in Your Profit Sharing Plan Account during Employment

Borrowing against Your Account

While you are actively employed (or on an approved leave of absence) with Fidelity, you may borrow against your 401(k), Catch-up, Vested Company-matching, Vested Profit Sharing*, Vested Retirement Savings, After-Tax, and Rollover sources *for any reason*. Unlike a withdrawal, any money you borrow and repay is not taxed as income to you and is not subject to any penalties.

The minimum you can borrow is $1,000. The maximum you can borrow is 50 percent of the Vested balance up to $50,000 (minus your highest outstanding loan balance during the previous 12 months). Up to 50 percent of your Vested balance is pledged as security of the loan. You may only have a maximum of two outstanding loans at a time and must wait 30 days after repayment of a loan before becoming eligible to apply for another.

When you borrow from your Profit Sharing Plan account, you repay with After-Tax dollars. Your entire loan repayment, including any interest, is reinvested in your Profit Sharing Plan account.

For purposes of the Retirement Program, you are considered to be married only if you have a spouse who is a member of the opposite sex, in accordance with how the terms "marriage" and "spouse" are defined under the Federal *Defense of Marriage Act of 1996*.

Please note that, if you are married, any loan taken from a source that requires spousal consent, such as a loan from the Vested portion of your Retirement Savings source, will require Notarized consent from your spouse.

Interest Rates. Loan interest rates are set based on the prime rate as of the last business day of the month preceding the month in which the loan is taken, announced by Bank of America. For general-purpose loans, the interest rate is the rate announced by Bank of America plus one-half of 1 percentage point. For loans of 5 or more years (available for the purchase of a primary residence only), the interest rate is the rate announced by Bank of America plus 1 percentage point. The interest rate is fixed for the duration of the loan.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Applying for a Loan. To request a loan from your 401(k), Catch-up, Vested Company-matching, Vested Profit Sharing*, Vested Retirement Savings, After-Tax, and Rollover sources, call HR Solutions at 800-835-5099 (TDD 888-343-0860). You can complete your loan application over the phone. Please note that loans from a source that requires spousal consent, such as a loan from the Vested portion of your Retirement Savings source, will require Notarized consent from your spouse if you are married. A form will be mailed to your address of record. Once your completed spousal consent paperwork is received, a check will be mailed to your address of record or funds will be sent via ACH to your bank account.

To apply for a loan for the purchase of a primary residence from your 401(k), Catch-up, Vested Company-matching, Vested Profit Sharing*, Vested Retirement Savings, After-Tax, and Rollover balances, request a loan application from HR Solutions. Submit your completed application before the expiration date printed on your application, together with any required documentation, to the address printed in the loan application instructions.

Loans from a source that requires spousal consent, such as a loan from the Vested portion of your Retirement Savings source, will require Notarized spousal consent if you are married. Once your loan is approved, a check will be mailed to your address of record or funds will be sent via ACH to your bank account.

In both cases, the amount of your loan is taken from each investment option in which the source(s) from which you are taking the loan is invested, on a pro-rata basis. For example, if you have 50 percent of your Company-matching source invested in two investment options and you have requested a loan from your Company-matching source, 50 percent of the amount of your loan will be taken from each investment option in which your Retirement Savings source is invested.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Repaying Your Loan. You repay your loan, with interest, through payroll deductions on an After-Tax basis. Your loan repayments are invested in the same investment options as your most recent contribution elections.

If your loan is approved, your repayments will begin as soon as administratively practicable, depending on your pay frequency and when your loan is approved.

Depending on the reason for your loan, you may choose the repayment period that works best for you. For general purpose loans, the maximum repayment period is five years. If your loan is for the purchase of a primary residence, the repayment period can be for as many as 10 years.

If you are receiving Short-Term Disability (STD) payments, loan repayments automatically are deducted from your STD payments. If you are receiving Long-Term Disability benefits, or are on an unpaid leave of absence, you may either make your loan repayments via certified check or through an auto debit feature that uses ACH. If you elect to make loan repayments using the certified check payment method, you must send monthly repayments, payable to FIIOC, to the following address:

HR Solutions
P.O. Box 770003
Cincinnati, OH 45277-0065

You should include your name and Social Security number (or customer identification number) on the check.

If you elect to make loan repayments through an auto debit feature that uses ACH, you must visit NetBenefits® or contact HR Solutions at 800-835-5099 (TDD 888-343-0860) to set up repayments.

You may make additional loan repayments in addition to regular payroll deductions via certified check or auto debit as well.

If you fail to make timely loan repayments, your outstanding loan amount will be deemed a distribution and will be subject to applicable income taxes and Internal Revenue Code (IRC) early withdrawal penalties (see page 165 for details). For more information, visit NetBenefits® or call HR Solutions at 800-835-5099 (TDD 888-343-0860).

If you leave Fidelity, you will have the opportunity to continue to make payments over the term of the loan via automatic, monthly deductions from your bank account. If you elect not to continue making loan repayments via automatic monthly deductions from your bank account, you must repay the outstanding balance of your loan. If you fail to make loan repayments for greater than 90 days, the unpaid portion of your loan will be treated as a deemed distribution and will become subject to income taxes and applicable IRC penalties.

You may make a withdrawal from your After-Tax, Thrift Employer Match, or Rollover balances at any time for any reason. For more information, call HR Solutions at 800-835-5099 (888-343-0860).

Withdrawals during Employment

Hardship Withdrawals. While employed, you may request a hardship withdrawal from your 401(k), Catch-up, Vested Company-matching, and Vested Profit Sharing contributions*, provided that you satisfy certain requirements. To be eligible to receive a hardship withdrawal, you must have exhausted your ability to borrow from the Profit Sharing Plan, and you must have taken distributions from any After-Tax or Rollover sources you may have in the Profit Sharing Plan. In addition, the hardship withdrawal must be for an immediate and heavy financial need that cannot be satisfied by using other means that reasonably are available to you.

The maximum amount you may request to withdraw is the total of the amount needed to meet your hardship, plus enough to pay any applicable taxes and penalties upon the withdrawal.

Hardship Withdrawals from Your 401(k), Catch-up, Vested Company-Matching, and Vested Profit Sharing* Sources. You may request a hardship withdrawal from your 401(k), Catch-up, Vested Company-matching, and Vested Profit Sharing sources to pay, or assist in paying, for the following:

- Uncovered medical care received by you, or your dependents, or the amount necessary for you or your dependents to obtain such care.
- The purchase of your primary residence, excluding mortgage payments.
- Post-secondary tuition and related educational fees for you or your dependents for the next 12 months that are not covered by tuition reimbursement.
- Payments necessary to prevent eviction from or foreclosure of a mortgage on your primary residence.
- Payments for burial or funeral expenses for deceased parents, spouses, children, or dependents.
- Expenses to repair damage of your primary residence that qualify for a casualty deduction under IRC section 165.

When you receive a hardship withdrawal from your 401(k) contributions, you are prohibited from making 401(k) and Catch-up contributions, as well as any contributions to the FMR LLC Non-Qualified Deferred Compensation Plan, for 12 months following the month in which the withdrawal is made.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

You may request a hardship withdrawal of up to 50 percent of your Vested Profit Sharing source. Hardship withdrawals are not permitted from your Retirement Savings source. Your eligibility for the annual Profit Sharing contribution* is not affected when you take a hardship withdrawal. Effective January 1, 2003, only two hardship withdrawals are permitted in a rolling 12-month period. As a result, all hardship withdrawals taken on or after January 1, 2003, are subject to this limitation.

Hardship withdrawals are not permitted from your Retirement Savings source balance.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Requesting a Hardship Withdrawal. You must submit a request for a hardship withdrawal generally no later than 60 days after the date the eligible expense is incurred and provide acceptable documentation of the expense.

To request a hardship withdrawal log on to NetBenefits>Savings and Retirement>FMR Profit Sharing Plan>Loans or Withdrawals>Withdrawals. You may also request a hardship withdrawal by calling HR Solutions at 800-835-5099 (TDD 888-343-0860) prompt 1.

If your request for a hardship withdrawal is approved, a check will be mailed to your address of record or, if you elect, the funds will be sent to your bank account via ACH. You will be notified if your request for a hardship withdrawal is not approved.

SUMMARY OF LOAN AND HARDSHIP WITHDRAWAL OPTIONS

This chart summarizes when you may request a loan or hardship withdrawal from the sources that make up your total Profit Sharing Plan account while you are an employee. You may never borrow or withdraw more than the Vested value of a particular balance.

For This Feature	You May Request a Loan for:	You May Request a Hardship Withdrawal for:
401(k) Balance	Any reason	Hardship reasons
Catch-up Balance	Any reason	Hardship reasons
Vested Company-Matching Balance	Any reason	Hardship reasons
Vested Profit Sharing Balance**	Any reason	Hardship reasons
Rollover Balances	Any reason	Any reason
Employer Thrift Match Balance	Any reason	Any reason
After-Tax Balance	Any reason	Any reason
Vested Retirement Savings Balance*	Any reason	Not permitted

*Please note that any loan taken from a source that requires spousal consent, such as your Vested Retirement Savings balance, will require Notarized consent from your spouse, if married.

**Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

In-Service Withdrawals. Employees who are participating in the Profit Sharing Plan and who are age 65 or older with at least 10 Years of Vesting Service are eligible to take in-service withdrawals from the Vested portion(s) of their Profit Sharing Plan account balance for any reason. All contributions and rollover sources are eligible for withdrawal, either in whole or in part. Eligible employees may direct from which funds or sources, in whole or in part, the in-service withdrawal may be made.

For purposes of the Retirement Program, you are considered to be married only if you have a spouse who is a member of the opposite sex, in accordance with how the terms "marriage" and "spouse" are defined under the Federal *Defense of Marriage Act of 1996*.

Requesting an In-Service Withdrawal. To make an in-service withdrawal request, call HR Solutions at 800-835-5099, prompt 1, business days from 8:30 A.M. to 8:00 P.M., ET (except New York Stock Exchange holidays) and speak with a Representative. Please note, any distribution from the Employer Thrift Matching source will result in a 12-month suspension from making any new contributions to the Profit Sharing Plan. Additionally, if you are married and you request an in-service withdrawal that includes a withdrawal from a source that requires spousal consent, such as your Retirement Savings source, your spouse's consent is needed before your request will be processed. If applicable, spousal consent paperwork will be mailed to your address of record. Once you return it with your spouse's Notarized consent, your entire in-service withdrawal request will be processed.

Taxes on Hardship and In-Service Withdrawals. Current federal law states that money you withdraw is includable in your taxable income for the year in which the withdrawal is made (excluding any After-Tax and Roth contributions, although earnings on After-Tax contributions are taxable). Earnings on Roth contributions are includable in income unless the employee has had the designated Roth account for five years and is either disabled or over age 59½. The taxable portion of your withdrawal that is eligible for rollover into a Traditional IRA is subject to 20 percent mandatory federal income tax withholding unless it is directly rolled over to an IRA. No portion of a hardship withdrawal is eligible for rollover. Withdrawals made before you reach age 59½ may be subject to an additional 10 percent early withdrawal penalty. You are encouraged to consult with a tax or financial adviser before taking an in-service withdrawal.

Receiving Payment

The Vested portion of your Profit Sharing Plan account balance is the portion that you have a nonforfeitable right to receive. Your Vested Profit Sharing account balance is payable to you (or your beneficiary(ies) if applicable) no sooner than 30 days after your:

- Retirement after attaining your normal retirement date (the first day of the month following the date you reach age 65).
- Retirement after attaining your early retirement date (the first day of the month following the date you reach age 55, provided you have at least 5 Years of Vesting Service).
- Termination of Employment.
- Retirement after attaining your disability retirement date (the date on which you become disabled, as determined by the Social Security Administration).
- You are actively employed and have reached age 65 and have at least 10 years of service.
- Death.

Your *Vested Profit Sharing Plan account balance* is the total of your:

- Pre-Tax and Roth 401(k) contributions, plus any applicable earnings.
- Catch-up contributions, plus any applicable earnings.
- Vested Company-matching contributions, plus any applicable earnings.
- After-Tax Contributions, plus any applicable earnings.
- Rollover contributions, plus any applicable earnings.
- Vested Profit Sharing contributions,* plus any applicable earnings.
- Vested Retirement Savings contributions, plus any applicable earnings.
- Vested Thrift Employer-Match, plus any applicable earnings.
- Vested portion of any other frozen source, grandfathered sources, or those sources that are added to the plan from time to time.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Minimum Required Distributions (MRDs)

Pursuant to the *Worker, Retiree, and Employer Recovery Act of 2008* you are not required to take distributions for the 2009 Plan Year. Participants that first became eligible in 2008 and deferred their 2008 MRD to 2009 will still be required to take that distribution. Specific questions should be directed to Fidelity at 800-835-5095.

If you are no longer actively working for Fidelity when you reach age 70½, the IRC requires that you begin taking a minimum required amount from your Profit Sharing Plan account for the calendar year in which you reach age 70½. This required amount is calculated using the value of your Profit Sharing Plan account as of the end of the year prior to the distribution, as well as a divisor provided in IRS tables based on your age (and in certain cases, the age of your spousal Beneficiary).

You may defer taking the first required distribution until no later than April 1 of the calendar year following the calendar year in which you reach age 70½. In this case, you also must take another required distribution by December 31 of the calendar year in which you received the first required distribution. For example, if you attain age 70½ in 2008, you must take a required distribution for 2008 (the year you attained age 70½) by April 1, 2009, and you also must take a required distribution for the 2009 calendar year no later than December 31, 2009. Both distributions are considered taxable income for the year in which they are received. Thereafter, you must take a required distribution by December 31 of each year. If you do not, you will be required to pay a 50 percent penalty tax.

If you still are actively working for Fidelity when you reach age 70½, you may defer taking required distributions until April 1 of the calendar year following the calendar year in which you retire from the Company. If you own more than 5 percent of the Company, however, you are not eligible to defer your required distributions under this rule.

In the event of your death, your Profit Sharing Plan account is subject to minimum required distribution rules. Your Beneficiary(ies) generally must receive required distributions over his or her life expectancy and required distributions generally must begin by the end of the calendar year following your death. Special rules may apply to spousal Beneficiaries and in other situations. Your Beneficiary(ies) should consult a tax or financial adviser for more information.

Choosing a Payment Form

When your employment with Fidelity ends, you may choose to receive payment immediately or defer payment to a later date. Benefits under the Profit Sharing Plan, except for the Vested portion of your Retirement Savings balance, normally are paid as a series of cash distributions in installments over a period of years. If you are married, the installment period will not exceed the joint life and last survivor expectancy of you and your spouse (the number of years that you and your spouse are expected to live). If you are single, the installment period cannot exceed your life expectancy. Life expectancies are recalculated each year, unless you elect otherwise.

If you are not married at the time benefit payments begin, the normal form of benefit for the Vested portion of your Retirement Savings balance will be paid in the form of a single life annuity. If you are married at the time payments begin, the normal form of benefit for the Vested portion of your Retirement Savings balance will be paid in the form of a qualified joint and 50 percent survivor annuity. Under a qualified joint and 50 percent survivor annuity, you will receive monthly payments for as long as you live, and if you die before your spouse, your spouse will receive benefit payments equal to one-half the payment amount you were receiving prior to your death. These payments will continue for your spouse's lifetime.

When you retire or leave the Company, you will receive a package explaining your distribution options and their general tax implications. You also are encouraged to consult a tax or financial adviser before taking a distribution from the Profit Sharing Plan.

For purposes of the Retirement Program, you are considered to be married only if you have a spouse who is a member of the opposite sex, in accordance with how the terms "marriage" and "spouse" are defined under the Federal *Defense of Marriage Act of 1996*.

Alternate Payment Forms. If you prefer, you may choose to receive benefits under the Profit Sharing Plan in one of the following alternate payments forms:

- Lump-sum distribution in cash or in kind. In kind means that if you take a distribution and roll it over to a Fidelity Rollover IRA, any shares that you own in the investment options will be transferred to the Fidelity Rollover IRA *in kind*, and you will not pay the redemption fee(s) that otherwise accompanies cash distributions.
- Direct Rollover of an "eligible rollover distribution" to a new or existing Fidelity Rollover IRA, Fidelity Brokerage Rollover IRA, or an IRA at another institution.
- Direct Rollover of an "eligible rollover distribution" to an Eligible Employer Plan.
- Partial cash distribution of at least 25 percent of your Vested Profit Sharing Plan account balance, or $25,000, whichever is less, with your remaining Vested Profit Sharing Plan account balance paid in installments.

Please note that if you are married, your spouse must provide Notarized consent if you elect an alternate form of payment. Further, none of the following constitutes an "eligible rollover distribution":

- Required minimum distributions.
- Distributions payable over at least a 10-year period or over life expectancy.
- Hardship withdrawals.

Upon Termination of Employment, you will receive information describing the payment options available to you under the Profit Sharing Plan. You must make your election at least 30 days before the date you would like payments to begin.

If your vested account balance is less than or equal to $1,000 and you do not make a distribution election, your account will be automatically cashed out in a single-sum distribution.

To discuss your options, call HR Solutions at 800-835-5099 (TDD 888-343-0860), Monday through Friday from 8:30 A.M. to 8:00 P.M. ET (except New York Stock Exchange holidays). You are encouraged to consult a tax or financial adviser before taking a distribution from the Profit Sharing Plan.

A WORD ABOUT SOCIAL SECURITY

In addition to the benefit you receive under the Profit Sharing Plan, you may be eligible for Social Security benefits. You must apply for these benefits at your local Social Security office at least three months before you want your payments to begin. For more information, call the Social Security Administration at 800-772-1213 (TTY 800-325-0778).

Important Information about Taxes

When you retire or leave the Company, you will receive a package explaining your distribution options and their general tax implications. You also are encouraged to consult a tax or financial adviser before taking a distribution from the Profit Sharing Plan.

Your Profit Sharing Plan account balance (consisting of various types of contributions and related earnings) is not taxable as long as the money remains in the Profit Sharing Plan. Taxes apply only when you make a withdrawal or receive a distribution from your Profit Sharing Plan Account. Special rules apply for withdrawals of Roth contributions; see the Roth Contributions section below for more information.

As required by law, Fidelity withholds 20 percent of the taxable portion of any withdrawal, or distribution paid to you that is eligible for rollover (but not directly rolled over), for federal income taxes. You may owe more or less than the amount withheld when you file your income tax return. In addition, state and/or local income taxes may be required to be withheld.

In addition to state and federal income taxes, you also may be subject to an additional 10 percent penalty for early distribution. For example, you may be subject to an early withdrawal penalty if you do not repay a loan on time or receive a distribution (including a hardship withdrawal) before reaching age 59½.

In some cases, you may be able to continue deferring taxes on the money in your Profit Sharing Plan account by rolling it over into a rollover IRA or your new employer's Eligible Employer Plan. If the check is made out to you, you must roll over your entire distribution no later than 60 days after the date you receive it or your distribution will be subject to applicable taxes. In addition, if you wish to defer taxes on the entire distribution, you must add, or make up for, any amounts withheld.

Roth Contributions

Qualified distributions of Roth contributions are not includable in gross income. A qualified distribution is a distribution of Roth contributions and any related earnings that is taken at least five tax years after the year of your first Roth contribution and after you have reached age 59½, become disabled, or deceased.

Additional Plan Information

Internal Revenue Code Limits on Pre-Tax Contributions

Federal law prohibits assignment or attachment of your benefits under the Profit Sharing Plan, except in the case of a Qualified Domestic Relations Order (QDRO). For more information about QDROs, refer to the ***Administrative*** section of this SPD.

The Internal Revenue Code (IRC) limits the amount of compensation that can be taken into account in allocating contributions to the Profit Sharing Plan. In 2010, this compensation limit is $245,000. The IRS adjusts this amount periodically.

In addition, the IRC limits the amount you may contribute to certain tax-favored accounts during any calendar year (see page 147). For 2010, the maximum amount you may contribute on a Pre-Tax and/or Roth basis to the 401(k) feature is $16,500 (Section 402(g) limit). This amount is adjusted periodically. This limit applies to 401(k) contributions for all plans in which you participate during one year, even if the plans are sponsored by different employers. If eligible, you also may elect to contribute up to $5,500 in 2010 in Catch-up contributions (see page 147).

Total Profit Sharing Plan Limits

The IRC also limits your total Profit Sharing Plan contributions to the lesser of 100 percent of your gross compensation or an annual limit which is $49,000 for 2010 (Section 415 limit). Your total Profit Sharing Plan contributions include your Pre-Tax and Roth 401(k) contributions as well as Profit Sharing* and Company-matching contributions*. Catch-up contributions are not part of this limit.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

If the total of the 401(k) contributions you make and the Profit Sharing* and Company-matching* contributions Fidelity makes on your behalf, exceeds this limit, the amounts credited to your Profit Sharing account (plus related earnings) will be refunded to satisfy the limit in the following order:

- Employee unmatched Pre-Tax contributions
- Employee unmatched Roth contributions
- Employee matched Pre-Tax contributions and Company-matching contributions (in an amount equal to employee matched Pre-Tax contributions)
- Employee matched Roth contributions and Company-matching contributions (in an amount equal to employee matched Roth contributions)
- Profit Sharing contributions

If you exceed the Section 415 limit, you will be notified and receive information about the tax consequences of the refund.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed in a retail branch location, are not eligible for a Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

IRS Limits for 2010

The Internal Revenue Code (IRC) maximum annual limit for 401(k) contributions for 2010 is $16,500.

The IRC maximum annual limit for Catch-up contributions for 2010 is $5,500.

The IRC compensation limit for 2010 is $245,000.

The IRC maximum annual contribution limit (Section 415 limit) for 2010 is $49,000.

Pension Benefit Guaranty Corporation

Your benefits under the Profit Sharing Plan are not insured by the Pension Benefit Guaranty Corporation (PBGC). The Profit Sharing Plan is not insured by the PBGC because any benefit you receive is based on the Vested balance in your Profit Sharing Plan account.

Assignment of Benefits

In general, you may not assign or alienate your benefits under the Profit Sharing Plan. In addition, creditors cannot reach your Profit Sharing Plan account balance. However, you may secure a loan under the Profit Sharing Plan using a portion of your Vested Profit Sharing Plan account balance as security (see "Borrowing against Your Account" on page 158).

In addition, in certain circumstances, a court may order all or a portion of your Profit Sharing Plan account to be paid to another individual(s), such as your ex-spouse or child(ren), pursuant to a Qualified Domestic Relations Order (QDRO) (see the ***Administrative*** section of this SPD for more information).

A WORD ABOUT QUALIFIED DOMESTIC RELATIONS ORDERS

If HR Solutions, on behalf of the Plan Administrator, receives a Domestic Relations Order (DRO) that affects the payment of benefits under the Profit Sharing Plan and the Plan Administrator determines that the DRO is a Qualified Domestic Relations Order (QDRO), distribution of your Profit Sharing Plan account will be made in accordance with the QDRO. As a result, payment may be made to an alternate payee before you reach your normal or early retirement date.

For more information about QDROs, refer to the *Administrative* section of this SPD. For a copy, at no charge to you, of the Fidelity *QDRO Approval Guidelines*, visit NetBenefits® or call HR Solutions at 800-835-5099 (888-343-0860).

Retiree Health Reimbursement Plan

About the Fidelity Retiree Health Reimbursement Plan

The Fidelity Retiree Health Reimbursement Plan* (RHRP) is designed to provide you with a way to help pay for eligible medical expenses you incur in retirement. This plan is known as a health reimbursement arrangement, or "HRA."

How the RHRP Works

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

Eligibility to Accrue Credits

You automatically receive RHRP credits if you:

- Are a Regular Employee who is regularly scheduled to work 20 or more hours per week,
- Are at least 18 years old,
- Work for a Participating Fidelity Company, and
- Satisfy the eligibility requirements below.

Initial Eligibility to Accrue Credits

You are eligible to receive RHRP credits as of the first business day of the month coinciding with or following your completion of twelve consecutive months of employment during which you have been credited with at least 1,000 hours of service. For this purpose, the first 12-month period is measured from your date of hire or adjusted date of hire if applicable.

Note that employees who were actively employed by a Participating Fidelity Company as of January 1, 2007, will receive credit for prior service for the purpose of determining eligibility to receive RHRP credits.

Ongoing Eligibility to Accrue Credits

Each year, to be eligible to receive RHRP credits, you must:

- Be actively employed by Fidelity on the last business day of the Plan Year
- Be credited with at least 1,000 hours of service during the Plan Year

Generally, you are credited with an *hour of service* for each hour of which you are entitled to be paid by Fidelity, including both working hours and paid non-working hours, such as vacation, holidays, sick days, severance, and the like. Please note, however, that you will only be credited once for any hour of service for which you worked and also received holiday, sick, overtime, or other such pay. During any single period of paid absence from work, you generally cannot be credited with more than 501 hours of service.

How Your Service Is Measured

How Your Hours of Service Are Counted. If you are regularly scheduled to work 30 or more hours per week, you will be credited with 190 hours of service for each month in which you work at least one hour for purposes of both accruing and receiving Plan credits.

If you are regularly scheduled to work fewer than 30 hours per week, the number of hours of service that you are credited with equals the actual number of hours you work.

If you are on an approved leave of absence from work because of the birth or adoption of a child, you will be credited with no more than 501 hours of service in the Plan Year during which the absence begins.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

If You Leave and Are Rehired. If you have satisfied the eligibility criteria to receive RHRP credits when you leave Fidelity, and you are later rehired, you will become eligible to receive the RHRP credits again immediately upon your rehire, provided that you meet the ongoing eligibility requirements. You will receive a pro-rated RHRP credit in the year of rehire equal to one-twelfth of the annual RHRP credit multiplied by the number of the months during the Plan Year in which you are credited with service.

If you were eligible to access your RHRP credits and are later rehired, your access to your RHRP credits will be suspended.

If you had credits in your RHRP account when you left Fidelity, and you did not incur a 5 year break in service, your credits will be reinstated upon your rehire.

While on paid leave, you will receive credit for your leave hours (up to 501) for purposes of accruing and receiving Plan credits for any single continuous period of leave.

If You Were Employed by Certain Capital Companies, Fidelity International Ltd. (FIL), Fidelity Investments Canada Limited (FICL), and Are Hired by or Transfer to Fidelity or if You Were an Albuquerque-Based Fidelity HR Services Employee and You Begin Working for an RHRP Participating Business Unit: You generally may be credited for your prior service for the purposes of receiving and/or accessing credits in the RHRP. Contact HR Solutions at 800-835-5099 (TDD 888-343-0860) and provide your work history. HR Solutions will work with Employee Benefits to research your request.

Receiving Plan Credits*

If you meet the ongoing eligibility requirements, Fidelity will make an annual RHRP credit to your RHRP account. The amount of the credit will be determined by Fidelity on an annual basis. Regular Employees who are regularly scheduled to work 30 hours per week or more may receive a greater credit amount than Regular Employees who are regularly scheduled to work at least 20 but fewer than 30 hours per week.

Interest on Credits. While actively employed by a Participating Fidelity Company, the credits you receive will earn a fixed interest rate that will be determined on an annual basis. Interest will be credited daily and posted to the Acclaris website on a monthly basis.

*Subject to sufficient Company profits and cash flows.

Service Credit

Employees who were actively employed by a participating Fidelity Company as of January 1, 2007, will receive credit for prior service for the purposes of determining if you have satisfied the service requirement needed to access credits.

CREDITS

Participants can view their credits on the Acclaris website which can be accessed through NetBenefits®. Acclaris provides administrative services for the RHRP.

Pro-rated Credits

If, after meeting the initial eligibility requirement, but prior to meeting the ongoing eligibility requirements for the Plan Year, you meet one of the following criteria below, a pro-rated annual RHRP credit will be made to your account for the year in which the event occurs.

- Are age 55 with 10 years of service and leave the Company,
- Leave and go to a Fidelity Company that is not participating in the RHRP, or
- You die.

The amount of the credit will be equal to one-twelfth of the annual RHRP credit multiplied by the number of months during the Plan Year in which you are credited with service prior to the date of termination or death.

Eligibility to Access RHRP Credits

You are eligible to submit expenses for reimbursement and will become a participant in the RHRP, provided you meet the following age and service criteria:

- Your employment with Fidelity ends,
- You are credited with 10 or more years of service, and
- You have reached age 55.

If you leave the Company before your 55th birthday but after you have satisfied the service requirement, you will be eligible to submit your reimbursement requests for eligible medical expenses you incur after you reach age 55. If you leave the Company after attaining age 55 but have not completed the service requirement, your RHRP credits will be forfeited. The amount of credits you forfeited will be reinstated if you return to employment within 5 years of your termination date.

Expenses Eligible for Reimbursement

Retiree Health Reimbursement Plan credits can only be used for the reimbursement of eligible medical expenses that you incur in retirement and are not otherwise covered by a medical, dental, vision, or other health plan. Eligible expenses include all medical expenses determined by the IRS to be qualified medical expenses. Expenses must be incurred by you or your opposite-sex spouse.

Eligible expenses recognized by the IRS include, but are not limited to, the following:

- Deductibles
- Co-payments
- Out-of-pocket medical expenses not covered—or partially covered—by medical, dental, or other group health plans
- Medical plan premiums, including COBRA premiums
- Medicare premiums, including Part A, Part B, Part D, and Medicare HMOs for individuals over age 65
- Long-term-care insurance premiums, subject to certain limits

For more information about eligible expenses, refer to IRS publication 502 or contact the Acclaris Reimbursement Center at 866-203-9358.

HOW TO FILE A CLAIM FOR REIMBURSEMENT

After you have incurred and paid for eligible expenses, complete a *Fidelity Retiree Health Reimbursement Plan Reimbursement Request* claim form, available on the Acclaris Reimbursement Center, which can be accessed via NetBenefits®. Submit the completed claim form, along with proof of payment to: Acclaris Reimbursement Center, PO Box 20571, Tampa, FL 33622-0571. Or, via fax to: 813-830-7900. If you have a credit amount of $50 or less in your account, Fidelity has the discretion to send you a check for the remaining amount in your account.

If You Die before Benefit Payments Begin

If you should die while employed with Fidelity, your surviving opposite-sex-spouse immediately will be eligible to access the credits in your RHRP account and will be considered a Plan participant. You do not have to meet the age and service requirements prior to your death for your surviving spouse to be eligible to access the credits in your account.

If you do not have a surviving spouse upon your death, your RHRP credits will be forfeited back to the Company.

If Both You and Your Spouse Are Employed by Fidelity

If your surviving opposite-sex spouse is actively employed by Fidelity at the time of your death, your surviving opposite-sex spouse will not have immediate access to the credits in your RHRP account until they terminate.

When No RHRP Benefit Is Payable

You are not entitled to receive a benefit under the RHRP if you:

- Leave Fidelity with fewer than 10 Years of Credited Service.
- Die and do not have a surviving opposite-sex spouse.

Divorce

If you are not eligible to access your RHRP credits and you get divorced, your ex-spouse will not be entitled to any benefit under the Plan.

Continuation of Coverage for Ex-Spouses. If you are eligible to access RHRP credits and you get divorced, your opposite-sex spouse may be able to continue coverage for a limited time under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA).

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Administrative

Administrative Information

The Fidelity benefits program is broad and complex, and is regulated and governed by a number of federal agencies. As a result, there are many administrative requirements that are important for you to know about.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

A Word about Life Changes

Many of your life changes—including, but not limited to, getting married, having a baby, or changing your work schedule—may affect the benefits described in this SPD. Refer to the ***Life & Work Events*** section of this SPD to learn what steps you must take to continue to get the most from your benefits.

As a participant, you are encouraged to learn as much as possible about Fidelity's benefit plans. Providing this SPD is one way we help you stay informed. If you have any questions about your benefits, contact HR Solutions at 800-835-5099 (TDD 888-343-0860).

This Summary Plan Description (SPD) provides information about how the benefit plans are structured and administered. It provides an explanation of your rights as a participant or Beneficiary. The SPD for each plan includes the ***Benefits Overview, Administrative,*** and ***Glossary*** sections, together with the section that describes the benefits of a particular plan.

You may examine copies of the Fidelity plan documents, and any related contracts, without charge and obtain copies of them for a reasonable charge.

This section addresses the disclosure requirements for health, welfare, and pension benefit plans under the following applicable laws:

- *Employee Retirement Income Security Act* (ERISA).
- *Consolidated Omnibus Budget Reconciliation Act* (COBRA).
- *Health Insurance Portability and Accountability Act* (HIPAA).
- *Newborns' and Mothers' Health Protection Act* (NMHPA).
- *Women's Health and Cancer Rights Act* (WHCRA).
- *Uniformed Services Employment and Reemployment Rights Act* (USERRA).

Coordination of Benefits

If you or a covered family member is covered by another group medical or dental plan (for example, your spouse's employer's plan), or through a governmental or tax-supported program, the HealthFlex Plan, the Fidelity Health Plan, and the Dental Plan each coordinates with that other plan regarding the payment of benefits under that other plan to ensure that your total payments from all sources do not exceed the actual cost of services provided. This is called *coordination of benefits*. (If you have coverage under the Group Long-Term Care Insurance Plan, please refer to page 131 for information regarding coordination of benefits.) Please note: there is no coordination of benefits for prescription drug coverage.

Each of the Health Maintenance Organization (HMO) medical options also contains a coordination of benefits provision. You should review the detailed description of the HMO coverage provided by the HMO to learn the specific details of its provisions.

The plan that pays first depends on which plan is *primary* and which plan is *secondary*. The primary plan pays first. Generally, Fidelity's plan is primary for a covered active Fidelity Regular Employee and secondary for a spouse who also is covered by his or her own employer's plan. For those enrolled in COBRA continuation coverage, Medicare is primary and Fidelity's plan is secondary.

The primary plan for your covered Eligible Dependent child(ren) is determined by the *birthday rule*—meaning that the plan of the parent whose birthday occurs first during the calendar year pays first. For example, if you and your spouse are covered by different group plans and you each cover your dependent child(ren) and your birthday is in June and your spouse's birthday is in October, your plan is the primary plan for your child(ren) and your spouse's plan is the secondary plan.

If you and your spouse have the same birthday, the plan that has covered the parent for a longer period of time is the primary plan for the child(ren). If your spouse's plan does not use the birthday rule, your children's primary plan generally is their father's plan. If you and your same-sex spouse or Domestic Partner have the same birthday, the plan that has covered the parent for a longer period of time is the primary plan for the child(ren). If you are divorced, your children's primary plan is the plan of the parent with financial responsibility for the children.

To ensure that your total payments from all sources do not exceed the actual cost of services provided, benefits from your Fidelity medical and dental plans are coordinated with other benefits you may be eligible to receive. This is called *coordination of benefits*.

This chart summarizes the primary and secondary plans:

COVERED INDIVIDUAL	PRIMARY PLAN	SECONDARY PLAN
You (active Regular Employee)	Your Fidelity plan	Your spouse's group plan
Your spouse	Your spouse's group plan	Your Fidelity plan
Your Eligible Dependent child(ren)	Plan of parent whose birthday occurs first in the calendar year	Other parent's plan

The information in this chart summarizes the coordination of benefit provisions under the HealthFlex Plan, the Fidelity Health Plan and the Dental Plan. Different provisions may apply to HMO and Group Long-Term Care coverage. Contact the carriers directly for more information.

When the Fidelity plan is the secondary plan, combined benefits from the primary plan and your Fidelity plan may not total more than what your Fidelity plan otherwise would have paid alone. In other words, the Fidelity plan *only* provides benefits up to the normal levels, even with coordination of benefits. This type of coordination is known as *non-duplication* of benefits.

When filing claims, you should always file the claim with the primary plan first. If you are unsure which plan is primary and which is secondary, contact HR Solutions at 800-835-5099 (TDD 888-343-0860).

Right of Recovery

Fidelity, its Claims Administrators, and its insurance carriers reserve the right to recover any claim payments you or a covered family member may receive from a third party because of that third party's legal liability. A third party includes any uninsured or underinsured motorist coverage. For example, if you receive payment from an automobile insurer, Fidelity may be able to recover all or part of that payment to recoup benefits paid from a Fidelity plan.

Fidelity, its Claims Administrators, and its insurance carriers may sue to recover any refund for benefits paid under a Fidelity plan. If you sue the responsible party or accept a settlement, the applicable plan still has the right to pursue recovery including, but not limited to, filing a suit to impose a constructive trust on the amounts you recover. Where a right of recovery exists, it is your responsibility to reimburse the Fidelity plan for any benefits paid.

Qualified Domestic Relations Orders

Benefits under the Profit Sharing Plan are intended for participants and their Beneficiaries. Generally, you cannot transfer your rights to your benefits to another as a settlement of a debt, or use them as collateral to secure a loan, other than in the case of certain loans under the Profit Sharing Plan.

In addition, your benefits under the Profit Sharing Plan generally are not subject to creditors' claims, although your benefits are subject to attachment by the Internal Revenue Service (IRS).

However, if Fidelity Employer Services Company LLC ("FESCo"), on behalf of the Plan Administrator, receives a Domestic Relations Order (DRO), and the Plan Administrator determines that it is a Qualified Domestic Relations Order (QDRO), as that term is defined under both ERISA and the Internal Revenue Code, the portion of your benefit specified in the QDRO must be paid to the person or persons named in the QDRO. The person(s) named in the QDRO, known as *alternate payee(s)*, may include any opposite-sex spouse, former opposite-sex spouse, child, or other dependent who, pursuant to a QDRO, has a right to receive all or a portion of your benefit. A QDRO is a legal judgment, decree, or court order relating to child support, alimony, or marital property that the Plan Administrator has determined is qualified and that clearly specifies, among other things, the amount of your benefit payment to be paid to one or more alternate payees.

Before making any payments to an alternate payee, the Plan Administrator must determine whether the DRO is qualified. The Plan Administrator has adopted *QDRO Approval Guidelines* for this purpose, which are available to participants and Beneficiaries, free of charge, by logging on to qdro.fidelity.com or by contacting HR Solutions.

Upon FESCo's receipt of a DRO, you will be notified in writing. You will be informed of the initial determination of whether the DRO is qualified, and thereby constitutes a QDRO, no later than 90 days after receipt of the DRO. If a final determination is not made within an 18-month period, your benefit will be treated as if the DRO was never received.

For further information and to request a copy, free of charge, of the Fidelity *QDRO Approval Guidelines*, call HR Solutions at 800-835-5099 (TDD 888-343-0860).

Qualified Medical Child Support Orders

As required by ERISA, Fidelity's group health (medical, dental, and EAP) plans recognize Qualified Medical Child Support Orders (QMCSOs). A QMCSO is an order, issued by a state administrative agency, in accordance with federal and state laws, that the Plan Administrator has determined is qualified and thereby requires an Alternate Recipient (for example, a child or stepchild) to be covered under a participant's group health coverage.

Fidelity's health plans honor QMCSOs that meet the legal requirements for such orders. It's important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available under the plan to which the order applies. However, a QMCSO may require a plan to provide a benefit or option not otherwise available if it is necessary to meet the requirements of the *Social Security Act* relating to the enforcement of state child support laws and reimbursement of Medicaid.

A medical child support order must be provided to Fidelity Employer Services Company LLC ("FESCo"). FESCo determines in accordance with the Plan Administrator's direction, if the medical child support order meets the legal requirements for a QMCSO. If it does, the Alternate Recipient is considered a Beneficiary for purposes of ERISA and is enrolled in the plan(s) set forth in the QMCSO as a dependent of the employee. If the Plan Administrator receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether it satisfies the legal requirements for a QMCSO.

For further information, and to request a copy of the Fidelity *QMCSO Procedures and Approval Guidelines*, free of charge, call HR Solutions at 800-835-5099 (TDD 888-343-0860), prompt 1.

Continued Coverage under COBRA

(Medical, Dental, and EAP Coverage, as well as the Health Care Flexible Spending Account and the Health Care HSA-Compatible Flexible Spending Account and any other plan subject to COBRA)
The *Consolidated Omnibus Budget Reconciliation Act* (COBRA) is a federal law which governs instances in which you and/or your covered Eligible Dependents may be allowed to continue certain Fidelity-sponsored benefit coverage at the group rates following certain events. As COBRA is a federal law, the definitions of marriage (a legal union between one man and one woman) and spouse (a husband or wife who is a member of the opposite sex) as described in the *Defense of Marriage Act of 1996* (DOMA) apply for purposes of determining who is an Eligible Dependent who is eligible for COBRA. Please refer to the COBRA-like coverage section for additional information regarding continuation coverage for an Eligible Dependent who is a same-sex spouse or Domestic Partner. COBRA is offered if you and/or your Eligible Dependents were covered under the applicable plan on the day before the COBRA Qualifying Event and lose eligibility for coverage because of one of the following COBRA Qualifying Events:

- Termination of Employment.
- Reduction of work hours.
- Divorce or legal separation, as those terms are defined under federal law, of an employee.
- Employee's death.
- The covered employee's entitlement to Medicare benefits.
- Loss of status as an Eligible Dependent.

Duration of Continued Coverage

The maximum period for which group health plan coverage is continued under COBRA differs depending on which Qualifying Event has occurred. You and your Eligible Dependents are entitled to elect 18 months of continuation coverage if the Qualifying Event is your Termination of Employment or reduction in your work hours. However, if a second qualifying event occurs during the 18-month period, this period may be extended for up to 36 months from the original COBRA Qualifying Event date. For example, if you terminate employment (your first COBRA Qualifying Event), you and your Eligible Dependents may be eligible for up to 18 months of COBRA continuation coverage. If, during this 18-month period, your covered dependent child ceases to be an Eligible Dependent under the terms of the Fidelity plan (the second COBRA Qualifying Event), your child's 18-month continuation period may be extended for up to 36 months.

If you have elected to receive COBRA continuation coverage, you have the same rights as an active Regular Employee who is covered under the plan for purposes of changing your coverage options during the Annual Benefits Enrollment period or qualifying for a special enrollment period.

If you or any of your covered Eligible Dependents:

- Become disabled at any time before the 60th day of COBRA continuation coverage, and
- Are determined to be disabled by the Social Security Administration, you and your Qualified Beneficiaries may continue coverage for up to an additional 11 months after the 18-month period, for a maximum total of 29 months. To be eligible for the additional 11 months of coverage, you must notify HR Solutions at 800-835-5099 (TDD 888-343-0860) before the end of the initial 18-month period and no later than 60 days after the Social Security Administration's determination.

For all other COBRA Qualifying Events listed above, other than termination of your employment or reduction of your work hours, your covered Eligible Dependents are entitled to elect 36 months of continuation coverage.

PROVIDING NOTICE OF QUALIFIED EVENT – PROCEDURES FOR EMPLOYEES AND THEIR COVERED ELIGIBLE DEPENDENTS

You and your covered Eligible Dependents are required to provide notice of certain events. Failure to provide such notices may affect your and your Eligible Dependents' eligibility for COBRA continuation coverage.

You and your covered Eligible Dependents are required to notify HR Solutions within 60 days of a divorce, legal separation, or child ceasing to be a dependent child under the terms of the plan.

You and your covered Eligible Dependents must notify HR Solutions within 60 days of a second qualifying event that is a death, divorce, legal separation, or a dependent child ceasing to be a dependent under the terms of the plan if the second qualifying event occurs during the 18-month COBRA continuation period.

You and your covered Eligible Dependents must notify HR Solutions of a determination of disability by the Social Security Administration. The notification must be provided within 60 days of the Social Security disability determination and before the 18-month period. You and your covered Eligible Dependents must also notify HR Solutions within 30 days of any final determination by the Social Security Administration that such is no longer disabled.

To provide notification of any of the events described above, call HR Solutions at 800-835-5099 Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 A.M. and 8:00 P.M. ET. You must provide the date of the event. You may also be required to provide the names and Social Security numbers of your covered Eligible Dependents that are affected by the events.

Electing Continued Coverage

If the COBRA Qualifying Event that causes you or your Eligible Dependent(s) to lose coverage is your Termination of Employment, reduction in hours or entitlement to Medicare, HR Solutions automatically will be notified and your COBRA election notice will be mailed to you. However, if the COBRA Qualifying Event that causes you or your Eligible Dependent(s) to lose coverage is your divorce or legal separation from an opposite-sex spouse, or if a dependent ceases to satisfy the definition of Eligible Dependent under the terms of the Fidelity plan(s), you or your covered Eligible Dependent(s) must notify HR Solutions no later than 60 days after the COBRA Qualifying Event. You or your covered Eligible Dependent(s) then will receive an election notice describing the applicable premiums for the COBRA continuation coverage.

You and your covered Eligible Dependent(s) will have 60 days from the later of: the date your coverage with the applicable plan would have stopped because of the COBRA Qualifying Event or the date your COBRA election notice is sent.

The cost of the COBRA continuation coverage is 102 percent of the full group rate premium. The cost increases to 150 percent of the full group rate for the 11-month disability extension. However, the premium remains at 102 percent of the full group rate premium if only the non-disabled individuals are covered during the 11-month extension period.

Generally, if you or your covered Eligible Dependent(s) elect COBRA continuation coverage, the coverage levels previously in effect will be extended. In addition, you will be given the opportunity to select new options during the Annual Benefits Enrollment period.

In the Event of Your Death

If you die while employed by Fidelity, your covered Eligible Dependent(s) may continue medical coverage by electing COBRA continuation coverage. Your covered Eligible Dependent(s) will receive a COBRA election notice describing their rights under COBRA shortly after your death. Your covered Eligible Dependent(s) will have 60 days from the later of: the date their coverage under the applicable plan would have stopped because of your death or the date their COBRA election notice is sent. Provided that your covered Eligible Dependent(s) elect COBRA coverage, continued coverage for the first six months after your death will be available at no cost to your covered Eligible Dependent(s). After this six-month period, your covered Eligible Dependent(s) will be responsible for paying the full COBRA premium for the remaining COBRA coverage period.

Please note: if your surviving spouse is a benefits eligible Fidelity employee your surviving spouse may elect medical, dental, and EAP coverage as an employee, instead of continuing coverage under COBRA. In order to elect coverage as an employee, your surviving spouse must contact HR Solutions within 31 days of your death. If your surviving spouse does not elect coverage as an employee and rather chooses to continue coverage under COBRA, they are not eligible to receive 6 months of COBRA coverage at no cost.

When COBRA Continuation Coverage Ends

The law provides that your COBRA continuation coverage may be terminated for any one of the following reasons:

- After you make your COBRA election, you become covered by another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that you or your covered dependents may have. If the other group health plan has pre-existing condition exclusions or limitations but they will not apply because of HIPAA requirements, your COBRA coverage also may end. However, if you or your covered Eligible Dependent(s) have a pre-existing condition and are not covered under the other group plan because of a pre-existing condition exclusion or limitation, COBRA coverage will continue and will not terminate.
- After you make your COBRA election, you become entitled to Medicare.
- After you make your COBRA election, you fail to make timely premium payments.
- You extend coverage for up to 29 months because of your own, or your covered Eligible Dependent's, disability, and during that 29 months there has been a subsequent determination by the Social Security Administration that you or your covered Eligible Dependent(s) is no longer disabled.

If your coverage under a Fidelity group health plan ends, or your employment terminates and you are eligible for continued coverage under COBRA, Fidelity will provide you and your covered Eligible Dependents with a written certificate of creditable coverage. Except with respect to same-sex spouses, this certificate will enable you to reduce or eliminate any pre-existing condition limitations or exclusions a new employer's group health plan may impose. Be sure to keep this certificate when you receive it.

When enrolled, you are able to cancel your COBRA coverage at any time without a Change in Status by contacting HR Solutions at 800-835-5099 (TDD 888-343-0860).

COBRA-like Coverage

Although same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the Medical and Dental Plans and the Employee Assistance Program. Please note, however, that same-sex spouses and Domestic Partners are not eligible for COBRA-like coverage under the Health Care Flexible Spending Accounts.

Your Rights under HIPAA

(Medical, Dental, and EAP Coverage, as well as the Health Care Flexible Spending Account and Health Care HSA-Compatible Flexible Spending Account)

The *Health Insurance Portability and Accountability Act* (HIPAA) is a federal law that is designed to make it easier for you and your covered family members to have continued group health coverage when changing jobs. As HIPAA is a federal law, the definitions of marriage (a legal union between one man and one woman) and a spouse (a husband or wife who is a member of the opposite sex), as described in the *Defense of Marriage Act of 1996* (DOMA) apply.

Special Enrollment Period

If you decline group health coverage for yourself, or your Eligible Dependents, because of other group health coverage, you may be able to enroll yourself and/or your Eligible Dependents in a Fidelity group health plan in the future if your other group health coverage ends (or if the employer stops contributing towards your or your dependents' other coverage), provided that you request enrollment in a Fidelity group health plan within 31 days of the date on which your other group health coverage ends (or after the employer stops contributing toward the other coverage).

This special enrollment right is available only if the other group health coverage ends:

- In the case of COBRA coverage, because the maximum COBRA period has expired.
- Because of loss of eligibility through no fault of your own.

In addition, if you had previously declined group health coverage and have a new dependent as a result of marriage, birth, adoption, or placement for adoption (a *Change in Status*), you may be eligible to enroll yourself and your dependents, provided you request enrollment within 31 days of the date on which the Change in Status occurs.

To request special enrollment or obtain more information call HR Solutions at 800-835-5099 (TDD 888-343-0860).

In addition, you may enroll in medical, dental, and Health Care Flexible Spending Account coverage for yourself and your eligible dependents if:

- Your or your eligible dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility.
- You or your eligible dependents become eligible for employment assistance under Medicaid or CHIP coverage.

To request special enrollment or obtain more information, you must contact HR Solutions at 800-835-5099, prompt 1, **within 60 days** of the date of termination or the date you or your eligible dependents are determined to be eligible for assistance.

HIPAA Certificates of Coverage

If your coverage under a Fidelity group health plan ends, Fidelity will provide you and your covered Eligible Dependents, including an Eligible Dependent who is a same-sex spouse, with a written certificate of creditable coverage defining your periods of group health coverage at Fidelity. Except with respect to a same-sex spouse, this certificate will enable you to reduce or eliminate any pre-existing condition limitations or exclusions that a new employer's group health plan may otherwise impose, so long as you do not incur a 63-day break in coverage when changing jobs. Although a same-sex spouse or Domestic Partner may present a certificate of creditable coverage to support a request to reduce or eliminate any pre-existing condition limitations or exclusions that a new employer's group health plan may otherwise impose, the new employer's group health plan is under no legal obligation, based on federal law, to accept the same-sex spouse or Domestic Partner's certificate of creditable coverage and thereby reduce or eliminate the pre-existing condition limitation. Be sure to keep this certificate when you receive it.

A certificate of creditable coverage will be provided automatically to any covered person after that individual loses coverage under a Fidelity group health plan. The names of your covered Eligible Dependents will be included on the certificate sent to you. If you do not receive a certificate within two weeks of losing group health plan coverage or if the certificate does not include your covered dependents' names, promptly call HR Solutions.

Requesting a Certificate. You may request a certificate of creditable coverage within 24 months after losing group health coverage under a Fidelity plan. You may contact HR Solutions at 800-835-5099 (TDD 888-343-0860) to request a certificate of creditable coverage.

Your Rights under NMHPA

(Medical Coverage)

The *Newborns' and Mothers' Health Protection Act* (NMHPA) provides that 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 a 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If a state law provides for a hospital length of stay in connection with childbirth for the mother or newborn child that is greater than 48 hours following a vaginal delivery, or greater than 96 hours following a cesarean section, the state law provision will apply to the extent that state law is applicable.

Your Rights under WHCRA

The *Women's Health and Cancer Rights Act* (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy to provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending Physician and the patient. This coverage may be subject to annual deductibles and Coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable plan. Please refer to the ***Medical*** section of this SPD for information regarding deductibles and Coinsurance under the HealthFlex and Fidelity Health Plan. For information regarding the HMO medical plans, please contact the HMO(s) directly.

Your Rights under USERRA

The *Uniformed Services Employment and Reemployment Rights Act* (USERRA) extends various benefit plan rights to individuals who return to employment after completing an approved military leave. In order to obtain the benefits available under USERRA, you must:

- Provide reasonable advance notice of your military leave.
- Reapply or arrive for work in a timely manner after your discharge.
- Have been honorably discharged from all military leaves, generally not to exceed a total of 5 years.

For purposes of USERRA, military leave includes the following duties on a voluntary or involuntary basis in the U.S. armed forces and reserves, including the Coast Guard, the Army National Guard, and the Air National Guard; full-time National Guard; the commissioned corps of the Public Health Service, and certain types of service in the National Disaster Medical System during a public health emergency:

- Active duty, including training.
- Inactive duty for training.
- Absence for the purposes of an examination to determine fitness to perform such duty.

If your scheduled military leave is less than 31 days, you generally must return to work by the start of the first full, regularly scheduled work period that begins at least 8 hours after you return home from service. If your military leave is more than 30 days but fewer than 181 days, you generally must return to work no later than 14 days after you return home from service. If your military leave is more than 180 days, you generally must return to work no later than 90 days after you return home from service. Special time-to-return rules apply if an injury or illness is incurred or aggravated while on military leave.

For more information about USERRA, call HR Solutions at 800-835-5099 (TDD 888-343-0860).

How USERRA Affects Profit Sharing Plan Benefits

When you return from the USERRA-recognized military leave, you are credited with hours of service for your period of absence. This time counts for eligibility, Years of Service, Years of Vesting Service, and Benefit Service purposes. In other words, upon your return from USERRA-recognized military leave, you will be entitled to receive the same benefits that you otherwise would have received but for the USERRA-recognized military leave. Also, when you return, you will immediately resume participation, provided you were a participant and you return to a regular position with a Participating Fidelity Company.

The *Employee Retirement Income Security Act* (ERISA) provides you with certain rights and protection(s) for benefits offered by Fidelity.

In addition, when you return from your USERRA-recognized military leave, you have the right to make up 401(k) and/or Catch-up contributions, if applicable (through payroll deductions from your Eligible Compensation), that could have been made to the Profit Sharing Plan if you had not been on the USERRA-recognized military leave. If the 401(k) contributions would have received Company-matching contributions, you will also receive those contributions provided you first make the 401(k) contributions. You must make up 401(k) and/or Catch-up contributions, if applicable, by the fifth anniversary of your return or within three times the period of your leave, if shorter.

In addition, Fidelity will make up any Profit Sharing contributions that you would have received if you were not on the USERRA-recognized military leave. You are not entitled to any past earnings on makeup contributions.

Call HR Solutions at 800-835-5099 (TDD 888-343-0860) for more information on how to make up 401(k) contributions and/or Catch-up contributions, if applicable, or if you have questions about how USERRA affects your Profit Sharing Plan benefits.

Your ERISA Rights

As a participant in Fidelity's benefit plans, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974* (ERISA), as amended. 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 worksites, all documents governing the plans, including insurance contracts, 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 documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, opposite-sex spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer 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.

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 you and other plan participants and Beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension and/or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension and/or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report 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 administrator. If you have a claim for benefits which 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 your plan(s), 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 in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A claim is a demand to the Claims Administrator for coverage or payment of benefit.

Claims and Appeals Procedures

Introduction

If you believe you are entitled to a benefit, or to a greater amount of benefits under the Fidelity plan(s) than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator. If your claim is denied, in whole or in part, you also have the right to appeal this decision with the applicable Appeals Administrator. Depending on the plan, there may be multiple levels of appeal available to you.

For certain plans, there is an internal committee, the FMR LLC Appeals Committee, which makes the final determination on an appeal. Specifically, the FMR LLC Appeals Committee is the Appeals Administrator who makes final determinations on appeal under the following plans:

- Employee Assistance Program
- Profit Sharing Plan
- Retiree Health Reimbursement Plan
- Tobacco Cessation Program

Written appeals for benefits under the plans listed above may be submitted to the FMR LLC Appeals Committee at the following address:

FMR LLC Appeals Committee
c/o Employee Benefits
82 Devonshire Street
Mailzone ZE6C
Boston, Massachusetts 02109

For the following plans, the applicable Appeals Administrator has the discretion to make the final determination on an appeal:

- HealthFlex Plan
- Fidelity Health Plan
- HMO Plans
- Prescription Drug Coverage
- Dental Plan
- Health Care Flexible Spending Account
- Health Care HSA-Compatible Flexible Spending Account
- Dependent Care Flexible Spending Account
- Core Life Insurance Plan (includes Employee and Dependent Life Insurance Plans)
- Business Travel Accident Insurance Plan
- Variable Life Insurance Plan
- Short-Term Disability Plan
- Long-Term Disability Plan (includes Core and Supplemental Long-Term Disability coverage)
- Group Long-Term Care Insurance Plan

Written appeals for benefits under these plans should be submitted to the applicable Appeals Administrator and not to the FMR LLC Appeals Committee.

In most cases, the time frames during which you may file a claim or an appeal, as well as the time frames within which the applicable Claims Administrator or Appeals Administrator must provide you with an answer, are governed by the *Employee Retirement Income Security Act of 1974*, as amended ("ERISA"). Generally, the time frames applicable to your claim or appeal are based on the type of plan under which you are filing your claim or appeal. This section will review the claims and appeals procedures, including the applicable time frames, for each of the three broad categories of plans.

Category I: Group Health Plans

The claims and appeals procedures for "group health plans" will apply if you are filing a claim or an appeal for a benefit under one of the following plans:

- **HealthFlex Plan**
- **Fidelity Health Plan**
- **HMO Plans**
- **Prescription Drug Coverage**
- **Dental Plan**
- **Health Care Flexible Spending Account**
- **Health Care HSA-Compatible Flexible Spending Account**

- **Employee Assistance Program**
- **Tobacco Cessation Program**
- **Retiree Health Reimbursement Plan**

Types of Claims under Group Health Plans

Under a "group health plan" there are three different types of claims that you may file. These types of claims are determined by whether the terms of the applicable plan require you to obtain approval prior to receiving medical care under the plan. The three types of claims are defined as follows:

Pre-Service Claim – A claim for benefits under a group health plan that, by its terms, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Urgent Care Claim – A pre-service claim for benefits where the otherwise applicable time frames for obtaining approval either: 1) could seriously jeopardize your life or health or your ability to regain maximum function, or 2) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be managed adequately without the care or treatment.

Post-Service Claim – A claim for benefits under a group health plan that is not a pre-service claim or an urgent care claim.

Initial Claims for Benefits under Group Health Plans

If you believe you are entitled to a benefit, or to a greater amount of benefits under the applicable group health plan(s) than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator (see the Claims and Appeals Administrator Directory on pages 191–195 for the address of the Claims Administrator(s)). In many cases, your initial claim for benefits is filed when you or your provider submits a request for benefit payment to the applicable Claims Administrator. In response to submission of this claim, you receive an "Explanation of Benefits" from the Claims Administrator, which indicates if your claim for benefits was approved or denied (either in full or in part).

General Rule. If you file a claim for benefits under a group health plan, the applicable Claims Administrator must notify you of its benefit determination within the time frame(s) set forth below, based on the type of claim you filed:

Initial Urgent Care Claim – within 72 hours of receipt of the claim

Initial Pre-Service Claim – no later than 15 days after receipt of the claim

Initial Post-Service Claim – no later than 30 days after receipt of the claim

Missing Information. If you file an urgent care claim for benefits under a group health plan and it is missing information, the applicable Claims Administrator must notify you no later than 24 hours after it receives your urgent care claim. In this case, the applicable Claims Administrator must give you 48 hours to provide the missing information.

If you file a pre-service or a post-service claim for benefits under a group health plan and it is missing information, the applicable Claims Administrator may, but is not required to, notify you that information is missing. However, if you are notified that information is missing, the applicable Claims Administrator must give you 45 days to provide the missing information.

Extension of Time. If the applicable Claims Administrator is unable to make a benefit determination within the time frames set forth above due to reasons beyond its control, the applicable Claims Administrator may extend the time frames for pre-service and post-service claims as follows:

Extension for Initial Pre-Service Claim – up to an additional 15 days

Extension for Initial Post-Service Claim – up to an additional 30 days

In the case of an extension, the applicable Claims Administrator must notify you in writing prior to the expiration of the initial review period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Claims Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination. Please note, no extension is available for urgent care claims.

Denial of Initial Claim for Benefits under Group Health Plans

If your claim for benefits under a group health plan is denied, in whole or in part, the applicable Claims Administrator will notify you of the denial. The denial notice will:

- Explain the specific reason(s) why your claim was denied.
- Reference the applicable group health plan's provision(s) on which the denial is based.
- Describe any additional material or information that would be required to reconsider your claim and why that material or information is necessary.
- Explain the applicable group health plan's appeal procedures.
- Provide either a copy of any internal rule, guideline, or protocol relied upon in making the determination or a statement that such rule, guideline, or protocol was relied upon in making the determination and that it will be provided, upon request, free of charge.
- Explain any scientific or clinical judgment involved in the determination, or state that such an explanation will be provided, upon request, free of charge.

Upon receipt of a written denial of benefits from the applicable Claims Administrator, you will have the opportunity to submit written comments, documents, records, and other information related to your claim for benefits. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal of Denied Claim for Benefits under Group Health Plans

If you wish to appeal the denial of your claim for benefits under a group health plan, in most cases you must file a complete written appeal no later than 180 days after you receive the initial claim denial notice. However, for denied urgent care claims only, you may submit your appeal orally or in writing. Appeals should be submitted either to the applicable Appeals Administrator as set forth in your denial notice or refer to the Claims and Appeals Administrator Directory located on pages 191–195 for the address of the Appeals Administrator(s).

For some plans, there may be two levels of appeal permitted. The information provided by the Claims Administrator with your initial claim denial will indicate whether there is more than one level of appeal. If you are filing an appeal under a plan that has two levels of appeal and your first appeal is denied, you must file your second complete appeal no later than 60 days after your first appeal is denied. The applicable Appeals Administrator will review your second (and final) appeal and provide written notice of a final decision.

Regardless of whether there is one level of appeal or two available under the applicable group health plan, the appeal(s) will not be reviewed by the same person, or a subordinate of the person, who made the initial determination and deference will not be given to the initial review(s). In addition, if the appeal involves medical judgment, the applicable Appeals Administrator will consult with an appropriately trained medical professional (e.g., a Physician or other professional licensed, accredited, or certified under state law to perform specified medical functions).

General Rule. If you file an appeal for benefits under a group health plan, the applicable Appeals Administrator must notify you of its benefit determination on appeal within the time frame(s) set forth below, based on the type of claim you are appealing:

Appeal of Urgent Care Claim – within 72 hours of receipt of appeal

Appeal of Pre-Service Claim – no later than 30 days after receipt of appeal (15 days after receipt of appeal if there are two levels of appeal)

Appeal of Post-Service Claim – no later than 60 days after receipt of appeal (30 days after receipt of appeal if there are two levels of appeal).

Extension of Time. The applicable Appeals Administrator may extend the time frames for making its benefit determination on appeal.

Final Determination on Appeal for Benefits under Group Health Plans

If your appeal is denied, the final determination on appeal will include the reason for the decision, along with specific references to the pertinent group health plan provision(s) upon which the decision is based. It also will provide you with a copy of any internal rule, guideline, or protocol relied upon, or a statement that such rule, guideline, or protocol will be provided to you, upon request, free of charge. To the extent that any scientific or clinical judgment was used in making the determination, an explanation of such or a statement that such explanation will be provided, upon request, free of charge. In addition, the final determination on appeal will provide that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, and it will include a statement regarding your right to bring an action under Section 502 of ERISA.

Category II: Plans Providing Disability Benefits

The claims and appeals procedures for disability benefits will apply if you are filing a claim or an appeal for a disability benefit under plans that provide for disability benefits, including, but not limited to, the following plans:

- **Short-Term Disability Plan**
- **Long-Term Disability Plan (includes Core and Supplemental Long-Term Disability coverage)**

Initial Claims for Disability Benefits

If you believe you are entitled to a benefit, or to a greater amount of benefits under the applicable Fidelity plan(s) than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator (see the Claims and Appeals Administrator Directory on pages 191–195 for the address of the Claims Administrator(s)).

General Rule. If you file a complete claim for disability benefits, the applicable Claims Administrator must notify you of its benefit determination within the time frame set forth below:

Initial Claim for Disability Benefits – within 45 days of receipt

Extension of Time. If, for reasons beyond its control, the applicable Claims Administrator is unable to make a benefit determination within the time frame set forth above, the applicable Claims Administrator may extend the time frame as follows:

Extension of Time for Disability Benefit Claim – up to an additional 30 days

In the case of an extension, the applicable Claims Administrator must notify you in writing prior to the expiration of the initial 45-day review period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Claims Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination.

If, at the end of the first extension period, the applicable Claims Administrator, for reasons beyond its control, still is unable to make a benefit determination, the applicable Claims Administrator may extend the time frame for a second time as follows:

2nd Extension of Time for Disability Benefit Claim – up to an additional 30 days

In the case of a second extension, the applicable Claims Administrator must notify you in writing prior to the expiration of the first 30-day extension period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Claims Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination.

Denial of Initial Claim for Disability Benefits

If your claim for disability benefits is denied, in whole or in part, the applicable Claims Administrator will notify you of the denial. The denial notice will:

- Explain the specific reason(s) why your claim was denied.
- Reference the pertinent plan provision(s) on which the denial is based.
- Describe any additional material or information that would be required to reconsider your claim and why that material or information is necessary.
- Explain the applicable plan's appeal procedures.
- Provide either a copy of any internal rule, guideline, or protocol relied upon in making the determination or a statement that such rule, guideline, or protocol was relied upon in making the determination and that it will be provided, upon request, free of charge.
- Explanation of any scientific or clinical judgment involved in the determination, or a statement that such explanation will be provided, upon request, free of charge.

Upon receipt of a written denial of benefits from the applicable Claims Administrator, you will have the opportunity to submit written comments, documents, records, and other information related to your claim for benefits. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal of Denied Claim for Disability Benefits

If you wish to appeal the denial of your claim for disability benefits, you must file a complete written appeal no later than 180 days after you receive the initial claim denial notice. Complete appeals should be submitted to the applicable Appeals Administrator as set forth in your denial notice. In the case of the Short-Term Disability Plan, your denial notice will indicate that you should submit your written appeal to the Claims Administrator; however, the information that you submit ultimately will be provided to the applicable Appeals Administrator, and the applicable Appeals Administrator will make the final determination on appeal. In all other cases, the applicable Appeals Administrator will review your appeal and provide written notice of a final decision.

The appeal will not be reviewed by the same person, or a subordinate of the person, who made the initial determination and deference will not be given to the initial review. In addition, if the appeal involves medical judgment, the applicable Appeals Administrator will consult with an appropriately trained medical professional (e.g., a Physician or other professional licensed, accredited, or certified under state law to perform specified medical functions).

General Rule. If you file an appeal for disability benefits, the applicable Appeals Administrator must notify you of its benefit determination on appeal within the time frame set forth below:

Appeal for Disability Benefits – within 45 days of receipt of appeal

Extension of Time. If, for reasons beyond its control, the applicable Appeals Administrator is unable to make a benefit determination on appeal within the time frame set forth above, the applicable Appeals Administrator may extend the time frame as follows:

Extension of Time for Disability Benefit Appeal – up to an additional 45 days

In the case of an extension, the applicable Appeals Administrator must notify you in writing prior to the expiration of the initial 45-day review period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Appeals Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination.

Final Determination on Appeal for Disability Benefits

If your appeal is denied, the final determination on appeal will include the reason for the decision, along with specific references to the pertinent plan provision(s) upon which the decision is based. It also will provide you with a copy of any internal rule, guideline, or protocol relied upon, or a statement that such rule, guideline, or protocol will be provided to you, upon request, free of charge. To the extent that any scientific or clinical judgment was used in making the determination, an explanation of such or a statement that such explanation will be provided, upon request, free of charge. In addition, the final determination on appeal will provide that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and it will include a statement regarding your right to bring an action under Section 502 of ERISA.

Category III: Retirement and Other Benefit Plans

The claims and appeals procedures for retirement and other benefit plans will apply, in most cases, if you are filing a claim or an appeal for a benefit under one of the following plans:

- **Profit Sharing Plan**
- **Dependent Care Flexible Spending Account**
- **Core Life Insurance Plan (includes Employee and Dependent Life Insurance Plans)**
- **Business Travel Accident Insurance Plan**
- **Variable Life Insurance Plan**
- **Group Long-Term Care Insurance Plan**

Initial Claims for Benefits under Retirement or Other Benefit Plans

If you believe you are entitled to a benefit, or to a greater amount of benefits under the applicable Fidelity plan(s) than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator (see the Claims and Appeals Administrator Directory on pages 191–195 for the address of the Claims Administrator(s)).

General Rule. If you file a complete claim for benefits under a retirement or other benefit plan, the applicable Claims Administrator must notify you of its benefit determination within the time frame set forth below:

Initial Claim – within 90 days of receipt

Extension of Time. If, for reasons beyond its control, the applicable Claims Administrator is unable to make a benefit determination within the time frame set forth, the applicable Claims Administrator may extend the time frame as follows:

Extension of Time for Initial Claim – up to an additional 90 days

In the case of an extension, the applicable Claims Administrator must notify you in writing prior to the expiration of the initial 90-day review period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Claims Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination.

Denial of Initial Claim for Benefits under Retirement or Other Benefit Plans

If your claim for benefits is denied, in whole or in part, the applicable Claims Administrator will notify you of the denial. The denial notice will:

- Explain the specific reason(s) why your claim was denied.
- Reference the pertinent plan provision(s) on which the denial is based.
- Describe any additional material or information that would be required to reconsider the claim and why that material or information is necessary.
- Explain the applicable plan's appeal procedures.

Upon receipt of a written denial of benefits from the applicable Claims Administrator, you will have the opportunity to submit written comments, documents, records, and other information related to your claim for benefits. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal of Denied Claim for Benefits under Retirement or Other Benefit Plans

If you wish to appeal the denial of your claim for retirement or other benefits, you must file a written appeal no later than 60 days after you receive the initial claim denial notice. Appeals should be submitted to the applicable Appeals Administrator as set forth in your denial notice (or refer to the Claims and Appeals Administrator Directory located on pages 191–195 for the address of the Appeals Administrator(s)). The applicable Appeals Administrator will review your appeal and provide written notice of a final decision.

General Rule. If you file an appeal for benefits under a retirement or other benefit plan, the applicable Appeals Administrator must notify you of its benefit determination on appeal within the time frame set forth below:

Appeal of Claim – within 60 days of receipt of appeal

Extension of Time. If, for reasons beyond its control, the applicable Appeals Administrator is unable to make a benefit determination within the time frame set forth above, the applicable Appeals Administrator may extend the time frame as follows:

Extension of Time for Appeal of Claim – up to an additional 60 days

In the case of an extension, the applicable Appeals Administrator must notify you in writing prior to the expiration of the initial 60-day review period. In addition, the extension notice must explain why the extension is necessary, the date by which the applicable Appeals Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination.

Final Determination on Appeal for Benefits under Retirement or Other Benefit Plans

If your appeal is denied, the final determination on appeal will include the reason for the decision, along with specific references to the pertinent plan provision(s) upon which the decision is based. In most cases, the final determination on appeal also will provide that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and it will include a statement regarding your right to bring an action under Section 502 of ERISA.

Claims and Appeals Administrator Directory

PLAN NAME	CLAIMS ADMINISTRATOR	APPEALS ADMINISTRATOR
Category I: Group Health Plans		
HealthFlex Plan	Medical Benefit Claims: UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 800-331-0265 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical Benefit Appeals: UnitedHealthcare National Appeals Service Center P.O. Box 30432 Salt Lake City, UT 84130-0432 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Fidelity Health Plan	Medical Benefit Claims: UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 877-240-4016 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical Benefit Appeals: UnitedHealthcare National Appeals Service Center P.O. Box 30432 Salt Lake City, UT 84130-0432 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Health Management Center	Eligibility Only* FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Aetna (CT, NJ, NY, PA, TX)	Medical Benefit Claims: Aetna P.O. Box 981107 El Paso, TX 79998 800-238-6291 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical Benefit Appeals: Aetna Attn: National Accounts CRT P.O. Box 14463 Lexington, KY 40512 800-238-6291 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422

*Eligibility claims and appeals include, but are not limited to, those claims and appeals associated with an individual's eligibility for enrollment in one of Fidelity's benefit coverage options. Examples of eligibility claims and appeals include determinations regarding whether or not a certain family member satisfies the definition of an Eligible Dependent under the Plans. Eligibility claims and appeals do not include those claims and appeals associated with coverage for benefits under a specific Plan.

Claims and Appeals Administrator Directory *continued*

PLAN NAME	CLAIMS ADMINISTRATOR	APPEALS ADMINISTRATOR
CIGNA HealthCare of North Carolina, Inc.	Medical Benefit Claims: CIGNA Member Services P.O. Box 5200 Scranton, PA 18505-5200 800-CIGNA24 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical Benefit Appeals: CIGNA Member Services P.O. Box 5200 Scranton, PA 18505-5200 800-CIGNA24 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Harvard Pilgrim Health Care (MA, ME, NH, RI)	Medical Benefit Claims: Harvard Pilgrim Health Care P.O. Box 699183 Quincy, MA 02269 888-333-4742 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical Benefit Appeals: Harvard Pilgrim Health Care P.O. Box 699183 Quincy, MA 02269 888-333-4742 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Humana	Medical and Prescription Drug Benefit Claims: Humana Claim Center P.O. Box 14601 Lexington, KY 40512-4601 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical and Prescription Drug Benefit Appeals: Humana Health Plan of Ohio Grievance & Appeals P.O. Box 14618 Lexington, KY 40512-4618 866-427-7478 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
SelectHealth (UT)	Medical Benefit Claims: SelectHealth 4646 West Lake Park Blvd. Salt Lake City, UT 84120 800-538-5038 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Medical Benefit Appeals: SelectHealth 4646 West Lake Park Blvd. Salt Lake City, UT 84120 800-538-5038 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Prescription Drug Coverage	Prescription Drug Benefit Claims: Medco Health Solutions, Inc. 8111 Royal Ridge Parkway Irving, TX 75063 Attn: Coverage Reviews 866-383-7314	Prescription Drug Benefit Appeals*: Medco Health Solutions, Inc. 8111 Royal Ridge Parkway Irving, TX 75063 Attn: Coverage Reviews 866-383-7314

*Eligibility claims and appeals include, but are not limited to, those claims and appeals associated with an individual's eligibility for enrollment in one of Fidelity's benefit coverage options. Examples of eligibility claims and appeals include determinations regarding whether or not a certain family member satisfies the definition of an Eligible Dependent under the Plans. Eligibility claims and appeals do not include those claims and appeals associated with coverage for benefits under a specific Plan.

Claims and Appeals Administrator Directory *continued*

PLAN NAME	CLAIMS ADMINISTRATOR	APPEALS ADMINISTRATOR
Dental Plan	Dental Benefit Claims: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 888-660-1046 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Dental Benefit Appeals: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 888-660-1046 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Health Care Flexible Spending Account	Reimbursement Claims: Claims Administrator P.O. Box 14053 Lexington, KY 40512 877-924-3967 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Reimbursement Appeals: WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991 877-924-3967 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Health Care HSA-Compatible Flexible Spending Account	Reimbursement Claims: Claims Administrator P.O. Box 14053 Lexington, KY 40512 877-924-3967 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Reimbursement Appeals: WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991 877-924-3967 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Employee Assistance Program (EAP)	CIGNA Behavioral Health 11095 Viking Drive Suite 350 Eden Prairie, MN 55344 877-675-3760	FMR LLC Appeals Committee c/o Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109
Tobacco Cessation Program	Tobacco Cessation Claims: Fidelity Investments 82 Devonshire Street Mailzone ZE6C Boston, MA 02109 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Tobacco Cessation Appeals: Fidelity Investments 82 Devonshire Street Mailzone ZE6C Boston, MA 02109 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422

*Eligibility claims and appeals include, but are not limited to, those claims and appeals associated with an individual's eligibility for enrollment in one of Fidelity's benefit coverage options. Examples of eligibility claims and appeals include determinations regarding whether or not a certain family member satisfies the definition of an Eligible Dependent under the Plans. Eligibility claims and appeals do not include those claims and appeals associated with coverage for benefits under a specific Plan.

Claims and Appeals Administrator Directory *continued*

PLAN NAME	CLAIMS ADMINISTRATOR	APPEALS ADMINISTRATOR
Category II: Plans Providing Disability Benefits		
Short-Term Disability Plan	CIGNA Group Insurance Disability Management Solutions P.O. Box 709015 Dallas, TX 75370-9015 800-982-4888	Appeals should be submitted to: CIGNA Group Insurance Disability Management Solutions P.O. Box 709015 Dallas, TX 75370-9015 800-982-4888 However, upon receipt, CIGNA Group Insurance will forward the appeal to Medical Review Institute of America, Inc. for a final determination.
Long-Term Disability Plan (includes Core and Supplemental Long-Term Disability coverage)	CIGNA Group Insurance Disability Management Solutions P.O. Box 709015 Dallas, TX 75370-9015 800-982-4888	CIGNA Group Insurance Disability Management Solutions P.O. Box 709015 Dallas, TX 75370-9015 800-982-4888

*Eligibility claims and appeals include, but are not limited to, those claims and appeals associated with an individual's eligibility for enrollment in one of Fidelity's benefit coverage options. Examples of eligibility claims and appeals include determinations regarding whether or not a certain family member satisfies the definition of an Eligible Dependent under the Plans. Eligibility claims and appeals do not include those claims and appeals associated with coverage for benefits under a specific Plan.

Claims and Appeals Administrator Directory *continued*

PLAN NAME	CLAIMS ADMINISTRATOR	APPEALS ADMINISTRATOR
Category III: Retirement and Other Benefit Plans		
Profit Sharing Plan	FMR LLC Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109	FMR LLC Appeals Committee c/o Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109
Retiree Health Reimbursement Plan	FMR LLC Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109	FMR LLC Appeals Committee c/o Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109
Dependent Care Flexible Spending Account	Reimbursement Claims: Claims Administrator P.O. Box 14053 Lexington, KY 40512 877-924-3967 Eligibility Claims*: FMR LLC Claims Level Review c/o Employee Benefits 82 Devonshire Street Mailzone ZE6C Boston, MA 02109	Reimbursement Appeals: WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991 877-924-3967 Eligibility Appeals*: Medical Review Institute of America, Inc. P.O. Box 25547 Salt Lake City, UT 84125 800-654-2422
Core Life Insurance Plan (includes Employee and Dependent Life Insurance Plans)	MetLife GroupLife Claims P.O. Box 6122 Utica, NY 13504-6122 800-310-7770	MetLife GroupLife Claims P.O. Box 6122 Utica, NY 13504-6122 800-310-7770
Business Travel Accident Insurance Plan	ACE American Insurance Company 1 Beaver Valley Road P.O. Box 15417 Wilmington, DE 19850 800-336-0627	ACE American Insurance Company 1 Beaver Valley Road P.O. Box 15417 Wilmington, DE 19850 800-336-0627
Variable Life Insurance Plan	Minnesota Life Group Insurance Div. 400 Robert St. North St. Paul, MN 55101-2098 888-567-2882	Minnesota Life Group Insurance Div. 400 Robert St. North St. Paul, MN 55101-2098 888-567-2882
Group Long-Term Care Insurance Plan	John Hancock Life Insurance Company Group Long-Term Care Division P.O. Box 111 Boston, MA 02117 888-333-5731	John Hancock Life Insurance Company Group Long-Term Care Division P.O. Box 111 Boston, MA 02117 888-333-5731

*Eligibility claims and appeals include, but are not limited to, those claims and appeals associated with an individual's eligibility for enrollment in one of Fidelity's benefit coverage options. Examples of eligibility claims and appeals include determinations regarding whether or not a certain family member satisfies the definition of an eligible dependent under the Plans. Eligibility claims and appeals do not include those claims and appeals associated with coverage for benefits under a specific Plan.

The Retirement Program Trust Funds

The Profit Sharing Plan is an ERISA 404(c) *defined contribution plan*. The assets in the Profit Sharing Plan are held in a separate trust fund. This trust fund was established in order to hold, manage, and allow participants to direct the investment of both Company and employee contributions to the Profit Sharing Plan for the benefit of Plan participants and their Beneficiaries.

Contributions to all Retirement Program plans are held by the same plan trustee:

Fidelity Management Trust Company
82 Devonshire St., V5B
Boston, MA 02109

Benefits under the Profit Sharing Plan are paid only out of the Profit Sharing Trust. The trustee invests and reinvests all Profit Sharing Plan contributions according to your investment directions. Your benefits are determined solely by the value of the investments in your Vested Profit Sharing Plan account balance at the time payment is made.

The Retiree Health Reimbursement Plan's benefits are paid out of the FMR LLC Welfare Benefit Plans VEBA Trust. The trustee invests and reinvests Company contributions according to the Trust Agreement. This Trust is available only for the payment of the Retiree Health Reimbursement Plan benefits and expenses, and assets may not be withdrawn by Fidelity.

Retirement Program Benefit Payment Limitations

Fidelity reserves the right to amend or terminate, in whole or in part, the Profit Sharing Plan and/or Retiree Health Reimbursement Plan at any time. You will be notified of any material modifications made to the Profit Sharing Plan and/or Retiree Health Reimbursement Plan. In the event of the termination of the Profit Sharing Plan, you become fully Vested in your Profit Sharing Plan account balance under the Profit Sharing Plan. These amounts are paid out in a time determined by the Plan Administrator.

Plan Disclosure Information

ERISA also requires companies to disclose certain detailed information to you so that you have it available for reference purposes. If you need additional information, you are encouraged to call HR Solutions at 800-835-5099 (TDD 888-343-0860). If you have questions regarding coverage and claim payments, you can obtain more information from the individual Claim Administrators listed in the chart beginning on the next page.

Plan Year

January 1 to December 31

Plan Documents

If you wish to receive a copy of any plan document pursuant to which you are a participant or Beneficiary, you may send your written request to:

FMR LLC
Employee Benefits
82 Devonshire St., ZE6C
Boston, MA 02109

Plan Sponsor

FMR LLC
82 Devonshire St., ZE6C
Boston, MA 02109

Employer Identification Number

04-3532603

Agent for Service of Legal Process
FMR LLC
Employee Benefits
82 Devonshire St., ZE6C
Boston, MA 02109

Plan Directory: Health & Welfare Plans

PLAN NAME	PLAN NUMBER	CLAIMS ADMINISTRATOR	PLAN ADMINISTRATOR	FUNDING*	PLAN TYPE
Fidelity Employees Business Travel Accident (BTA) Insurance Plan	501	ACE American Insurance Company 1 Beaver Valley Road Wilmington, DE 19850 800-336-0627	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Fully insured and funded entirely by FMR LLC	Employee welfare plan providing business travel life and accident insurance benefits
Fidelity Group Employees Disability Plan	503	CIGNA Group Insurance (Life Insurance Company of North America underwrites this policy) Disability Management Solutions P.O. Box 709015 Dallas, TX 75370-9015 800-982-4888	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Fully insured and funded by employee and employer contributions	Employee welfare plan providing long-term disability benefits
Fidelity Group Employees Life Insurance Plan	504	MetLife GroupLife Claims P.O. Box 6122 Utica, NY 13504-6122 800-310-7770	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Fully insured and funded entirely by FMR LLC	Employee welfare plan providing employee life and dependent life insurance benefits
Fidelity Investments HealthFlex Plan	506**	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 800-331-0265	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Preferred Provider Organization (PPO)
Fidelity Investments Fidelity Health Plan	506**	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 877-240-4016	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Preferred Provider Organization (PPO)

If you would like to contact a Plan Administrator by means other than mail, please call HR Solutions.

*Funding describes who pays for the cost of the plan, including premiums and administrative fees.

**Plan 506 is the Fidelity Group Employees Medical, Dental, and Cafeteria Plan.

Plan Directory: Health & Welfare Plans *continued*

PLAN NAME	PLAN NUMBER	CLAIMS ADMINISTRATOR	PLAN ADMINISTRATOR	FUNDING*	PLAN TYPE
Harvard Pilgrim Health Care (MA, ME, NH, RI)	506**	Harvard Pilgrim Health Care P.O. Box 699183 Quincy, MA 02269 888-333-4742	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Health Maintenance Organization (HMO)
SelectHealth (UT)	506**	4646 West Lake Park Blvd. Salt Lake City, UT 84120 800-538-5038	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Health Maintenance Organization (HMO)
Humana (IN, KY, OH)	506**	Humana Humana Claim Office P.O. Box 14610 Lexington, KY 40512 888-357-6767	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Health Maintenance Organization (HMO)
Aetna (CT, NJ, NY, PA, TX)	506**	Aetna P.O. Box 981106 El Paso, TX 79998-1106 800-238-6291	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Health Maintenance Organization (HMO)
CIGNA HealthCare of North Carolina, Inc.	506**	CIGNA Member Services P.O. Box 5200 Scranton, PA 18505-5200 800-CIGNA24	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing group medical coverage under a Health Maintenance Organization (HMO)
Prescription Drug Coverage	506**	Medco Health Solutions, Inc. 8111 Royal Ridge Parkway Irving, TX 75063 Attn: Coverage Reviews 866-383-7314	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing prescription benefits
FMR LLC Group Dental Insurance Plan	506**	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79888-1282 888-660-1046	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employee and employer contributions	Employee welfare plan providing dental benefits
Tobacco Cessation Program	506**	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded by employer contributions	Employee welfare plan providing tobacco cessation services
FMR Flexible Spending Accounts (Health Care, Health Care HSA-Compatible, and Dependent Care)	506**	Claims Administrator P.O. Box 14053 Lexington, KY 40512 877-924-3967	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Funded entirely by employee contributions	Employee Welfare Plan (Health Care Flexible Spending Account and Health Care HSA-Compatible Flexible Spending Account only) Dependent Care Assistance Program (Dependent Care Flexible Spending Account only)

If you would like to contact a Plan Administrator by means other than mail, please call HR Solutions.

*Funding describes who pays for the cost of the plan, including premiums and administrative fees.

**Plan 506 is the Fidelity Group Employees Medical, Dental, and Cafeteria Plan.

Plan Directory: Health & Welfare Plans *continued*

PLAN NAME	PLAN NUMBER	CLAIMS ADMINISTRATOR	PLAN ADMINISTRATOR	FUNDING*	PLAN TYPE
Fidelity Investments Group Employee Short-Term Disability Plan	530	CIGNA Group Insurance Disability Management Solutions P.O. Box 709015 Dallas, TX 75370-9015 800-982-4888	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded entirely by employer contributions	Employee welfare plan providing short-term disability benefits
Fidelity Group Employees Variable Life Insurance Plan	532	Minnesota Life Group Insurance Div. 400 Robert St. North St. Paul, MN 55101-2098 888-567-2882	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Fully insured and funded by employee and employer contributions	Employee welfare plan providing life insurance benefits
Fidelity Group Long-Term Care Insurance Plan	550	John Hancock Life Insurance Company Group Long-Term Care Division P.O. Box 111 Boston, MA 02117 888-333-5731	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Fully insured and funded entirely by employee contributions	Employee welfare plan providing long-term care insurance benefits
Behavioral Health Managed Care Plan (Employee Assistance Program)	560	CIGNA Behavioral Health P.O. Box 209010 Austin, TX 78720 877-675-3760 (TTY 800-855-2880)	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	Self-insured and funded entirely by employer contributions	Employee welfare plan providing group medical coverage through face-to-face counseling services

If you would like to contact a Plan Administrator by means other than mail, please call HR Solutions.

*Funding describes who pays for the cost of the plan, including premiums and administrative fees.

Plan Directory: Retirement Plans

PLAN NAME	PLAN NUMBER	CLAIMS ADMINISTRATOR	PLAN ADMINISTRATOR	FUNDING*	PLAN TYPE
FMR LLC Retiree Health Reimbursement Plan	561	FMR LLC Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	**Trustee:** Fidelity Management Trust Company 82 Devonshire St. Boston, MA 02109	Employee welfare plan providing retiree medical benefits
FMR LLC Profit Sharing Plan	002	FMR LLC Employee Benefits 82 Devonshire St., ZE6C Boston, MA 02109	FMR LLC 82 Devonshire St., ZE6C Boston, MA 02109	**Trustee:** Fidelity Management Trust Company 82 Devonshire St. Boston, MA 02109	Tax-qualified ERISA 404(c) defined contribution retirement plan

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Life & Work Events

LIFE CHANGES
Eligibility

YOU ARE NEWLY HIRED

YOU GET MARRIED

YOU GET DIVORCED

YOU HAVE A BABY OR ADOPT A CHILD

YOUR CHILD NO LONGER QUALIFIES AS A DEPENDENT

YOU MOVE

YOU TAKE A LEAVE
Approved Family Care or Military Leaves of Absence without Pay

Approved Disability Leaves while Receiving Short-Term Disability Benefits

Approved Disability Leaves while Receiving Long-Term Disability Benefits

Approved Disability Leaves while Receiving Workers' Compensation Benefits

Approved Military Leaves with Pay

Any Other Approved Leaves without Pay (Except for Family Care and Military Leaves of Absences)

TIME AWAY FROM WORK
Bereavement, Holidays, Jury Duty, Vacation

YOU RETIRE OR LEAVE THE COMPANY

YOU DIE

YOUR SCHEDULED HOURS CHANGE
From 30 or More Hours per Week to at Least 20 but Fewer than 30 Hours per Week

From 30 or More Hours per Week to Fewer than 20 Hours per Week

From at Least 20 but Fewer than 30 Hours per Week to 30 or More Hours per Week

From at Least 20 but Fewer than 30 Hours per Week to Fewer than 20 Hours per Week

From Fewer than 20 Hours per Week to 30 or More Hours per Week

From Fewer than 20 Hours per Week to at Least 20 but Fewer than 30 Hours per Week

Life Changes

When your life changes, you may not be thinking about your benefits. But any changes to your family status, marital status, and work hours—among other life and work events—may have a direct effect on the benefits you receive or are eligible for. When you experience a life or work-related change, refer to the list of events in this section to better understand what steps you may need to take to continue to get the most from your benefits.

A Word about Important Terms

Understanding the terms used in this section will help you make the most of your benefits. Many of the terms that are capitalized are defined in the ***Glossary*** section of this Summary Plan Description (SPD).

ELIGIBILITY

Regular Employees regularly scheduled to work ***30 or more hours per week*** are eligible for the following:

- Medical coverage.
- Dental coverage.
- Flexible Spending Accounts.
- Life Insurance.
- Business Travel Accident Insurance.
- Disability coverage.
- Group Long-Term Care Insurance.
- Employee Assistance Program (EAP).
- Tobacco Cessation Program
- Retirement Program, including the Profit Sharing Plan (including 401(k)) and the Retiree Health Reimbursement Plan*.

Regular Employees regularly scheduled to work ***at least 20 but fewer than 30 hours per week*** are eligible for the following:

- Medical coverage.
- Dental coverage.
- Flexible Spending Accounts.
- Business Travel Accident Insurance.
- Group Long-Term Care Insurance.
- Employee Assistance Program (EAP).
- Tobacco Cessation Program
- Retirement Program, including the Profit Sharing Plan (including 401(k)) and the Retiree Health Reimbursement Plan*.

Regular Employees regularly scheduled to work ***less than 20 hours per week*** are eligible for Business Travel Accident Insurance.

Regular Employees who are regularly scheduled to work at least 20 but fewer than 30 hours per week share in a greater portion of the cost for medical and dental coverage than Regular Employees who are regularly scheduled to work 30 or more hours per week.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

You Are Newly Hired

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- You are eligible for coverage on your date of hire. You must enroll yourself and any Eligible Dependents within 31 days of your date of hire in order to be covered. Please note, however, that if you are electing coverage for your same-sex spouse, online enrollment via NetBenefits® is not available. You must enroll by calling HR Solutions.

Flexible Spending Accounts

- You are eligible to elect to contribute on your date of hire. You must elect to contribute within 31 days of your date of hire.

Life Insurance and Business Travel Accident Insurance

- You are eligible for all Core Life Insurance, Business Travel Accident Insurance, and Company-reimbursed life insurance coverages on the first day you are Actively at Work and you do not need to enroll.
- If you elect to enroll for supplemental coverage under the Variable Life Insurance Plan, that coverage will become effective on the first of the month after your application has been approved. You must enroll in Variable Life Insurance no later than 60 days after your date of hire to be covered without providing evidence of insurability (proof of good health).

Disability

- You are eligible for Short-Term Disability and Core Long-Term Disability coverage on the first day you are Actively at Work. This coverage is provided to you at no cost and you do not need to enroll.
- You also are eligible for Supplemental Long-Term Disability coverage on the first day you are Actively at Work and will be automatically enrolled. If you wish to decline coverage, you must do so within 31 days of your date of hire.

Group Long-Term Care Insurance

- You are eligible to enroll for coverage on the first day you are Actively at Work. You must enroll no later than 60 days after your date of hire in order to be covered without providing evidence of insurability (proof of good health).
- Shortly after your date of hire, John Hancock will mail a personalized information kit to your address of record.

Employee Assistance Program

- You are eligible for coverage on your date of hire. This coverage is provided to you at no cost and you do not need to enroll.

Tobacco Cessation Program

- You are eligible for coverage on your date of hire; however, coverage begins when you enroll in the program.

Profit Sharing

- You are eligible upon your date of hire to participate in the 401(k), Catch-up, and Rollover features of the Profit Sharing Plan, if you are a Regular Employee regularly scheduled to work 20 or more hours per week. You will be automatically enrolled in the 401(k) feature upon your date of hire.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
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  www.acclarisonline.com

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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

- You become eligible to participate in the Company-matching contribution* and Profit Sharing contribution* features on the 1st of the month coinciding with or following the month in which you have completed your first 12 months of service and have been credited with at least 1,000 hours of service in those 12 months. Please note, if you are not credited with 1,000 hours of service during your first 12 consecutive months of employment, you will become eligible to participate in the Company-matching contribution or Profit Sharing contribution feature on January 1 following the first calendar year (beginning with the calendar year in which your first employment anniversary occurs) in which you are credited with at least 1,000 hours of service.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Retiree Health Reimbursement Plan*

- You are eligible to receive RHRP credits as of the first business day of the month coinciding with or following your completion of twelve consecutive months of service during which you have been credited with at least 1,000 hours of service during the Plan Year and are actively employed by Fidelity on the last business day of the Plan Year. Once you satisfy these initial eligibility requirements, you will receive the annual credit amount for each subsequent year in which you are credited with 1,000 hours of service. You do not need to enroll in the Retiree Health Reimbursement Plan.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

You Get Married

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- You must notify HR Solutions within 31 days of the event to elect coverage; increase your coverage tier (e.g., individual to individual plus one); or drop your coverage, provided you become covered under your opposite-sex spouse's plan. Please note, if you get married to an opposite-sex spouse, you are entitled to a special enrollment right under HIPAA which allows you to change your medical coverage option. You must notify HR Solutions within 31 days of the date the event occurs to change your medical coverage election.
- The change you request must be consistent with your Change in Status.

Flexible Spending Accounts

- You must notify HR Solutions within 31 days of the date of your marriage to an opposite-sex spouse to elect to start making contributions, increase, decrease, or stop your contributions.
- The change you request must be consistent with your Change in Status.

Life Insurance and Business Travel Accident Insurance

- You must notify HR Solutions within 31 days of the event.
- Your spouse automatically is covered under the Dependent Life Insurance Plan and you are the Beneficiary.
- You may want to consider your Beneficiary designations for your other life insurance coverage(s).

Disability

- Your coverage is not affected by this event.

Group Long-Term Care Insurance

- You must notify HR Solutions within 31 days of the event.
- Your spouse automatically is eligible to apply for coverage. Contact John Hancock to apply or for additional information.

Employee Assistance Program

- Your spouse automatically is covered.

Tobacco Cessation Program

- Your spouse is eligible to participate in the Tobacco Cessation Program.

Profit Sharing

- You may want to submit a new *Beneficiary Designation Form*. The form is available from HR Solutions—online or by phone—or on NetBenefits®.
- Your spouse automatically is deemed your primary Beneficiary. To name a different primary Beneficiary, your spouse must provide Notarized consent authorizing you to name a different primary Beneficiary. Please note that for purposes of the Profit Sharing Plan, spouse means opposite-sex spouse per federal law.

Retiree Health Reimbursement Plan

- You must notify HR Solutions within 31 days of the event.
- Your benefit, if any, is not affected by this event.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

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- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

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  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

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- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

You Get Divorced

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- You must notify HR Solutions within 31 days of the event to drop coverage for your former spouse. You may change your coverage tier (e.g., family to individual). You cannot change your medical coverage election (e.g., HealthFlex to an HMO).
- You may elect coverage for you and/or your Eligible Dependents provided that you and/or your Eligible Dependents were covered under your former spouse's plan(s).
- Provided that you notify HR Solutions no later than 60 days after the event, your former opposite-sex spouse (and/or your former spouse's dependent child(ren) who loses coverage as a result of the event) will be offered the option to continue coverage for up to 36 months by electing COBRA. (If you are enrolled in an HMO, please refer to the HMO's detailed description of coverage for other applicable information.) Please see page 179 for information about continuation coverage for same-sex spouses or Domestic Partners.
- The change you request must be consistent with your Change in Status.

Flexible Spending Accounts

- You must notify HR Solutions within 31 days of the date of your divorce from an opposite-sex spouse to elect to start making contributions, increase, decrease, or stop your contributions.
- The change you request must be consistent with your Change in Status.
- Provided that you notify HR Solutions no later than 60 days after the event, your former opposite-sex spouse (and/or your former spouse's dependent child(ren) who loses coverage as a result of the event) may elect to make contributions to the Health Care Flexible Spending Account or the Health Care HSA-Compatible Flexible Spending Account on an After-Tax basis, until the end of the Plan Year in which the event occurs, by electing COBRA.

Life Insurance and Business Travel Accident Insurance

- Dependent Life Insurance coverage for your former spouse ends 31 days after the event. Coverage for your former spouse's dependent child(ren) who loses coverage as a result of the event ends on the date of the event. Your former spouse (and/or your former spouse's dependent child(ren)) may convert coverage to an individual policy if a conversion application is submitted to MetLife no later than 60 days after the event. You may contact HR Solutions for a conversion application.
- You may want to consider your Beneficiary designations for your life insurance coverage(s).
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- Your coverage is not affected by this event.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- If your former spouse is enrolled in this insurance, you must contact John Hancock to stop the deductions from your paycheck and your former spouse must contact John Hancock to update his or her address of record so John Hancock may send bills to your former spouse for direct payment to John Hancock.
- If your former spouse is enrolled in this insurance and wants to drop coverage, your former spouse should contact John Hancock directly.

Employee Assistance Program

- You must notify HR Solutions within 31 days of the event.
- Provided that you notify HR Solutions no later than 60 days after the event, your former opposite-sex spouse (and/or your former spouse's dependent child(ren) who loses coverage as a result of the event) will be offered the option to continue coverage for up to 36 months by electing COBRA.

Tobacco Cessation Program

- If your former spouse is currently participating in the Tobacco Cessation Program, he/she may continue participating up to 12 months following the date he/she first contacted the Quit For Life program.

Profit Sharing

- Your Profit Sharing Plan account is not affected by this event, unless the Profit Sharing Plan receives a Domestic Relations Order (DRO) and the Plan Administrator determines that it constitutes a Qualified Domestic Relations Order (QDRO).
- You may want to review your Beneficiary designation(s).

Retiree Health Reimbursement Plan

- If you are not yet eligible to file claims for reimbursement, your Retiree Health Reimbursement Account is not affected by this event.
- If you are eligible to file claims for reimbursement and you notify HR Solutions within 60 days of the event, your former opposite-sex spouse who loses coverage as a result of the event will be offered the option to continue coverage for up to 36 months by electing COBRA.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

You Have a Baby or Adopt a Child

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- You must notify HR Solutions within 31 days of the event to elect coverage; increase your coverage tier (e.g., individual plus one to family coverage); or change your medical coverage option. The effective date of the change is the date of the event.
- To cover your child, you must enroll the child, even if you already have family coverage.
- The change you request must be consistent with your Change in Status.

Flexible Spending Accounts

- You must notify HR Solutions within 31 days of the event to elect to start making contributions, increase, decrease, or stop your contributions.
- The change you request must be consistent with your Change in Status.

Life Insurance and Business Travel Accident Insurance

- Your child automatically is covered under the Dependent Life Insurance Plan, so long as he or she is at least 2 days old, and you are the Beneficiary.
- You may want to consider your Beneficiary designations for your other life insurance coverage(s).
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- The Short-Term Disability Plan covers pregnancy-related disabilities. Contact CIGNA Group Insurance to initiate a Short-Term Disability claim. If necessary, the Long-Term Disability Plan may provide coverage as well.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.

Employee Assistance Program

- Eligible Dependents automatically are covered.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- Your Profit Sharing Plan account is not affected by this event.
- You may want to review your Beneficiary designation(s). A *Beneficiary Designation Form* is available from HR Solutions—online or by phone—and on NetBenefits®.

Retiree Health Reimbursement Plan

- Your Retiree Health Reimbursement Plan account is not affected by this event.

Your Child No Longer Qualifies as a Dependent

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- You must notify HR Solutions within 31 days of the event to decrease your coverage tier (e.g., family coverage to individual plus one). You cannot change your medical coverage election (e.g., HealthFlex to an HMO). The effective date of the change is the last day of the month in which the date of the event occurs.
- Provided that you notify HR Solutions no later than 60 days after the event, your child will be offered the option to continue coverage for up to 36 months by electing COBRA.
- The change you request must be consistent with your Change in Status.

Flexible Spending Accounts

- You must notify HR Solutions within 31 days of the event to decrease or stop your contributions.
- The change you request must be consistent with your Change in Status.
- Provided that you notify HR Solutions no later than 60 days after the event, your child may elect to make contributions to the Health Care Flexible Spending Account or the Health Care HSA-Compatible Flexible Spending Account on an After-Tax basis, until the end of the Plan Year in which the event occurs, by electing COBRA.

Life Insurance

- Your Dependent Life Insurance coverage for your child ends on the day that he or she no longer is an Eligible Dependent. Your child may convert coverage to an individual policy if a conversion application is submitted to MetLife no later than 60 days after the event. You may contact HR Solutions for a conversion application.

Disability

- Your coverage is not affected by this event.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.

Employee Assistance Program

- You must notify HR Solutions within 31 days of the event.
- Provided that you notify HR Solutions no later than 60 days after the event, your child will be offered the option to continue coverage for up to 36 months by electing COBRA.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- Your Profit Sharing Plan account is not affected by this event.

Retiree Health Reimbursement Plan

- Your Retiree Health Reimbursement Plan account is not affected by this event.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

You Move

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- If you are enrolled in an HMO and you move out of that HMO's service area, you must notify HR Solutions within 31 days of the event to make a change to your medical coverage election (e.g., an HMO to HealthFlex). You cannot change your medical coverage tier (e.g., family coverage to individual plus one). The effective date of the change is the date you report the event.
- Your Dental coverage is not affected by this event.

Flexible Spending Accounts

- Your Flexible Spending Account(s) is not affected by this event.

Life Insurance and Business Travel Accident Insurance

- Your coverage is not affected by this event.

Disability

- Your coverage is not affected by this event.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- Your Profit Sharing Plan account is not affected by this event.

Retiree Health Reimbursement Plan

- Your Retiree Health Reimbursement Plan account is not affected by this event.

You Take a Leave

APPROVED FAMILY CARE OR MILITARY LEAVES OF ABSENCE WITHOUT PAY

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- Your coverage continues.
- You are required to pay your share of the cost directly to Fidelity. Your initial payment is due 45 days from your unpaid leave start date and includes any regular monthly payment(s) that become(s) due between your leave start date and the end of the 45-day period. All subsequent payments are due on the first day of each month. HR Solutions will mail to your address of record a monthly invoice describing how much you must pay, as well as when and where to mail your payments. Please note: your payments must be made by the due date even if you do not receive an invoice from HR Solutions. If you are getting close to the due date and have not received an invoice, contact HR Solutions to find out your payment amount due and the address in which to send your payments.
- If your leave is related to the birth or adoption of a child, please refer to page 208 for additional information on how your benefits may be affected.
- You must notify HR Solutions within 31 days of the event to drop coverage.
- The change you request must be consistent with your Change in Status.

Flexible Spending Accounts

- Dependent Care Flexible Spending Account
  - Your contributions automatically are suspended until you return to work.
  - You may request reimbursement, but only for expenses incurred prior to the date you went out on leave.
- Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account
  - You continue to contribute on an After-Tax Basis. HR Solutions will mail to your address of record an invoice describing how much you must pay. Your initial payment is due 45 days from your unpaid leave start date. All future payments are due on the first day of each month. Please note: your payments must be made by the due date even if you do not receive an invoice. If you are getting close to the due date and have not received an invoice, contact HR Solutions to find out how much you must pay, as well as when and where to mail your payments.
  - If you are making contributions on an After-Tax Basis, you may continue to request reimbursement for expenses incurred during the Plan Year, provided that you continue making contributions for the entire Plan Year.
  - If you stop making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which your leave began.
  - You can decrease or stop your contributions provided that you notify HR Solutions within 31 days of the event.
- The change you request must be consistent with your Change in Status.

Life Insurance and Business Travel Accident Insurance

- All Core Life Insurance coverage continues.
- You are responsible for paying for your Variable Life Insurance (Variable Basic and Variable Supplemental, if applicable) coverage by submitting payments directly to Minnesota Life, who will send bills to your address of record. Fidelity will not reimburse you for the payments for Variable Basic Life Insurance coverage.
- Your Business Travel Accident Insurance coverage will suspend until you are Actively at Work.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

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  Online:
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  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
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  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

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  Online:
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  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
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- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
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- **Minnesota Life Insurance Company:**
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- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Disability

- You must be Actively at Work within the last 5 days prior to your leave or on an approved family care or military leave of absence without pay at the time the disability begins, in order to be eligible for Short-Term Disability benefits.
- Coverage for Long-Term Disability continues for 90 days while you are on an unpaid leave of absence. If you become disabled during that 90-day period, you are eligible to file a claim.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- You and/or your spouse or Domestic Partner, if enrolled, are responsible for paying for your Group Long-Term Care Insurance coverage by submitting payments directly to John Hancock, who will send bills to your address of record.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- You are credited with up to 501 hours of service for any continuous period of absence, only if necessary to prevent you from incurring a One-Year Break in Service. These hours are not counted toward Years of Vesting Service or toward the 1,000-hour requirement for the initial eligibility for Company-matching contributions or for the Profit Sharing contribution* that Fidelity makes.
- Loan repayments may be suspended for the length of time that you are on an approved leave, up to one year. Upon your return from leave, you will be responsible for making up any missed loan repayments through payroll deduction. While on leave you may continue to make loan repayments by certified check or by electing to have your loan repayment automatically deducted from your bank account, through ACH, during your unpaid leave.
- Generally, you have no Eligible Compensation while on unpaid leave; therefore you will not be able to make any 401(k) contributions or Catch-up contributions, if applicable.
- Please note: If you are on a military leave, the affect on your benefits is described on page 181 (USERRA section of the ***Administrative*** section). You also may contact HR Solutions for more information.

*Subject to sufficient Company profits and cash flow. Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Retiree Health Reimbursement Plan

- Your Retiree Health Reimbursement Plan account is not affected by this event.

You Take a Leave

APPROVED DISABILITY LEAVES WHILE RECEIVING SHORT-TERM DISABILITY BENEFITS

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- Your coverage continues for as long as you are disabled and receiving Short-Term Disability (STD) benefits.
- Your share of the cost(s) is deducted from your STD benefits.
- If your STD leave is pregnancy related, please refer to page 208 for additional information on how your benefits may be affected.

Flexible Spending Accounts

- Dependent Care Flexible Spending Account
  - Your contributions automatically are suspended until you return to work.
  - You may request reimbursement, but only for expenses incurred prior to the date you went out on leave.
- Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account
  - Your contributions are deducted from your STD benefits.
  - You may continue to request reimbursement.

Life Insurance and Business Travel Accident Insurance

- All Core Life Insurance coverage continues.
- The cost for your Variable Life Insurance (Variable Basic and Variable Supplemental, if applicable) is deducted from your STD benefits.
- Your Business Travel Accident Insurance coverage will suspend until you are Actively at Work.

Disability

- You are eligible for disability coverage for the first 5 days you are out on leave. If you become disabled after this 5-day period, you are not eligible for Short-Term Disability benefits.
- If your disability is expected to last longer than 180 days, you may want to apply for Long-Term Disability, Social Security Disability Income, and Medicare benefits.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- The cost of Group Long-Term Care Insurance coverage for you and/or your spouse or Domestic Partner, if enrolled, is deducted from your STD benefits.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- You are credited with up to 501 hours of service for any continuous period of paid leave of absence.
- Your 401(k) contributions and Catch-up contributions, if applicable, continue to be deducted from your STD benefits.
- Eligible Compensation will include STD benefits.
- Your loan repayments continue to be deducted from your STD benefits.

Important Contact Information

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  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
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- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
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  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Retiree Health Reimbursement Plan*

- You are credited with up to 501 hours of service for any continuous period of paid leave of absence.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

You Take a Leave

APPROVED DISABILITY LEAVES WHILE RECEIVING LONG-TERM DISABILITY BENEFITS

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- Your coverage continues for as long as you are disabled and receiving Long-Term Disability (LTD) benefits.
- You are required to pay your share of the cost(s) directly to Fidelity. HR Solutions will mail, to your address of record, a monthly invoice describing how much you must pay, as well as when and where to mail your payments.

Flexible Spending Accounts

- Dependent Care Flexible Spending Account
  - Your contributions automatically are suspended until you return to work.
  - You may request reimbursement, but only for expenses incurred prior to the date you went out on leave.
- Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account
  - You continue to contribute on an After-Tax basis.
  - If you are making contributions on an After-Tax basis, you may continue to request reimbursement for expenses incurred during the Plan Year, provided that you continue making contributions for the entire Plan Year.
  - You can decrease or stop your contributions provided that you notify HR Solutions within 31 days of the event.
  - If you stop making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which you went out on leave.
- The change you request must be consistent with your Change in Status.

Life Insurance and Business Travel Accident Insurance

- All Core Life Insurance coverage continues.
- You are responsible for paying for your Variable Life Insurance (Variable Basic and Variable Supplemental, if applicable) coverage by submitting payments directly to Minnesota Life, who will send bills to your address of record. Fidelity will not reimburse you for the payments for Variable Basic Life Insurance coverage.
- After 180 days of being totally and permanently disabled, as determined by Minnesota Life, you are eligible to apply for waiver of premium under the Variable Life Insurance Plan. You should contact Minnesota Life directly to apply. You should continue to pay your premiums directly to Minnesota Life until a decision is made about your waiver of premium application.
- Your Business Travel Accident Insurance coverage will suspend until you are Actively at Work.

Disability

- You are eligible for disability coverage for the first 5 days you are out on leave. If you become disabled after this 5-day period, you are not eligible for Short-Term Disability benefits.
- Your LTD benefits continue until the earlier of: you no longer are disabled; for a maximum of 24 months for a disability due to mental illness or substance abuse; until you reach the maximum age limitation; or you no longer satisfy any other requirements for LTD benefits under the LTD Plan.

Important Contact Information

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  By phone: 800-835-5099
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  (User name: fidelity;
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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

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  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
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- **Minnesota Life Insurance Company:**
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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- You and/or your spouse or Domestic Partner, if enrolled, are responsible for paying for your Group Long-Term Care Insurance coverage by submitting payments directly to John Hancock, who will send bills to your address of record.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- You are credited with up to 501 hours of service for any continuous period of paid leave of absence.
- Eligible Compensation will not include any LTD benefits; therefore you generally will not be able to make any 401(k) contributions or Catch-up contributions, if applicable.
- Loan repayments may be suspended for the length of time that you are on an approved leave, up to one year. Upon your return from leave, you will be responsible for making up any missed loan repayments through payroll deduction. While on leave you may continue to make loan repayments by certified check or by electing to have your loan repayment automatically deducted from your bank account, through ACH, during your LTD leave.
- In certain circumstances, your Profit Sharing Plan account balance may be available to you.
- In certain circumstances, you may become 100 percent Vested in your Profit Sharing Plan account balance.

Retiree Health Reimbursement Plan*

- You are credited with up to 501 hours of service for any continuous period of paid leave of absence.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

You Take a Leave

APPROVED DISABILITY LEAVES WHILE RECEIVING WORKERS' COMPENSATION BENEFITS

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- Your coverage continues for as long as you are disabled and receiving workers' compensation benefits.
- You are required to pay your share of the cost(s) directly to Fidelity. HR Solutions will mail, to your address of record, a monthly invoice describing how much you must pay, as well as when and where to mail your payments.

Flexible Spending Accounts

- Dependent Care Flexible Spending Account
  - Your contributions automatically are suspended until you return to work.
  - You may request reimbursement, but only for expenses incurred prior to the date you went out on leave.
- Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account
  - You continue to contribute on an After-Tax basis.
  - If you are making contributions on an After-Tax basis, you may continue to request reimbursement for expenses incurred during the Plan Year, provided that you continue making contributions for the entire Plan Year.
  - You can decrease or stop your contributions provided that you notify HR Solutions within 31 days of the event.
  - If you stop making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which you went out on leave.
- The change you request must be consistent with your Change in Status.

Life Insurance and Business Travel Accident Insurance

- All Core Life Insurance coverage continues.
- You are responsible for paying for your Variable Life Insurance (Variable Basic and Variable Supplemental, if applicable) coverage by submitting payments directly to Minnesota Life, who will send bills to your address of record. Fidelity will not reimburse you for the payments for Variable Basic Life Insurance coverage.
- After 180 days of being totally and permanently disabled, as determined by Minnesota Life, you are eligible to apply for waiver of premium under the Variable Life Insurance Plan. You should contact Minnesota Life directly to apply. You should continue to pay your premiums directly to Minnesota Life until a decision is made about your waiver of premium application.
- Your Business Travel Accident Insurance coverage will suspend until you are Actively at Work.

Disability

- You are eligible for disability coverage for the first 5 days you are out on leave. If you become disabled after this 5-day period, you are not eligible for Short-Term Disability benefits.
- You may be eligible for Long-Term Disability (LTD) benefits after you have been disabled for at least 180 days. Refer to page 215 for information about how LTD leaves may affect your benefits.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- You and/or your spouse or Domestic Partner, if enrolled, are responsible for paying for your Group Long-Term Care Insurance coverage by submitting payments directly to John Hancock, who will send bills to your address of record.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
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  800-982-4888
- **MetLife:**
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- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- You will not be credited with any hours of service towards eligibility and Vesting.
- Eligible Compensation will not include any workers' compensation payments; therefore you generally will not be able to make any 401(k) contributions or Catch-up contributions, if applicable.
- Loan repayments may be suspended for the length of time that you are on an approved leave, up to one year. Upon your return from leave, you will be responsible for making up any missed loan repayments through payroll deduction. While on leave you may continue to make loan repayments by certified check or by electing to have your loan repayment automatically deducted from your bank account, through ACH, during your LTD leave.

Retiree Health Reimbursement Plan

- You will not be credited with any hours of service towards eligibility and Credited Service.

You Take a Leave

APPROVED MILITARY LEAVES WITH PAY

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- Your coverage continues.
- Your share of the cost(s) continues to be deducted from your pay.

Flexible Spending Accounts

- Dependent Care Flexible Spending Account
  - – Your contributions automatically are suspended until you return to work.
  - – You may request reimbursement, but only for expenses incurred prior to the date you went out on leave.
- Your Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account is not affected by this event.

Life Insurance and Business Travel Accident Insurance

- All Core Life Insurance coverage continues.
- Your Variable Life Insurance (Variable Basic and Variable Supplemental, if applicable) cost(s) will continue to be deducted from your pay and your Company reimbursement for Variable Basic Life Insurance coverage will continue.
- Your Business Travel Accident Insurance coverage will suspend until you are Actively at Work.

Disability

- You are eligible for disability coverage for the first 5 days you are out on leave. If you become disabled after this 5-day period, you are not eligible for Short-Term Disability benefits.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- The cost of Group Long-Term Care Insurance coverage for you and/or your spouse or Domestic Partner, if enrolled, is deducted from your pay.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- Your Profit Sharing Plan account is not affected by this event.

Retiree Health Reimbursement Plan

- Your Retiree Health Reimbursement Plan account is not affected by this event.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

You Take a Leave

ANY OTHER APPROVED LEAVES WITHOUT PAY (EXCEPT FOR FAMILY CARE AND MILITARY LEAVES OF ABSENCES)

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- Your coverage continues.
- You are required to pay your share of the cost(s) directly to Fidelity. HR Solutions will mail, to your address of record, a monthly invoice describing how much you must pay, as well as when and where to mail your payments.
- You must notify HR Solutions within 31 days of the event to drop coverage.
- The change you request must be consistent with your Change in Status.

Flexible Spending Accounts

- Dependent Care Flexible Spending Account
  - Your contributions automatically are suspended until you return to work.
  - You may request reimbursement, but only for expenses incurred prior to the date you went out on leave.
- Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account
  - You continue to contribute on an After-Tax Basis. HR Solutions will mail to your address of record an invoice describing how much you must pay. Your initial payment is due 45 days from your unpaid leave start date. All future payments are due on the first day of each month. Please note: your payments must be made by the due date even if you do not receive an invoice. If you are getting close to the due date and have not received an invoice, contact HR Solutions to find out how much you must pay, as well as when and where to mail your payments.
  - If you are making contributions on an After-Tax Basis, you may continue to request reimbursement for expenses incurred during the Plan Year, provided that you continue making contributions for the entire Plan Year.
  - If you stop making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which your leave began.
  - You can decrease or stop your contributions provided that you notify HR Solutions within 31 days of the event.
- The change you request must be consistent with your Change in Status.

Life Insurance and Business Travel Accident Insurance

- All Core Life Insurance coverage continues.
- You are responsible for paying for your Variable Life Insurance (Variable Basic and Variable Supplemental, if applicable) coverage by submitting payments directly to Minnesota Life, who will send bills to your address of record. Fidelity will not reimburse you for the payments for Variable Basic Life Insurance coverage.
- Your Business Travel Accident Insurance coverage will suspend until you are Actively at Work.

Disability

- You are eligible for disability coverage for the first 5 days you are out on leave. If you become disabled after this 5-day period, you are not eligible for Short-Term Disability benefits.
- All Core Life Insurance coverage continues.
- Coverage for Long-Term Disability continues for 90 days while you are on an approved unpaid leave of absence. If you become disabled during that 90-day period, you are eligible to file a claim.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.
- You and/or your spouse or Domestic Partner, if enrolled, are responsible for paying for your Group Long-Term Care Insurance coverage by submitting payments directly to John Hancock, who will send bills to your address of record.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- You are responsible for making loan repayments by certified check or by electing to have your loan repayment automatically deducted from your bank account, through ACH, during your unpaid leave.
- Generally, you have no Eligible Compensation while on unpaid leave; therefore you will not be able to make any 401(k) contributions or Catch-up contributions, if applicable.
- You will not be credited with any hours of service towards eligibility and Vesting.

Retiree Health Reimbursement Plan

- Your Retiree Health Reimbursement Plan account is not affected by this event.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
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- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Time Away from Work

BEREAVEMENT, HOLIDAYS, JURY DUTY, VACATION

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental
- Your coverage is not affected by this event.

Flexible Spending Accounts
- Your Flexible Spending Account(s) is not affected by this event.

Life Insurance
- Your coverage is not affected by this event.

Disability
- Your coverage is not affected by this event.

Group Long-Term Care Insurance
- Your coverage is not affected by this event.

Employee Assistance Program
- Your coverage is not affected by this event.

Tobacco Cessation Program
- Your coverage is not affected by this event.

Profit Sharing
- Your Profit Sharing Plan account is not affected by this event.

Retiree Health Reimbursement Plan
- Your Retiree Health Reimbursement Plan account is not affected by this event.

You Retire or Leave the Company

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- Your coverage ends on the last day of the month in which your employment with the Company ends.
- You, your opposite-sex spouse, and/or Eligible Dependents who lose coverage as a result of the event will be offered the option to continue coverage for up to 18 months by electing COBRA.*

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Flexible Spending Accounts

- Your contributions to your Flexible Spending Account(s) end as of your last payroll period prior to the date that your employment ends.
- You may continue making contributions to your Health Care Flexible Spending Account or your Health Care HSA-Compatible Flexible Spending Account on an After-Tax basis until the end of the Plan Year by electing COBRA. If you elect to continue making contributions, you may continue to request reimbursement for expenses incurred during the Plan Year in which you retire or leave the Company, provided that you continue making contributions for the entire Plan Year.
- If you do not elect to continue making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which you retired or left the Company.
- You may request reimbursement from your Dependent Care Flexible Spending Account, but only for expenses incurred on or before the date your employment with the Company ends.

Life Insurance and Business Travel Accident Insurance

- Employee Life Insurance coverage for you and Dependent Life Insurance coverage for your spouse, Domestic Partner, and your Eligible Dependents end 31 days after your last day of employment with the Company.
- You may convert your Employee Life Insurance coverage and Dependent Life Insurance coverage for your spouse, Domestic Partner, and Eligible Dependents to an individual policy(ies) if a conversion application(s) is submitted to MetLife no later than 60 days after your employment with the Company ends. You may contact HR Solutions for a conversion application.
- You may continue your Variable Life Insurance coverage by submitting premium payments directly to Minnesota Life.
- Business Travel Accident Insurance coverage ends on your last day of employment with the Company. There is no conversion option for Business Travel Accident Insurance coverage.

Disability

- Your Short-Term Disability coverage ends on your last day of employment with the Company.
- Your Long-Term Disability (LTD) coverage ends on your last day of employment with the Company. Generally, if you leave the Company for reasons other than retirement, your LTD coverage may be converted to an individual policy if you submit a conversion application to Life Insurance Company of North America, the policy underwriter, no later than 31 days after your employment with the Company ends without providing medical or other evidence of insurability. If you apply for coverage later than 31 days, but within 62 days of the event, you will be required to provide evidence of insurability. You may contact HR Solutions for the eligibility requirements and a conversion application.

Group Long-Term Care Insurance

- You may continue Group Long-Term Care Insurance coverage for you and/or your spouse or Domestic Partner, if enrolled, by submitting payments directly to John Hancock Life Insurance Company. John Hancock will start billing you directly within four to six weeks following the date your employment with the Company ends. Contact John Hancock for additional information.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Employee Assistance Program

- Your coverage ends on the last day of the month in which your employment with the Company ends.
- You, your opposite-sex spouse, and/or Eligible Dependents who lose coverage as a result of the event have the option to continue coverage for up to 18 months by electing COBRA.*

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Tobacco Cessation Program

- If you or your Eligible Dependents are currently participating in the program when you leave or retire from the Company, benefits will continue until 12 months following the date that you/they first enrolled in the program.

Profit Sharing

- Your Vested Profit Sharing Plan account balance is available to you.
- If you retire after your 65th birthday and you are not already 100 percent Vested, you automatically become 100 percent Vested in your Profit Sharing Plan account balance.
- If you are age 55 with 5 Years of Vesting Service, or age 65 or older, when you retire, and you have met the applicable eligibility requirements, you may receive a final Profit Sharing contribution,* if one is made, based on the Eligible Compensation you earned during the Plan Year prior to the date you retired. If you take a distribution before the Profit Sharing contribution* is posted (typically in January), you will have a residual balance in your Profit Sharing Plan account.
- You are responsible for making loan repayments by certified check or by electing to have your loan repayments automatically deducted from your bank account, through ACH, when you leave or retire from the Company, as long as you do not take a distribution of your account balance.

Retiree Health Reimbursement Plan*

- If you are at least age 55 and have completed at least 10 years of service, you are eligible to begin submitting claims for reimbursement of eligible medical expenses once you leave or retire from the Company.
- If you do not have at least 10 years of service when you leave or retire from the Company, your Retiree Health Reimbursement Plan credits will be forfeited.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

You Die

Please note: In the event of the death of a participant, HR Solutions' Survivor Services Unit provides one primary contact for the survivor/Beneficiary to resolve benefits-related questions and to provide assistance working through the maze of paperwork. To contact the Survivor Services Unit, please call HR Solutions and ask to be transferred to the Survivor Services Unit.

*Provided that you were a Regular Employee of a Participating Fidelity Company and you satisfied the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- Your opposite-sex spouse and/or Eligible Dependents who loses coverage as a result of the event will be offered the option to continue coverage for up to 36 months by electing COBRA.*
- Provided that they elect COBRA coverage, the first six months of medical and dental COBRA coverage is provided at no cost to your spouse and/or Eligible Dependents. Please note: if your surviving spouse is a benefits eligible Fidelity employee your surviving spouse may elect medical, dental, and EAP coverage as an employee, instead of continuing coverage under COBRA. In order to elect coverage as an employee, your surviving spouse must contact HR Solutions within 31 days of your death. If your surviving spouse does not elect coverage as an employee and rather chooses to continue coverage under COBRA, they are not eligible to receive 6 months of COBRA coverage at no cost.
- The change you request must be consistent with your Change in Status.

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Flexible Spending Accounts

- Your contributions to your Flexible Spending Account(s) end as of your last payroll period.
- Health Care Flexible Spending Account or Health Care HSA-Compatible Flexible Spending Account
  - Your opposite-sex spouse and/or Eligible Dependents can continue making contributions on an After-Tax basis, until the end of the Plan Year in which your death occurs, by electing COBRA.
  - If your opposite-sex spouse and/or Eligible Dependents elect to continue making contributions on an After-Tax basis, they may continue to request reimbursement for expenses incurred during the Plan Year in which you die, provided that they continue making contributions for the entire Plan Year.
  - If your opposite-sex spouse and/or Eligible Dependents do not elect to continue making contributions, they may request reimbursement, but only for expenses incurred prior to the date of your death.
- Dependent Care Flexible Spending Account
  - Your contributions end as of your last payroll period.
  - Your opposite-sex spouse and/or Eligible Dependents may request reimbursement, but only for expenses incurred prior to the date of your death.

Life Insurance and Business Travel Accident Insurance

- Generally, your Beneficiary(ies) receives the benefits from all life insurance plans.
- Dependent Life Insurance coverage for your spouse, Domestic Partner, and/or Eligible Dependents continues for 31 days following the date of your death and coverage may be converted to an individual policy(ies) if a conversion application is submitted to MetLife no later than 60 days after the date of your death. Conversion applications are available from HR Solutions.
- Generally, your Beneficiary(ies) receives the benefits from Business Travel Accident Insurance if your death occurs while traveling on Company business.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Disability

- If you were receiving Long-Term Disability (LTD) benefits at the time of your death, your spouse, Domestic Partner or Eligible Dependents may receive a death benefit under the LTD Plan equal to three times your monthly LTD benefit.

Group Long-Term Care Insurance

- If you were enrolled in Group Long-Term Care Insurance at the time of your death, your estate may receive a Return of Premium at Death benefit, which pays a portion of the premiums you paid, less any benefits paid or payable, should you die prior to age 70 while covered under the Group Long-Term Care Insurance Plan.
- The Return of Premium at Death benefit is not payable if you were age 70 or older or if coverage is in reduced paid-up status at the time of your death.
- The portion of the premium that is payable under the Return of Premium at Death benefit is based on your age at the time of death.
- The Return of Premium at Death benefit is not available to residents of Arkansas or Washington.
- If your spouse or Domestic Partner was enrolled in Group Long-Term Care Insurance at the time of your death, your spouse or Domestic Partner must contact John Hancock so John Hancock may send bills to your spouse or Domestic Partner for direct payment to John Hancock.

Employee Assistance Program

- Your opposite-sex spouse and/or Eligible Dependents may choose to continue coverage for up to 36 months by electing COBRA.*

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Tobacco Cessation Program

- If your Eligible Dependents are currently participating in the program when you die, benefits will continue until 12 months following the date that they first enrolled in the program.

Profit Sharing

- Your Beneficiary(ies) receives your Vested Profit Sharing Plan account balance.
- If you are employed by the Company at your time of death and you are not already Vested, you automatically become 100 percent Vested in your Profit Sharing Plan account balance.
- If you are employed by the Company at your time of death and you have met the applicable eligibility requirements, you may receive a final Profit Sharing contribution,* based on the Eligible Compensation you earned during the Plan Year prior to the date of your death. If your Beneficiary(ies) takes a distribution before the Profit Sharing contribution* is posted (typically in January), there will be a residual balance.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Retiree Health Reimbursement Plan

- Upon your death, any balance in your Retiree Health Reimbursement Plan account will become available for use by your opposite sex spouse for reimbursement of eligible medical expenses.
- If your surviving opposite-sex spouse is actively employed by Fidelity at the time of your death, your surviving opposite-sex spouse will not have immediate access to the credits in your RHRP account until they meet the age and service requirements.

Your Scheduled Hours Change

FROM 30 OR MORE HOURS PER WEEK **TO** AT LEAST 20 BUT FEWER THAN 30 HOURS PER WEEK

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- You remain eligible for coverage; however, your share of the cost(s) will increase.
- Provided that you notify HR Solutions within 31 days of the date your scheduled hours change, you can drop your coverage.

Flexible Spending Accounts

- Provided that you notify HR Solutions within 31 days of the date your scheduled hours change, you can decrease or stop your contributions to your Dependent Care Flexible Spending Account.
- The change you request must be consistent with your Change in Status.
- Your Health Care Flexible Spending Account or your Health Care HSA-Compatible Flexible Spending Account is not affected by this event.

Life Insurance and Business Travel Accident Insurance

- Employee Life Insurance coverage for you and Dependent Life Insurance coverage for your spouse, Domestic Partner and Eligible Dependents ends 31 days after the date your scheduled hours change.
- You may convert your Employee Life Insurance coverage and Dependent Life Insurance coverage for your spouse, Domestic Partner and Eligible Dependents to an individual policy(ies) if a conversion application(s) is submitted to MetLife no later than 60 days after the date your scheduled hours change. You may contact HR Solutions for a conversion application.
- You may continue your Variable Life Insurance coverage by submitting premium payments directly to Minnesota Life.
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- Your Short-Term Disability coverage ends on the date your scheduled hours change.
- Your Long-Term Disability (LTD) coverage ends on the date your scheduled hours change. Your LTD coverage may be converted to an individual policy if you submit a conversion application to Life Insurance Company of North America, the policy underwriter, no later than 60 days after the date your scheduled hours change. You may contact HR Solutions for a conversion application.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- For purposes of calculating Years of Service, the number of hours of service credited to you will be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

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Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

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- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Retiree Health Reimbursement Plan*

- For purposes of calculating Years of Service, the number of hours of service credited to you will be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Your Scheduled Hours Change

FROM 30 OR MORE HOURS PER WEEK **TO** FEWER THAN 20 HOURS PER WEEK

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- Your coverage ends on the last day of the month in which your scheduled hours change.
- You, your opposite-sex spouse, and/or Eligible Dependents who lose coverage as a result of the event will be offered the option to continue coverage for up to 18 months by electing COBRA.*

*Please note: Same-sex spouses are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Flexible Spending Accounts

- Your contributions to your Flexible Spending Account(s) end generally as of your last payroll period prior to the date your scheduled hours change.
- You may continue making contributions to your Health Care Flexible Spending Account or your Health Care HSA-Compatible Flexible Spending Account on an After-Tax basis until the end of the Plan Year by electing COBRA. If you elect to continue making contributions, you may continue to request reimbursement for expenses incurred during the Plan Year in which your scheduled hours change, provided that you continue making contributions for the entire Plan Year.
- If you do not elect to continue making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which your scheduled hours change.
- You may request reimbursement from your Dependent Care Flexible Spending Account, but only for expenses incurred prior to the date your scheduled hours change.

Life Insurance and Business Travel Accident Insurance

- Employee Life Insurance coverage for you and Dependent Life Insurance coverage for your spouse, Domestic Partner, and your Eligible Dependents end 31 days after the date your scheduled hours change.
- You may convert your Employee Life Insurance coverage and Dependent Life Insurance coverage for your spouse, Domestic Partner, and Eligible Dependents to an individual policy(ies) if a conversion application(s) is submitted to MetLife no later than 60 days after the date your scheduled hours change. You must contact HR Solutions for a conversion application.
- You may continue your Variable Life Insurance coverage by submitting premium payments directly to Minnesota Life.
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- Your Short-Term Disability coverage ends on the date your scheduled hours change.
- Your Long-Term Disability (LTD) coverage ends on the date your scheduled hours change. Your LTD coverage may be converted to an individual policy if you submit a conversion application to Life Insurance Company of America, the policy underwriter, no later than 60 days after the date your scheduled hours change. You may contact HR Solutions for a conversion application.

Group Long-Term Care Insurance

- You may continue Group Long-Term Care Insurance coverage for you and/or your spouse or Domestic Partner, if enrolled, by submitting payments directly to John Hancock Life Insurance Company. John Hancock will start billing you directly within four to six weeks following the date your scheduled hours change. Contact John Hancock for additional information.

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  www.quitnow.net/fidelity
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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Employee Assistance Program

- Your coverage ends on the last day of the month in which your scheduled hours change.
- You, your opposite-sex spouse, and/or Eligible Dependents who lose coverage as a result of the event have the option to continue coverage for up to 18 months by electing COBRA.*

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Tobacco Cessation Program

- Your eligibility to enroll in the program ends on the last day of the month in which your scheduled hours change.
- If you or your Eligible Dependents are currently participating in the program at the time your scheduled hours change, your/their coverage will end 12 months following the date you/they first enrolled in the program.

Profit Sharing

- If you already have satisfied the eligibility requirements for participation in the 401(k) feature, you may remain a participant in the Profit Sharing Plan and therefore may continue to make 401(k) contributions and Catch-up contributions, if applicable.
- For purposes of calculating Years of Service, the number of hours of service credited to you will be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.

Retiree Health Reimbursement Plan*

- For purposes of calculating Years of Service, the number of hours of service credited to you will be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked. If you do not complete 1,000 hours of service during the year you will not be eligible to receive the annual Credit.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Your Scheduled Hours Change

FROM AT LEAST 20 BUT FEWER THAN 30 HOURS PER WEEK **TO** 30 OR MORE HOURS PER WEEK

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- You remain eligible for coverage and your share of the cost(s) will be reduced.
- Provided that you notify HR Solutions within 31 days of the date your scheduled hours change, you may elect coverage or increase your coverage tier (e.g., individual plus one to family). You cannot change your existing medical coverage election (e.g., HealthFlex to an HMO).

Flexible Spending Accounts

- You are not eligible to make any change to your contributions to your Health Care Flexible Spending Account or your Health Care HSA-Compatible Flexible Spending Account.
- Provided that you notify HR Solutions within 31 days of the date your scheduled hours change, you can enroll in or increase your contributions to your Dependent Care Flexible Spending Account.

Life Insurance and Business Travel Accident Insurance

- You are eligible for all Core Life Insurance and Company-reimbursed life insurance coverage on the date your scheduled hours change provided that you are Actively at Work on that date and you do not need to enroll.
- If you elect to enroll for supplemental coverage under the Variable Life Insurance Plan, that coverage will become effective on the first of the month after your application has been approved. You must enroll in Variable Life Insurance no later than 60 days after the date your scheduled hours change to be covered without providing evidence of insurability (proof of good health).
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- You are eligible for Short-Term Disability and Core Long-Term Disability coverage on the date your scheduled hours change provided that you are Actively at Work on that date. This coverage is provided to you at no cost and you do not need to enroll.
- You also are eligible for Supplemental Long-Term Disability coverage on the first day you are Actively at Work and will be automatically enrolled. If you wish to decline coverage, you must do so within 31 days of your scheduled hours change.

Group Long-Term Care Insurance

- Your coverage is not affected by this event.

Employee Assistance Program

- Your coverage is not affected by this event.

Tobacco Cessation Program

- Your coverage is not affected by this event.

Profit Sharing

- For purposes of calculating Years of Service, you will be credited with 190 hours of service for each month in which you work at least one hour, rather than counting actual hours worked.

Retiree Health Reimbursement Plan*

- For purposes of calculating Years of Service, you will be credited with 190 hours of service for each month in which you work at least one hour, rather than counting actual hours worked.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Your Scheduled Hours Change

FROM AT LEAST 20 BUT FEWER THAN 30 HOURS PER WEEK **TO** FEWER THAN 20 HOURS PER WEEK

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- Your coverage ends on the last day of the month in which your scheduled hours change.
- You, your opposite-sex spouse, and/or Eligible Dependents who lose coverage as a result of the event will be offered the option to continue coverage for up to 18 months by electing COBRA.*

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Flexible Spending Accounts

- Your contributions to your Flexible Spending Account(s) end generally as of your last payroll period prior to the date your scheduled hours change.
- You may continue making contributions to your Health Care Flexible Spending Account or your Health Care HSA-Compatible Flexible Spending Account on an After-Tax basis until the end of the Plan Year by electing COBRA. If you elect to continue making contributions, you may continue to request reimbursement for expenses incurred during the Plan Year in which your scheduled hours change, provided that you continue making contributions for the entire Plan Year.
- If you do not elect to continue making contributions, you may request reimbursement, but only for expenses incurred prior to the end of the month in which your scheduled hours change.
- You may request reimbursement from your Dependent Care Flexible Spending Account, but only for expenses incurred prior to the date your scheduled hours change.

Life Insurance and Business Travel Accident Insurance

- You are not eligible for coverage under the Employee Life Insurance, Dependent Life Insurance, or Variable Life Insurance Plans. Only Regular Employees who are regularly scheduled to work 30 or more hours per week are eligible for this coverage.
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- You are not eligible for coverage under the Short-Term and Long-Term Disability Plans. Only Regular Employees who are regularly scheduled to work 30 or more hours per week are eligible for this coverage.

Group Long-Term Care Insurance

- You may continue Group Long-Term Care Insurance coverage for you and/or your spouse or Domestic Partner, if enrolled, by submitting payments directly to John Hancock Life Insurance Company. John Hancock will start billing you directly within four to six weeks following the date your scheduled hours change. Contact John Hancock for additional information.

Employee Assistance Program

- Your coverage ends on the last day of the month in which your scheduled hours change.
- You, your opposite-sex spouse, and/or Eligible Dependents who lose coverage as a result of the event have the option to continue coverage for up to 18 months by electing COBRA.*

*Please note: Same-sex spouses and Domestic Partners are not entitled to continuation coverage rights under COBRA. However, Fidelity offers same-sex spouses and Domestic Partners COBRA-like coverage under the medical and dental plans and the Employee Assistance Program. This coverage is similar to continuation coverage provided under COBRA. Please see page 179 for more information.

Tobacco Cessation Program

- Your eligibility to enroll in the program ends on the last day of the month in which your scheduled hours change.
- If you or your Eligible Dependents are currently participating in the program at the time your scheduled hours change, your/their coverage will end 12 months following the date you/they first enrolled in the program.

Profit Sharing

- If you already have satisfied the eligibility requirements for participation in the 401(k) feature, you may remain a participant in the Profit Sharing Plan and therefore may continue to make 401(k) contributions and Catch-up contributions, if applicable.
- For purposes of calculating Years of Service, the number of hours of service credited to you will continue to be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.

Retiree Health Reimbursement Plan*

- For purposes of calculating Years of Service, the number of hours of service credited to you will continue to be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Important Contact Information

If you experience one of these life or work events, here are some phone numbers and websites you can use to access needed forms, have your questions answered, or get information:

- **HR Solutions:**
  Online:
  hrsolutions.fidelity.com
  By phone: 800-835-5099
  (TDD 888-343-0860)
- **NetBenefits®:**
  netbenefits.fidelity.com
- **John Hancock Life Insurance Company:**
  888-333-5731
  fidelitygroup.jhancock.com
  (User name: fidelity;
  Password: mybenefit)
- **CIGNA Behavioral Health:**
  877-675-3760
  www.cignabehavioral.com
  (Employer ID: fidelity)
- **Tobacco Cessation Program:**
  866-784-8454
  www.quitnow.net/fidelity
- **CIGNA Group Insurance:**
  800-982-4888
- **MetLife:**
  888-660-1046
  mybenefits.metlife.com
- **Minnesota Life Insurance Company:**
  888-567-2882
  www.lifebenefits.com
- **ACE American Insurance Company:**
  800-336-0627
  (within U.S. and Canada)
  302-476-6187
  (outside U.S. and Canada)
- **Acclaris Reimbursement Center:**
  866-203-9358
  www.acclarisonline.com

Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Your Scheduled Hours Change

FROM FEWER THAN 20 HOURS PER WEEK **TO** 30 OR MORE HOURS PER WEEK

Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the ***Benefits Overview*** *section of this SPD:*

Medical, Dental

- You are eligible for coverage on the date your scheduled hours change. You must enroll yourself and any Eligible Dependents within 31 days your scheduled hours change in order to be covered. Please note, however, that if you are electing coverage for your same-sex spouse, online enrollment via NetBenefits® is not available. You must enroll by calling HR Solutions.

Flexible Spending Accounts

- You are eligible to elect to contribute on the date your scheduled hours change. You must elect to contribute within 31 days of the date your scheduled hours change.

Life Insurance and Business Travel Accident Insurance

- You are eligible for all Core Life Insurance and Company-reimbursed life insurance coverages on the date your scheduled hours change; you do not need to enroll.
- If you elect to enroll for supplemental coverage under the Variable Life Insurance Plan, that coverage will become effective on the first of the month after your application has been approved. You must enroll in Variable Life Insurance no later than 60 days after your scheduled hours change to be covered without providing evidence of insurability (proof of good health).
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- You are eligible for Short-Term Disability and Core Long-Term Disability coverage on the date your scheduled hours change. This coverage is provided to you at no cost and you do not need to enroll.
- You also are eligible for Supplemental Long-Term Disability coverage on the first day you are Actively at Work and will be automatically enrolled. If you wish to decline coverage, you must do so within 31 days of the date your scheduled hours change.

Group Long-Term Care Insurance

- You are eligible to enroll for coverage on the date your scheduled hours change. You must enroll no later than 60 days after your scheduled hours change in order to be covered without providing evidence of insurability (proof of good health).
- Shortly after your scheduled hours change, John Hancock will mail a personalized information kit to your address of record.

Employee Assistance Program

- You are eligible for coverage on the date your scheduled hours change. This coverage is provided to you at no cost and you do not need to enroll.

Tobacco Cessation Program

- You and your Eligible Dependents are eligible to enroll in coverage on the date your scheduled hours change. This coverage is provided at no cost to you, but you do need to enroll to participate in the program.

Profit Sharing

- You may immediately begin to make 401(k) contributions and Catch-up contributions, if applicable.
- You become eligible to participate in the Company-matching contribution* and Profit Sharing contribution* features on the 1st of the month coinciding with or following the month in which you have completed your first 12 months of service and have been credited with at least 1,000 hours of service in those 12 months. Please note, if you are not credited with 1,000 hours of service during your first 12 consecutive months of employment, you will become eligible to participate in the Company-matching contribution or Profit Sharing contribution feature on January 1 following the first calendar year (beginning with the calendar year in which your first employment anniversary occurs) in which you are credited with at least 1,000 hours of service.

Retiree Health Reimbursement Plan*

- You are eligible to receive credits on the first business day of the first month after completing 12 consecutive months and have been credited with 1,000 hours of service in those 12 months. Once you satisfy these initial eligibility requirements, you will receive the annual credit amount for each subsequent year in which you are credited with 1,000 hours of service. You do not need to enroll in the Retiree Health Reimbursement Plan.
- For purposes of calculating Years of Service, you will be credited with 190 hours of service for each month in which you work at least one hour.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive the Profit Sharing contribution or Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Important Contact Information

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Name, Address, or Marital Status Changes

- If you are an active employee, you may change your name, address, or marital status information on NetBenefits® by going to the "Pay" tab.
- If you are retired or have left the Company, call HR Solutions to update this information.
- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Important Contact Information

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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

Your Scheduled Hours Change

FROM FEWER THAN 20 HOURS PER WEEK **TO** AT LEAST 20 BUT FEWER THAN 30 HOURS PER WEEK

*Provided that you are a Regular Employee of a Participating Fidelity Company and you satisfy the applicable eligibility requirements described in the **Benefits Overview** section of this SPD:*

Medical, Dental

- You are eligible for coverage on the date your scheduled hours change. You must enroll yourself and any Eligible Dependents within 31 days of the date your scheduled hours change in order to be covered.

Flexible Spending Accounts

- You are eligible to elect to contribute on the date your scheduled hours change. You must elect to contribute within 31 days of the date your scheduled hours change.

Life Insurance and Business Travel Accident Insurance

- You are not eligible for coverage under the Employee Life Insurance, Dependent Life Insurance, or Variable Life Insurance Plans. Only Regular Employees who are regularly scheduled to work 30 or more hours per week are eligible for this coverage.
- Your Business Travel Accident Insurance coverage is not affected by this event.

Disability

- You are not eligible for coverage under the Short-Term and Long-Term Disability Plans. Only Regular Employees who are regularly scheduled to work 30 or more hours per week are eligible for this coverage.

Group Long-Term Care Insurance

- You are eligible to enroll for coverage on the date your scheduled hours change provided that you are Actively at Work on that date. You must enroll no later than 60 days after the date your scheduled hours change in order to be covered without providing evidence of insurability (proof of good health).
- Shortly after the date your scheduled hours change, John Hancock will mail a personalized information kit to your address of record.

Employee Assistance Program

- You are eligible for coverage on the date your scheduled hours change. This coverage is provided to you at no cost and you do not need to enroll.

Tobacco Cessation Program

- You are eligible to enroll in the program on the date that your scheduled hours change.

Profit Sharing

- You may immediately begin to make 401(k) contributions and Catch-up contributions, if applicable.
- For purposes of calculating Years of Service, the number of hours of service credited to you will be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.
- You become eligible to participate in the Company-matching contribution* and Profit Sharing contribution* features on the 1st of the month coinciding with or following the month in which you have completed your first 12 months of service and have been credited with at least 1,000 hours of service in those 12 months. Please note, if you are not credited with 1,000 hours of service during your first 12 consecutive months of employment, you will become eligible to participate in the Company-matching contribution or Profit Sharing contribution feature on January 1 following the first calendar year (beginning with the calendar year in which your first employment anniversary occurs) in which you are credited with at least 1,000 hours of service.

*Subject to sufficient Company profits and cash flow. Note: Albuquerque-based Fidelity HR Services employees, excluding individuals employed in a retail branch location, are not eligible for the Profit Sharing contribution. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

Retiree Health Reimbursement Plan*

- You are eligible to receive credits on the first business day of the first month after completing 12 consecutive months and have been credited with 1,000 hours of service in those 12 months. Once you satisfy these initial eligibility requirements, you will receive the annual credit amount for each subsequent year in which you are credited with 1,000 hours of service. You do not need to enroll in the Retiree Health Reimbursement Plan.
- For purposes of calculating Years of Service, the number of hours of service credited to you will be the actual number of hours you work. Hours of service are credited for the year in which they are paid, not for the year in which they are worked.

*Albuquerque-based Fidelity HR Services employees, excluding individuals employed at a retail branch location, are not eligible to receive Retiree Health Reimbursement Plan credits. Albuquerque-based does not include those individuals working in Albuquerque on a temporary basis.

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- To change your marital status or add Domestic Partner benefits, call HR Solutions.

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Glossary

Glossary

Actively at Work. You are Actively at Work on your regularly scheduled workday and performing the regular duties of your job on that day. You are considered Actively at Work on a day that is not your regularly scheduled workday (for example, a holiday or weekend day) if you are Actively at Work on the preceding scheduled workday.

After-Tax. Deductions that are taken from your pay for your cost of, or contributions toward, certain benefits after all payroll taxes have been deducted from your pay.

Alternate Recipient. An Alternate Recipient is any child of an employee who is participating in a Fidelity-sponsored group health plan who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under a Fidelity group health plan and thereby is enrolled as an Eligible Dependent of the employee.

Annual Benefits Enrollment. The period in the fall of each year during which benefit elections are selected for the upcoming Plan Year.

Appeals Committee. The FMR LLC Appeals Committee appointed by the Board of Directors of FMR LLC.

Appliance. A device used to provide function or therapeutic (healing) effect.

Base Salary or Base Salary Earnings. Your Base Salary, including the amounts that you contribute on a Pre-Tax basis (for example, your 401(k) contributions to the Profit Sharing Plan, contributions to the Flexible Spending Accounts, as well as your share of the cost for your medical and dental coverage). If variable compensation may comprise a significant portion of your annualized earnings, your Base Salary Earnings refers to your Benefits Base, which is equal to your Base Salary, including the cost of employee benefits you elect in lieu of basic compensation paid in cash (see above), plus 75 percent of your variable compensation (as both are paid throughout the calendar year). Base Salary does not include bonuses, overtime, other payments, or amounts earned while performing services for a Nonparticipating Fidelity Company.

Beneficiary. The person or persons eligible to receive a benefit if you die. A Beneficiary also can be a trust or an estate. Refer to each plan for specific Beneficiary information, including designating a Beneficiary(ies).

Benefits Base. Benefits Base is a calculation used to ensure that employees with significant variable compensation (including, but not limited to, sales incentives or commissions, sales bonuses, commission draws, and other recurring variable pay) are treated comparably to other employees for purposes of determining retirement and salary-based health and welfare benefits (including, but not limited to, STD, LTD, Supplemental LTD, Business Travel Accident Insurance, and Variable Life Insurance). The Benefits Base calculation for retirement benefits is equal to Base Salary, plus 75 percent of variable compensation (as both are paid throughout the calendar year). The Benefits Base calculation for salary-based health and welfare benefits is equal to Base Salary, plus 75 percent of variable compensation (as paid in the prior calendar year). If you recently were hired or moved into a Benefits Base qualified position and have received Benefits Base variable compensation for less than 12 consecutive calendar months, your Benefits Base for salary-based health and welfare benefits will be calculated on your Base Salary as of your hire date, plus 75 percent of your position's target variable compensation level (as defined in the sales plan for your position, or, if not defined in your sales plan, as otherwise determined by the Company).

Calendar-Year Maximum. The limit on how much the applicable plan will pay for care in any calendar year.

Change in Status. Certain life or work changes that enable you to make certain changes to your Pre-Tax benefit elections outside of the Annual Benefits Enrollment period, as provided by applicable law and to the extent permissible under the plan. Change in Status events include: marriage to an opposite-sex spouse; divorce; legal separation; the birth, adoption, or placement for adoption of a child; a dependent child ceasing to satisfy the eligibility requirements for coverage; termination or commencement of employment; a change in worksite; a change in residence that results in the loss of eligibility for a medical coverage election; and a change in employment status of an employee or an employee's spouse.

For same-sex spouse and Domestic Partner Life events, please refer to page 10 of this SPD.

Claims Administrator. The entity responsible for reviewing and providing decisions on claims submitted by plan participants, their covered Eligible Dependents, Beneficiaries, or Qualified Beneficiaries. (See the ***Administrative*** section of this SPD for a complete listing of Claims Administrators.)

COBRA Qualifying Event. An event—such as Termination of Employment, divorce, legal separation, an employee's death, an employee's entitlement to Medicare, the loss of status as an Eligible Dependent, or a reduction in hours—that causes the employee and/or the employee's Eligible Dependents to lose coverage under a Fidelity group health plan and results in eligibility for continuation coverage under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA).

Coinsurance. The specific percentage that you pay toward the cost of certain Covered Services. For example, a 30 percent Coinsurance for Out-of-Network Coverage means that the plan pays 70 percent of the cost of the Covered Service, based on the Reasonable and Customary Amount for the Covered Service, and you pay any remaining balance, which generally is 30 percent of the Reasonable and Customary Amount. Although not part of the Coinsurance, you also are responsible for the difference between the amount charged by an out-of-network provider and the Reasonable and Customary Amount.

Company. FMR LLC ("Fidelity") and its affiliates, under Section 1563 of the Internal Revenue Code (IRC).

Consolidated Omnibus Budget Reconciliation Act (COBRA). The *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA) is a federal law that requires employers with more than 20 employees to offer continuation of group health plan coverage for a specified period to certain Qualified Beneficiaries if they would otherwise lose coverage due to a COBRA Qualifying Event.

Cosmetic. Any procedure or service performed primarily to change a person's appearance.

Covered Service. A service or treatment that is eligible for payment under the applicable plan.

Direct Rollover. A transfer of the eligible portion of a Retirement Program distribution directly from the Profit Sharing Plan to an Individual Retirement Account (IRA) or to an Eligible Employer Plan that accepts rollovers. After-Tax contributions only may be rolled over to: a Traditional IRA; a plan that is both qualified under Section 401(a) and accepts rollovers of After-Tax contributions; and a 403(a) annuity plan that accepts rollovers of After-Tax contributions. This option generally is available only for lump-sum distributions. This can also refer to a transfer of assets from an Eligible Employer Plan into the Profit Sharing Plan.

Domestic Partner. For purposes of the medical, dental, life insurance, tobacco cessation, business travel accident insurance plans and the survivor benefit under the long-term disability plan, a Domestic Partner (including, without limitation, civil union partners) shall mean a person who:

1. Is a same-sex person in a committed, marriage-like relationship with a Fidelity employee (Note: If you or your partner are age 62 or older and eligible for Social Security benefits or Supplemental Security Income (SSI) based on age, a Domestic Partner may be of the opposite sex);
2. Is at least 18 years old, not related to the employee, and not married to any other person;

3. Is not a member of another domestic partnership or civil union with someone else unless the domestic partnership or civil union was terminated, dissolved, or adjudged a nullity;
4. Is capable of consenting to the domestic partnership;
5. Shares a common residence with a Fidelity employee; and
6. Has legally formalized the domestic partnership with the Fidelity employee, if the employee lives in a state where such legal means exist, by having either: (i) legally formalized the domestic partnership in the employee's state of residence; or (ii) formalized the domestic partnership in another state that permits non-resident registration. [For example, employees with a same-sex partner in New Hampshire must either enter into a civil union in New Hampshire or register their partner as a Domestic Partner in another state that permits non-resident Domestic Partner registration, such as California.]

For purposes of the EAP and Long-Term Care, a Domestic Partner is a same-sex or opposite-sex person in a marriage-like relationship with a Regular Employee. The Domestic Partner must have reached the age of majority, not be a relative of the Regular Employee, and not be married to any other person. The Regular Employee and the Domestic Partner must have been living together for at least one year, with the intent to be life partners, and generally must be economically interdependent.

Eligible Bonus. For purposes of the Supplemental LTD Plan, quarterly, semiannual, and annual bonuses (excluding annual nonexempt gifts) averaged over the past two years. If two years of bonus history is not available, Eligible Bonus will be based on the available history. Sales and commission bonuses are not covered in the bonus coverage. For Benefits Base employees, eligible sales and commissions bonuses are factored into your insurance base rate.

Eligible Compensation. Under the Profit Sharing Plan, your Base Salary, plus overtime and regular performance bonus(es), if applicable. If variable compensation may comprise a significant portion of your annualized earnings, your Eligible Compensation is your Benefits Base, which is equal to your Base Salary, plus 75 percent of your variable compensation (as both are paid throughout the calendar year).

Eligible Dependents.

- *For the medical and dental plans:*
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
  - Those for whom coverage is required by a Qualified Medical Child Support Order (QMCSO).
- *For reimbursement from the Health Care Flexible Spending Account and the Health Care HSA-Compatible Flexible Spending Account:*
  - Your legal spouse who is a member of the opposite sex, as evidenced by a marriage certificate.
  - Your dependent(s), as defined under Section 152 of the Internal Revenue Code, including, but not limited to, your dependent children.
- *For reimbursement from the Dependent Care Flexible Spending Account:*
  - Your dependent child(ren) younger than age 13, who generally spends at least eight hours per day in your home, and for whom you provide more than one-half of the individual's support.
  - Any other dependent who is physically or mentally disabled and therefore incapable of self-care, who lives in your home for more than one-half of the tax year, for whom you provide more than one-half of the individual's support.

- *For the dependent life insurance plans:*
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Unmarried dependent children who are at least 2 days old and younger than age 19 (age 23, if your unmarried dependent is a full-time student who is dependent upon you for care and support).
  - Any other person designated as eligible under applicable state law.
- *For the Long-Term Disability Survivor Benefit:*
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Unmarried, dependent children younger than age 23, including your natural children, legally adopted children, and foster children who are dependent on you for financial support.
  - Any other person designated as eligible under applicable state law.
- *For the EAP:*
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Children up to age 26, provided the child is not eligible for other employer-sponsored group health coverage which is contributed to, in whole or in part, by the employer.
- *For the Tobacco Cessation Program:*
  - Your legal spouse, as evidenced by a marriage certificate.
  - Your Domestic Partner as defined on page 5 of this SPD.
  - Unmarried dependent children age 18 and over.
- For all plans, your children are:
  - Your natural children.
  - Legally adopted children (including a child for whom legal adoption proceedings have begun and who has been placed in your home).
  - Stepchildren for whom you are a legal guardian.
  - Children for whom you are a legal guardian and whom you claim as dependents on your income tax return.

Eligible Employer Plan. Includes a plan qualified under section 401(a) of the Internal Revenue Code, including a 401(k) plan, profit-sharing plan, defined benefit plan, stock bonus plan, and money purchase plan; a section 403(a) annuity plan; a section 403(b) tax-sheltered annuity; and an eligible section 457(b) plan maintained by a governmental employer (governmental 457 plan).

Individual Retirement Account (IRA). An account you may be eligible to open and contribute to as a way of increasing your personal savings for retirement. A rollover IRA is a special IRA that you can open in order to roll over your lump-sum distribution into an Eligible Employer Plan at a later date. For more information about IRAs, see IRS Publication 590 and/or consult with your financial or tax adviser.

In-Network Coverage. Care provided by an in-network provider.

Nonparticipating Fidelity Company. An affiliate of FMR LLC that is not participating in one or both of the plans under the Retirement Program.

Notarized. A signature that has been witnessed by a Notary Public.

Notary Public. A person licensed by the state to be a legal witness to the validity of a signature on a document. You can find a Notary Public in your area at a bank or through the telephone yellow pages.

One-Year Break in Service. Any calendar year in which you are credited with fewer than 501 hours of service.

Out-of-Network Coverage. Care provided by an out-of-network provider. Generally, care is subject to an annual deductible and a covered person under the HealthFlex Plan or the Fidelity Health Plan pays a percentage of the Reasonable and Customary Amount for Covered Services as well as the difference between the total cost charged by the out-of-network provider and the Reasonable and Customary Amount for such service. With the Health Maintenance Organizations (HMOs), out-of-network care generally is covered only in emergency situations.

Participating Fidelity Company. An affiliated Company of FMR LLC whose business units have elected to participate in one or both of the plans under the Retirement Program.

Physician. A person who is all of the following:

- A doctor of medicine, osteopathy, psychology, or other healing art recognized by the Claims Administrator, and
- Licensed to practice in the state or jurisdiction where care is being given, and
- Practicing within the scope of that license.

Plan Year. The calendar, policy, or fiscal year on which the records of the plans described in this Summary Plan Description (SPD) are maintained. The Plan Year is January 1 through December 31.

Pre-Tax. Deductions that are taken from your pay for your cost of, or contributions toward, certain benefits, generally before federal and, in most cases, state and local income taxes have been deducted from your pay.

Prospectus. A document that provides a thorough description of an investment option. It explains the investment option's objective, how it invests its money, and describes fees and expenses associated with the investment option.

Qualified Beneficiary. An active Fidelity Regular Employee and/or the Regular Employee's Eligible Dependents who is covered under a Fidelity-sponsored group health plan on the day before a COBRA Qualifying Event occurs and who loses coverage as a result of the COBRA Qualifying Event.

Qualified Domestic Relations Order (QDRO). A domestic relations order issued by a state domestic relations court that provides for the assignment of benefits under a qualified retirement plan, such as the plans under the Retirement Program, to your spouse, former spouse, child, or other dependent that the Plan Administrator determines is qualified.

Qualified Medical Child Support Order (QMCSO). A medical child support order that the Plan Administrator determines is qualified. The QMCSO creates or recognizes the existence of an Alternate Recipient's right to receive benefits under a Fidelity-sponsored group health plan.

Qualified Plan. A retirement plan that the Internal Revenue Service (IRS) has determined satisfies the requirements under Section 401(a) of the Internal Revenue Code (IRC). Qualified Plans receive special tax advantages.

Reasonable and Customary Amount. The prevailing cost for corresponding treatment, services, or supplies for similar medical or dental conditions in your geographic area, as determined by the Claims Administrator. Consideration is given to the complexity and range of services provided when determining whether a charge is reasonable. The Reasonable and Customary Amount may be different than the amount charged by an out-of-network provider.

Regular Employee. An employee who is hired for and employed in a position for which the Company anticipates a continuing need and that has been approved as a regular position. Regular Employees who are regularly scheduled to work 20 or more hours per week are eligible for certain benefits under Fidelity's benefit plans (see the ***Benefits Overview*** section of this SPD for more information).

Retirement Committee. The FMR LLC Retirement Committee appointed by the Board of Directors of FMR LLC.

Summary Plan Description (SPD). This benefit plan summary. The Summary Plan Description (SPD) for each Fidelity-sponsored plan includes: the ***Benefits Overview*** section, the specific benefit plan section, the ***Administrative*** section, the ***Life & Work Events*** section, and the ***Glossary*** section.

Tax-Deferred. When taxes on money placed in an investment option and/or its earnings are not considered taxable until a later date, generally when withdrawals are taken from the investment.

Termination of Employment. The retirement, resignation, death, or other voluntary or involuntary cessation of your employment relationship with the Company. Generally, transferring between Fidelity Companies does not constitute a Termination of Employment under the plans under the Retirement Program.

Uniformed Services Employment and Reemployment Rights Act (USERRA). This law provides eligible Regular Employees who return to employment after completing an approved military leave with certain rights under various benefit plans. (See the ***Administrative*** section of this SPD.)

Vest, Vested, or Vesting. Your nonforfeitable right to receive a benefit.

Year of Service. A calendar year in which you are credited with at least 1,000 hours of service.

Year of Vesting Service. A Year of Service that is taken into account for purposes of determining Vesting under the Profit Sharing Plan.

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Resources

BENEFIT PLAN PROVIDERS

BENEFIT PLAN PROVIDERS		
Medical	Aetna (CT, NJ, NY, PA, TX)	800-238-6291, www.aetna.com
	CIGNA HealthCare of North Carolina, Inc.	800-CIGNA24, www.cigna.com
	Harvard Pilgrim Health Care	888-333-4742, www.harvardpilgrim.org
	Health Dialog	888-923-4393
	Fidelity Health Plan (UnitedHealthcare)	877-240-4016, www.myuhc.com
	HealthFlex Plan (UnitedHealthcare)	800-331-0265, www.myuhc.com
	Humana	888-357-6767 www.humana.com
	SelectHealth	800-538-5038, www.selecthealth.org
Prescription Drug	Medco	866-383-7314, www.medco.com
Dental	MetLife	888-660-1046, mybenefits.metlife.com
Flexible Spending Accounts	Health and Dependent Care	UnitedHealthcare at 800-331-0265, www.myuhc.com
	Health Care Limited	UnitedHealthcare at 877-240-4016, www.myuhc.com
Life Insurance	Employee Life Insurance Dependent Life Insurance	HR Solutions at 800-835-5099 (TDD 888-343-0860)
	Variable Life Insurance	Minnesota Life Insurance Company 888-567-2882 (8:00 A.M. to 7:00 P.M. ET) www.lifebenefits.com
	Business Travel Accident Insurance	ACE American Insurance Company within U.S. and Canada 800-336-0627 outside U.S. and Canada 302-476-6187
Disability	CIGNA Group Insurance	800-982-4888
Group Long-Term Care Insurance	John Hancock Life Insurance Company	888-333-5731, fidelitygroup.jhancock.com (User name: fidelity; Password: mybenefit)
Employee Assistance Program (EAP)	CIGNA Behavioral Health	www.cignabehavioral.com Employer ID: fidelity; PIN: member 877-675-3760 (TTY 800-855-2880)
Tobacco Cessation Program	Quit For Life® program	866-784-8454, www.quitnow.net/fidelity
Retirement Program	Profit Sharing Plan Retiree Health Reimbursement Plan	NetBenefits® at netbenefits.fidelity.com or HR Solutions at 800-835-5099 (TDD 888-343-0860)
NetBenefits® *Personal benefits information on the Internet*	netbenefits.fidelity.com	Manage your health benefits, access health resources, manage your retirement plan account(s), including running online statements or requesting paper statements, and more
HR Solutions *Benefits information on Fidelity's Intranet site*	hrsolutions.fidelity.com	Online benefits information, including the electronic version of *Benefits at Fidelity*, forms, and other tools
HR Solutions *Representatives are available Monday through Friday from 8:30 A.M. to 8:00 P.M. ET., except New York Stock Exchange holidays. The Voice Response System (VRS) is available virtually 24 hours a day, 7 days a week*	800-835-5099 (TDD 888-343-0860)	Enroll in and review your benefits, ask questions, and obtain information on all of your benefits and programs


Fidelity
INVESTMENTS

Benefits at Fidelity

Your Summary Plan Description