SUMMARY PLAN DESCRIPTION

LINGER, PETERSON & SHRUM
CAFETERIA PLAN

Full-Time and Part-Time Employees of
Linger, Peterson & Shrum

Premium Conversion Plan
Effective February 2, 2016

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SUMMARY PLAN DESCRIPTION

INTRODUCTION

This booklet is a Summary Plan Description (is a Summary Plan Linger, Peterson & Shrum (LPS) Premium Conversion Plan ("Plan"). The SPD describes the basic features of the Plan, its rules of eligibility and coverage, and how it operates, as of February 2, 2016.

If you are a full-time employee of Linger, Peterson & Shrum; you are eligible for certain company sponsored salary reduction benefits. In this summary plan description, we give you important information about this Plan and when and how you are able to receive benefits from it. We also tell you what to do when you have questions or problems or need other information regarding this Plan. You should therefore read this summary plan description carefully.

Please keep in mind that this is only a summary of benefits, eligibility requirements, and other Plan details. More thorough information about the Plan is available in the Plan documents. By contacting the Plan Administrator, you can arrange to read or receive a copy of the Plan documents.

The name of the Plan is the Linger, Peterson & Shrum Cafeteria Plan. Your employer has assigned Plan number 001 to the plan. The Plan Administrator is your employer, Linger, Peterson & Shrum (Employer Identification No.81-1342570). Linger, Peterson & Shrum's address and phone number is: 575 E. Locust Ave., Suite 308, Fresno, CA 93720-2928; (559) 438-8740. Written inquiries about the Plan should be mailed to Linger, Peterson & Shrum.

This plan has a January 1 - December 31 Plan Year and is operated for the exclusive benefit of our employees. We intend to offer the Plan indefinitely to our employees. However, we reserve the right to change or terminate any aspect of this Plan at any time.

The effective date of this Plan is February 2, 2016.

SUMMARY

The Plan consists of one component, referred to as the "Premium Conversion Plan," allows eligible employees to pay certain premiums for coverage under Linger, Peterson & Shrum Medical Plan, the Linger, Peterson & Shrum Dental Plan, and the Linger, Peterson & Shrum Vision Plan (the "LPS Health Care Plans") on a pre-tax basis. This Plan does not govern the operation of any benefit options other than the Premium Conversion Plan. The benefits provided by the LPS Health Care Plans are outlined in more detail in the separate Summary Plan Description for each plan and are not explained in this Summary.

PREMIUM CONVERSION PLAN

The Premium Conversion Plan provides eligible employees the ability to pay premiums for coverage under the LPS Health Care Plans on a pre-tax basis.

Eligibility

You are an "eligible employee" and are eligible for the Plan on the date you satisfy the requirements for coverage under any of the insurance benefit plans or other salary reduction programs maintained by your employer. You are eligible to participate in the Premium Conversion Plan if you are classified as a full-time employee or part-time employee of the Employer and you are enrolled or automatically enrolled in a LPS Health Care Plan. Your insurance benefit booklet describes the Plan eligibility and enrollment rules in greater detail as related to the "premium only" portion of the Plan. However, the following classes of individuals are not considered to be full-time or part-time employees:

- Contract or leased employees.
- Seasonal, substitute, temporary or temporary agency employees.

To enroll in the Plan, you must complete an application to participate in the Plan that authorizes us to reduce your wages to pay the insurance premiums for the coverage you have elected, and for other qualified expenses for which you are to be reimbursed.

To the extent permitted under the LPS Health Care Plans, if you are enrolled as a participant, you may also enroll your eligible dependents.

Note: The law does not allow an eligible employee to pay the cost of coverage under the LPS Health Care Plans for a domestic partner or the child of such an individual (or any other individual) on a pre-tax basis, unless the individual qualifies as the eligible employee's dependent under federal tax law.

Enrollment

The Plan has two regular enrollment periods: (1) The initial election period and (2) the annual open enrollment period.

Initial Election Period

If you wish to participate in a LPS Health Care Plan when you first become eligible, you must enroll during your initial election period. To elect to participate during your initial election period, you must complete the forms provided by the Plan Administrator in the manner specified. Eligible employees who enroll in the LPS Health Care Plan and who are required to contribute to the cost of such coverage are automatically enrolled in the Premium Conversion Plan and is deemed to have elected to pay for the cost of such coverage on a pre-tax basis, generally the first day of the eligible employee's date of participation in the applicable LPS Health Care Plan.

Annual Open Enrollment Period

The Plan operates on a calendar year cycle (January 1 to December 31), referred to as the "Plan Year." Before the beginning of each Plan Year, the Plan Administrator holds open enrollment. During this time, you may change your elections for the upcoming Plan Year, or elect to enroll in the LPS Health Care Plan for the first time. This is the Plan's "annual open enrollment period," and each year it will be set and announced in advance by the LPS Benefits Department.

If you do not actively make changes to your benefit elections during the annual open enrollment period, your benefit elections under the applicable LPS Health Care Plans and the pretax premium portion of the Premium Conversion Plan will carry over automatically into the new Plan Year, unless you are notified that re-enrollment is required.

Note: Your elections for the Working Spouse/Domestic Partner Premium Waiver will **not** automatically carry over into the next plan year; you must actively re-enroll each year if you wish to continue participation.

PLAN FUNDING AND BENEFITS ADMINISTRATION

Prior to the beginning of each year, you can elect to have your wages reduced to pay the insurance premiums for the coverage you elect under any of the insurance benefit plans or other qualified programs we sponsor. Your wages will be reduced by payroll reduction on a pro rata basis during the year in the amounts requested for the coverage you elect. This amount is not subject to federal income tax, social security tax, Medicare tax, and applicable State of California payroll taxes.

You may change your election as allowed by the insurance benefit plan. Your insurance benefit booklet describes the situations when your election can be changed for the "premiums only" portion. Other salary reduction elections may be changed annually prior to the beginning of a new plan year or at other times when a family status change has occurred.

BENEFITS

The Election to Participate form contains the benefits (i.e. insurance coverage) currently offered. If any additional benefits become available, we will revise the election form. Under this plan, you can choose to receive all of your compensation in cash or elect to use a portion to pay any insurance premiums that you are responsible for (i.e. those premiums the Company does not pay for), or to pay for allowable, reimbursable medical and/or dependent care expenses.

The benefits provided by insurance coverage are governed by the Plan document for each particular covered benefit. You may obtain a copy of the Plan document or the booklet for such benefits from the Plan Administrator.

The benefits you elect (or are deemed to have elected) to pay on a pre-tax basis during the initial enrollment period or annual open enrollment period will remain in effect for the entire Plan Year unless you experience an event that qualifies you to make an election change.

BENEFIT PAYMENTS

The amount of pay you elect to reduce your wages by will be used to pay the premiums for the insurance coverage you elect, and for other allowable medical and/or dependent care expenses. The provisions of the applicable insurance policies will govern any benefits available through insurance coverage, and medical and/or dependent care expense reimbursements to you will be governed by Section 125 of the Internal Revenue Code.

Any funds not used to pay for premiums on insurance and elected expenses are forfeited. Thus, you should be sure to elect only the amounts required to pay premiums on the desired coverage and the allowable medical and/or dependent care expenses.

HOW BENEFITS CAN TERMINATE

Your benefits under this Plan can terminate if:

1. your employment with us ends,

2. you are no longer a full-time employee, or

3. the Plan is discontinued.

In any of the above situations, the Plan pays benefits for insurable events that occur through your last day of coverage.

LIMITS FOR HIGHLY COMPENSATED EMPLOYEES

The Internal Revenue Code provides that this Plan cannot discriminate in favor of highly compensated participants or key employees. Generally, these are employees that are owners, officers, or highly paid employees. Such individual's contributions and benefits may be limited so that the Plan does not favor these individuals. Under these rules, an individual is unfairly favored if that individual receives more than 25% of all of the nontaxable benefits provided under the Plan.

The Plan Administrator will notify you if your contributions or benefits are subject to being limited.

SERVICE OF LEGAL PROCESS

Your rights to benefits under this Plan are legally enforceable. Legal process should be served on the Plan Administrator at the address provided in Section I above.

YOUR RIGHTS UNDER ERISA

As a participant in the Linger, Peterson & Shrum Cafeteria Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of any documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for operation of the employee benefit plan. These people who operate the 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 benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

1. If you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

2. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court.

3. 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 was frivolous).

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

- Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.
- If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.
- For any adverse benefit determination, you will be provided with an explanation of the bases for disagreeing or not following the views of: (1) health care professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.
- For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.
- Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.
- If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.
- Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under Section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in Section 503-1(l).