BeneTemps, Inc. dba BTHR Solutions

GROUP HEALTH INSURANCE PLAN
SUMMARY PLAN DESCRIPTION

AllWays Health Partners Complete HMO HSA 2500

AllWays Health Plan Complete PPO HSA 2500

Both Plans with Health Savings Account

Amended and Restated

January 1, 2020

ERISA Summary Plan Description. This document, together with the subscriber certificate (Member Handbook) issued by the Insurance Company, constitutes the Summary Plan Description required by ERISA. Handbooks are available upon request and included on our employee website.

BeneTemps, Inc. dba BTHR Solutions
GROUP HEALTH INSURANCE PLAN

January 1, 2020

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i. General Information About the Plan

Plan Name:	BeneTemps, Inc. dba BTHR Solutions Group Health Insurance Plan **"The Plan" throughout this document**
Type of Plan:	Group health plan
Plan Year:	October 1 – September 30
Plan Number:	502
Original Effective Date:	January 1, 1995 (the Plan has been amended several times since its original effective date)
Plan Sponsor:	BeneTemps, Inc. dba BTHR Solutions 738 Main Street, #337 Waltham, MA 02451 781-726-6070 **"BTHR Solutions" throughout this document**
Plan Sponsor's Employer Identification Number:	02-0452407
Insurance Company:	AllWays Health Partners 399 Revolution Drive Somerville, MA 02145 866-414-5533 **the "Insurance Company" throughout this document**
Plan Administrator:	BeneTemps, Inc. dba BTHR Solutions 738 Main Street, #337 Waltham, MA 02451 Attn: Office Manager
Named Fiduciary:	BeneTemps, Inc. dba BTHR Solutions 738 Main Street, #337 Waltham, MA 02451 781-726-6070

Agent for Service of Legal Process:	Sam Gruenbaum BeneTemps, Inc. dba BTHR Solutions 738 Main Street, #337 Waltham, MA 02451 781-726-6070 Service of legal process may also be made on the Plan Administrator
Plan Document:	Portions of this document together with the Member Handbook constitute the written plan document for the BTHR Solutions Group Health Insurance Plan required by ERISA.
Type of Plan Administration:	This Plan is fully insured. Benefits are provided under a group insurance contract between BeneTemps, Inc. dba BTHR Solutions and AllWays Health Partners. Claims for benefits are sent directly to the Insurance Company and the Insurance Company (not BeneTemps, Inc.) is responsible for paying claims. BeneTemps, Inc. dba BTHR Solutions and the Insurance Company share responsibility for administering the Plan as discussed in Section 6 below.
Important Disclaimer:	Benefits hereunder are provided pursuant to an insurance contract between the Plan Sponsor and the Insurance Company. If the terms of this summary document conflict with the terms of the Plan Document, the terms of the Plan Document will control, unless superseded by applicable law.

ii. Cost of Health Plan

Monthly Health Insurance Cost

AllWays Health Partners

Rates Effective October 1, 2019

Employee cost is 50% of total cost

	HMO Plan	
	100%	*50%*
Individual	$612.03	$306.02
EE+Child	$1,132.26	$566.13
EE+Spouse	$1,124.06	$612.03
Family	$1,744.29	$872.15

	PPO Plan	
	100%	*50%* *
Individual	$828.36	$414.18
EE+Child	$1,532.48	$766.24
EE+Spouse	$1,656.73	$828.37
Family	$2,360.84	$1,180.42

* These premiums only apply to employees not covered in the HMO service area.

If employee is covered in the HMO service area and chooses to enroll in the PPO plan, the employee cost will be based on BTHR paying 50% of the HMO premium and employee pays the difference.

See table below:

	PPO Plan (if covered in **HMO** service area)	
	100%	*Employee Cost*
Individual	$828.36	$522.34
EE+Child	$1,532.48	$966.35
EE+Spouse	$1,656.73	$1,044.70
Family	$2,360.84	$1,488.69

1. Introduction

BTHR Solutions maintains a group health insurance plan (the “Plan”) for the exclusive benefit of and to provide health benefits to its eligible employees, their legal spouses and eligible dependents. The Plan includes both the AllWays Complete HMO HSA 2500 and AllWays Complete PPO HSA 2500 options for participants. Both plans include a Health Savings Account (HSA)

These benefits are currently provided under an insurance contract entered into between BTHR Solutions and the Insurance Company. These benefits are summarized in the Member Handbook issued by the Insurance Company.

2. Eligibility and Participation Requirements

Eligibility

Full-time employees and their eligible dependents (eligible dependent definition according to Federal Law) will be eligible to enroll on the first day following their 90 day employment anniversary (this is the "Initial Eligibility Period"). Full-time employees are those who maintain a minimum of 390 hours during any consecutive 90 day period AND who are paid directly by BTHR Solutions. Employees will be notified by BTHR upon reaching eligibility for the Plan.

Termination of Participation

Eligibility for Plan benefits will end:

- on the last day of the month in which an employee has ended an assignment, is terminated, or voluntarily terminates employment;
- on the last day of the last fully paid month if an employee fails to pay his/her portion of the monthly premium.

Additional provisions for termination of participation including but not limited to termination of the group plan, member’s death, termination of marriage, age limitations for dependent children, end of student status, etc. are listed in the Member Handbook. Coverage for spouse and dependents stops when the employee’s coverage stops or for other reasons as listed in the Member Handbook.

***Note**: employees who were enrolled in our health plan before 10/1/16 with no break in coverage and are still currently enrolled will be grandfathered under our previous termination policy. They may be eligible for an additional 30 days of coverage after employment ends, if certain criteria are met.*

Rehire Eligibility

If an employee has a break between assignments for longer than 60 days, the employee must satisfy a new 90 day waiting period and accrue 390 hours before being eligible to enroll in the health plan. Employees enrolled in the health plan who have a break between assignments for longer than 60 days AND who have remained on COBRA will be allowed to re-enroll as an active employee in the health plan on the date they are rehired.

If an employee has a break between assignments under 60 days, the employee will remain on the health plan with no break in coverage, as long as employee’s portion of premium is caught up once back on assignment. Upon a return to active status in the health plan, the employee will pay the monthly premium at the 50% split rate, or the alternate rate if the employee is on the PPO plan while covered in the HMO service area.

3. Continuation of Coverage Under COBRA

What is COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) is a law that allows you and your covered dependents to continue your employer-sponsored group health coverage. Your coverage and that of your covered dependents will continue under certain circumstances when coverage would have otherwise terminated.

Continuation of Coverage

Covered employees or their covered dependents covered under the employer's group health plan, may have the right to choose to continue group health coverage for up to 18 months if coverage is lost due to:

a. the employee's reduction in hours of employment; or
b. the employee's termination of employment (for other than gross misconduct).

Covered employees or their covered dependents who become disabled at any time during the first sixty (60) days of coverage continued as a result of termination of employment or reduction of work hours, and continues to be disabled at the end of the initial 18 month period may have their coverage continuation extended an additional 11 months for a total of 29 months. Disability must be determined by the Social Security Administration (SSA) Title II or Title XVI. For the disability extension to apply, a copy of the SSA Determination of Disability letter must be provided to the employer within 60 days after the latest of (1) the date of the SSA determination of disability; (2) the date on which the qualifying event occurs; or (3) the date on which the qualified beneficiary loses coverage. The premium payment for the first 18 months may be up to 102% of the applicable group premium. For the next 11 months, premium payment may be up to 150% of the applicable group premium. Your coverage may be terminated during the extended period if it is determined that you are no longer disabled.

Covered dependents may elect to continue health coverage for up to 36 months if the loss of coverage is due to:

a. the death of an employee;
b. divorce or legal separation;
c. the employee's entitlement to Medicare; or
d. the child ceasing to be a dependent child as defined under the group health plan.

Notice Obligations

In accordance with the law, covered employees or dependents are responsible for notifying the Plan Administrator (usually your employer) of:

1. divorce or legal separation;
2. when a child is no longer a dependent as defined under your employer's group health plan.

Written notice must be provided within sixty (60) days after the event of the date coverage terminates, whichever is later. The employer will then notify the employee or dependent of the right to continue coverage under COBRA. If written notice is not provided to the Plan Administrator within sixty (60) days, COBRA continuation will not be offered.

In the case of the employee's death, termination of employment, reduction in hours or Medicare entitlement, the employer has the responsibility to notify the covered employee and dependents of their right to coverage continuation under COBRA.

Election Procedures
Covered employees and their covered dependents will be notified of their right to elect to continue coverage once the Plan Administrator has been made aware that one of the events listed above has occurred. Covered employees and dependents will have sixty (60) days from the termination date of coverage or the date of the notice, whichever is later, to elect to continue health coverage.

Separate elections may be made by each person who has lost group health coverage under your employer's group health plan. If coverage is not continued, group health coverage may terminate under your employer's group health plan.

Who Pays the Premium?
The person electing to continue coverage under the employer's group health plan will be responsible for paying the premium. In most cases, the maximum amount that may be charged is 102% of your group premium.

The first premium payment is due 45 days following the date you elect to continue coverage. Future premium payments must be made on a monthly basis. A grace period of 30 days (or one equal in length to the employer's grace period, if longer) will be allowed for payment of any monthly premium. Continuation of coverage may be terminated if the premium payment is not received by the end of the grace period.

How Long Will COBRA Be Effective?
COBRA coverage will be in effect for 18, 29 or 36 months depending on the qualifying reason for coverage continuation as outlined above. Continued coverage may also terminate before the end of the 18, 29 or 36 month period when:

1. the former employer no longer provides a group health plan to any of its active employees;
2. the premium is not paid by the end of the grace period;
3. participants become covered under another employer-sponsored group health plan that does not limit or exclude a pre-existing condition; or
4. participants become entitled to Medicare.

Can Coverage Be Extended Under COBRA? (Referred to as Second Qualifying Events)
Yes, if your covered dependents have chosen to continue their group coverage for 18 months due to termination of your employment or reduction in work hours, your dependents may extend coverage beyond the end of this 18 month period if:

1. you, the employee dies;
2. you divorce or become legally separated;
3. you become entitled to Medicare; or
4. your child ceases to be a dependent child as defined under the group health plan.

In each case, coverage may be extended for up to 36 months from the date coverage was originally lost.

Pre-Existing Medical Conditions
In most instances, once you have become covered under another employer-sponsored group health plan, your COBRA coverage terminates. However, if you have a pre-existing condition that is not covered under the employer-sponsored plan, you may continue COBRA coverage until the earlier of the pre-existing conditions exclusion period of the new plan ends or until the COBRA continuation period ends.

4. Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth or adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

5. Summary of Plan Benefits

The Plan provides eligible employees and their dependents with health insurance. These benefits are provided under a group insurance contract entered into between BTHR Solutions and the Insurance Company. A summary of the benefits provided under the Plan is set forth in the Member Handbook issued by the Insurance Company, and included at the end of this document.

The Plan will, through the group insurance contract, provide benefits in accordance with the applicable requirements of federal laws, such as COBRA, HIPAA, the NMHPA, and the WHCRA.

Health Savings Account (HSA)

The Plan is supported by a Health Savings Account (HSA) designed to fund the out-of-pocket deductible and a host of other eligible health care expenses on a pre-tax basis.

- Each participant will need to enroll in their HSA thru BTHR Solutions within the first month of their health coverage, so that employer contributions can be made to their HSA even if the participant chooses not to contribute.
- The HSA will be administered by HRC Total Solutions (HRCTS) who has been contracted by BTHR Solutions. An enrollment form with instructions will be provided by BTHR Solutions.
- BTHR Solutions will contribute to each HSA up to $1,000 per individual or $2,000 per family each plan year (Oct 1-Sept 30) in monthly installments of $83.33 or $166.67 respectively, for as long as the employee remains actively employed (i.e. on assignment), continues to meet eligible criteria and is enrolled in the Plan.
- Participants can choose to contribute to their HSA on a pre-tax basis via payroll deduction.
- Each participant will own their HSA and funds will not be lost due to changes in employment or healthcare plans.

- Participants can receive tax-free distributions from their HSA to pay or be reimbursed for qualified medical expenses incurred after establishing the HSA. If distributions are received for other reasons, the amount withdrawn will be subject to income tax and may be subject to an additional 20% tax.

For complete tax information on HSAs, see IRS Publication 969 at https://www.irs.gov

The participant must also meet the following criteria in order to enroll in a HSA:

- Has a valid Social Security Number (SSN) and be a primary residence in the U.S.
- Is not covered by any other type of health plan, including Medicare Part A or Medicare Part B.
- Has not accessed VA medical benefits in the past 90 days (to contribute to an HSA).
- Is not as a dependent on another person's tax return (unless it's your spouse).

Qualified Medical Child Support Orders
This Plan will also extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA.

Benefits for Adopted Children
The Plan will also extend benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries.

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

Benefits under the WHCRA
If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

a) All states of reconstruction of the breast on which the mastectomy was performed;
b) Surgery and the reconstruction of the other breast to produce a symmetrical appearance;
c) Prostheses; and
d) Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the Plan.

Health Insurance Portability Accountability Act of 1996 (HIPAA)
Group health plans and health insurance issuers generally may not, under Federal law, impose a pre-existing condition exclusion before notifying the participant, in writing, of the existence of the terms of any pre-existing exclusion under the plan and the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods). When you switch group insurance policies, you are entitled to a "Certificate of Creditable Coverage," free of charge, from any prior plan or issuer, which may reduce the preexisting condition exclusion period. If you need assistance in obtaining this certificate from your prior plan or issuer, contact your Plan Administrator.

Mental Health Parity Act of 2008
The Mental Health Parity Act (MHPA) provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. MHPA does not apply to benefits for substance abuse or chemical dependency. Health plans are not required to include mental health benefits in their benefits package. MHPA only applies to those plans that do offer mental health benefits.

6. Plan Funding

Insurance premiums are paid in part by the Plan Sponsor out of its general assets, and in part by employees' payroll deductions. Employee payroll deductions are taken pre-tax if the employee elects to participate in BTHR Solutions' Section 125 Plan, or after-tax if not participating in the Section 125 Plan.

- Upon initial enrollment in the Plan, BTHR Solutions will contribute 50% of the monthly premium, employees contribute 50% of the monthly premium.
- Monthly premium payments are deducted through payroll deduction on the last pay date of each month for the following month's coverage.
- If an employee terminates from the company or otherwise experiences a break in service, the employee may re-join the health plan at the split rate of 50% or the alternate rate if employee is on the PPO plan while covered in the HMO service area.

Section 125
Employees may elect to have their health plan premiums deducted on a pre-tax basis under the guidelines of Section 125 of the IRS through BTHR Solutions' Section 125 Plan.

7. Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Office Manager of BTHR Solutions is the person who acts on behalf of the Plan Administrator. BTHR Solutions has agreed to indemnify the Office Manager for any liability he or she incurs as a result of acting on behalf of the Plan Administrator, except if such liability is due to his or her gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

BTHR Solutions bears the incidental costs of administering the Plan.

Power and Authority of Insurance Company

This plan is fully insured. Benefits are provided under a group insurance contract entered into between BTHR Solutions and the Insurance Company. Claims for benefits are sent directly to the Insurance Company. The Insurance Company is responsible for paying claims, not BTHR Solutions.

The Insurance Company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan.
- Prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the Plan.

The Insurance Company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have any general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the Insurance Company.

8. Denial or Loss of Benefits

Eligibility for Plan benefits will end in accordance with the provisions outlined in Section 4 above. Other circumstances which can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to preexisting conditions, and exclusions for certain medical procedures) are described in the attached member handbook issued by the Insurance Company. Please read the member handbook carefully.

Depending on the reason the coverage was terminated, you and your covered spouse and dependents might have the right to continue coverage temporarily under COBRA as outlined in Section 4 above and also in the member handbook.

9. Amendment or Termination of the Plan

BTHR Solutions as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the President of BTHR Solutions who is authorized to amend or terminate the Plan and to sign insurance contracts with the Insurance Company or other carriers, including amendments to those contracts.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and BTHR Solutions to the effect that you will be employed for any specific period of time.

11. Claims Procedures

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and outlined in the attached member handbook. The

Insurance Company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

If the Insurance Company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

Appealing a Denied Claim
If your claim is denied, you may appeal to the Insurance Company for a review of the denied claim. The Insurance Company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and outlined in the attached member handbook.

If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

12. Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits
You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report, if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room for the Pension and Welfare Benefit Administration.

You may obtain, on 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 and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report.

COBRA and HIPAA Rights
You may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage.

You have the right to a reduction or elimination of exclusionary periods of coverage for preexisting 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 preexisting 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 on 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 (if any) 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.

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, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.