2024 - 2025

BENEFIT GUIDE

HOSPICE EMPLOYEES

AlliedServices

HUMAN RESOURCES DEPARTMENT
100 Abington Executive Park

Enrollment Steps

1. Benefits Orientation and/or Review Benefit Booklet

2. Benefit Choices
   - Read benefit information

3. Review Rates
   - Estimate insurance costs

4. Enroll in Benefits:

◊ You will need to have your covered dependents & beneficiary's dates of birth and social security numbers. If this is your first time enrolling or you are adding dependents/beneficiaries, you will need this information to enroll.
   - Online—see log in information below, or
   - Paper
     - Use paper enrollment form included in packet
     - Return completed enrollment form to Human Resources.

If you have never logged in to Dimensions….follow the information below:

Web page = https://alliedservices.prd.mykronos.com/

Your USERNAME is: the first letter of your first name and the first 5 letters of your last name

Example: John Thompson would be: jthomp
Note: This can be entered in either uppercase or lowercase letters

Your PASSWORD is: your whole last name – with the first letter capitalized, @, your month (MM) and year of birth (YYYY)

Example: Thompson@011950

At the time of your initial login, you will be required to change your password. The new password is required to have at least one number, one UPPERCASE letter and one lower-case letter, and one of the following characters: ! # $ @ % - _ = + < >

Once you are logged in, Click Main Menu ☰ My Information / My Benefits

Issues logging in? Forgot Password?

If you are having any issues logging in, please call Allied Services Help Desk at 570-341-4333.

Table of Contents

Please note: the contents of this booklet are a summary of your benefits. Please refer to your summary plan description for more details. You may contact Human Resources if you need another Summary Plan Description sent to you. The terms and conditions of the contract govern all benefits offered through Allied Services.

Welcome!

We appreciate your commitment—to our patients, residents, consumers, and clients, as well as the overall success of Allied Services. We are proud to offer you and your family a benefits program that is valuable, flexible, and competitive.

HOW TO PROCEED

This Benefits Guidebook will help familiarize you with the Allied Services Benefits Program. Carefully consider each benefit option, the cost and value to you, and if it meets your particular needs.

Please make sure that you submit your benefit elections on or before the enrollment deadline (contact Human Resources at 570-348-1348 if you have questions about this deadline.)

If you need any help along the way, please take advantage of the resources identified on the contact information page at the end of this Guidebook.

Plan Notes

PLAN YEAR

Allied Services' benefit plan year begins on July 1st and ends on June 30th of the following year. This Benefit Guidebook outlines the benefits that apply to this plan year. Your medical and pharmacy insurance will run on a calendar year, January 1 to December 31st.

ELIGIBILITY

Generally, if you are a regular full-time employee (scheduled to work 80 hours bi-weekly) or part-time benefit eligible employee (scheduled to work at least 40 hours bi-weekly) you are eligible for the benefits described in this Benefit Guidebook.

DEPENDENTS

Your eligible covered dependents are:

- Your lawful spouse
- Your unmarried children, stepchildren, children legally placed for adoption, legally adopted children, handicapped individuals and children covered under guardianship that are dependent upon you for support and who are under the age of 19
- Children under the age of 26, regardless of full-time student status, marital status, residency with the employee, financial dependency on the employee, or employment or eligibility for other coverage (medical only)
- Children between the ages of 19 and 23 who are regular, full-time students at an accredited educational institution and chiefly reliant upon you for maintenance and support (dental and vision)
- Children under age 25 (additional life and AD&D insurance)
- Children 19 years of age or older who are incapable of self-support due to an intellectual disability or physical disability, either of which commenced prior to age 19 and has been continuously present and has been certified by a physician.
- Children who are covered by a Qualified Medical Child Support Order (QMCSO)

WHEN BENEFITS WILL START FOR NEW EMPLOYEES

Benefit	Start Date
Employee Assistance Program, Holiday Pay, 401(k) (auto-enrolled after 30 days), Employee Discounts	First Day of Work
Medical (Including Prescription), Dental, Vision, Core & Additional Life Insurance, Accidental Death & Dismemberment Insurance, Short Term Disability, Long Term Disability, Dependent FSA, Health Savings Account, & Voluntary Benefits (Critical Illness and Cancer, Group Accident & Hospital Indemnity Insurance)	First of the Month Coincident With or Following 60 Days of Eligible Employment
Personal Time, Sick Time, Vacation Time	After 90 Days of Eligible Employment
Medical FSA	First Open Enrollment After One Year of Continuous Employment

Life Events

CHANGING YOUR BENEFITS (Qualifying Life Events)

The Internal Revenue Service (IRS) states that employees enrolled in pre-tax benefit plans may only make elections to these plans once a year. As such, your benefit choices are binding through June 30th of each year. Medical Insurance is binding through December 31st of each calendar year.

The following special circumstances are the **ONLY** reasons you may change your benefits during the year for certain benefits:

- Marriage
- Birth or adoption of an dependent child
- Divorce or legal annulment
- Unavoidable loss or gain of healthcare coverage
- Death of a spouse or dependent
- Loss or eligibility for state medical assistance programs including Medicare, Medicaid, or CHIPS programs (within 60 days of loss/eligibility)
- A change in your employment that affects your participation or price
- A spouse's or parent's open enrollment
- Receiving a Qualified Medical Child Support Order (QMSCO)

The change in coverage must be consistent with the life event.

You may not change plan types (i.e. Enhanced Dental to Basic Dental) until an open enrollment period. You may only change your level of medical coverage (single, family, etc.) due to a life event, or elect or drop coverage. Medical coverage life events are governed under the summary plan description for your Individual Contribution Healthcare Reimbursement Account (ICHRA).

These special circumstances, often referred to as "Qualifying Life Events" or life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform Human Resources of the event and provide the requested documentation within **30** days of the event. Failure to do so will mean you cannot make any changes until the next annual open enrollment period. Changes that are requested due to a "change of mind" cannot be allowed until the next open enrollment period, unless within 30 days of initial enrollment. For medical and prescription coverage, benefits will not begin until the date of the event or the first of the month after notice is received, if received timely based on the terms outlined in the ICHRA Summary Plan Description which govern the operation of the plan.

Medical Plan

Individual Coverage Health Reimbursement Account (ICHRA)

Effective January 1, 2024, Allied Services will be offering an Individual Coverage Health Reimbursement Account (ICHRA) to all benefit-eligible Hospice employee.

What is an Individual Coverage Health Reimbursement Arrangement (ICHRA)?
An ICHRA is a group benefit plan provided by Allied Services to contribute money (we refer to these funds as “employer dollars”) that can be applied toward the cost of qualified health plans through the individual market.

What can my ICHRA funds be used toward?
ICHRA funds can be used toward the cost of premiums for qualified health plans through the individual market, or for Medicare A, B, and C plan premiums. The plan will not reimburse for any out-of-pocket expenses such as copays, deductibles, etc.

If I choose a Qualified Consumer Driven Health Plan (CDHP) from the marketplace, can I still participate in the HSA?
Yes, if you meet all of the criteria to have a Health Savings Account, you will still be able to elect a Health Savings Account payroll deduction.

I’m covered by my spouse/parent’s group plan; can I use the funds in my ICHRA toward these premiums?
No, you cannot use your ICHRA funds toward the cost of your spouse or parent’s group premiums.

Medical Plan

Who is Gravie?
Allied Services has partnered with Gravie to help walk you through the process of choosing a medical plan that meets your unique needs, lifestyle, and budget. Gravie's easy-to-use platform allows you to compare plan options, enroll in coverage, and manage your benefits through the year.

By enrolling with Gravie, you will get Gravie Care, which includes support from a dedicated team of advisors available to help you navigate the complexities of health benefits and answer your questions throughout the year.

Need help choosing a plan? Understanding your coverage? Finding a new doctor or specialist? The Gravie Care Team has you covered!

Connect with the Gravie Care Team
Call us at 800.501.2920 or send a secure message at member.gravie.com/contact

How It Works
Go to member.gravie.com/ to create your account. Once your account is set up, all you need to do is complete these three easy steps:

Step 1. Enroll in your Individual Coverage HRA (Health Reimbursement Arrangement)

Step 2. View plan options to find the coverage that's right for you

Step 3. Complete enrollment for your health plan online

MEDICAL AND PRESCRIPTION COVERAGE IS EFFECTIVE THROUGH DECEMBER 31st EACH YEAR AND DOES NOT QUALIFY FOR CHANGES UNDER THE JULY 1 OPEN ENROLLMENT PERIOD.

Medical Plan

I'm currently receiving a government tax credit toward the cost of my individual policy; will this be impacted by the ICHRA?
The tax credit amount you are eligible to receive may be impacted by the ICHRA. Enrolling in the ICHRA means that you or anyone in your household are not eligible for tax credits. You should notify the exchange within 30 days of receiving your employer's notice of the ICHRA offering. The Gravie Care Team can assist you with reporting this to the exchange.

How do I access my ICHRA funds?
We've made it easy! During the online enrollment process at gravie.com, you'll set up recurring monthly reimbursements. If you're using ICHRA funds toward the cost of Medicare plan premiums, you'll need to fill out and submit a paper claim form.

How will my premium get paid?
For the first month after you choose your plan, Gravie will direct deposit your funds into your bank account and you will need to pay the premium directly to the insurance company. Going forward, Gravie will deposit the funds directly to your bank account around the 25th of each month and you will need to pay the insurance company directly. Contact Gravie Care with any additional questions

What should I do with my monthly invoice?
Depending on which insurance carrier you elect for your medical coverage, that carrier should instruct you what, if anything you need to do with your monthly invoice.

Do I need to use Gravie to choose my plan?
No, you do not need to use Gravie to choose a medical plan. You may go directly to the carrier to choose a plan. However, if you do go to the carrier directly, you will also need to coordinate your coverage with Gravie so you can get premium reimbursement.

When will I need to make my next enrollment election?
Since Marketplace plans run on a calendar year timeline, you will need to make an election in November/December of 2024, with an effective date of coverage for January 1st, 2025. More information should come from your insurance carrier towards the end of the calendar year about enrollment elections.

Medical Plan

Individual Coverage Health Reimbursement Account (ICHRA) Reimbursement Amounts

Below are the reimbursement amounts that you are eligible for to purchase your own non-group medical insurance. If you elect coverage that costs more than the reimbursement amount listed below, we will withhold the overage amount via payroll deduction.

For example, if you are eligible for a $1,000 reimbursement, but you select coverage that costs $1200 per month, you would have $100 withheld for the first two paychecks of each month.

Please note: the below monthly reimbursement amounts are based off of scheduled hours:

FULL TIME & PART TIME

Your reimbursement amount will be based upon your scheduled hours.

60-80 Hours Per Pay / 30-40 Hours Per Week

Tier	Age as of 7/1/23: Under 30	Age as of 7/1/23: 30-54	Age as of 7/1/23: 55 and Older
Single	$250	$500	$750
Parent & Child (ren)	$375	$750	$1,125
Employee & Spouse	$500	$1,000	$1,500
Family	$750	$1,500	$2,000

PART TIME

Your reimbursement amount will be based upon your scheduled hours.

40-59 Hours Per Pay / 20-29.5 Hours Per Week

Tier	Age as of 7/1/23: Under 30	Age as of 7/1/23: 30-54	Age as of 7/1/23: 55 and Older
Single	$125	$250	$375
Parent & Child (ren)	$188	$375	$563
Employee & Spouse	$250	$500	$750
Family	$375	$750	$1000

Health Savings Account

In addition to the Medical plans described on the previous pages, the below account may be available to you if you choose to enroll in a Qualified Consumer Driven Health plans (QCDHP).

Health Savings Account (HSA)s

A Health Savings Account (HSA) is an employee established savings account allowing pre-tax contributions to pay for qualified medical expenses. An HSA may only be opened by employees enrolled in a Qualified Consumer Driven Health Plan (QCDHP).

- You may only open an HSA if you meet all four criteria below:
  - Are enrolled in a Qualified Consumer Driven Health Plan
  - Are not covered by any other health plan that is not a QCDHP (including a Flexible Spending Account)
  - Are not enrolled in Medicare
  - Are not claimed as a dependent on another person's tax return.
- You may contribute up to the IRS limits.
  - For Calendar Year 2024 they are $4,150 for single and $8,300 for family.
  - You may also contribute an additional $1,000 at age 55+
- Funds roll over from year to year and will not be forfeited a the end of the plan year.
- The account is portable.
- You can invest the money into a variety of mutual fund options once you reach a minimum balance.
- You may use the funds to pay for qualified medical, prescription, dental, vision, and some over the counter expenses for yourself, your spouse, and your tax-dependents (even if they are not covered under your medical insurance).
- You may review a list of qualified expenses online at www.irs.gov and search "Publication 502" and "Publication 969" or contact Human Resources.
- If you take a distribution for non-qualified health related expenses, you may be subject to taxes and an additional 20 percent IRS tax penalty.

To open an HSA, you need to elect to make pre-tax payroll deductions from your paycheck. Once your account is open:

- Your pre-tax deductions will be deposited into your account with Bank of America on your behalf each pay.
- You can change the amount of your contribution throughout the year.
- You will receive a Welcome Kit and a credit/debit card from Bank of America.
- You may also request additional credit/debit cards from Bank of America.
- You may download the Bank of America mobile app to have access to your account on your phone.

Dental Plan

Your dental plans are designed to encourage preventative care by paying the full cost of routine care. Dental insurance is offered through United Concordia Dental, which is a subsidiary of Highmark and is part of the Blue Edge Dental Plan. Allied Services offers two dental plans; Basic and Enhanced. These plans cover the four main types of dental expenses:

1. **Preventive and Diagnostic Care -** routine exams and cleanings, fluoride treatments, sealants, bitewing, x-rays and full mouth x-rays
2. **Basic Care –** extractions, fillings, root canals
3. **Major Care –** caps, crowns, bridges, dentures
4. **Orthodontia –** coverage for dependent children up to age 19

The below summary shows the major highlights of the Basic and Enhanced Dental plans and shows the coverage for using an in-network dentist. You may use an out-of-network dentist, but you may be balanced billed for any charges above the United Concordia Dental reimbursement schedule.

You may obtain a cleaning once every six months at no charge to you.

Additional added benefits:
Blue 365 Discounts include Lasik vision discounts, Hearing Aid Discount, Travel, Fitness, and more.

Type of Service	Basic Plan	Enhanced Plan
Preventative & Diagnostic	100% of Contract Allowances*[1]	100% of Contract Allowances*[1]
Basic	100% of Contract Allowances*	100% of Contract Allowances*
Oral Surgery	Covered	Covered
Periodontics	Covered	Covered
Major Services	Not Covered	50% of Contract Allowances*
Orthodontics (for dependents only up to age 19)	Not Covered	50% of Contract Allowances*
Maximum Dental	$1,000 per person	$1,500 per person
Maximum Orthodontics	Not applicable	$1,500 per dependent child over lifetime

** Reimbursement is based on United Concordia contract allowances and not necessarily each dentist's actual fees*
[1] Preventative cleanings and exams do not apply towards the maximums.

The above comparisons are for informational purposes only. The terms of the contract shall govern all coverage and eligibility. Please refer to the Group Master Contract and Group Policy for a specific list of benefits and exclusions.

Vision Plan

Vision Insurance is offered through Vision Service Plan (VSP). **Please note that no ID card will be issued.**

The below summary shows the major highlights of the Vision Plan for both In-Network and Out-Of-Network services.

Additional added benefit:
Hearing Aid Discount available through TruHearing.

Benefit	In-Network	Out-of-Network
Eye Exam	Paid in full once every 12 months (age 1-19); every 24 months (age 19 and over)	Up to $45
Eye Glass Lenses	Covered once every 12 months (age 1-19); every 24 months (age 19 and over) Single vision Lined bifocal Lined trifocal Lenticular Polycarbonate lenses for dependent children	Up to $30 single Up to $50 bifocal Up to $65 trifocal Up to $100 lenticular
Lens Options	Up to a 20% discount on scratch resistant, anti-reflective and progressives. Additional prescription and sunglasses.	None
Eye Glass Frames	Frame allowance - Every 24 months Frame of your choice covered up to $120, plus an additional 20% of any out-of-pocket costs. Selected Brands have an additional $50 frame allowance.	Up to $70
Contact Lenses	$120 allowance, copay does not apply Contact lens exam (fitting and evaluation) up to $60 copay. Elective evaluation/fitting materials Necessary evaluation/fitting materials	Up to $105 elective Up to $210 necessary
Laser Surgery	In-network provider discount Call (800) 877-7195 www.vsp.com	None

*One pair of eyeglasses **OR** one pair of contacts is available during a benefit period per eligible member.*

The above comparisons are for informational purposes only. The terms of the contract shall govern all coverage and eligibility. Please refer to the Group Master Contract and Group Policy for a specific list of benefits and exclusions.

Life Insurance

Allied Services provides you with Basic Group Term Life Insurance at no cost to you, as well as the option to purchase Supplemental Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance. Your Basic and Supplemental Life and AD&D Insurance benefits are insured through NY Life.

Basic Group Term Life Insurance (Core Benefit)

- Amount of coverage is one times your annual salary, paid in full by Allied Services.
- This coverage can be converted to an individual policy upon termination.
- The policy contains an imminent death benefit.
- You can also take advantage of NY Life's Value added services, including:
    - The Life Assistance Program which provides legal and financial consultations,
    - My Secure Advantage: 30 days of pre-paid expert money-coaching, state specific wills and other important legal documents,
    - Healthy Rewards: discounts on health and wellness services including vision, diet programs and more
    - NY Life Secure Travel: which provides pre-trip planning, assistance while traveling 100 miles or more from your home.

Additional Life Insurance (Voluntary Benefit)

- You may elect additional life insurance for yourself and/or your spouse in $10,000 increments (minimum of $10,000 to a maximum of $300,000; not to exceed 5 times your annual salary for employee.)
- You may elect coverage for dependent child(ren) in the amount of $2,500, $5,000, $7,500 or $10,000.
    - Dependent children ages birth to 25 years old.
- Employee must be covered in order for spouse and dependents to be covered. Their amount can not exceed 100% of employee's amount of core + additional coverage.
- A health statement and/or physical may be required by the carrier:
    - New Hire Elections: The non-medical issue amount is 2x your annual salary. An *Evidence of Insurability (EOI)* form is required for amounts in excess of 2x your annual salary for additional employee coverage and in excess of $30,000 for additional spouse coverage.

Accidental Death & Dismemberment Insurance (AD&D) (Voluntary Benefit)

- NY Life's AD&D insurance pays you benefits if you suffer in a covered accident, which may result in such conditions as paralysis or the loss of limb, speech, hearing or sight, brain damage, or coma.
- The employee must be covered in order for spouse and dependents to be covered.
- Certain occupations may be excluded from coverage. Please see Group Policy for additional information.

The above summary is for informational purposes only. The terms of the contract shall govern all coverage and eligibility. Please refer to the Group Master Contract and Group Policy for a specific list of benefits and exclusions.

Disability Insurance

Short-Term Disability Insurance (Voluntary Benefit)

Short-Term Disability Insurance (STD) provides 66.67% of weekly base compensation up to a $1,000 maximum weekly benefit for approved non work-related accidents, injuries or illnesses. Allied Services offers two voluntary plans that you may choose from. Benefits are provided by NY Life.

Plan Benefits	Plan A 24 Week Plan	Plan B 22 Week Plan
Percent of your base pay that you will receive	66.67%	66.67%
Date compensation starts	15th day of disability	31st day of disability
Maximum duration of benefits (earlier of recovery or time listed)	24 weeks	22 weeks

- Your STD payroll contribution is made with after-tax dollars. In the event you become disabled your STD benefit will not be taxed.
- ***Pre-Existing Condition Limitations apply***. Any period of disability beginning within one year from the effective date of coverage for a condition that was treated in the three (3) months prior to the effective date of coverage is excluded.
- **This coverage is only guaranteed to be issued as a new hire or as a first time eligible.** Contact Human Resources with any questions.

Long-Term Disability Insurance (Core Benefit)

Allied Services provides Long-Term Disability Insurance (LTD) as a core benefit. Benefits are provided by NY Life.

- Coverage provides 50% of monthly compensation to a maximum of $15,000 per month.
- This benefit begins following 180 days of approved disability.
- The premium is paid in full by Allied Services, and therefore is required to be taxed in the event that you become disabled and receive benefits.
- ***Pre-Existing Condition Limitations apply***. Any period of disability beginning within one year from the effective date of coverage for a condition that was treated in the three (3) months prior to the effective date of coverage is excluded.

The above summary is for informational purposes only. The terms of the contract shall govern all coverage and eligibility. Please refer to the Group Master Contract and Group Policy for a specific list of benefits and exclusions.

Medical Spending Account

Your Flexible Benefits Plan offers you the opportunity to pay for certain health expenses on a pre-tax basis through a Medical Spending Account. This benefit is available to benefit-eligible employees with at least one (1) year of continuous service.

The Flexible Spending Account (FSA) is processed by Highmark.

Examples of these expenses include:

- Deductibles
- Co-Payments
- Prescriptions
- Eye Glasses
- Some over-the-counter items
- Hearing Aids
- Preventive Care
- Chiropractic Care
- Orthodontia/other dental
- Physician prescribed medical related expenses
- Coinsurance
- Medical Equipment
- Contact Lenses/Solutions
- Long-Term Care
- Fertility Enhancement

Expenses that qualify are those not covered, or only partially covered, by your group health plans.

The above is a summary list of eligible expenses. You may review a list of qualifying expenses online at www.irs.gov and search 'Publication 502' or contact Human Resources.

How to use your Medical Spending Account

- During Open Enrollment, you decide how much you want to contribute to your Medical Spending Account. To do this, estimate the amount of health care expenses which will not be covered by your health plan during the coming year. It is important to estimate carefully; if you do not use all of the money in your Medical Spending Account by the end of the plan year, ***Federal law requires you to forfeit the balance.***
- The maximum allowable contribution per plan year is **$3,200.**
- Pre-tax contributions are withheld 2 times per month.
- You may present claims against your account. Claims must be incurred during the plan year, July 1 to June 30 to be eligible for reimbursement under the plan.
- You will receive a debit card from Highmark to use for eligible expenses.

Dependent Spending Account

Under your Flexible Benefits Plan you may establish a Dependent Care Flexible Spending Account. This account allows you to pay for dependent care expenses on a pre-tax basis.

Expenses for care of the following persons may be paid through your Dependent Care Spending Account.

- Children under age 13 for whom you are able to take a tax exemption.
- Any dependent or non-dependent spouse who is physically or mentally incapable of independent care.
- A parent incapable of independent care who lives with you and whom you claim as a dependent on your tax return.

You may use your Dependent Care Spending Account to pay for dependent care expenses that you incur from a provider in order for you and your spouse to be gainfully employed. A provider can be any person or organization, including your own child over age 19, who is not claimed on your income tax return as a dependent.

Note: "Provider" must pay taxes on earned income

How to use Your Dependent Care Spending Account

- At Open Enrollment, you decide how much you want to contribute to your Dependent Care Spending Account. To do this, estimate the amount of dependent care expenses you expect to incur during the coming year. It is important to estimate carefully; if you do not use all of the money in your Dependent Care Spending Account by the end of the plan year, ***Federal law requires you to forfeit the balance***.
- Pre-tax contributions are withheld from each paycheck.
- You may present claims against your account.
- To make a claim, complete the Dependent Care Spending Account Claim Form and forward to Highmark with the appropriate itemized bill(s) or receipt(s) attached. Reimbursements are made directly to you.

Tax Credit versus Dependent Care Spending Account

Under current law, you may claim part of your dependent care expenses as a credit on your federal income tax return. Expenses that you apply to the federal tax credit are not eligible for reimbursement through the Dependent Care Spending Account, and vice versa. Depending on your situation, you may benefit the most from using the spending account or tax credit, or a combination of the two.

Any amount funded through a Dependent Care Spending Account will reduce the amount of the tax credit ceiling, and in many cases will eliminate the entire tax credit available. You will want to compare which is more favorable for you. The maximum allowable contribution to a Dependent Care Spending Account is $5,000 or $2,500 if you are married and filing a separate return.

Your annual contribution cannot exceed the lowest of:

- $5,000
- Your Annual Earned Income
- Your Spouse's Annual Earned Income

For more information about how these provisions apply to your tax situation, contact a qualified tax advisor.

Supplemental Benefits

Allied Services offers a supplemental health voluntary benefit "all in one" plan that is available for you and your dependents.

Coverage is currently offered through Prudential.

If you have any questions regarding this insurance or wish to enroll in coverage as a new hire, please contact Shanna at TriBen Insurance at 1-888-264-2147, option 6.

All three benefits are available as one election and will include Accident, Critical Illness and Cancer and Hospital benefits.

Group Critical Illness and Cancer Insurance

This coverage provides a lump sum payable benefit upon the diagnosis of a covered catastrophic illness. The money can be used immediately and at the policyholder's discretion. Payable benefits can be used to help offset any out of pocket expenses associated with a catastrophic illness such as a heart attack, stroke, cancer, sudden cardiac arrest, etc. There is an annual $50 Wellness Benefit included as an added benefit payout. Family coverage is available.

Group Accident Indemnity Insurance

This coverage provides benefits for certain injuries and expenses related to covered accidents occurring off the job. Payable benefits can be used to help offset any out of pocket co-pays or deductibles associated with accident related injuries such as fractures and lacerations. Emergency room, urgent care treatments, Physician's treatment, major diagnostic testing and necessary medical appliances complete the benefits within this section of the policy. Family coverage is available.

Hospital Indemnity Insurance

This coverage is designed to supplement major medical coverage and assist employees with out of pocket costs and deductibles related to initial hospitalization and prolonged hospital stays. Pre-existing conditions can be covered under this plan. Family coverage is available.

The above summary is for informational purposes only. The terms of the contract shall govern all coverage and eligibility. Please refer to the Group Master Contract and Group Policy for a specific list of benefits and exclusions.

Benefit Time

Personal Time

- Allied Services provides a personal time program for all regular full-time employees and regular benefit-eligible, part-time employees who have successfully completed their initial ninety (90) day period of employment.
- The personal time benefit provides for up to forty (40) hours per year for regular full-time employees based on actual hours paid. Regular benefit-eligible, part-time employees receive pro-rated personal time based on actual hours paid.
- The maximum accrual is sixty (60) hours.

Sick Time

- Allied Services provides a sick time program for all regular full-time employees and regular benefit-eligible, part-time employees who have successfully completed their initial ninety (90) day period of employment.
- The sick time benefit provides for up to forty (40) hours per year for regular full-time employees based on actual hours paid. Regular benefit-eligible, part-time employees receive pro-rated sick time based on actual hours paid.
- There is an unlimited accrual.

Vacation Time

- Allied Services provides a vacation time program for all regular full-time employees and regular benefit-eligible, part-time employees who have successfully completed their initial ninety (90) day period of employment. Regular benefit-eligible, part-time employees receive pro-rated vacation time based on actual hours paid.
- Vacation time can be taken when requested in advance by the employee and approved by the employee's immediate supervisor.

Step 1: Employees can accrue up to ten (10) vacation days per year (80 hours).
Step 2: After completion of five (5) years of continuous benefit-eligible service, employees will have the opportunity to accrue an extra five (5) days of vacation per year (120 hours).
Step 3: After completion of fifteen (15) years of continuous benefit-eligible service, employees will have the opportunity to accrue an extra five (5) days of vacation per year (160 hours).

- The maximum accrual is one and one-half times your annual allotted vacation benefit time i.e., Step 1 maximum accrual is 120 hours (80 x 1.5).

Note: If you do not have at least 40 hours of hours worked or paid time per pay, you will not generate any accruals for that pay. The maximum number of hours that you will accrue on per pay is 80 hours.
Non Benefit Eligible employees and Special Program employees including those classified as "weekend," "weekday" and "call-in" and federal programs with health & welfare credit may be ineligible for the above benefit time programs.

Benefit Time

Holiday Time

- Allied Services provides a holiday time program for all regular full-time employees and regular benefit-eligible, part-time employees. The program provides for six (6) holidays per year based on schedule hours as shown below.

- Any employee who works on a recognized holiday will receive time and one half compensation for any hours worked on the holiday. In addition, benefit/accrual eligible employees will also accrue holiday time to use within 180 days following the actual holiday.

Recognized Holidays:
New Year's Day
Memorial Day
Fourth of July
Labor Day
Thanksgiving Day
Christmas Day

Scheduled Hours	Number of Paid Hours Per Holiday
Full-Time 80 Hours	8
Part-Time 70-79 Hours	7
Part-Time 60-69 Hours	6
Part-Time 50-59 Hours	5
Part-Time 40-49 Hours	4

This is a summary of benefit-time programs. Please see Allied Service's Policies and Procedures manual for more detailed information on the benefit time programs. The Policies and Procedures manual and your divisional policies will govern all paid time off programs.

Additional Benefits

Direct Deposit

All employees are encouraged to enroll in direct deposit. Most employees have access to their funds on Thursday morning of payroll week, subject to your financial institution's posting schedule.

Help save a tree! Contact payroll to stop your paystubs from printing, as you have access to your payroll data in Dimensions.

Employee Assistance Program

Allied Services offers an Employee Assistance Program (EAP) as an employee benefit that is designed to provide confidential assessment and referral for appropriate counseling services.

All Allied Services employees, their spouses, and dependents are eligible for EAP services upon date of hire. Employees will be allowed to have up to four (4) free confidential sessions with an EAP counselor each calendar year. Employees may schedule one session during working hours. The other three sessions, if necessary, will be conducted during non-working hours.

Employees may utilize the free confidential benefit offering without jeopardizing job security, career prospects, or reputation.

For information and counseling help contact Allied's provider, AllOne Health, at 1-800-451-1834 or log on to **www.mylifeexpert.com**. *(Company Code to sign-up: allied)*
Available 24/7 AllOne Health also provides:

- Financial and legal consultations services
- Personal concierge services to conduct research, offer advice or plan tasks and projects
- Child and elder care resources
- On-line access to other work/life tools

Vacation Trade-In

Employees may elect to trade in their vacation time on an annual basis. This election can only be made during open enrollment.

- You may trade up to forty (40) hours of your vacation time for cash in one-hour increments.
- You must maintain at least sixteen (16) hours in your vacation bank.
- Vacation Trade-In dollars will be paid to you in **one lump sum check in June**.

Additional Benefits

Tuition Assistance

Recognizing the importance of the educational development of its employees, and to improve job performance and individual skills, Allied Services offers tuition assistance for education. Please contact Human Resources for complete information.

Benefit requirements:

- Six (6) months of continuous service.
- Must be employed full-time or part-time by Allied for the full duration of the course.
- Tuition assistance is granted at 100% up to a maximum of:
  - $5,000 full-time ($2,500 per fall and spring semester)
  - $2,500 part-time ($1,250 per spring and fall semester)
- Tuition Assistance is for tuition only (no books, fees, etc.)
- Refer to Human Resources Tuition Assistance Policy #3.07 for complete details.

Lackawanna College Business Partner Scholarship

Allied Services offers a partnership with Lackawanna College that will allow employees to attend college tuition-free. Eligible full-time and part-time employees can pursue a bachelor's or an associate's degree.
For more information, please contact Maurya Incavido—570-348-1278.

PA Tuition Account Program - PA529 Plan

Allied Services offers employees the option to open and contribute to a savings account for their children's higher educational needs. A PA529 plan gives special tax breaks to encourage saving. There are two plans to choose from: a Guaranteed Savings Plan or an Investment Plan.
For more information, please contact 1-800-440-4000 or visit www.pa529.com.

Pet Insurance from Nationwide - My Pet Protection

Allied Services offers eligible employees the option to enroll in elective healthcare coverage for their Pets through Nationwide's Pet Insurance. With two budget-friendly plans plus a $500 wellness benefit option. Get cash back on eligible vet bills: Choose 50% or 70% reimbursement Easy to use: Base plans have a $250 annual deductible and $7,500 in annual benefits Just for employees: Preferred pricing offered only through your company Use any vet, anywhere: No networks, no pre-approvals
For more information, please contact 877-738-7874 or visit https://benefits.petinsurance.com/alliedservices

Retirement Plans

401(k) Retirement Savings Plan

The 401(k) Plan for employees of Allied Services can assist you in building a strong financial foundation for retirement. You are eligible to participate in the plan after you reach age 18. You are eligible for any employer sponsored contributions at age 21 and after completion of one (1) year of service. To complete one year of service, you must work 1,000 hours during your first year of employment or any plan year (January 1 - December 31) following your date of hire. Non-resident aliens, leased, piecework, per-diem, independent contractors and employees under a federal work-study program or who receive government health and welfare benefits are not eligible to participate in the plan.

The plan provides:

- Auto-enrollment at 1% of eligible earnings, the first of the month after 30 days of employment.
- Immediate vesting of your contributions.
- Employer matching contributions to eligible participants.
- Full vesting of employer contributions after three years of vesting service.
- The ability to take a loan against your contributions.

As an employee, you may contribute up to a maximum of $23,000 per calendar year (2024 combined between your 401(k) and 403(b) plans.) Employees age 50+ may make an additional $7,500 catch-up contribution. For a complete Summary Plan Description on Allied Services 401(k) Retirement Savings Plan please contact Human Resources.

Tax Deferred Annuities (TDA) or 403(b)

A Tax Deferred Annuity is a long-term savings plan which provides a supplemental income during retirement years. Two distinct advantages of Tax Deferred Annuities include their pre-tax status and tax-deferred growth on your investments. As an employee, you may contribute up to a maximum of $23,000 per calendar year (2024 combined between your 401(k) and 403(b) plans). Employees age 50+ may make an additional $7,500 catch-up contribution. Allied Services TDA program provides the convenience of pre-tax payroll deductions and forwarding your contributions to your selected annuity company. You may contact Human Resources for a complete list of Tax Deferred Annuity companies that participate in our salary reduction program.

457(b)

Allied Services offers a 457(b) plan to eligible employees. Please contact Human Resources for more information.

Social Security

Allied Services contributes to Social Security an amount equal to your Federal Insurance Contributions Act Tax (FICA). For calendar year 2024, Allied's portion is 6.20% of your earnings up to $168,600 plus a 1.45% Medicare tax.

Regulatory Notices

HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Allied Services Integrated Health System ("Allied Services") health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Allied Services Health and Welfare Plan (the "Plan"). The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Allied Services as an employer— that's the way the HIPAA rules work. Different policies may apply to other Allied Services programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

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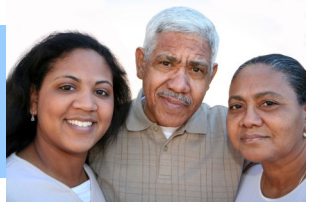

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Allied Services

The Plan, or its health insurer, may disclose your health information without your written authorization to Allied Services for plan administration purposes. Allied Services may need your health information to administer benefits under the Plan. Allied Services agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Allied Services benefits staff are the only Allied Services employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Allied Services, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to Allied Services, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer, may disclose to Allied Services information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that Allied Services cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Allied Services from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

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The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work- related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

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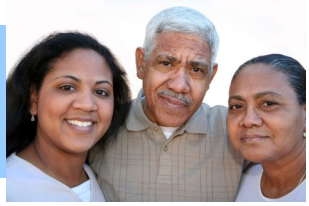

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

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If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

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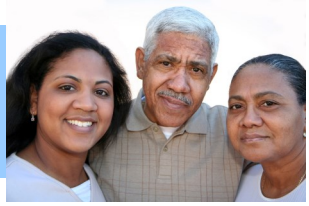

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice by e-mail.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint with us, obtain a complaint form from Carmela Fox, Assistant Vice President, Human Resources, and when completed should be returned to Carmela Fox.

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact our Privacy Officer:
Stacey Lewis, Director of Application Architecture & Gap Development
Allied Services Integrated Health System
100 Abington Executive Park, Clarks Summit, PA 18411
570-348-2259

Regulatory Notices

Women's Health and Cancer Rights Act Notice

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 consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please contact Carmela Fox, Assistant Vice President, Human Resources at (570) 348-1454.

Newborns' and Mothers' Health Protection Act Notice

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 you would like more information on maternity benefits, please contact Carmela Fox, Assistant Vice President, Human Resources at (570) 348-1454.

Notice of Special Enrollment Rights for Health Plan Coverage

Please refer to your summary plan description (SPD) for the Individual Contribution Health Reimbursement account special enrollment periods. You may contact Human Resources for a copy of the SPD if you do not have one readily available to you. In most cases you must notify the plan within 30 days of your event, and coverage will not begin until the day of the event or the first of the month following the event depending on the type of event. The plan will also permit special enrollment periods consistent with open enrollment periods under the marketplaces served by the healthcare.gov platform and state based marketplaces (other than special enrollment period related to becoming newly eligible for advance payment of the premium tax credit and cost sharing reductions**).**

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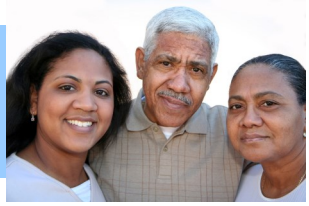

Special Enrollment Rights under HIPAA and the Children's Health Insurance Program (CHIP)

The Health Insurance Portability and Accountability Act (HIPAA) mandates Special Enrollment rights when you and/or your eligible dependents decline health coverage during the initial enrollment period.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Allied Services also allows a special enrollment opportunity if you or your eligible dependents either lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or become eligible for a state's premium assistance subsidy under Medicaid or CHIP.

For these new enrollment opportunities, you have 60 days – instead of 30 – from the date of the Medicaid/ CHIP eligibility change to request enrollment in this plan. Note that this 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

To request HIPAA special enrollment rights or obtain more information, contact Carmela Fox, Assistant Vice President, Human Resources at (570) 348-1454.

Regulatory Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility –

PENNSYLVANIA—MEDICAID

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx

Phone: 1-800-692-7462

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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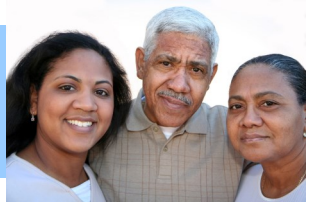


** Continuation Coverage Rights Under COBRA**

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Regulatory Notices

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Carmela Fox, Assistant Vice President, Human Resources, Allied Services, 100 Abington Executive Park, Clarks Summit, PA 18411. You will be required to submit proof of status change (i.e., birth certificate, marriage license, divorce papers).

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

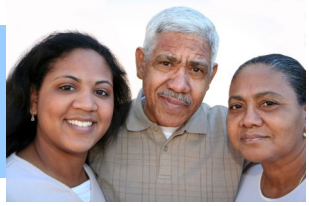
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notification must be made within 60 days of the later of (i) the determination of disability by the Social Security Administration, (ii) the qualifying event date, (iii) the date coverage is lost under the plan as a result of the qualifying event or (iv) the date that you receive this notice of the SDP. In addition, notice of the Social Security Administration's determination of disability must be provided before the end of the original 18-month continuation coverage period (irrespective of when the 60-day period would otherwise end). Notice must include a copy of the Social Security Administration determination letter.

Regulatory Notices



Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Allied Services Health and Welfare Plan, Carmela Fox, Assistant Vice President, Human Resources, Allied Services, 100 Abington Executive Park, Clarks Summit, PA 18411, 570-348-1454.

ALL RATES ARE PER PAY PERIOD (24 DEDUCTIONS PER YEAR)

RATES

Individual Coverage Health Reimbursement Account (ICHRA)

Below are the reimbursement amounts that you are eligible for to purchase your own non-group medical insurance. If you elect coverage that costs more than the reimbursement amount listed below, we will withhold the overage amount via payroll deduction.

For example, if I am eligible for a $1,000 reimbursement, but I select coverage that costs $1200 per month, I would have $100 withheld for the 1st two paychecks of each month.

MEDICAL/PRESCRIPTION REIMBURSEMENT

Please note: the below monthly reimbursement amounts are based off of scheduled hours:

FULL TIME & PART TIME

Your reimbursement will be based upon your scheduled hours.

60-80 Hours Per Pay / 30-40 Hours Per Week

Tier	Age as of 7/1/23: Under 30	Age as of 7/1/23: 30-54	Age as of 7/1/23: 55 and Older
Single	$250	$500	$750
Parent & Child (ren)	$375	$750	$1,125
Employee & Spouse	$500	$1,000	$1,500
Family	$750	$1,500	$2,000

PART TIME

Your reimbursement will be based upon your scheduled hours.

40-59 Hours Per Pay / 20-29.5 Hours Per Week

Tier	Age as of 7/1/23: Under 30	Age as of 7/1/23: 30-54	Age as of 7/1/23: 55 and Older
Single	$125	$250	$375
Parent & Child (ren)	$188	$375	$563
Employee & Spouse	$250	$500	$750
Family	$375	$750	$1000

RATES

ALL RATES ARE PER PAY PERIOD (24 DEDUCTIONS PER YEAR)

DENTAL RATES

FULL-TIME DENTAL RATES		
Status	***Basic***	***Enhanced***
Single	$0.00	$6.29
Family	$12.71	$29.41
PART-TIME DENTAL RATES		
Your cost will be based upon your scheduled hours, not actual hours worked.		
Status	***Basic***	***Enhanced***
70-79 Hours Per Pay / 35-39.5 Hours Per Week		
Single	$ 0.97	$7.26
Family	$13.68	$30.38
60-69 Hours Per Pay / 30-34.5 Hours Per Week		
Single	$1.94	$8.23
Family	$14.65	$31.35
50-59 Hours Per Pay / 25-29.5 Hours Per Week		
Single	$2.91	$9.20
Family	$15.62	$32.32
40-49 Hours Per Pay / 20-24.5 Hours Per Week		
Single	$3.88	$10.17
Family	$16.59	$33.29

VISION RATES

FULL-TIME VISION RATES			PART-TIME VISION RATES		
			Your cost will be based upon your scheduled hours, not actual hours worked.		
Single	***Family***			***Single***	***Family***
$0.00	$4.38		70-79 hours per pay	$.27	$4.65
			60-69 hours per pay	$.54	$4.92
			50-59 hours per pay	$.81	$5.19
			40-49 hours per pay	$1.08	$5.46

Please note: whenever there is a third paycheck in a month, no benefit elections will be deducted from your paycheck.

ALL RATES ARE PER PAY PERIOD (24 DEDUCTIONS PER YEAR)

RATES

LIFE INSURANCE RATES

FULL AND PART-TIME RATES

Employee or Spouse: (rate) X (10,000 of coverage) = per pay deduction

Child(ren): Rates listed below

Employee / Spouse	
Age Ranges (last birthday)	*Rates per $10,000 coverage bi-weekly*
under age 25	$0.25
25-29	$0.35
30-34	$0.40
35-39	$0.45
40-44	$0.55
45-49	$0.80
50-54	$1.25
55-59	$2.30
60-64	$3.55
65-69	$6.75
70+	$10.30

Dependent Child(ren)	
	Rates
$2,500	$.39
$5,000	$.59
$7,500	$.79
$10,000	$.99

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE(AD&D)

FULL-TIME AND PART-TIME RATES

(rate) X ($10,000 of coverage)

Bi-weekly rates per $10,000 of coverage:

Employee rate	$.22
Spouse rate	$.17
Child (ren) rate	$.35

Please note: whenever there is a third paycheck in a month, no benefit elections will be deducted from your paycheck.

RATES

ALL RATES ARE PER PAY PERIOD
(24 DEDUCTIONS PER YEAR)

DISABILITY RATES

FULL-TIME AND PART-TIME RATES					
PLAN	**WEEKLY SALARY**		**PER PAY PREMIUM COST FACTOR**		**PER PAY DEDUCTION**
Plan A 24 Week		x	**.030015**	=	
Plan B 22 Week		x	**.015341**	=	

SUPPLEMENTAL BENEFITS (Critical Illness & Cancer, Accident, & Hospitalization

FULL TIME AND PART TIME RATES	
Tier	***Rates***
Employee Only	$13.43
Employee & Spouse	$26.41
Employee & Child(ren)	$19.73
Family	$32.71

MEDICAL & DEPENDENT SPENDING ACCOUNTS

FULL-TIME AND PART-TIME RATES
Annual amount selected divided by 24 pays

HEALTH SAVINGS ACCOUNT

FULL-TIME AND PART-TIME RATES
Annual amount selected divided by 24 pays *(This election may be changed by the employee through-out the year.)*

VACATION TRADE-IN

FULL-TIME AND PART-TIME RATES				
Hourly Rate as of July 1st	X	Total Hours Traded	=	Lump Sum Payment

Employee Discounts

Allied Services does not endorse the below businesses or services. Allied Services does not take responsibility for products or services provided by these companies. Our goal is to pass on discounts to employees and their families so employees can enjoy corporate savings. They are subject to change at any time. Please see employee intranet for the most up-to-date listing.

AUTOMOTIVE
CeeKay's One Million Auto Parts
Firestone (Viewmont Mall)
Forty Fort Lube (Forty Fort & Kingston locations)
Kost Tire and Muffler
McCarthy Tire Service
Steve Shannon Tire & Auto Center

COMPUTER /PHONE/TV
AT&T
Verizon Wireless

FAMILY FUN/RESORTS/HOTELS
Best Western Plus (Clarks Summit)
Bounce Party Rentals
Claws 'N' Paws
Clyde Peeling's Reptiland
Courtyard Marriott (Montage Mountain)
Crayola Experience
Cruise One
Dorney Park
Electric City Trolley Museum
Great Wolf Lodge
Medieval Times
Mohegan Sun Arena at Casey Plaza
Pocono Rocks!
Residence Inn (Scranton)
Sky Zone
Sleep Inn & Suites (Dunmore)
Tickets@Work (Disney World, Universal Studios, Six Flags, Sesame Place, Las Vegas shows, sporting events, movie tickets, hotels, and more!!)
Woodloch Resort

CLOTHING/UNIFORM
Eagle Cleaners
Med Plus Uniforms & Scrubs

EDUCATION
Drexel University Online
Misericordia University
University of Phoenix
University of Scranton

Employee Discounts

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HEALTH/FITNESS/SPA
Ben Domiano Optical
Crunch Fitness
Danko's Gym (Plains & Back Mountain locations)
Greater Pittston YMCA
Odyssey Fitness
O'Hora Eye Care Center
Pocono Family YMCA
Sapphire Salon (all locations)
Scranton JCC
Secrets Hair Salon
Spectrum Health & Racquet Club
Woodhouse Spa (winter discount)

RESTAURANTS/FOOD
Alter House Restaurant
Nina's Wing Bites & Pizza
Perkins Restaurants
Rita's (Kingston & Dunmore locations)
Smokey Bones (Wilkes-Barre)
Tipsy Turtle

MISCELLANEOUS
Benchmark/McCabe Mortgage Group
Comics on the Green
Invisible Fence
Jackson Hewitt
Jerry's Comfort Flooring
Laurelwood, Morgan Manor, & Summit Point Apartments
Tomlinson Floral & Gifts

ALLIED SERVICES
Dr. Aronica Wellness Center – Scranton Campus
Cafeterias

Common Questions

What happens if I do not choose any benefits?

New Benefit-Eligible Employees
When you become eligible to participate in Allied Services Benefits Program for the first time, you must enroll within 30 days of your benefits effective date. If you do not enroll in benefits within this timeline, you will only be assigned the following basic benefits: Core Life Insurance, Long Term Disability Insurance, and the Employee Assistance Program. You will not be enrolled in the following benefits: Medical, Dental, Vision, Additional Life Insurance, Accidental Death & Dismemberment Insurance, Short Term Disability Insurance, Health Savings Account, Medical Spending Account, Dependent Spending Account, or Supplemental Benefits.

For New Hires, unless otherwise elected, eligible employees will be auto-enrolled in the 401(k) plan at 1% of eligible earnings the first of the month after 30 days of employment.

Existing Employees
If you are an existing employee outside of your initial benefit eligibility period and you do not enroll by the annual open enrollment period deadline, you will automatically be defaulted in the benefits you currently maintain. However, your Flexible Spending Accounts and Vacation Trade-In elections do not roll over from year to year and must be elected annually.

Why do I pay for some benefits with pre-tax money?

Taking the money out before your taxes are calculated lowers the amount of your taxable income. Therefore, you pay less in taxes. However, this tax advantage is not available for all benefits in accordance with IRS rules. Your pre-tax benefits include Medical, Dental, Vision, Medical and Dependent Spending Accounts, Health Savings Account, 401(k), 403(b), and 457(b).

How do I request time off?

Please contact your supervisor to inquire about the appropriate process for your division/department.

How do I cancel or change my direct deposit?

Please contact Payroll—Trish Bator at 570.348.1452 or Sandy Murphy at 570.348.1330.

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What can I access through the Employee Self-Service portal in Dimensions?

- View and change your personal information (address, phone number, emergency contact, local taxing authority, and email.)
- View your earnings history (including printing copies of check stubs) and prior year W2s
- View and change direct deposit and tax withholdings
- View current job openings

Contacts

Please call Human Resources with any questions or to register a life event change

HUMAN RESOURCES

Main Number	(570) 348-1348
Toll Free	(800) 368-3910
Employee Benefits Coordinator	(570) 348-1463
Employee Services/Leave Coordinator	(570) 341-4559
Compensation/Benefits Analyst	(570) 341-4344
Human Resources Assistant Vice President	(570) 348-1454

BENEFIT PROVIDERS

Contact	Phone & Website	Group Numbers	For Questions Regarding
Gravie (Third Party Administrator)	(800) 501-2920 member.gravie.com/	N/A	Medical Insurance - Individual Coverage Health Reimburse-ment Account (ICHRA)
Highmark	(800) 241-5704 www.highmarkbcbs.com	Employee SSN	Flexible Spending Account (FSA)
Bank of America	(800) 718-6710 myhealth.bankofamerica.com	Employee ID#/SSN	Health Savings Account (HSA)
United Concordia	(866) 568-6008 www.highmarkbcbs.com	Basic: 10520555 Enhanced:10520557	Dental Insurance
Vision Service Plan	(800) 877-7195 www.vsp.com	12313244	Vision Insurance
NY Life	(800) 238-2125 nyl.com/customer-forms	Life: FLI960305 AD&D: OK970958	Life Insurance & Accidental Death & Dismemberment
NY Life	(888) 842-4462 nyl.com/customer-forms	STD:VDT963097 LTD: LK966303	Short-Term & Long Term Disability Insurance
Prudential	http://www.prudential.com/mybenefits Phone: 844-455-1002 M-F 8am – 8pm EST. VBservices@prudential.com	71878	Supplemental Insurance (Accident, Critical Illness & Hospital)
Lincoln Financial	(800) 234-3500 www.lincolnfinancial.com	ALLI-001	401(k) Retirement Plan
AllOne Health	(800) 451-1834 www.mylifeexpert.com Company Code: allied	N/A	Employee Assistance Program

AlliedServices
INTEGRATED HEALTH SYSTEM

HUMAN RESOURCES DEPARTMENT

570.348.1348

100 Abington Executive Park
Clarks Summit, PA 10411

alliedservices.org