JAN 1 - DEC 31

2020 Benefits Enrollment Guide

crossroads

WHAT'S INSIDE THIS GUIDE?

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare your options.

This benefit summary has been prepared to help you review the key factors that are associated with our benefit plans. This summary does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.

INTRODUCTION

At Crossroads Church, we value each and every employee. Our commitment to our employees is to provide an enriching environment where employees are engaged and are proud to be part of the Crossroads Church family.

The cost of health care and other benefits continue to rise year after year. Each year, we analyze our costs and try to manage increases by reviewing our plans and benefit providers. We are conscious of the fact that changing health insurance plans is often difficult for our employees, so whenever possible, we work with our benefit providers to create solutions that will work financially and will be less disruptive.

Employers across the country are all facing the same challenge. But the fact is that 70 percent of health care costs are due to preventable conditions that cost the U.S. health care system about $100 billion every year. Smoking, obesity, and high blood pressure are all preventable or treatable conditions that, left untreated, can lead to such illnesses as cancer, Type II Diabetes, or heart failure.

Crossroads Church continues to promote a culture of health and wellness, establishing a work environment that promotes healthy lifestyles, decreases the risk of disease, and enhances your quality of life.

Crossroads takes your wellness seriously.

The goal of the Crossroads Church Wellness Program is to promote behavioral changes and motivate each of us to change from high risk behavioral factors to healthy/low risk factors and keep them there.

- To obtain the best possible price for your health care coverage needs
- To support you and your family in practical ways to improve your health
- To provide a supportive work environment that encourages healthy lifestyles
- To become a more educated health care consumer
- To work towards living a healthier lifestyle and improving your health
- To better understand and use the tools and resources that make for wiser health and health care choices

EMPLOYEE CONTRIBUTION RATES

2020 MONTHLY EMPLOYEE CONTRIBUTIONS

MEDICAL INSURANCE– UMR Coverage Election	*Employee Contribution Gold Go365 Status	Employer Contribution
Single Coverage	$0.00	$477.08/mo
Employee/Spouse Coverage	$0.00	$1,212.74/mo
Employee/Child(ren) Coverage	$0.00	$1,212.74/mo
Family Coverage	$0.00	$1,212.74/mo

Please note that if you have not achieved GOLD Status with Humana Go365 program, you will be responsible for a portion of the medical premium.

HEALTH REIMBURSEMENT ACCOUNT

Crossroads provides a Health Reimbursement Account for eligible employees who enroll in the medical plan. Employees who are enrolled on a medical plan for all 12 months of the plan year could receive the following in healthcare reimbursements through Chard Snyder:

EE Only — $5,000

Employee + 1 or more $10,000

DENTAL—MetLife	Low Plan Employee Cost	Low Plan Employer Contribution	High Plan Employee Cost	High Plan Employer Contribution
Single Coverage	$13.80	$13.80	$16.84	$16.84
Employee/Spouse Coverage	$32.53	$32.53	$39.69	$39.69
Employee/Child(ren) Coverage	$31.46	$31.46	$38.39	$38.39
Family Coverage	$49.45	$49.45	$60.35	$60.35

VISION—EyeMed	Employee Rate	Employer Rate
Single Coverage	$0.00	$5.08/mo
Employee/Spouse Coverage	$0.00	$8.81/mo
Employee/Child(ren) Coverage	$0.00	$10.55/mo
Family Coverage	$0.00	$13.08/mo

GET MORE VALUE FROM YOUR PLANS

Minimize your out-of-pocket expenses

Here are a few key points to help you get the most value out of your health plan:

Many plans require a primary care physician (PCP) who will provide or direct your health care. Look for a Family Practice, Internal Medicine, General Practice, OB/GYN, and/or Pediatric physician. You will always save money by using providers in your medical plan's network. Also, if you need to see a specialist, look for the "Two Shaded Hearts" on www.UMR.com. A Two Shaded Heart provider will be a $40 Specialist Copay instead of a $65 copay.

What are your options? You may want to consider the following the next time you need care:

Use the Emergency Room ONLY for emergencies

For a Life Threatening Emergency

In a true medical emergency – such as an apparent heart attack, serious injury, or other life-threatening situation – always call 911 or your local emergency number right away!

For Less Critical Issues, if the emergency is NOT life threatening

- Call your physicians office (even after hours, someone is typically on call to answer questions). Your doctor will know you and your medical history and may be able to schedule you for a visit the same (or next) day.
- If your condition starts or worsens on the weekend, or after your doctor's office has closed for the day, you may want to consider a visit to an Urgent Care facility. These clinics are not affiliated with hospitals, but they do have doctors and nurses on staff and are open in the evenings and on weekends.

If You are Traveling and You Need Urgent Care

Your medical plan covers urgent care. An urgent condition is one that requires immediate care, but isn't life-threatening. If you seek urgent care while traveling, you or someone acting on your behalf should notify your doctor within 48 hours of the onset of the urgent condition.

Annual physical exams and cancer screening tests are 100% covered!

Take advantage of the fact the Medical plan covers 100% of scheduled annual physical exams and cancer screening tests related to the physical exam when you use an in-network provider. There's no copay or deductible, however keep in mind that if your physician orders a test that isn't part of the scheduled preventative care exam/test, those procedures may result in some out-of-pocket expense for you. It's always a good idea to check with your doctor's office before your visit, to see what tests or exams are planned. Then, call your health plan to make sure you understand if and how those tests will be covered.

Preventive dental care is covered 100%!

Your dental plan is designed to provide the dental coverage you need with the features you want. Take advantage of what this plan has to offer without compromising what matters most - including the freedom to visit the dentist of you and your dependents choice – an "in-network" dentist or an "out-of-network" dentist. Don't forget that your preventive care, if performed by an in-network provider – is covered at 100% once every six months. Out of Network providers could charge more, resulting in additional fees.

Save tax dollars and enroll in a Flexible Spending Account

For those medical, dental or vision care expenses (copays, deductibles, etc) that you do pay for out-of-pocket, don't forget to take advantage of the Health Care Flexible Spending Account. You can set aside up to $2,750 a year on a before-tax basis and then reimburse yourself for eligible expenses. You can also contribute up to $5,000 for dependent care. Contact Chard Snyder for more information.

MEDICAL BENEFITS-UMR

Policy #76-412708
Website: www.umr.com
Phone Number: 800-826-9781

Everyone has different medical benefit needs. Crossroads Church offers medical benefits through UMR with the United Healthcare Network. You are eligible for this benefit upon your date of hire.

Remember: In order to receive the highest benefit level and reduce your potential out-of-pocket expenses, please be sure to use an in-network provider whenever possible. If you choose to use an out-of-network provider you may be responsible for balance billing.

Annual Deductible **$5,000 / $10,000**

Annual Out-of-Pocket Maximum **$6,350 / $12,700**

(Includes your annual deductible, coinsurance and copays)

Medical PPO All Employees	In-Network	Out-of-Network
Coinsurance	100% unless otherwise noted below	70% unless otherwise noted below
Physicians Office Visit	$25 copay	70% after deductible
Specialists Office Visit*	$40 copay (2 Shaded Heart)/$65 copay	70% after deductible
Preventive Care Services	100%	70% after deductible
Diagnostic X-Ray & Laboratory	100% after deductible	70% after deductible
Hospitalization		
• **Inpatient**	100% after deductible	70% after deductible
• **Outpatient**	100% after deductible	70% after deductible
Home Health Care (100 visits per year)	100% after deductible	70% after deductible
Immunizations	100%	70% after deductible
Maternity	100% after deductible	70% after deductible
Cardiac Rehabilitation	100% after deductible	70% after deductible
Chiropractic (60 visit max combined with Physical, Occupational, Audiology and Cognitive Rehabilitation. 10 visit max if out of network)	$40 copay (2 Shaded Heart)/$65	70% after deductible
Dialysis Treatment		
Physical, Occupational & Speech Therapy (60 visit max combined with Physical, Occupational, Audiology and Cognitive Rehabilitation. 10 visit max if out of network.)	$40 copay (2 Shaded Heart)/$65	70% after deductible
Emergency Room	$250 copay, waived if admitted	$250 copay waived if admitted
Urgent Care	$100 copay	70% after deductible
Prescription Drugs (Retail)		
• **Generic**	$10 copay	$10 copay
• **Preferred Brand**	$40 copay	$40 copay
• **Non-Preferred Brand**	$70 copay 25% specialty	$70 copay 25%specialty
• **Maximum Day Supply**	30 days	30 days

***For Specialist that are in the designated network (notated on UMR's website with Two Shaded Hearts), your copay will be $40 for your office visit. If the provider has 0 or 1 heart, the copay will be $60. Go to www.UMR.com to see if your specialist is considered a provider with Two Shaded Hearts. If your specialist is in a specialty that isn't yet rated, you will have a $60 copay.**

DENTAL BENEFITS

POLICY # 5933429
Website: www.metlife.com
Phone Number: 800-942-0854

Regular dental care is essential to good health. Crossroads Church provides you with an opportunity to purchase Dental coverage with MetLife Inc. You are eligible for this benefit upon your date of hire.

SUMMARY OF DENTAL BENEFITS

In-network vs. out-of-network

Crossroads Church offers two Dental Plans that are designed to provide the dental coverage you need with the features you want. Take advantage of what these plans have to offer without compromising what matters most - including the freedom to visit the dentist of you and your dependents choice – an "in-network" dentist or an "out-of-network" dentist.

Be prepared and plan ahead

For the best savings, use a MetLife Inc participating dentist or specialist. You can find a dentist by visiting www.metlife.com. You can also call 800-638-5000. Just show your dental plan card when you visit the dentist. If you choose a dentist who does not participate in our dental plan, your out-of-pocket expenses may be more, and you will be responsible for paying any difference between the dentist's fee and the plan's payment for the approved service.

If Dental work is required, request a pretreatment estimate from your Dentist. Your Dentist will contact MetLife Inc. You and your dentist can review your care and costs before treatment. It's a great way to be prepared and plan ahead.

Dental PPO Low Plan	In-Network	Out-of-Network
Preventive Care/Diagnostic • **Oral Examinations: 2 in 12 months** • **Topical Fluoride Application: 2 in 1 year for children up to 18th birthday** • **Full Mouth X-Rays: 1 in 36 months** • **Bitewing x-rays: 1 in 12 months**	100%	100% Out of network Providers may charge additional fees
Basic Restorative • **Endodontics - root canal: 1 per tooth in 24 months** • **General Anesthesia: for oral surgery, extractions or other covered services** • **Oral surgery (simple extractions)** • **Periodontal scaling and root planning: 1 in 12 months per quadrant**	80% after deductible	80% after deductible Out of network Providers may charge additional fees

DENTAL BENEFITS (CONTINUED)

Major Restorative • **Implants: Services – 1 service per tooth in 10 years** • **Implants: Repairs – 1 per tooth in 12 months** • **Bridges, Dentures, Crowns / Inlays / Onlays: 1 per tooth in 60 months**	50% after deductible	50% after deductible Out of network Providers may charge additional fees
Orthodontia • **Dependent children are Covered to age 26; please see your Plan Description for complete details** • **All procedures performed in connection with orthodontic treatment are payable as Orthodontia**	50% up to a lifetime maximum of $1,000	50% up to a lifetime maximum of $1,000 Out of network Providers may charge additional fees

Dental PPO High Plan	**In-Network**	**Out-of-Network**
Preventive Care/Diagnostic • **Oral Examinations: 2 in 12 months** • **Topical Fluoride Application: 2 in 1 year for children up to 18th birthday** • **Full Mouth X-Rays: 1 in 36 months** • **Bitewing x-rays: 1 in 12 months**	100%	100% Out of network Providers may charge additional fees
Basic Restorative • **Endodontics - root canal: 1 per tooth in 24 months** • **General Anesthesia: for oral surgery, extractions or other covered services** • **Oral surgery (simple extractions)** • **Periodontal scaling and root planning: 1 in 12 months per quadrant**	90% after deductible	80% after deductible Out of network Providers may charge additional fees
Major Restorative • **Implants: Services – 1 service per tooth in 10 years** • **Implants: Repairs – 1 per tooth in 12 months** • **Bridges, Dentures, Crowns / Inlays / Onlays: 1 per tooth in 60 months**	60% after deductible	50% after deductible Out of network Providers may charge additional fees
Orthodontia • **Dependent children are Covered to age 26; please see your Plan Description for complete details** • **All procedures performed in connection with orthodontic treatment are payable as Orthodontia**	50% up to a lifetime maximum of $1,500	50% up to a lifetime maximum of $1,000 Out of network Providers may charge additional fees

VISION BENEFITS

POLICY #104484
Website: www.eyemed.com
Phone Number: 866-804-0982

Crossroads Church offers vision insurance through EyeMed Vision Care.
You are eligible for this benefit on your date of hire.

SUMMARY OF VISION BENEFITS

Using your vision benefit is easy!

To find a participating eye care provider or to review your plan coverage before your appointment, visit www.eyemed.com or call 1-866-804-0982.

Vision All Employees	In-Network
Co-pays	
• **Materials**	$25 copay
Exam	
• **Benefit**	$10 copay
• **Frequency**	12 months
Lenses	
• **Single Vision**	$25 copay
• **Bifocal**	$25 copay
• **Trifocal**	$25 copay
• **Lenticular**	$25 copay
• **Frequency**	12 months
Frames	
• **Benefit**	$130 allowance
• **Frequency**	24 months
Contact Lenses (in lieu of Lenses & Frames)	
• **Elective**	$130 allowance
• **Medically Necessary**	$0 copay
• **Frequency**	12 months

INCOME PROTECTION BENEFIT

Policy #416990
Website: www.unum.com
Phone Number: 866-679-3054

If something were to happen to you, would your loved ones be financially secure?

Crossroads Church offers Basic Life, Accidental Death and Dismemberment (AD&D), Short Term Disability and Long Term Disability Insurance at no cost to you.

SUMMARY OF BENEFITS

Benefit Type	Summary
Basic Life	Maximum of $15,000
AD&D	Maximum of $15,000
Short-Term Disability	Weekly Benefit: 60% of weekly earnings to a maximum benefit of $500 per week.
Long-Term Disability	Monthly Benefit: 66% of monthly earnings up to a maximum benefit of $9,000 per month.
Voluntary Life Insurance	
Eligibility of Coverage	All active employees regularly working a minimum of 25 hours per week.
Eligibility Waiting Period	None. You are eligible upon your Date of Hire.
Benefit Waiting Period	Before collecting STD benefits, you must satisfy the benefit waiting period following your date of disability. For your plan, this period is 14 days for Accident and 14 days for Sickness. The maximum benefit duration is 11 weeks. LTD benefits starts after 90 days of Continuous Disability. If disability benefits are payable to you under this policy, you may be eligible for benefits from other income benefits. If so, we may reduce the disability benefits by the amount of such other income benefits. Please refer to your employee certificate for a complete list of what payments qualify as other income benefits.

CONTACT NUMBERS & WEBSITE LINKS

We encourage all of our employees and their families to become familiar with and use the resources offered.

Below is a list of websites and telephone numbers where you can obtain information about your benefit plan coverage. In most cases, you can register to securely access your benefit information online. This will enable you to review important information about your coverage, locate a doctor, view your claims history and research various health related topics.

Medical Plan	UMR	Policy #76-412708	Website: www.umr.com Phone Number: 800-826-9781
Dental Plan(s)	MetLife Inc	Policy #5933429	Website: www.metlife.com Phone Number: 800-942-0854
Vision Plan	EyeMed Vision Care	Policy #104484	Website: www.eyemed.com Phone Number: 866-804-0982
Life and AD&D	UNUM	Policy #416990	Website: www.unum.com Phone Number: 866-679-3054
Short Term Disability	UNUM	Policy #416990	Website: www.unum.com Phone Number: 866-679-3054
Long Term Disability	UNUM	Policy #416990	Website: www.unum.com Phone Number: 866-679-3054
Voluntary Life	UNUM	Policy #416990	Website: www.unum.com Phone Number: 866-679-3054

For additional information on all Crossroads benefits, please refer to the Human Resources 2020 Benefits folder on the Google Drive.

THE BENEFIT RESOURCE CENTER

The Benefit Resource Center (BRC) is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm EST via phone 855-874-6699 or via e-mail BRCEast@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

You can obtain benefit enrollment forms in the Human Resources office.

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This guide is provided to you by Crossroads Church and USI

Crossroads Church

Important Legal Notices

(AKA, LEGAL MUMBO JUMBO)

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 12 for more details.

***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not consider all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in 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. Therefore, the following deductibles and coinsurance apply:

- Deductible $5,000/$10,000; Coinsurance 100%
- Deductible $3,000/$6,000; Coinsurance 100%

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 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 toward 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days or any longer period that applies under the plan from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

Wellworks wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a premium incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Crossroads may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact LaTasha Patrick at 513-731-7400 x1645.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 513-731-7400 x1645 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $152 per day (up to a $1,527 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If the plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

LaTasha Patrick
Crossroads Church
3500 Madison Road
Cincinnati, Ohio 45209
513-731-7400 x1645
lpatrick@crossroads.net

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice 01/01/2020
- Name of the privacy official, her email address and phone number is listed below.

LaTasha Patrick
lpatrick@crossroads.net
513-731-7400 x1645

Important Notice from Crossroads Church About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Crossroads Church and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Crossroads Church has determined that the prescription drug coverage offered by the UMR is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Crossroads coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Crossroads coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Crossroads and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Crossroads changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	01/01/2020
Name of Entity/Sender:	Crossroads
Contact--Position/Office:	LaTasha Patrick, Human Resources
Address:	3500 Madison Road. Cincinnati, Ohio 45209
Phone Number:	(513) 731-7400 x1645

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 NO**W 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. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+:https://www.colorado.gov/pacific/hcpf/child-health-plan-plus	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

CHP+ Customer Service: 1-800-359-1991/ State Relay 711	

KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov	Website: https://www.scdhhs.gov

Medicaid Phone: 1-800-992-0900	Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment–based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Crossroads	4. Employer Identification Number (EIN) 31-1442447	
5. Employer address 3500 Madison Road	6. Employer phone number (513) 731-7400 x1645	
7. City Cincinnati	8. State Ohio	9. ZIP code 45209
10. Who can we contact about employee health coverage at this job? LaTashia Partick		
11. Phone number (if different from above)	12. Email address lpatrick@crossroads.net	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Full time employees working 30+ hours a week
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Dependent children up to age 26
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)