

Mid-year CHANGE Form

Ancira Enterprises Employee Benefits Plan

This form is required to change your current Medical, Dental, Vision, Individual Group Life Benefits, Disability Income Insurance, or other as may be allowed. Changes are subject to evaluation. Other forms may be required, depending on changes you want to make. Read instructions carefully.

FIRST, MI, LAST NAME		CURRENT ADDRESS:	
EMP ID#	STORE	DEPT	JOB TITLE
CHANGE/s REQUESTED:			FOR EFFECTIVE DATE:

Note: FEDERAL LAW REQUIRES A "QUALIFYING EVENT" (QE) THAT IS CONSISTENT WITH THE CHANGE REQUEST. ALL REQUESTS ARE SUBJECT TO REVIEW AND MAY BE DECLINED IF THEY ARE DEEMED "UNQUALIFIED".

SECTION 2: PLEASE CHECK ALL THAT APPLY

<p>Medical Coverage: (midyear enrollment not permitted without QE)</p> <p><input type="checkbox"/> NO CHANGE to Medical Or CHANGE AS FOLLOWS:</p> <p><input type="checkbox"/> Cancel Medical Attach proof of other coverage and sign Page 4</p> <p>ADD MEDICAL: (midyear change between plans is not permitted)</p> <p><input type="checkbox"/> HCA /Bucket Plan Single / Self+Child/ren / Self+Spouse* / Self+Family \$162 \$385 \$430 \$661 <small>Note: Eligibility restrictions apply. Call 800-207-3172 to discuss if you are eligible for this option. Rates shown do <u>not</u> include G4U*</small></p> <p><input type="checkbox"/> MPO/Entry Plan Single / Self+Child/ren / Self+Spouse* / Self+Family \$86 \$144 \$185 \$329 <small>This is a mini-med plan with maximum benefit of \$25,000 per calendar year per insured. Participation in the Entry Plan is required to establish eligibility for HCA.</small></p> <p>CHANGE to:</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus child/ren <input type="checkbox"/> Employee plus spouse* <input type="checkbox"/> Family</p> <p><small>Note: If cancelling dependent/s, it is your duty to inform them.</small></p> <p>Dental Coverage: (midyear enrollment not permitted without QE)</p> <p><input type="checkbox"/> NO CHANGE to Dental Or CHANGE AS FOLLOWS:</p> <p><input type="checkbox"/> Cancel Dental</p> <p>CHANGE to:</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus child/ren <input type="checkbox"/> Employee plus spouse** <input type="checkbox"/> Family</p> <p><small>Note: If cancelling dependent/s, it is your duty to inform them.</small></p> <p><small>*LEGAL SPOUSE (proof may be required; common-law only permitted with certified copy of Common-Law Marriage certificate) ** Good4U pays you \$25/mo. if you're in the HCA, but it is only offered during open enrollment annually.</small></p>	<p>Vision Coverage:</p> <p><input type="checkbox"/> NO CHANGE to Vision Or CHANGE AS FOLLOWS:</p> <p><input type="checkbox"/> Cancel this benefit</p> <ul style="list-style-type: none"> This ancillary product is only offered during Open Enrollment or when first eligible for benefits. You can cancel this benefit at any time, but you will have a 6-month waiting period to be able to re-enroll AND may be subject to pre-existing exclusions. <p>DreamTrips Travel Benefit:</p> <p><input type="checkbox"/> NO CHANGE to DreamTrips Or CHANGE AS FOLLOWS:</p> <p><input type="checkbox"/> Cancel this benefit</p> <ul style="list-style-type: none"> This ancillary product is only offered during Open Enrollment or when first eligible for benefits. You can cancel this benefit at any time, but you will have a 6-month waiting period to be able to re-enroll. <p>Disability Income Insurance:</p> <p><input type="checkbox"/> NO CHANGE to Disability Insurance Or CHANGE AS FOLLOWS:</p> <p><input type="checkbox"/> Cancel SHORT TERM DISABILITY <input type="checkbox"/> Cancel EXTENDED TERM DISABILITY</p> <ul style="list-style-type: none"> This ancillary product is only offered during Open Enrollment or when first eligible for benefits. You can cancel this benefit at any time, but you will have a 6-month waiting period to be able to re-enroll AND may be subject to pre-existing exclusions.
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Group Life Insurance with Reliastar ING

- NO CHANGE to Group Life Insurance
Or CHANGE AS FOLLOWS:
- Cancel this benefit
- Canceling yourself from this benefit automatically cancels any dependents you have insured with the life insurance, as well.
 - This ancillary product is only offered during Open Enrollment or when first eligible for benefits.
 - You can cancel this benefit at any time, but you will have a 6-month waiting period to be able to re-enroll AND may be subject to pre-existing exclusions.

_____ INITIAL here acknowledging you have read and understand the cancellation terms and obligations stated above, including waiting periods, underwriting/pre-existing exclusions and changes to dependent coverage.

ADD, CHANGE, END COVERAGE

If ENDING COVERAGE, the name and birthdate is all that is needed plus your signature. If ADDING coverage, consider all information necessary.

If we have questions, what's the best number to reach you? _____

- Dependents must meet policy definitions of "dependent"
- Certificate of Common Law issued by your county of residence is required for Common Law dependents; otherwise your request will be denied.
- Coverage **cannot be canceled** if an active child support order is on file with your employer. If your change is a result of you being RELEASED from a court-ordered dependent medical support, ATTACH A COPY OF THE STATE RELEASE TO YOUR CHANGE FORM.

This one form is intended to communicate a variety of EMPLOYEE OPTIONS.

You must WRITE THE FOLLOWING: A for ADD; C for CHANGE; E for END EXISTING coverage

A, C, or E	First, Middle Initial, and Last Name PRINT If spouse last name is different, attach proof of marriage	Social Security # REQUIRED	Birthdate mm-dd-yy	If adding MEDICAL, does this person have access to medical coverage elsewhere?	Does this child live with you or at another address?	Age of this child at time of your signature on this document?	Notes or Special Instructions Use this space to more clearly explain what you're trying to do (i.e. "cancel spouse life")
	Employee Name						
	Spouse Name			Failure to answer truthfully is considered insurance fraud			
	Name []son []daughter []OTHER QUALIFIED*			Failure to answer truthfully is considered insurance fraud			
	Name []son []daughter []OTHER QUALIFIED*			Failure to answer truthfully is considered insurance fraud			
	Name []son []daughter []OTHER QUALIFIED*			Failure to answer truthfully is considered insurance fraud			
	Name []son []daughter []OTHER QUALIFIED*			Failure to answer truthfully is considered insurance fraud			

*If you are ADDING dependent/s, attach a current copy of CERTIFICATE OF CREDITABLE COVERAGE from the prior insurance carrier. COPY THIS PAGE if you have more DEPENDENTS than this page allows. STAPLE PAGES TOGETHER FIRMLY.

➔ **ADDING** your dependent child to Medical with Ancira? **IF YES, YOU MUST ANSWER THE FOLLOWING.** Benefits access may be denied until insurability is verified.

- Is any child/ren to be covered employed? Yes No (If yes, COMPLETE SECTION 3)
- Is any child/ren to be covered able to obtain medical coverage elsewhere? Yes No (If yes, COMPLETE SECTION 3)
- Is any child/ren 26 or older? Yes No (age 26 or older are not insurable under the Ancira group medical policies)
- Adding child/ren who must file an income tax return may create new tax obligations for you, including added taxable (imputed) income you must report in your income taxes. You may obtain the dollar value annually by written request to Ancira Team Services, P. O. Box 29719, SA TX 78229.

By signing, I hereby certify that all of the information provided by me is true, complete and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved and all supplemental forms and information have been submitted by me and that all requests are subject to review and may be approved or denied by the Benefits Administrator. I understand that if approved, I may not change coverage elections that I make until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. I have educated myself of the benefits, potential restrictions I may be subject to such as pre-existing waiting periods, compliance and/or underwriting requirements, and similar. I have read the enrollment information and authorize the changes to coverage and related payroll deductions for premiums. If the change/s is approved, the deductions will appear in the deduction section of my pay statement according to my selected benefits. If terminating coverage, I understand that without a qualified event, I will be required to wait until my employer's open enrollment to change this decision and will be subject to underwriting and waiting periods the policy may require. This form shall supersede all former elections and beneficiary designations, as applicable. I understand premiums are collected a month in advance of coverage/policy effective dates to ensure timely payment to carriers and that any added premium costs will need to be caught-up accordingly. My failure or delays to provide requested supporting documents/signatures/etc. may compromise my request for enrollment and/or prevent a change from being allowed [if you do not know what this means, re-read the General Information – Change Requests provided on page 4 or call Team Services @ 558-5005!].

EMPLOYEE SIGNATURE

DATE

DO NOT WRITE IN THIS BOX – TEAM SERVICES OFFICE USE ONLY

PR: _____ UMR: _____ PP+G4 ENR: _____ DEP✓: _____ ING Enr: _____ ING eoi: _____ DT: _____ HR FINAL: _____

APPLICATION FOR CHANGE UNDER SECTION 125 FLEXIBLE BENEFIT PLAN

REQUIRED ONLY if changing MEDICAL or DENTAL. If you're not changing either, you can skip this page.

Information provided must be accurate and complete.

The employer has the right to request back-up documentation relating to your request.

The requested change must be consistent with the EVENT and is subject to review and possible rejection.

Employee: _____ STORE: _____ EMP ID# 99 _____

Social Security #: _____ Ph# _____

Current Address: _____
Street / P.O. Box City State Zip

REQUESTED CHANGE/s: Add } Dependent } Medical
(Check each that applies) Change } Coverage } Dental
Cancel }

Do not complete this page unless you are requesting a change to medical or dental

- REQUESTED EFFECTIVE DATE: _____
- DATE YOU FIRST KNEW THIS CHANGE WOULD BE NEEDED: _____ (APPROXIMATE OK)

INDICATE WITH A ONE OF THE FOLLOWING (MOST APPLICABLE) "QUALIFIED EVENT" BASED UPON YOUR REQUEST FOR THIS CHANGE:

- Change in legal marital status (marriage, divorce, death of spouse, legal separation, annulment)
- Change in number of tax dependents (birth, adoption, placement for adoption, or death)
- Change in employment status affecting benefit eligibility of you, your spouse, or dependent (termination or commencement of employment, change in hours or classification, strike/lockout, commencement or return from unpaid leave of absence or qualified change in worksite affecting access to benefits)
- Tax dependent satisfies or ceases to satisfy eligibility requirement (attainment of other coverage, marriage, etc.)
- Residence change of you, spouse, or dependent significantly affecting access to care under the plan
- Significant cost Increase OR Decrease – AMOUNT: \$ _____ OR Coverage Reduced
- Change in coverage under another employer's plan including significant change/improvement
- Loss of coverage under group health plan of governmental or educational institution
- FMLA leave
- HIPAA special enrollment
- Entitlement to, or loss of eligibility for, Medicare or Medicaid
- COBRA qualifying event
- Judgment, decree, order (e.g., QMCSO/Medical Support Order)

WRITE AN EXPLANATION FOR YOUR SELECTION – THE SPECIFIC CAUSE FOR THE REQUESTED CHANGE:

Your signature acknowledges each of the following (1) your understanding and acceptance of the Section 125 change restrictions and the Administrator's ruling; (2) that you have read in entirety and agree to comply with the information provided within this form; (3) that inaccurate statements or omissions can be considered insurance fraud and result in loss of benefits; (4) the Ancira Enterprises Employee Benefits Program and Section 125 rulings are subject to the employer's Exchange program and the Section 125 Administrator and (5) your signature certifies your statements and documentation to be true, accurate, and complete.

Signature _____

Date _____

General Information regarding Change Requests

- All change requests are subject to approval by the Benefits Administrator and rely upon all necessary documentation being provided within the required timelines.
- If terminated & rehired within 30 days, you must "step back" into previous election.
- If you have a change in status event, you must provide factual information explaining the request for a change in your Section 125 election within 30 days of the occurrence or the request will be denied. If accepted, changes shall be effective according to Section 125 stipulations and plan document/s provisions, when applicable.
- Your requested change must be on account of and corresponding with a change in status that affects eligibility for coverage under an employer's plan.
- If the status change is your divorce, annulment, or legal separation, the death of your spouse or dependent, or a dependent who ceases to satisfy eligibility requirements for coverage, you can cancel coverage for the affected person only.
- If you, your spouse, or dependent gains eligibility for coverage under another employer's cafeteria plan or qualified benefit plan as a result of a change in marital or employment status, you can cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under another employer's plan.
- Life, disability, or vision is deemed to be ancillary coverage by the plan sponsor and are not included under this Section 125 plan. Therefore, any benefits paid to the beneficiary/recipient are non-taxable. Medical and dental premiums are not taxable under Section 125 and as such, are subject to different rules.
- You can only make an election change to medical or dental if (1) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan, (2) the election change is on account of and corresponds with a change in status that affects eligibility of dependent care expenses under Section 125, or (3) the election change is on account of and corresponds with a change in cost or change in coverage provided under the sponsor's plan.
- Federal law governs changes allowed to medical and dental. Your request must be made within the time restrictions required under Federal law for notice of a qualifying event and the plan sponsor's existing policies. Your request will be evaluated both in light of the law and documentation/statements submitted by you or on your behalf by another party. Judgment shall be made by the Benefits Administrator as to whether or not a requested change meets current legal requirements.
- Submission of a new election form to the Benefits Administrator revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are consistent with a valid status change, or other qualifying event.
- Enrollment will automatically cease upon employment termination. Only medical and dental are offered through COBRA. COBRA is subject to separate enrollment by you.

Patient Protection Required Notice if newly electing/adding MEDICAL

Dependent Coverage to Age 26 Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. Individuals may request enrollment for such children for 30 days from the date of this notice.

Lifetime Limit No Longer Applies The lifetime limit for the HCA Bucket Plan are now tiered based upon HHS guidelines. The Ancira medical plans had no individuals whose coverage ended by reason of reaching a lifetime limit under the plan/s. However, this notice is required by law.

Designation of Primary Care Providers The Ancira medical plans have never required "designation" of primary care providers. You are free to choose at any time what provider you see. However, you are urged to use only In-Network providers to ensure you receive the best value for your insurance dollar.

Direct Access to OB/Gyns You do not need and have never needed under the Ancira medical plan/s prior authorization (or a referral) to obtain direct access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your member ID card for a phone number and/or Website.

Additional Legal Notices relating to MEDICAL & Prescription Drug

The Ancira Enterprises Employee Benefit Plan (medical group health plan) is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or visit the website at www.healthreform.gov or www.hhs.gov/ocio/regulations. PLEASE REVIEW this notice CAREFULLY. THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of ANCIRA AUTO GROUP HEALTH PLAN (the "Plan") to protect the privacy of your medical information. The Plan provides health and/or dental benefits to you as described in your summary plan description(s) and the Rx benefits are considered CREDITABLE by CMS guidelines. The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan hires business associates to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The Plan is sponsored by Ancira Enterprises, Inc. (the "Plan Sponsor"). The Plan reserves the right to change the terms of this notice at any time. If the Plan makes changes to this notice, the Plan will revise it and send a new notice to all subscribers covered by the Plan at that time. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new notice. The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Purposes for which the Plan May Use or Disclose Your Medical Information Without Designated Authorization

Health Care Providers' Treatment Purposes. Our Health Plan may disclose your medical information to your doctor, at the doctor's request, for your treatment by him and may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.

Health Care Operations. Our Health Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage the Plan. The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities. Our Health Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws. Our Health Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information. The Health Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor will not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

For Complaints, or More Information, or to Report a Problem: If you have questions and would like additional information concerning this Notice, please contact the Plan Sponsor in writing at: Ancira Enterprises, Inc., Attn: HIPAA Policy – Plan Sponsor c/o P. O. Box 29719, San Antonio, TX 78229 or email teamservices@ancira.com for more prompt attention.