

LARGE GROUP PLAN

2019 Employee Enrollment/Change Form

Enrollment

You have the right to read the Group Subscriber Contract and *Evidence of Coverage and Disclosure Form (EOC)* before enrolling in Sutter Health Plus. To help you make an informed choice, we make available *Summary of Benefits and Coverage (SBC)* documents. *SBCs* summarize important information about our health coverage options in a standardized format so you can easily compare benefits and coverage offered by Sutter Health Plus with those of other carriers. To obtain a copy, contact your employer or call Sutter Health Plus Member Services 1-855-315-5800 (TTY 1-855-830-3500). This enrollment form is part of the Group Subscriber Contract and *EOC*. You are accepting the terms, conditions, and provisions of the Group Subscriber Contract and *EOC*.

Important Note

The Affordable Care Act (ACA) requires Sutter Health Plus to collect the Social Security numbers (SSN) for all enrolled family members. Sutter Health Plus is required to provide IRS Form 1095-B to the IRS with a copy to you. Form 1095-B includes information you will need to report on your income tax return showing that you and your covered family members had qualifying health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. Sutter Health Plus will not use or share your SSN other than as required by law. **Please be sure to include all SSNs where requested.**

Change Request

This form is also used to inform us of changes to existing members, such as a name, an address, telephone number or sub-account change. **This form is not used to notify us of a termination.** All changes to accounts, including effective dates and dependent status, will be made in accordance with the contractual agreement between the employer/purchaser and Sutter Health Plus.

For Sutter Health Plus to process your request, you must sign and return the last page of this form. Missing information may delay processing.

Fax your completed form to:

Active Employees: Please send to the attention of Vickie Weaver-Owens, (916) 568-3051

Early Retirees: Please send to the attention of Kris Kurk, (916) 568-3060

Language Assistance

If you have questions about completing this application, please contact Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plus provides translation services and other language assistance services to you free of charge.

Large Group Employee Enrollment / Change Form

Group Name

Los Rios Community College District

Effective Date

Subaccount Name

Enrollment – Please complete entire form.

Reason For Request:

Annual Open Enrollment

Prior Los Rios Medical Carrier, if applicable

Kaiser

WHA

Newly Eligible – Reason

New Hire

Active - Effective Date

Retiree - Effective Date

COBRA – Effective Date

Cal-COBRA* – Effective Date

* Cal-COBRA enrollees will receive a separate Cal-COBRA Election Notice and Enrollment Form to complete. The notice includes important information regarding health care coverage options and rates.

Change – Complete the required information in Sections B and C, if applicable.

Member ID (For Changes)

Add Dependent**

Add Newborn/Newly Adopted Child**

Remove Dependent – Effective Date

Name Change

Address Change

Subaccount

From Subaccount ID

To Subaccount ID

**Date of qualifying event (if not open enrollment)

You need to select a primary care physician (PCP) for yourself and each covered family member. Please include your PCP's name and provider ID in Sections B and C.

Section A – Benefit Plan Selection

Select the plan(s) you would like:

Los Rios \$15 Copay HMO (ML52)

Los Rios HDHP (HD16)

Section B – Employee Information

Last Name

First Name

MI

Gender

Date of Birth

Social Security Number (Required)

Subscriber ID Number

Los Rios ID Number

M F

Residential Address

City

State

ZIP

Home Phone

Mobile Phone

Work Phone

Email Address

Mailing Address (P.O. Box Accepted)

same as residential

City

State

ZIP

Previous Name (If Any)

Primary Spoken Language

Section B – Employee Information Cont.

PCP Information – If you do not select a PCP, one will be assigned to you. You have the opportunity to change your PCP by calling Member Services at 1-855-315-5800 (TTY 1-855-830-3500) or on the Member Portal. To find a PCP please visit sutterhealthplus.org/providersearch.

I would like to select my PCP

I would like a PCP assigned

Current Patient?

PCP Name Provider ID# P Yes No

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner

| | | | | | |
|---------------------|---|---------------|-----------------------------------|-------|-------|
| Add: | Last Name | Date of Birth | Gender | | |
| Spouse | | | M F | | |
| Domestic Partner | First Name | MI | Social Security Number (Required) | | |
| | | | | | |
| Residential Address | Mailing Address (P.O. Box Accepted) same as residential | | | | |
| | | | | | |
| City | State | ZIP | City | State | ZIP |
| | | | | | |

I would like to select my PCP

I would like a PCP assigned

Current Patient?

PCP Name Provider ID# P Yes No

Section C2 – Dependent One

| | | | | | |
|---------------------|---|---------------|-----------------------------------|-------|-------|
| Add: | Last Name | Date of Birth | Gender | | |
| Child 1 | | | M F | | |
| | First Name | MI | Social Security Number (Required) | | |
| | | | | | |
| Residential Address | Mailing Address (P.O. Box Accepted) same as residential | | | | |
| | | | | | |
| City | State | ZIP | City | State | ZIP |
| | | | | | |

I would like to select my PCP

I would like a PCP assigned

Current Patient?

PCP Name Provider ID# P Yes No

Section C3 – Dependent Two

| | | | | | |
|---------------------|---|---------------|-----------------------------------|-------|-------|
| Add: | Last Name | Date of Birth | Gender | | |
| Child 2 | | | M F | | |
| | First Name | MI | Social Security Number (Required) | | |
| | | | | | |
| Residential Address | Mailing Address (P.O. Box Accepted) same as residential | | | | |
| | | | | | |
| City | State | ZIP | City | State | ZIP |
| | | | | | |

I would like to select my PCP

I would like a PCP assigned

Current Patient?

PCP Name Provider ID# P Yes No

Section C – Dependent Information Cont.

Section C4 – Dependent Three

Add: Child 3

Last Name _____ **Date of Birth** _____ **Gender** M F

First Name _____ **MI** _____ **Social Security Number (Required)** _____

Residential Address _____ **Mailing Address (P.O. Box Accepted)** same as residential _____

City _____ **State** _____ **ZIP** _____ **City** _____ **State** _____ **ZIP** _____

I would like to select my PCP I would like a PCP assigned **Current Patient?**

PCP Name _____ **Provider ID# P** _____ **Yes** **No**

Section D – Other Coverage Information

Do you or any of your dependents covered under Sutter Health Plus have any other health plan coverage (in addition to Sutter Health Plus)?

Yes No (If "Yes," please complete all of the information below.)

Primary Policy Holder Name(s) (Last, First, MI) _____ **Policy Number** _____ **Effective Date** _____

Insurance Carrier Name _____ **Policy Holder Date of Birth** _____

All Dependents' Names and Other Health Plan ID Numbers

Section E – Agreement

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and EOC, upon completion and execution of this enrollment form.

Binding Arbitration

Sutter Health Plus handles and resolves member disputes through grievance, appeal and independent medical review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and EOC.

Employee Signature **Date**

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電Sutter Health Plus會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。 (Chinese)

نوکی دق (Sutter Health Plus) سالب ثلی هررتص نأ مل عاف اردادق نکت مل اذا! اذهءءارق یلع رداق تنأ له: تمهم عظوح لم قدعاسم یلع لوصحلل. کتغلُب ابوتکم هاقل تت نأ اضیأ کنکمى امک. صنلا اذهءءارق یف کتدعاسم هنکمى اصخش مهیدل فتاه یلع (Sutter Health Plus Member Services) سالب ثلی هررتص ءاضعأ تامدخب لاصتالا ءاجرب، ءىءاجم (Arabic) .(1-855-830-3500[TTY]) 1-855-315-5800

ԿԱՐԵՎՈՐՏԵՂԵԿՍՏՎՈՒԹՅՈՒՆ. Կարող եք կարդալ սա: Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնություն համար ինդրում ենք զանգահարել Sutter Health Plus-ի Անդամներին սպասարկման բաժին 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով: (Armenian)

សារ: សំខាន់៖ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យមានសេចក្តីនេះសរសេរជាភាសាបស់អ្នក ដទៃ។ សំរាប់ជំនួយដោយឥតគិតថ្លៃសូមទូរស័ព្ទទៅ ជូនកែសម្រួលសមាជិក Sutter Health Plus តាមលេខ 1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)

یدرف زا دن اوت یم Sutter Health Plus، دین اوت یم ن رگا؟ دیم هفب و دین اوخب ار بل اطم نی دین اوت یم ایآ: مهم هتکن تامدخ تفایرد یرب. دراد دوجو یراف نابز هب بل اطم نی مم جرت ناکم نین چمه. دن اوخب نات یرب ار ن ات در یگب کمک نفلت مرامش اب Sutter Health Plus یاضعأ تامدخ رتفد اب افطل، ناگیار کمک و (Farsi) 830-3500) سامت(1-855-315-5800 (TTY 1-855-

सहत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में सर्मथ हो सकते/सकती हैं। नि:शुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर सर्वसिस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができます？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스 1-855-315-5800 (TTY 1-855-830-3500)에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທ່ານອ່ານໄດ້ຈັດໝາຍສະບັບນີ້? ຖ້ອທ່ານອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມື້ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ ຂອງ Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਮਿ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਸਿ ਤੇ ਇਹ ਪੜ੍ਹਨ ਵੱਚਿ ਤੁਹਾਡੀ ਮੱਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਚਿ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮੱਦ ਲਈ ਕਰਿਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉੱਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)