

SMALL GROUP PLAN

2020 Employee Enrollment/Change Form

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. 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

You can use this form 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 subscriber 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 complete, sign and return this form. Missing information may delay processing.

Employers, email or fax your completed form to:

Email: shpenrollmentmailbox@sutterhealth.org

Fax: 916-736-5426

You must encrypt or secure any documents sent by email. If you cannot encrypt or secure emails, please fax all documents and keep a copy for your files.

Group Name

Effective Date

Subaccount Name

Enrollment – Please complete entire form.

Reason For Request:

Annual Open Enrollment

Newly Eligible – Reason

New Hire

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

STANDARD PLANS

Section A1 – HMO Standard Plan Selection

| Platinum | Gold | Silver | Bronze |
|----------|----------|---------------|---------------|
| MS38 HMO | MS57 HMO | SD37 HDHP HMO | SD28 HDHP HMO |
| MS41 HMO | MS42 HMO | MS64 HMO | MS66 HMO |
| MS60 HMO | MS63 HMO | | |

PLUS PLANS

Section A2 – HMO Plus Plan Selection (*Plus plans include embedded Infertility and Special Footwear benefits*)

| Platinum | Gold | Silver | Bronze |
|---------------|---------------|--------------------|--------------------|
| MP38 Plus HMO | MP57 Plus HMO | SP37 Plus HDHP HMO | SP28 Plus HDHP HMO |
| MP41 Plus HMO | MP42 Plus HMO | MP64 Plus HMO | MP66 Plus HMO |
| MP60 Plus HMO | MP63 Plus HMO | | |

Optional Adult Vision Benefit

If selected by your employer, you and your dependents age 19 and older will be automatically enrolled in the optional adult vision benefit plan. However, you may opt out of this coverage by checking the box below.

Please do not enroll me or my dependents in the optional adult vision benefit (if selected by my employer). I understand that I will not be able to obtain this coverage until the next applicable open enrollment or special enrollment period.

**Pediatric vision benefits for members age 19 and under (until the end of the month in which the member turns 19 years of age) are included in all Sutter Health Plus small group plans. Please refer to your EOC for coverage information.*

Section B – Employee Information

| | | | | |
|---|--------------------------|-----------------------------------|------------------|-----|
| Last Name | | First Name | | MI |
| Gender | Date of Birth (Required) | Social Security Number (Required) | Member 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 | | |

PCP Information – You need to select a primary care physician (PCP) for yourself and each covered family member. If you do not select a PCP, one will be assigned. 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

PCP First Name

PCP Last Name

Provider ID#

Current Patient?

P

Yes No

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner

Add to my plan

Remove from my plan

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

| I would like to select my PCP | I would like a PCP assigned |
|-------------------------------|-----------------------------|
| PCP First Name | PCP Last Name |
| Provider ID# P | Current Patient? Yes No |

Section C2 – Dependent One

Add to my plan

Remove from my plan

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

| I would like to select my PCP | I would like a PCP assigned |
|-------------------------------|-----------------------------|
| PCP First Name | PCP Last Name |
| Provider ID# P | Current Patient? Yes No |

Section C – Dependent Information Cont.

Section C3 – Dependent Two

Add to my plan

Remove from my plan

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

| I would like to select my PCP | I would like a PCP assigned |
|-------------------------------|-----------------------------|
| PCP First Name | PCP Last Name |
| Provider ID# P | Current Patient? Yes No |

Section C4 – Dependent Three

Add to my plan

Remove from my plan

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

| I would like to select my PCP | I would like a PCP assigned |
|-------------------------------|-----------------------------|
| PCP First Name | PCP Last Name |
| Provider ID# P | Current Patient? 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

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*, 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 هرتصن أن مل عاف ارّداق نکت مل اذا! اذه ةءارق یلع رداق تنأل ه: ةمهم ةظوح لم ةدع اسم یلع لوصحلل. کتغلُّب ابوتکم ءاقل تت نأ اضرئأ کنکمی امک. صنلا اذه ةءارق یف کتدع اسم هنکمی اصخش مهی دل فتاه یلع (Sutter Health Plus Member Services) سالب ثلی هرتصن ءاضعأ تامدخ لاصتال ءا جرب، ةنی ءام (Arabic) .(1-855-830-3500[TTY]) 1-855-315-5800

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ 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 օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով: (Armenian)

សារ:សំខាន់៖ តើអ្នកអាចអានសចក្កដីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យមានសចក្កដីនេះសរសេរជាភាសាបស់អ្នក ដែរ។ សំរាប់ជំនួយជាយុត្តិធម៌សម្រាប់ស្វែងរកស្តុមទូរស័ព្ទទៅ 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 اوب ار بل اطم نی دین اوت یم ای: مهم هتکن تامدخ تفایرد یرب. دراد دوجو یرسراف نابز هب بل اطم نی ام جرت ناکم نین چمه. دن اوب نات یرب ار ن ات دري گب کمک 1-855-315-5800 نفلت هرامش اب Sutter Health Plus یاضعأ تامدخ رتفد اب افطل، ناگیار کمک و (Farsi) (TTY 1-855-830-3500) سامت

महत्त्वपूर्ण: 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 समर्थ हो सकते/सकती हैं। नःशुल्क 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 ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਚਿ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮੱਦਦ 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)