Large Group Plan (101+)

Employer Healthcare Coverage Application

How to submit this application:

You must email or fax your signed and completed form to Sutter Health Plan. Missing information may delay processing your application.

EMAIL
shpserviceteam@sutterhealth.org

FAX
916-736-5418

To complete the application process, please make your initial premium payment online or by check. (Please select one.)

☐ ONLINE
Pay your initial premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment

If you paid online, please include the email confirmation number for faster processing.

Confirmation #_____

☐ CHECK
Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

If paying by check, please include a copy with your application for faster processing.

Legal Company Name | **DBA** (Account Name) | **Requested Effective Date**

Section A – Benefit Plan Selection

Section A1 – HMO Plan Selection

Summit	**Peak**	**Ridge**	**Vista**
☐ LG18 HMO	☐ LG23 HMO	☐ LG30 HMO	☐ HL10 HDHP HMO
☐ LG19 HMO	☐ LG24 HMO	☐ LG31 HMO	☐ HL11 HDHP HMO
☐ LG20 HMO	☐ LG25 HMO	☐ LG32 HMO	☐ HL12 HDHP HMO
☐ LG21 HMO	☐ LG26 HMO		☐ HL13 HDHP HMO
☐ LG22 HMO	☐ LG27 HMO		☐ HL14 HDHP HMO
	☐ LG28 HMO		
	☐ LG29 HMO		
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____

All Sutter Health Plan plans prescription drug coverage is, on average, expected to equal or exceed the standard Medicare Part D benefit value. This is considered creditable coverage. Since this coverage is creditable, Medicare-eligible individuals do not have to enroll in a Medicare prescription drug plan while they maintain this coverage. Be aware, however, that if the individual has a subsequent break in this coverage of 63 days or longer any time after they were first eligible to enroll in a Medicare prescription drug plan, the individual could be subject to a late enrollment penalty in addition to the Medicare Part D premium.

Sutter Health Plan

Section A – Benefit Plan Selection Cont.

Section A2 – Optional Benefits Selection

☐ **Decline all optional benefits**

Please select the plan(s) you would like:

Acupuncture and Chiropractic (ACN)
Not available for HDHPs

☐ Acupuncture-only plan ID ....
☐ Chiropractic-only plan ID ....
☐ Acupuncture and Chiropractic plan ID ....
☐ Decline

Orthotics and Special Footwear
Not available for HDHPs

☐ OP20 Orthotics and Special Footwear
☐ OH20 Orthotics and Special Footwear
☐ Decline

Vision (VSP)

☐ Plan A / VA01 12/24/24
☐ Plan B / VA02 12/12/24
☐ Plan C / VA03 12/12/12
☐ Decline

Section A3 – Subaccounts (Enrollment/Billing Unit)

Please select the subaccount type, provide the physical address, and indicate if a separate invoice is needed.

☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: ....

Street Address (P.O. Boxes not accepted)	**City**	**State**	**ZIP**

☐ **Separate Invoice** (If the billing address differs)

Billing Address	**City**	**State**	**ZIP**

☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: ....

Street Address (P.O. Boxes not accepted)	**City**	**State**	**ZIP**

☐ **Separate Invoice** (If the billing address differs)

Billing Address	**City**	**State**	**ZIP**

☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: ....

Street Address (P.O. Boxes not accepted)	**City**	**State**	**ZIP**

☐ **Separate Invoice** (If the billing address differs)

Billing Address	**City**	**State**	**ZIP**

☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: ....

Street Address (P.O. Boxes not accepted)	**City**	**State**	**ZIP**

☐ **Separate Invoice** (If the billing address differs)

Billing Address	**City**	**State**	**ZIP**

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

Section B – Group Information

Street Address (P.O. Boxes not accepted) | **City** | **County** | **State** | **ZIP**

Correspondence Address Same as street address | **City** | **County** | **State** | **ZIP**

Federal Employer ID Number | **SIC Code***

Phone | **Fax** | **Chief Executive Officer or Proprietor**

Workers' Compensation Carrier | **Workers' Compensation Policy Number**

Are your benefits subject to ERISA regulations? ☐ Yes ☐ No

* Look up your SIC Code on the Division of Corporation Finance: Standard Industry Classification (SIC) Code List at sec.gov/info/edgar/siccodes.htm.

Benefits Administrator | **Title** | **Phone** | **Email**

Billing Contact (If different from above) | **Billing Address** ☐ Same as correspondence address above

Billing City | **Billing State** | **Billing ZIP**

Billing Contact Email | **Billing Contact Phone**

Type of Organization ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other _____

Federal COBRA Administrator's Contact Information

Vendor | **Contact Name**

Correspondence Address | **City**

State | **ZIP** | **Phone** | **Email**

Please mail the COBRA billing statement to: ☐ COBRA Administrator ☐ Group Benefits Administrator

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Employer Contribution Employees _____ % of premium or $ _____ Dependents _____ % of premium or $ _____

Please apply: ☐ Across all plans ☐ To the lowest-cost plan

Note: Employer must contribute a minimum of 50% of eligible employee premium for the lowest-cost medical plan offered by the employer.

Sole Carrier: When the employer contributes 100% of the premium, all eligible employees must enroll, less valid waivers. If the employer contributes less than 100% of the premium, a minimum of 50% of all eligible employees must enroll, less valid waivers.

Slice Carrier: A minimum of 10 eligible employees must enroll in a Sutter Health Plan medical plan by renewal, with the employer offering no more than two additional carriers.

Section B – Group Information Cont.

Employee Eligibility Minimum hours worked per week _____

Total Employee Participation (Please enter a value for each line. If N/A, enter "0".)

_____ Full-time and full-time equivalent employees
_____ Eligible employees in group
_____ Eligible employees enrolling in Sutter Health Plan
_____ Eligible employees enrolling in other carrier(s)
_____ Eligible employees waiving medical coverage from all plans

Eligible Employees – Employees eligible for health plan benefits who live, physically work or reside within the Sutter Health Plan licensed service area.

Full-time Employee – Employee working a minimum of 30 hours per week on average.

Full-time Equivalent (FTE) Employee – A combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.

Will Sutter Health Plan be the only carrier? ☐ Yes ☐ No

If "No":

Name of other carrier(s) _____

Plan(s) offered _____

Prior carrier _____

Sutter Health Plan by default will set deductibles and out-of-pocket maximums to calendar year.

☐ Other (Requires prior approval) _____

Section C – Broker Information

Broker Agency Name

Agency License Number and Expiration Date Exp.

Sutter Health Plan Agency ID A-

Broker/Agent Name

Agent License Number and Expiration Date Exp.

Sutter Health Plan Agent ID C-

Broker Account Manager Name

Broker Account Manager Email

Section D – Premium Payment Information

Section D1 – Initial Premium Payment

You can make your initial premium payment online or by check. If paying by check, it must be in the form of a corporate check payable to Sutter Health Plan and received before the group submission is considered complete. Temporary checks will not be permitted unless accompanied by a letter from your financial institution confirming your account name and address.

ONLINE

Pay your initial premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment

CHECK

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

Section D2 – Subsequent Premium Payments

You can make your subsequent premium payments online or by check.

ONLINE

After you register for a portal account, you can pay your monthly premium online through your Sutter Health Plan portal account and the Sutter Health Plan Online Payment Center.

shplan.org/employerportal

CHECK

Please make your check payable to Sutter Health Plan and include your Sutter Health Plan account name and account number with your payment.

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

Section E – Employer Agreement

If you have questions about completing this form, please contact Sutter Health Plan Customer Service at **855-315-5800**.

This application is part of the Group Subscriber Contract, which includes the Evidence of Coverage and Disclosure Form (EOC). By signing this application form, you are accepting the terms, conditions, and provisions contained in the enrollment form as well as those in the Group Subscriber Contract and EOC. You have the right to read the Group Subscriber Contract and EOC before applying for coverage with Sutter Health Plan. To obtain a copy, contact your broker or call Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500).

Mandatory Arbitration

Group, member (including any heirs or assigns) and Sutter Health Plan agree and understand that any and all disputes by and between them, 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 claims subject to ERISA, shall be determined by submission to 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. Each party, including any heirs or assigns, to this Agreement is giving up its constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and EOC.

Employer Signature _____ **Date** _____

Print Name and Title _____

Note: Generally, employers cannot impose a waiting period greater than 90 days. Benefits are effective the first of the month following the waiting period. If you have questions about rules on waiting periods, please consult your legal counsel.