

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

- ☐ LG18 HMO
- ☐ LG19 HMO
- ☐ LG20 HMO
- ☐ LG21 HMO
- ☐ LG22 HMO

Peak

- ☐ LG23 HMO
- ☐ LG24 HMO
- ☐ LG25 HMO
- ☐ LG26 HMO
- ☐ LG27 HMO
- ☐ LG28 HMO
- ☐ LG29 HMO

Ridge

- ☐ LG30 HMO
- ☐ LG31 HMO
- ☐ LG32 HMO

Vista

- ☐ HL15 HDHP HMO
- ☐ HL16 HDHP HMO
- ☐ HL17 HDHP HMO
- ☐ HL18 HDHP HMO
- ☐ HL19 HDHP 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.

Section A2 – Optional Point-of-Service (POS) Plan Selection

(Only available when offered alongside a Sutter Health Plan HMO plan.)

Note: All POS plans are pending regulatory approval by the Department of Managed Health Care.

☐ **Decline all optional POS plans**

Two-Tier POS Plans

- ☐ LP01 \$0/\$20 Copay POS
- ☐ LP02 \$750/\$20 Low-Deductible POS
- ☐ LP03 \$1,500/\$20 Deductible POS

Three-Tier POS Plans

- ☐ LP04 \$0/\$20 Copay POS + Out-of-Network
- ☐ LP05 \$750/\$20 Low-Deductible POS + Out-of-Network
- ☐ LP06 \$1,500/\$20 Deductible POS + Out-of-Network
- ☐ LP07 \$750/\$20 Low-Deductible POS + Enhanced Out-of-Network

Section A3 – Deductible Funding

Deductible funding*: ☐ Yes ☐ No

If yes, please indicate the plan(s) and the monthly deductible funding amount:

Plan(s) Employee \$ Dependent \$

Section A4 – Optional Benefits Selection

☐ **Decline all optional benefits**

Please select the plan(s) you would like:

Acupuncture and Chiropractic

Not available for HDHPs

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

Orthotics and Special Footwear

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

* Not available for HDHPs

Vision (VSP)

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

Benefit Plan Selection Continues on page 3.

* "Deductible Funding" means any employer contribution or other employer-funded amount made available to employees through either an employer subsidy or direct funding, or as may be provided through employer contributions to an account-based plan or arrangement.

Section A5 – Subaccounts (Enrollment/Billing Unit)

Are any special or additional subaccounts needed (other than standard Active and/or COBRA)?

If Yes, complete the subaccount rows below. If a physical address is the same as listed in Section B, leave address blank.

☐ Yes ☐ No

Use this section to identify any subaccounts and provide address and billing details, if applicable. Complete one row for each subaccount. Standard Active and COBRA subaccounts do not need to be listed separately unless the physical address or billing setup differs from the primary street address listed in Section B below.

Subaccount #1**Subaccount Type** (select all that apply)
☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: _____
Physical street address for this subaccount (only complete if different from primary street address listed in Section B)

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate invoice needed for this subaccount? (If yes, provide address below.)☐ Yes ☐ No

Billing Address

City

State

ZIP

Subaccount #2**Subaccount Type** (select all that apply)
☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: _____
Physical street address for this subaccount (only complete if different from primary street address listed in Section B)

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate invoice needed for this subaccount? (If yes, provide address below.)☐ Yes ☐ No

Billing Address

City

State

ZIP

Subaccount #3**Subaccount Type** (select all that apply)
☐ Active ☐ COBRA ☐ Cal-COBRA* ☐ Early Retirees ☐ Other: _____
Physical street address for this subaccount (only complete if different from primary street address listed in Section B)

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate invoice needed for this subaccount? (If yes, provide address below.)☐ Yes ☐ No

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 A – Benefit Plan Selection Cont.

Section A5 – Subaccounts Cont.

Subaccount #4

Subaccount Type (select all that apply)

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

Physical street address for this subaccount (only complete if different from primary street address listed in Section B)

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate invoice needed for this subaccount? (If yes, provide address below.)

☐ Yes ☐ No

Billing Address

City

State

ZIP

Optional Notes / Clarifications

* 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.

Section B – Group Information Cont.

Benefits Administrator/Enrollment Contact	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 _____

Note: Additional contacts can be provided via a separate sheet. Please provide name, title, email address and phone number.

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			

Employer Premium 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.

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.

Section B – Group Information Cont.

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) _____

Note: Please be advised that Sutter Health Plan does not permit age-banded rates to be used alongside large employer rates.

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.