Large Group Plan (101+)

2022 Employer Health Care Coverage Application

For Sutter Health Plus to process your request, you must complete, sign, and return this application. Missing information may delay processing.

Email or fax your completed form to:
Email: *shpsales@sutterhealth.org*
Fax: 916-736-5418

To complete the application process, please mail your initial premium payment check to:
Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

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

Section A – Benefit Plan Selection

Section A1 – HMO Plan Selection

Summit	**Peak**	**Ridge**	**Vista**
☐ ML28 HMO*	☐ ML20 HMO*	☐ ML57 HMO*	☐ HD19 HDHP HMO*
☐ ML26 HMO*	☐ ML21 HMO*	☐ ML58 HMO*	☐ HD08 HDHP HMO*
☐ ML54 HMO*	☐ ML22 HMO*	☐ ML56 HMO*	☐ HD18 HDHP HMO*
☐ ML29 HMO*	☐ ML24 HMO*		☐ HD09 HDHP HMO*
☐ ML50 HMO*	☐ ML25 HMO*		☐ HD15 HDHP HMO*
☐ ML27 HMO*	☐ ML59 HMO*		☐ HD17 HDHP HMO*
☐ ML51 HMO*	☐ ML60 HMO*		
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____

**This plan's prescription drug coverage is, on average, expected to equal or exceed the value of standard Medicare Part D benefit. 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 he or she was 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 Plus
Your 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

Dental (Delta Dental)

- ☐ Dental Low / DL01
- ☐ Dental Mid / DL02
- ☐ Dental High / DL03
- ☐ Decline

Infertility

- ☐ IF50 Infertility 50% Coinsurance
- ☐ Decline

Orthotics and Special Footwear

- ☐ OH20 Orthotics and Special Footwear
  Only available for HDHPs
- ☐ OP20 Orthotics and Special Footwear
  Not available for HDHPs
- ☐ 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 any and all subaccounts that apply. Write the name of any additional subaccounts if needed.

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

Please list subaccounts (include address) that require a separate invoice:

.....

.....

.....

.....

**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.*

Section B – Group Information

Legal Company Name

Street Address *(P.O. Boxes Not Accepted)* | **City** | **County** | **State** | **ZIP**

Correspondence Address *(P.O. Boxes Accepted)* | **City** | **County** | **State** | **ZIP**

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

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

Who is Your 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 _____

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.

Employee Eligibility Minimum hours worked per week _____

Total Employee Participation

_____ Full-time and full-time equivalent employees

_____ Eligible employees in group

_____ Eligible employees waiving medical coverage from all plans

Note: A minimum of 50% participation of eligible employees is required, unless offered on a slice basis.

Eligible Employees – Employees eligible for health plan benefits who live, work or reside within the Sutter Health Plus 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.

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

☐ Other *(Requires prior approval)* .....

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

If "No," list total number of employees enrolled in other group health plan(s) .....

Name of other carrier(s) .....

Plan(s) offered .....

Prior carrier .....

Federal COBRA Administrator's Contact Information

Vendor	**Contact Name**

Correspondence Address	**City**

County	**State**	**ZIP**	**Phone**	**Email**

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

Section C – Broker Information

Broker/Agent Name	**Broker Agency**

Broker Account Manager Name	**Sutter Health Plus Agent ID**
	C-

Agenct License Number and Expiration Date	**Agency License Number and Expiration Date**
Exp.	Exp.

Section D – Premium Payment Information

Section D1 – Initial Premium Payment

Initial premium payment must be in the form of a corporate check payable to Sutter Health Plus and must be 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.

Please send initial premium payment to:
Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

Section D – Premium Payment Information Cont.

Section D2 – Subsequent Premium Payments

To ensure we promptly process and post payments to your account, please mail premium checks to the following address:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

Please include the Sutter Health Plus account name and account number in the memo line of your check.

You also have the choice to pay your premium online once you've created your Sutter Health Plus portal account. The online payment center is not available for initial payments. For more information, please call Sutter Health Plus Account Services at 1-855-325-5200.

Section E – Employer Agreement

If you have questions about completing this form, please contact Sutter Health Plus Account Services at 1-855-325-5200.

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 Plus. To obtain a copy, contact your broker or call Sutter Health Plus Account Services 1-855-325-5200 (TTY 1-855-830-3500).

Mandatory Arbitration
Group, member (including any heirs or assigns) and Sutter Health Plus 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.