# Small Group Plan

## 2024 Employer Healthcare Coverage Application

### How to submit this application:

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

EMAIL
*shpsales@sutterhealth.org*

FAX
1-916-736-5418

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

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

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

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

*sutterhealthplus.org/binderpayment*

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

Confirmation #_____

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

**Section A** – Benefit Plan Selection *(All deductibles and out of pocket maximums will accrue on a calendar year basis.)*

### STANDARD PLANS

**Section A1** – HMO Standard Plan Selection

| Platinum | Gold | Silver | Bronze |
|---|---|---|---|
| ☐ MS78 HMO | ☐ SD12 HDHP HMO | ☐ SD11 HDHP HMO | ☐ SD03 HDHP HMO |
| ☐ MS90 HMO | ☐ MS72 HMO | ☐ MS94 HMO | ☐ MS96 HMO |
| | ☐ MS87 HMO | | |
| | ☐ MS93 HMO | | |

### PLUS PLANS

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

| Platinum | Gold | Silver | Bronze |
|---|---|---|---|
| ☐ MP78 Plus HMO | ☐ SP12 Plus HDHP HMO | ☐ SP11 Plus HDHP HMO | ☐ SP03 Plus HDHP HMO |
| ☐ MP90 Plus HMO | ☐ MP72 Plus HMO | ☐ MP94 Plus HMO | ☐ MP96 Plus HMO |
| | ☐ MP87 Plus HMO | | |
| | ☐ MP93 Plus HMO | | |

** All Sutter Health Plus 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 Plus
Your Health Plan

## **Section A** – Benefit Plan Selection Continued

### **Section A3** – 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)**

- ☐ Adult Dental HMO/DS01
- ☐ Decline

**Vision (VSP)**

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

### **Section A4** – Subaccounts *(Enrollment/Billing Unit)*

**Please select any and all subaccounts that apply. Enter 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 healthcare coverage options and rates.*

## **Section B** – Group Information

**Street Address** *(P.O. Boxes not accepted)* | **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

**Type of Organization**

☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ LLC ☐ Other .....

** You can 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** | **Title**

**Phone** | **Email**

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

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

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

**Billing Contact Email** | **Billing Contact Phone**

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**Employer Contribution** *(A value is required for both employees and dependents. If N/A, enter "0".)*

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.*

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**Employee Eligibility** Minimum hours worked per week _____

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

_____ Full-time and full-time equivalent employees *(Sole proprietors, spouses of sole proprietors, partners of partnership and the spouses of partners are not eligible employees pursuant to California Health and Safety Code section 1357.500.)*

_____ Eligible employees in group

_____ Eligible employees enrolling in Sutter Health Plus

_____ Eligible employees waiving medical coverage from all plans *(Please include all medical plans offered by Sutter Health Plus and other carriers)*

**Eligible Employees –** Employees eligible for health plan benefits who live, physically 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.

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**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 _____

## **Section B** – Group Information Cont.

**Continuation Coverage**

☐ Federal COBRA *(20 or more employees for at least 50% of the previous calendar year.)*

☐ Cal-COBRA *(Up to 19 employees for at least 50% of the previous calendar year.)*

### 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

## **Section C** – Broker & General Agency Information

### **Section C1** – Broker Information

**Broker/Agent Name** | **Broker Agency**

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

**Agent License Number and Expiration Date**
Exp.

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

### **Section C2** – General Agency Information

**General Agency Name** | **General Agency Contact Name**

## **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 Plus 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.

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

ONLINE
Pay your initial premium through the
Sutter Health Plus Online Payment Center:
*sutterhealthplus.org/binderpayment*

## **Section D** – Premium Payment Information Cont.

### **Section D2** – Subsequent Premium Payments

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

CHECK

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

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

ONLINE

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

*shplus.org/employerportal*

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 at 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.