Sutter Health Plus
Your Health Plan

# Group Deductible Credit Cover Sheet

Sutter Health Plus offers new members, at the time of enrollment, the opportunity to apply deductible credits earned with your prior health plan to your new Sutter Health Plus plan.

For each family member covered by Sutter Health Plus, we will apply deductible credits from a prior carrier under the following circumstances:

1. The Sutter Health Plus plan type is the same as your prior coverage (employer-offered high-deductible plan or HMO deductible plan).
2. Only amounts paid for services that would have been covered under the Sutter Health Plus plan and subject to the deductible are eligible for the deductible credit.
3. You must submit a copy of the most recent *Explanation of Benefits (EOB)* or provide a letter from your previous health plan carrier, on official letterhead, noting the deductible values that have been met for that plan year. This information can be obtained from your prior carrier and must be submitted individually for yourself and each enrolled family member on a separate form.
*Note: No other forms of documentation will be accepted*
4. The *EOB* or letter can be sent with the enrollment form or it can be sent within the first 30 calendar days after the member's effective date, by postal mail, fax or email to the following:

| **US Postal Mail:** | **Fax:** | **Email:** |
|---|---|---|
| Sutter Health Plus<br>Attn: Claims<br>P.O. Box 160385<br>Sacramento, CA 95816 | Sutter Health Plus<br>Attn: Claims<br>916-736-5426 | *shpclaimsmailbox@sutterhealth.org* |

5. The *EOB* or a letter submitted by the previous health plan carrier must include each member's first and last name and date of birth. If the documents are submitted separate from the enrollment forms, the Sutter Health Plus member identification (ID) number must be included. Document submissions will not be considered after the 30-day period has elapsed from the effective start date of the new Sutter Health Plus plan.

**<u>Required</u>: Please complete the following information, keep a copy for your records and use this page as your cover sheet with *EOBs* or previous carrier letters attached:**

Sutter Health Plus Coverage Effective Date : ______________________________
***Note:*** *Last date to submit is 30 calendar days from the health plan effective date*
Date Submitted to Sutter Health Plus: ________________________________________________________________
Individual Deductible: _______________________ or Family Deductible: ____________________________
Complete Member Name (first & last, exactly as when you enrolled): ___________________________________
Date of Birth: ______________________________ Sutter Health Plus ID# (if known): ________________________
Attached *EOB*: ___________________________ Letter from Health Plan: ___________________________
Deductible Credit Amount: _________________

If you have additional question, please call Sutter Health Plus Member Services 1-855-315-5800.

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