CalCPA Health

Health plans for CPAs since 1959

FIRM ADMINISTRATION GUIDE

CalCPA Benefits Management Instructions for Firm Administrators

Introduction

The purpose of this guide is to present, in a clear and comprehensive manner, the policies and procedures applicable to all CalCPA Health members and their employees enrolled in the CalCPA Health programs.

This administrative guide should be retained for future reference. Please direct all questions concerning the content of this guide to Banyan Administrators – Managers for the CalCPA Health Programs (Banyan).

The procedures contained in this administrative guide have been adopted from the guidelines established by the Group Insurance Trust of the California Society of CPAs (The Trust), Anthem Blue Cross (Anthem), Delta Dental (Delta), Lincoln Financial (Lincoln), Vision Service Plan (VSP) and Banyan.

The Trust, Anthem, Delta, Lincoln, VSP and Banyan reserve the right to amend this administrative guide and request any and all documentation necessary to verify employee eligibility, business ownership, and compliance with the policies set forth in this administrative guide, at any time.

This entire guide is a plain-language summary of some of the key administrative provisions of the health and welfare programs offered by the Group Insurance Trust of the California Society of Certified Public Accountants. In the event of any conflicts between the information in this guide and the official plan documents, the plan documents will govern. The official plan documents are the Medical Plan Document and Disclosure Forms (MPDDs). Copies of these documents are available through the plan's administrator or on the website: www.CalCPAHealth.com. This guide is not intended to provide a guarantee of medical coverage or CalCPA membership. The Group Insurance Trust reserves the right to change benefits under CalCPA Health at any time.

Employer Eligibility

Employer Eligibility:

- CalCPA Health is available to accounting firms in public practice or firms offering general financial services, both of which are headquartered in the state of California. This includes Financial Advisors, Securities Brokers, Credit Unions, small Regional Banks, etc.
- To be eligible and retain such eligibility, more than 50% of all the firm's owners (principals, proprietors, partners, shareholders, or other owners) must be CPA members of CalCPA or Associate members of CalCPA. All owners must be members of CalCPA in good standing.
- More than 50% of the group's enrolled employees must reside in California.

Firms with one Eligible Employee:

- If you are the only Eligible Employee (as defined on the next page), you are eligible to enroll in the CalCPA Health's Medical, Dental, and Vision plans. Dental and Vision must be sold with Medical.
    - A Stand-alone Ancillary Administration Fee will be applied to Dental and Vision if Medical is cancelled and not renewed.
- Sole Practitioners must enroll during the Open Enrollment Period, or when there is a qualifying life event that creates a Special Enrollment Period. Sole Practitioner medical coverage cannot be obtained mid-year without a qualifying life event.

Employer Contribution Requirements:

- An employer must contribute a minimum of 50% of the cost of employee's medical premiums, and 100% of employee's dental, vision, life, or long-term disability premiums. This does not include the cost for dependents. Payroll deduction is required for employee contributions that are withheld to pay premium costs. If an employer pays 100% of the premiums, 100% employee participation is required.

Enrolling a New Employee

Who is an Eligible Employee?

- Eligible Employees must be employed on a permanent basis, with wages subject to withholding that are reported on a W-2 form. Seasonal, temporary, or substitute employees, defined as employees hired with a planned future termination date, are not eligible.
- Persons compensated on a 1099 basis are not eligible. A copy of the latest DE-9C is required to verify the employment relationship.
- Employees must work a minimum of either 20 or 30 hours per week to be considered full-time. Please refer to your Subscription Agreement, your most recent renewal packet, or contact Banyan Administrators to confirm your company's minimum hourly requirement for employees. *Note: Employees must work a minimum of 30 hours per a week to be eligible for Life or LTD.*

Employee Participation Requirements:

- If the employer is paying 100% of the employee medical premium, then all eligible employees must enroll. If the employee pays part of the premium, a minimum of 75% of the eligible employees must enroll.
- If the employer offers dental and/or vision coverage, then all eligible employees must enroll.
- All active, regular employees working at least 30 hours per week must enroll in Life and LTD plans.

What forms need to be completed?

- Only the employee may fill in or modify information on the Enrollment and Change form. Any changes to information must be initialed and dated by the employee. No alteration to preprinted material on the employee application is acceptable, and altered forms will be rejected.
- Provide the appropriate form(s) to the employee, based on your firms offerings:
    - Medical with or without Dental, Vision, Life, and LTD:
        - Enrollment and Change form
    - HSA:
        - Health Equity Form

When do forms need to be submitted to Banyan Administrators?

- Enrollment forms must be submitted to Banyan Administrators within 31 days of the Coverage Effective Date.
- The Coverage Effective Date is determined by:
    - Date of Hire: The date a permanent employee begins working full-time.
    - Waiting Period: Refer to your Subscription Agreement, your most recent renewal packet, or contact Banyan Administrators.
        - First of the month following Date of Hire, or
        - First of the month following 30 days of employment, or
        - First of the month following 60 days of employment

  Ex: A firm has a 30-day waiting period and hires an employee on July 7th. The Coverage Effective Date would be September 1st and the forms must be submitted by October 1st.
- If the Date of Hire is the first of the month, and the group has a Date of Hire waiting period, coverage will be effective on that date.
  Ex: An employee hired July 1st would have coverage effective July 1st. An employee hired July 2nd would have coverage effective August 1st.
- If the form is not submitted within 31 days, the employee cannot enroll until the next Open Enrollment period or until they have a qualifying life event.

What if an Eligible Employee does not want to enroll?

Are they enrolled in another *group* health plan?

- If yes, the waiver is considered valid.
    - The employee should complete Sections 2, 4, 6, and 7 of the Enrollment and Change form for your records.
- If no, the waiver is invalid and affects your compliance with the Employee Participation requirement.

Waiving Coverage:

- Any eligible employee and/or dependent waiving coverage at time of enrollment must complete an Enrollment and Change form indicating the waiver. The employee must complete Sections 2, 4, 6, and 7 of the Enrollment and Change form and must forward it to the Plan Agent or Banyan Administrators
- Employees enrolled in the group Kaiser plan are considered eligible waivers.
- Employees who waive coverage on the grounds that they have other group coverage are not counted as eligible employees.
- Employees who waive coverage on the grounds that they are covered by a group Kaiser plan offered by the group are not counted as eligible employees.

Adding or Removing Dependents

Who is an Eligible Dependent?

- Spouse: the plan participant's spouse under a legally valid marriage.
- Domestic partner: the plan participant's Opposite Sex and Same Sex domestic partner under a legally registered and valid domestic partnership.
- Child: the plan participant's spouse's or domestic partner's natural child, stepchild, or legally adopted child.
    - Children are eligible up to the age of 26. Coverage ends on the first of the month following their 26th birthday.
    - Disabled children of eligible employees who, with appropriate medical certification, are eligible for coverage up to any age.
        - Note: The disabled child must be enrolled at the time that the certification and request are submitted to be considered for continued enrollment.

What forms need to be completed?

- Enrollment and Change form

When do the forms need to be submitted to Banyan Administrators?

- The Enrollment and Change form must be submitted to Banyan Administrators within 31 days of the Qualifying Event. Qualifying Events include marriage, divorce, birth, adoption, loss of other coverage, etc.

When is the coverage effective date?

- Coverage will become effective on the first of the month following the qualifying event. ***Exception:*** birth or adoption of a child. The coverage effective date will be the date of birth or adoption. If the date of birth is on or before the 15th, the rate change will be applied that month. If it is after the 15th, the rate change will be applied in the next coverage month.

How will the change be reflected on the premium invoice?

- The coverage tier is listed above the premium amount. E for employee only, ES for employee and spouse, EC for employee and child, ECN for employee and children, and F for family. ***Please note*** that invoices are generated a month before the due date. If a change form is submitted after the invoice is generated, the change will be reflected on the following invoice.
  Ex: a change that is submitted on July 2nd will be reflected on the September invoice.

Rating/Billing Policies and Premium Payments

Rating policies:

- Premium level will be based upon number of permanent full-time employees.
- Approved out-of-state employees will be charged an area rate based on the location of the employer's business license.
- Groups that enrolled on or after January 1, 2014 will have their annual renewal on the anniversary of their effective date. The Open Enrollment period to submit changes begins two months before the renewal date, and it ends two Fridays prior to the renewal date.
  Ex: A group that enrolls on 6/1/2015 will have an Open Enrollment period from 4/1/2016 through 5/20/2016 for changes effective 6/1/2016.

Rate changes:

- Premium levels will be adjusted annually, at the start of the open enrollment period, and at the expiration of any Rate Guarantee Period based on an enrollment snapshot at that time.
- Firms who enroll with an effective date other than January 1 will have a minimum 12 month rate guarantee for the first year. The second rate year may be less than 12 months.
- First year medical rates are guaranteed for a minimum of 12 months. Focal renewal or anniversary month will determine timing of future adjustments.
- Changes to both premium rates and benefits can be made by CalCPA Health with 60 days notification.

Timeline of billing procedures:

- Due Date: Premium payments are due on the first day of the month of coverage.
  Ex: Payments for January's coverage are due January 1st.
- The bills are generated during the first week of the previous month, after the previous month's due date.
  Ex: The billing for February is generated as early as January 2nd. If your January payment posted after the due date, it would be reflected on the March bill.
- The bills are mailed approximately three weeks prior to the due date.
- Grace Period: Premium payments must post to your account within 30 days of the due date. If payment is not received and processed before the end of the grace period, coverage will be terminated.
- Notice of Premium Due: To comply with the California Assembly Bill 2470, late notices are sent by the 25th of each month. CalCPA Health realizes your premium is not yet past due on the 25th of a month, but we (and all health insurance organizations) are required by California law to provide notices on this legislatively mandated cycle.
  Ex: If your payment for February posts on or after January 26th, we are legally obligated to send a Notice of Premium Due.

Rating/Billing Policies and Premium Payments (cont.)

Online Electronic Billing Services:

- If you participate in Electronic Billing, you will be able to view your group's invoices and payment history for coverages you have through CalCPA Health.
- You must complete registration form to be able to access online billing.
    - CalCPA Health Registration form for Electronic Billing

Payment methods:

- **Online:** Go to www.CalCPAHealth.com/employers-plan-administrators/billing/pay-online/. Once you agree to the terms, you will be directed to the Trust's online bill pay system.
    - You will initially login using the company's Client Code and Billing Zip Code
    - You should, then, sign up with a username and password. We recommend that you store your username and password for future use.
    - Payments can be made with a checking or savings account. Credit and debit card payments *cannot* be accepted.
    - You can make a one-time payment or schedule recurring payments.
      Note: Recurring online payments are based on the amount that you enter into the system. If your monthly premium amount changes, you will need to log in to cancel the recurring payment and schedule one for the new amount.
- **Automatic Clearing House (ACH):** You will receive a notice of the amount that will be deducted each month and the premiums will be deducted from your checking account on the due date.
    - Automatic Deposit Authorization Form
- **Mail:** You can mail your payment stub with a check or money order made payable to: *Group Insurance Trust, PO Box 512516, Los Angeles, CA 90051-0516*

Non-Payment Cancellation

- If payment is not received by the end of the grace period, coverage is terminated retroactively to the last month for which premiums were paid in full. A Notice of Termination will be issued.
    - If payment is received after the end of the grace period, coverage is not automatically reinstated, and you must call Banyan to request reinstatement of coverage.
      Ex: If payment for January is received on February 1st (31 days after the due date), coverage is terminated back to December 31st.
    - If claims are paid for expenses incurred during a month for which premium was not paid, you will be required to reimburse the Trust for the claims paid.

Reinstatements

- Reinstatements of terminated groups will be reviewed by the Trust if the following terms are met:
  - The group contacts Banyan to request reinstatement within 15 days of the non-payment cancellation.
  - The current month's premium and any past due premiums are paid within 15 days of the cancellation.
- No more than 3 reinstatements within 18 months will be permitted. If a group is terminated for non-payment 4 times in 18 months, they will need to re-apply for coverage as a new group with a future effective date.
- *Reinstatement approval is solely at the discretion of the Trust.*

Non-Sufficient Funds (NSF):

- NSF is defined as a check, online payment, or ACH transaction not negotiated by your bank for any reason.
- When an ACH or check is returned for non-sufficient funds, the group will be charged $12, and have 15 days to provide a replacement payment.
- If three payments are returned for non-sufficient funds, the group will be required to submit all future payments in certified funds.

Termination of Employment and/or Benefits

What forms need to be completed?

- Enrollment and Change form

When do the forms need to be submitted to Banyan Administrators?

- Within 31 days of the date of a qualifying event

When is the coverage termination date?

- Coverage will remain effective through the last day of the month in which the qualifying event occurred.
  Ex: An employee that works on June 1st and resigns on June 2nd will have coverage effective through June 30th.

How will the termination be reflected on the premium invoice?

- If payment has been made for coverage past the employee's termination date, an adjustment will be included on the last page of their invoice. *Reminder that invoices are generated a month before the due date.* If a termination form is submitted after the invoice is generated, the change will be reflected on the *following* invoice.

Voluntary Group Termination

How to request a termination of benefits for entire group?

- Send a written request to Banyan Administrators via fax or email and include:
  - Company name and client code
  - Requested termination date
  - Lines of coverage to be terminated (medical, dental, vision, life, and/or disability.)

How far back can coverage be terminated?

- Coverage can be terminated as far back as 60 days from the first of the month in which the request is received, depending on the date of service for the most recent claim submitted to the carriers.
  Ex: If a group termination request is submitted to Banyan Administrators in March, coverage can be terminated back to January 1st if no claims have been submitted.
- If a claim has been submitted to the carriers for a date of service later than the requested termination date, coverage will be terminated on the first of the month following the date of service.
  Ex: If a group termination request is submitted to Banyan Administrators in March, a claim has been submitted for a service provided in March; the group coverage will be terminated on April 1st.

What if premiums have already been paid for coverage that is terminating?

- If coverage is terminated after it has been paid for, Banyan Administrators will issue a refund check to the group.
  - Refund checks generally arrive in 7-10 business days.

Federal COBRA Continuation of Coverage

Who is subject to Federal COBRA?

- Employers with 20 or more Full-Time Equivalent employees are required to offer Federal COBRA coverage.
- Employers with 2 to 19 Full-Time Equivalent employees are required to offer Cal-COBRA coverage.
- Calculating Full-Time Equivalent employees:
    - Full-time employees are the number of employees who work at least 40 hours per week (but not counting any owners of the business, family members of business owners, or seasonal workers working fewer than 120 days).
    - Part-time employees are counted by taking the total annual hours worked by all part-time employees and dividing that number by 2,080 -- this gives you the "total full-time equivalent for part-time employees."
    - Your total eligible Full Time Equivalent employees is the sum of: (1) the total number of full-time employees (as defined above); and (2) the total full-time equivalent for part-time employees (calculated in the manner described above, or other methods described by IRS Notice 2010-44).

Note: These definitions are used only for COBRA purposes, and they do not apply to the eligibility requirements of the plan.

What are the Employer's Responsibilities?

- The Employer is considered the Plan Administrator and Named Fiduciary of all aspects of COBRA for the purposes of ERISA. Under COBRA regulations, employers may cede their administrative functions to a third party, but the ultimate COBRA responsibility always remains with the employer.

Who administers the COBRA services?

- Federal COBRA groups may choose to:
    - Use services provided by CalCPA Health's COBRA vendor, bswift COBRA, with fees paid by the Group Insurance Trust.
    - Or, self-administer COBRA or utilize a COBRA services vendor at their own cost.
- If you would like to utilize CalCPA Health's COBRA vendor, bSwift COBRA, please contact Banyan Administrators to request a COBRA Administration Authorization Agreement.

What is the process for enrolling a participant in Federal COBRA coverage?

1. The employer sends notice of termination to Banyan Administrators by completing an Enrollment and Change form.
2. The vendor (or employer) sends the COBRA Election notice to the participant.
3. The participant returns the forms and their first payment to the vendor (or employer) within 60 days of the date of the Election notice.

Enrolling a participant in Federal COBRA coverage (cont.)

4. The employer sends Banyan Administrators an Enrollment and Change form within 10 days after receiving the Election notice from the employee.
5. Banyan Administrators sends the coverage information to the carriers.
6. The vendor (or employer) bills the participant and collects the premiums.
7. The participant is included on the group invoice, and the employer submits the premium payments to Banyan Administrators.

The above steps (other than the termination request) are also followed when a participant elects a Cal-COBRA extension.

How should changes be reported to Banyan Administrators?

- The employer must notify Banyan Administrators of any terminations, enrollment changes, and demographic changes within 10 days after the date the employer has knowledge that a change has occurred.
- The vendor (or employer) is responsible for sending Open Enrollment and Renewal information to each participant by December 1st.
- The employer must notify Banyan Administrators of any Open Enrollment changes by December 31st.

How to sign up for complimentary COBRA administrative services through bSwift COBRA:

- Contact Banyan Administrators to request a COBRA Administration Authorization Agreement. Complete and sign the agreement and return it to Banyan Administrators.
- Employers can elect to utilize services for COBRA only or COBRA and Cal-COBRA extensions.

Which COBRA services are provided by bSwift COBRA?

- Initial COBRA notices
- COBRA Election Notices
- Open Enrollment notices to COBRA Participants
- Billing and Processing of COBRA Participant premium payments

What are the Employer's Responsibilities?

- When utilizing services from bSwift COBRA, the employer is responsible for submitting an Enrollment and Change form.Once the form is complete and returned to Banyan, no further actions must be taken by the employer.

Who administers the Cal-COBRA services?

- The Group Insurance Trust automatically provides complimentary Cal-COBRA administration services to firms with less than 20 Full-Time Equivalent employees. Our contracted COBRA/Cal-COBRA administration vendor is bSwift COBRA.

How does a beneficiary elect Cal-COBRA coverage?

- When a Cal-COBRA group submits an Enrollment and Change form in a timely manner, the rest of the Cal-COBRA election process is handled by bSwift COBRA and the beneficiary. No other actions need to be taken by the employer.
- bSwift COBRA will mail an Election Notice to the beneficiary's residential address 1 to 2 weeks after the termination request is processed.
- To enroll, the beneficiary must submit their Election Form and first payment to bSwift COBRA within 60 days of the date of the Election Notice.
- The beneficiary is responsible for making timely payments directly to bSwift COBRA each month. They will receive all of their payment tickets at one time and may not receive a monthly invoice.
- If payment is not submitted within the required time period (grace period), coverage will be terminated *permanently*, with ***no*** possibility of reinstatement.

Medical Participants Ages 65 and Over

Can employees keep their coverage when they turn 65?

- Yes, if the employee is still actively working the minimum number of hours, they can continue their coverage through CalCPA Health.
- The CalCPA Health medical plans are not Medicare supplement plans.

How does Medicare enrollment status affect medical premiums?

- Medicare enrollment status does not affect medical premiums. The Affordable Care Act (ACA) mandates that rates be the same for ages 64 and up, regardless of Medicare enrollment status.

Who is the primary payer of medical claims? Medicare or CalCPA Health?

- Groups with 20 or more full-time employees:
  - *CalCPA Health* is the primary payer of medical claims.

- Groups with less than 20 full-time employees:
  - If the employee is enrolled in both Medicare parts A and B and has completed a small employer exception filing, *Medicare* is the primary payer.
  - If the employee is not enrolled in either part A or B or has failed to complete a small employer exception filing, *CalCPA Health* is the primary payer.

Why is a Medicare Secondary Payer survey (small employer exception filing) required?

- When a new employee is 65 or older or an existing employee is approaching age 65, a Medicare Secondary Payer survey must be completed by the group in order for Anthem to coordinate claim payments with Medicare.
  - Medicare Secondary Payer Statement of Employer Form

Coverage for dependents when an employee goes on Medicare:

- Spousal Medicare Eligibility Extension (SMEE): When a CalCPA Health employee leaves the plan and goes on Medicare, his/her younger spouse may remain in CalCPA Health at their own age band premium rate until the spouse reaches Medicare age or until the employee retires.
  Note: The Special Medicare Eligibility Extension (SMEE) is not available for HMO plans.

Coverage for dependents when an employee goes on Medicare (cont.) :

- If a spouse continues with CalCPA Health under SMEE, dependent children (under 26) may also continue on the CalCPA Health plan at the employer's premium rate while the spouse has coverage.
    - In a case where there is no spouse, or the spouse is, also, on Medicare, but there are dependents, the dependents are not eligible to continue on the Employer's CalCPA Health policy. Dependents may elect COBRA/CalCOBRA.
    - Dependent children must be enrolled before the employee transitions to Medicare. Dependent children *cannot* enroll after the employee goes on Medicare.

Open Enrollment

Open Enrollment runs from November 1st through mid-December, and changes are effective January 1st.

- The following changes are only permitted during Open Enrollment for groups that enrolled prior to 2014 or have a January 1st effective date. Groups that enrolled in 2014 or later will have changes effective on their anniversary date, with the Open Enrollment period during the two preceding months:
  - Which medical provider network is used, Statewide or SELECT (can offer a combination of both)
  - Adding or removing benefit offerings
  - Changes to the waiting period or minimum hourly requirement
  - Adding or removing employees and dependents that do not have a qualifying event
  - Changing individual employees' plan selections

Annual Open Enrollment Packets are mailed to Firm Administrators and brokers near the end of October.

** These packets contain important information regarding CalCPA Health insurance programs. **
It is imperative that all of the included material is read carefully as soon as possible.

- Open Enrollment Packets are mailed in a large folder and include:
  - A cover letter explaining the contents of the packet, important changes going into effect, an explanation of which forms must be used to request changes, and the deadlines for materials to be returned.
  - A comparison of current rates to the renewal rates.
  - Renewal rates for each employee for all the plans offered through CalCPA Health.
  - New plan benefit information.
  - Forms used to submit changes.
  - Other helpful resources and information.

Frequently Asked Questions

Q: Why isn't our latest payment/enrollment change reflected on our bill?

A: Bills are generated as early as the 2nd of the previous month. Ex: If your payment or enrollment change request is not processed before July 2nd, it will be reflected on the September bill.

Q: How do I change an employee's name or contact information?

A: Employee changes should be submitted on the Enrollment and Change form, or a simply email to Banyan Administrators will suffice. We cannot process these changes over the phone.

Q: How do I change the company's contact information?

A: If you need to change your billing address, contact phone number, or group contact name, please send an email to Banyan Administrators.

Q: What happens if my firm splits or merges, and we change our Federal Tax ID Number?

A: If a group's Tax ID changes, they are considered a new group and must re-apply for coverage.

Q: Can we print ID cards and Explanation of Benefits (EOBs) online?

A: The employee can register for an online account at the carrier websites listed on the contact sheet. They can print ID cards and view claim information online. Firm administrators and employers do not have access to employee information.

Q: Whom should I call if an employee has a question or problem regarding a medical claim?

A: The customer service unit at Anthem Blue Cross should be able to address the member's claims issues and/or questions. They can be reached at 888-209-7847 (PPO & HSA Plans) or 800-227-3641 (HMO Plans). If the employee still needs assistance with a claims issue after contacting Anthem Blue Cross, please contact Banyan Administrators at 877-480-7923. If you have received an Explanation of Benefits (EOB) from Anthem Blue Cross, please have that information available when you call.

Q: Why is the pharmacy telling a covered employee that they don't have coverage?

A: The employee may be using their Anthem ID card which is only for medical coverage. If they do not have their Express Scripts ID card for prescription coverage, they should call Express Scripts at 877-659-5144. If they are using the correct ID card, please call Banyan. If Banyan cannot find issue with the enrollment, they may refer the caller back to their pharmacy, so the pharmacy can call the Pharmacy Help Desk line at 800-922-1557.

Note: Employees enrolled in an HMO plan will use their Anthem ID card for both medical and prescriptions.

Q: How do I check to see which doctors are in our network?

A: Anthem's provider search tool can be found at *www.anthem.com/ca*. From the menu in the upper left side of the screen, choose the "Find a Doctor" option under the "Care" section. Under "Search as a Guest," click "Search by Selecting a Plan or Network." Choose Medical, California, and then under **Medical (Employer-Sponsored)**, choose the appropriate network for your plan.