CalCPA Health
FIRM ADMINISTRATION GUIDE

CalCPA Health Benefits Management Instructions for Firm Administrators

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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 – Manager 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), Banyan Administrators (Banyan), Anthem Blue Cross (Anthem), Express Scripts (ESI), Delta Dental (Delta), Vision Service Plan (VSP) and Lincoln Financial (Lincoln).

The Trust, Banyan, Anthem, ESI, Delta, VSP and Lincoln reserves the right to amend this administrative guide and request any and all documentation necessary to verify employment 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 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 (MPDD). 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. This includes Financial Advisors, Securities Brokers, Credit Unions, small Regional Banks, etc.

To be eligible and retain such eligibility, all participating firms must adhere to the following:

- More than 50% of all firm's owners (principals, proprietors, partners, shareholders, or other owners) must be CPA Members or Associate Members of CalCPA with active memberships in good standing. Proof of compliance may be requested from time to time.
    - The cost of membership can be found on the CalCPA site at https://www.calcpa.org/join/member-type-dues.
- Must be headquartered in the state of California.
- More than 50% of the group's enrolled employees must reside in California.

Firms with only One Eligible Employee

If you are the only Eligible Employee (as defined on the next page), you are eligible to enroll in CalCPA Health's medical, dental and vision plans as a Sole Practitioner (Solo). Dental and vision plans 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.
- Solos must enroll during the Open Enrollment Period, or when there is a qualifying life event that creates a Special Enrollment Period. Solo medical coverage cannot be obtained mid-year without a qualifying event.

Employer Contribution Requirements

An employer must contribute a minimum of 50% of the employee's medical premiums and 100% of employee's dental, vision, life or long-term disability (LTD) premiums. This does not include the cost for dependents.

- If an employer pays 100% of premiums, 100% employee participation is required.
- Payroll deduction is required for employee contributions that are withheld to pay premium costs.

Enrolling an Employee

Who is an Eligible Employee?

Eligible Employees must be employed on a permanent basis with wages subject to withholdings 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.
- Employees must work a minimum of either 20 or 30 hours per week to be considered full-time, as determined by the Employer. Please refer to the 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 week to be eligible for Life or LTD.*

Employee Participation Requirements

- Medical plans: If the employer pays 100% of the employee medical premium, all eligible employees must enroll. If the employee pays part of the premium, a minimum of 75% of eligible employees must enroll.
- Dental, vision, life and LTD plans: All eligible employees must enroll.
    - All active, regular employees working at least 30 hours per week must enroll in Life and LTD.

What forms need to be completed?

Each eligible employee must complete their own form. Any changes to information must be initialed and dated by the employee. No alterations to preprinted material on the employee application is accepted and altered forms will be rejected.

Employers should provide the appropriate form(s) to eligible employees based on their firm's offerings.

- **Enrollment and Change Form** is needed for firms with medical, dental, vision, life and/or LTD. All eligible employees will need to submit an Enrollment and Change form; including those who are waiving coverage.
- **HSA Member Enrollment Form** is needed for firms using Health Equity as their HSA administrator. Employees who would like to use Health Equity as their HSA administrator will need to submit an HSA Member Enrollment Form to establish their HSA savings account.
- **HSA Employer Admin Form** is needed for firms designating Health Equity (through CalCPA Health) as their company's HSA administrator.

Enrolling a New Employee *(continued)*

When do forms need to be submitted to Banyan Administrators?

Enrollment forms should be submitted to Banyan Administrators via secure email or through the CalCPA Secure Portal at www.calcpahealth.com/customer-support/.

- Enrollment forms must be submitted within 31 days of the Coverage Effective Date. *Note: Employees cannot enroll until the next Open Enrollment period or until they have a qualifying event if forms are not submitted within 31 days.*
    - Coverage Effective Date is determined by:
        - Date of Hire: The date a permanent employee begins working full-time. *Example: Employees hired on July 1st would have a Coverage Effective Date of July 1st while employees hired on July 2nd would have a Coverage Effective Date of August 1st.*
        - Waiting Period (as determined by the Employer on the Subscription Agreement):
            - 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.

What if an Eligible Employee does not want to enroll?

Eligible employees and/or dependents may submit a valid waiver if they are enrolled in another *group* health plan.

- Employees and/or dependents with a valid waiver would need to submit a valid waiver by completing Section 1, 2, 3, 4 and 5 on the Enrolment and Change Form.
    - All eligible employees and/or dependents must submit a valid waiver at the time of enrollment.
    - Employees with valid waivers are not counted as Eligible Employees.
    - Valid waivers include eligible employees and/or dependents enrolled in:
        - The group's Kaiser plan
        - Medicare
        - Medi-cal / Medicaid
        - TriCare
- Invalid waivers will affect your compliance with the Employee Participation requirements. *Ex: Declining coverage with no other insurance, Covered California, Individual "off-exchange".*

Adding or Removing Dependents

Who is an Eligible Dependent?

- Spouse: the employee's spouse under a legally valid marriage.
- Domestic Partner: the employee's Opposite Sex and Same Sex domestic partner under a legally registered and valid domestic partnership.
- Child: the employee's spouse/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 an eligible employee who, with appropriate medical certification, are eligible for coverage up to any age. *Note: The disabled child must be enrolled at the time the certification and request are submitted to be considered for continued enrollment.*

What forms need to be completed?

Enrollment and Change Form must be submitted to Banyan.

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

Enrollment forms should be submitted to Banyan Administrators via secure email or through the CalCPA Secure Portal at www.calcpahealth.com/customer-support/ within 31 days of the Qualifying Event.

- Qualifying Events are significant life changes, such as losing coverage, moving, marriage, divorce, legal separation, having a baby or adoption triggering a Special Enrollment Period.

When is the Coverage Effective Date?

The Coverage Effective Date will be the first of the month following the qualifying event. *Exception: The Coverage Effective Date for the birth or adoption of a child will be the date of birth or adoption. If the date of birth is on or before the 15th, the newborn will be added to the current month's invoice. If it is after the 15th, the newborn will be added to the next coverage month.*

How will the change be reflected on the premium invoice?

The coverage tier is listed above the premium amount.

- E: Employee
- ES: Employee and Spouse
- EC: Employee and Child
- ECN: Employee and Children
- F: Family

Note: Invoices are generated a month before the due date. Changes submitted after the invoice is generated will be reflected in the following month's invoice. For example, a change submitted on July 2nd will be reflected in the September invoice.

Termination of Benefits

What forms need to be completed?

Enrollment and Change Form must be submitted to Banyan Administrators.

When do the forms need to be submitted?

All forms must be submitted within 31 days of the qualifying event.

When is the coverage termination date?

Coverage will remain in effect 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 through June 30th.*

- If the termination of benefits is due to a death, the termination date is the actual date of death. *Ex: A member who passes away on June 3rd will have coverage through June 3rd.*

How will the termination be reflected on the invoice?

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

- If the termination of benefits is due to a death, the member will be removed from the following month's invoice with no pro-rated credit. *Ex: A deceased member's benefits are terminated on June 3rd and removed from the invoice for July. Premium credit for 6/4 – 6/30 will not be issued.*

Voluntary Termination of Group Policy

Cancellation of Group Policy

Groups wanting to cancel their policy for their entire firm must submit their request to Banyan in writing at least 30 days in advance of the requested termination date via the CalCPA Secure Portal, secure email or fax and should include the following.

- Company letter head
- Company name and client code
- Requested termination date
- Lines of coverage to be terminated (medical/rx, dental, vision, life and/or long-term disability

Retro Termination Requests

Retro terminations are solely at the discretion of the Trust.

- All requests must be submitted to Banyan in writing via the CalCPA Secure Portal, secure email or fax and should include the following:
  - Company letter head
  - Company name and client code
  - Requested termination date
  - Lines of coverage to be terminated (medical/rx, dental, vision, life and/or long-term disability
  - Detailed explanation of why 30 days advance notice was not sent
- Group retro-terminations will not be approved if there are any claims paid for the requested termination month.
- Group retro-terminations exceeding 60 days will not be approved.

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

If coverage is terminated after it has been paid for, a refund check will be issued to the group within 7-10 business days.

Rating/Billing Policies and Premium Payments

Rating Policies

- Premium level will be based upon the number of permanent full-time employees.
- Premium rates are calculated by Rating Regions. Rating Regions are based on the employee's home zip code.
    - Rating Regions for approved out-of-state employees are based on the employer's zip code.
- Groups will have their annual renewal on the anniversary of their effective date. *Note: Groups with a mid-year renewal will experience applicable rate changes on the anniversary of their effective date. Applicable benefit changes will apply on January 1st regardless of the group's renewal date.*

Rate Changes

- Premium level will be adjusted annually automatically upon renewal or 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 is due January 1st.*
- Invoices are generated during the first week of the previous month, after the previous month's due date. *Ex: February invoices are generated as early as January 2nd. If your January payment posted after the due date, it would be reflected in the March invoice.*
- Invoices are mailed approximately three weeks prior to the due date.
- Grace Period: Premium payments must post to your account 30 days of the due date. If payment is not received and processed before the end of the grace period, coverage will terminate.
- 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 the month but we (along with 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 *(continued)*

Online Electronic Billing Services

Access to online electronic billing is available to participating firms and their assigned brokers. Online billing allows you to view your group's invoices, make payments and payment history for your CalCPA Health coverage. To obtain access, you must complete the BSwift registration form.

- BSwift Full Access: available to groups with 20 or more employees.
- BSwift View Access: available to groups with under 20 employees.

Payment Methods

CalCPA Health accepts several methods of payment.

- Online: Go to www.calcpahealth.com/employers-plan-administrators/billing/pay-online/.
  - You will initially log in using your Client Code and Billing Zip Code.
  - Register your 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, cancel your recurring payment and schedule one with the new amount.*
- Automatic Clearing House (ACH): You will receive a monthly notice of the amount that will be deducted from your checking account. Premium payments will be deducted on the due date each month. To set up ACH payment, please complete an 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 104144, Pasadena, CA 91189-4144

Non-Sufficient Funds (NSF)

NSF is defined as a check, online payment or ACH transaction not negotiated by your bank for any reason.

- Groups will be charged $12 for any payments returned for NSF and have 15 days to provide a replacement payment.
- If three payments are returned for NSF, the group will be required to submit all future payments by certified funds.

Rating/Billing Policies and Premium Payments *(continued)*

Non-Payment Terminations

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. *Ex: If payment for January is received on February 1st (31 days after the due date), coverage is terminated back to December 31st.*

- If payment is received after the end of the grace period, coverage is *NOT* automatically reinstated. Any request for reinstatement must be submitted to Banyan in writing.
- If claims are paid for services incurred during a month for which premium was not paid, you will be required to reimburse the Trust for the claims paid.

Reinstatements

Any requests for reinstatement must be submitted in writing to Banyan. Reinstatement approval is solely at the discretion of the Trust.

- Reinstatement 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 Notice of Termination.
  - The current month's premium and any past due premiums are paid within 15 days of the Notice of Termination.
  - The group agrees to set up ACH for all future payments.
  - The group has no more than 2 reinstatements within 18 months. If a group is terminated for non-payment 3 times in 18 months, they will need to re-apply for coverage as a new group with a future effective date.

COBRA - Continuation of Coverage

Who is subject to COBRA?

Depending on how many Full-Time Equivalent Employees your firm has, continuation of coverage must be offered as follows.

- Federal COBRA: Employers with 20 or more Full-Time Equivalent employees
- Cal-COBRA: Employers with 2 to 19 Full-Time Equivalent employees

Calculating Full-Time Equivalent 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).

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

What are the Employer's COBRA 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. *Note: this includes the complimentary COBRA administration services offered through the Trust.*

Who administers the COBRA services?

- Federal COBRA: Employers choose who will be their COBRA administrator.
  - Clarity COBRA: CalCPA Health offers complimentary COBRA Administration through Clarity COBRA. Employers may elect to utilize services for COBRA only or COBRA and Cal-COBRA extension. To sign up, submit a COBRA Administration Authorization Agreement to Banyan. To follow is a list of COBRA services provided by Clarity COBRA:
    - Initial COBRA Notices
    - COBRA Election Notices
    - Open Enrollment Notices to participants
    - Renewal Notices to participants
    - Billing and Processing of COBRA participant premium payments

    Note: Employers are responsible for submitting an Enrollment and Change Form to initiate the COBRA process. Once the form is completed and returned to Banyan, no further action is needed by the employer.
  - COBRA vendor: Employer hires a COBRA service vendor at their own cost.
  - Self-Administer: Employer administers their own COBRA.

COBRA - Continuation of Coverage *(continued)*

- Cal-COBRA: The Trust automatically provides complimentary Cal-COBRA administration services through Clarity COBRA to firms with less than 20 Full-Time Equivalent Employees. *Note: Employers are responsible for submitting an Enrollment and Change Form to initiate the COBRA process. Once the form is completed and returned to Banyan, no further action is needed by the employer.*

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

1. The employer sends Notice of Termination to Banyan 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.
4. The employer sends Banyan an Enrollment and Change form within 10 days after receiving the Election Notice from the employee.
5. Banyan 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. *Note: Not applicable for groups with Clarity COBRA as their Federal COBRA administrator. Clarity COBRA bills the participant directly.*

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

1. The employer submits an Enrollment and Change form in a timely manner to Banyan.
2. Clarity COBRA sends COBRA Election Notice to the participant.
3. The participant must submit their Election Form and first payment to Clarity COBRA within 60 days of the date of the Election Notice in order to complete their enrollment.
4. The participant is responsible for making timely payments directly to Clarity COBRA each month as noted in the payment coupons. Monthly invoices and payment reminders are not issued.
5. If monthly payment is not submitted within the required time period (grace period), coverage will be terminated permanently with **no** possibility of reinstatement.

How should changes be reported to Banyan Administrators?

The employer must notify Banyan of any terminations, enrollment 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 of any Open Enrollment changes by December 31st.

Medical Participants Ages 65 and Over

Can employees keep their coverage when they turn 65?

Yes, as long as the employee is actively working the minimum number of hours, they can continue their coverage through CalCPA Health. *Note: CalCPA Health medical plans are not Medicare supplement plans.*

How does Medicare enrollment status affect medical premiums?

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

Does CalCPA Health coordinate benefits with Medicare?

Yes, depending on the size of the firm, CalCPA Health will coordinate benefits as follows.

- Groups with 20 or more full-time employees: CalCPA Health is the primary payor of medical claims.
- Groups with less than 20 full-time employees:
    - If the employee is enrolled in both Medicare part A and B, Medicare is the primary payor. *Note: Employers are required to complete the Medicare Secondary Payor (MSP) survey coordinated by Banyan.*

What is a Medicare Secondary Payor (MSP) survey?

The Center for Medicare and Medicaid Services (CMS) applies the Medicare Secondary Payor (MSP) rule to employers with less than 20 full-time employees. With the MSP survey, Banyan will file a Medicare Small Employer Exception (MSEE) with CMS for each qualifying employee. Employers are required to complete the MSP survey timely in order for CalCPA Health to coordinate benefits with Medicare accurately.

What happens to dependent coverage when an enrolled employee goes on Medicare?

An enrolled dependent spouse (not of Medicare age) of an employee who is waiving their medical coverage with CalCPA Health and enrolling in Medicare is eligible for a Spousal Medicare Eligibility Extension (SMEE). SMEE is only applicable until the Medicare employee retirees or the spouse turns age 65.

- The dependent spouse would remain on the current plan at their own age band premium rate until the dependent spouse reaches Medicare age or until the employee retires.
- SMEE is not available for HMO plans. If the employee's current plan is an HMO, the dependent spouse must choose a non-HMO to enroll in.
- Dependent children (under the age of 26) enrolled on the plan are eligible to enroll under the dependent spouse's SMEE policy.
    - SMEE is not extended to dependent children if there is no dependent spouse, or if the spouse is, also, on Medicare. Dependent children may elect to enroll in COBRA.

Open Enrollment / Renewals

When does Open Enrollment occur?

Open Enrollment will begin two months before the renewal date and ends two Fridays prior to the renewal date. *Ex: A group that enrolls on 6/1/2026 will have an Open Enrollment period from 04/01/2026 through 05/22/26 for change effective 06/01/2026.*

What happens during Open Enrollment?

The group's annual renewal packet will be issued to the Firm Administrator and broker. The renewal packet will contain the group's renewal information (including rates and benefit changes) and Open Enrollment. Open Enrollment is the only time that annual changes can be made to the group's plan offerings and employee's election changes without a qualifying event.

What changes can be made during Open Enrollment?

The following changes are permitted during Open Enrollment:

- Which medical provider networks will be used for the group. *Ex: HMO, Select HMO, PPO or Select PPO.*
- Adding or removing the group's benefit offerings such as medical/rx, dental, vision, life and/or LTD.
- Changing the group's waiting period.
- Changing the group's minimum hourly requirement.
- Adding or removing employees and dependents without a qualifying event.
- Changing an employee's plan selections.

What is included in the renewal packet?

Renewal packets contain important information regarding your group's plan offerings and Open Enrollment. It is *imperative* that you carefully review all the material provided and submit your renewal before the deadline. Be aware that failure to submit a renewal confirmation may result in previously elected plans to be removed from your firm's plan offerings for the upcoming year. Firms that do not send in a renewal confirmation will auto-renew upon payment of the new plan's invoice. Plans that auto-renew will renew with only the plans with active enrollment at the time the renewal is issued. Please contact Banyan if you have any questions regarding the information included in your packet or if you would like to schedule a meeting to review the material together. Groups can expect to receive the following in their packets:

- Cover letter explaining the contents of the packet, important changes going into effect, an explanation of the required forms to submit changes and deadlines for materials to be returned.
- A comparison of current rates to the renewal rates.
- Renewal rates for each enrolled employee for all plans offered through CalCPA Health.
- New plan offerings.
- Plan and benefit changes.
- Forms used to make changes to the group's plan offerings.
- Forms used to make employee election changes.

- Other helpful resources and information including an Open Enrollment FAQ.

Frequently Asked Questions

Q: Why isn't our last payment/enrollment change reflected on our current invoice?
A: Invoices 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 not be reflected on your invoice until your September invoice is generated on August 2nd.*

Q: How do I change an employee's name or contact information?
A: Employee changes should be submitted on an Enrollment and Change form to Banyan via the CalCPA Secure Portal, secure email or fax.

Q: How do I change the company's contact information?
A: The Firm Administrator (or authorized representative) should contact Banyan with to change the billing address, contact phone number of group contact name via the CalCPA Secure Portal, secure email or fax.

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 by submitting a new Subscription Agreement.

Q: Can we print ID cards and Explanation of Benefits (EOB) online?
A: The employee can register for an online account where they would have access to print digital ID cards and obtain their EOB. Employers do not have access to employee information.

- Medical plans through Anthem: www.anthem.com/ca
  - Coupe Health: www.coupehealth.com
- Rx plans:
  - Express Scripts (non-HMO): www.express-scripts.com
  - Carelon Rx (HMO): www.carelonrx.com
- Dental plans through Delta Dental: www.deltadental.com
- Vision plans through Vision Service Plan (VSP): www.vsp.com
- Life/LTD plans through Lincoln: www.lincolnfinancial.com

Q: How many ID cards should a member expect to receive?
A: Depending on what coverage a member has enrolled in, they should expect ID cards as follows:

- Medical plans: Anthem will issue a physical card to each member with digital cards available through the member portal.
- Rx plans:
  - Express Scripts (non-HMO): ESI will issue a physical card to each member with digital cards available through the member portal.
  - CarelonRx (HMO): Physical cards (and digital cards) are combined with their Anthem HMO cards.
- Dental plans through Delta Dental: Digital cards are available through the member portal.
- Vision plans through Vision Service Plan (VSP): ID Cards are not issued.

Frequently Asked Questions *(continued)*

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

A: Members should log on to their member portal to find a provider in their network.

- Medical plans through Anthem: www.anthem.com/ca/find-care/
  - Coupe Health: https://member.coupehealth.com/public-search
- Rx plans:
  - Express Scripts (non-HMO): www.express-scripts.com
  - CarelonRx (HMO): www.carelonrx.com/pharmacy-networks
- Dental plans through Delta Dental: www.deltadental.com/member/find-a-dentist/
- Vision plans through Vision Service Plan (VSP): www.vsp.com/eye-doctor

Q: Whom should I call if an employee has a question or issue with a claim?

A: Banyan Administrators is available to assist CalCPA Health members who need help navigating their benefits and can act as their Benefits Concierge. Additionally, CalCPA Health has a dedicated customer service team with each of our vendor partners. Our dedicated customer service numbers are listed on the members' ID cards.

- Banyan Administrators: (877) 480-7923
- Medical plans through Anthem: (888) 209-7847
  - Coupe Health: (855) 350-0214
- Rx plans:
  - Express Scripts (non-HMO): (877) 659-5144
  - Carelon Rx (HMO): (833) 261-2465
- Dental plans through Delta Dental: (800) 765-6003
- Vision plans through Vision Service Plan (VSP): (800) 877-7195
- Health Equity: (877) 582-4453
- Life/LTD plans through Lincoln: (800) 423-2765