2024 Benefits Open Enrollment – Frequently Asked Questions

Q. When is Open Enrollment?

A. October 1 through October 30, 2023, you may choose benefits plans that will begin on January 1, 2024.

Q. Am I required to re-enroll?

A. Yes, please log into Employee Space from the Forum to elect, change or confirm your benefit choices each year. This year, there are additional plans and changes to existing plans and costs, so it's more important than ever to review the benefit comparisons and use the Medical Benefits Cost Comparison tool to choose the plan that best meets your needs. Please note: for Health Care and Dependent Care Flexible Spending Accounts, if you do not enroll, you will not have FSA coverage for 2024.

Q. How do I enroll?

A. Benefits Open Enrollment must be done online through the Employee Space portal. From the Forum homepage, click on "Employee Space" or the "Open Enrollment" link, under "HR Quick Links."

Q. How can I enroll or change my Community Extras benefit coverage?

A. If you want to enroll in supplemental benefits with MetLife for critical illness, accident hospital indemnity or with LegalEASE for legal services, you may directly enroll at www.CommunityBenefitExtras.com. If you want to decline supplemental benefits that you are currently enrolled in, you must make this change through www.CommunityBenefitExtras.com or by calling 1-888-935-9595.

Q. What's the best way to calculate what my benefit premiums might cost next year?

A. Use the 'Medical Benefit Cost Comparison Tool' located on the Forum's Open Enrollment page found at the HR department page and in Employee Space. It shows you the premium difference for each plan and compares it to the impact on your paycheck with your upcoming 2024 adjustment.

Q. If I am on a Leave of Absence, do I need to re-enroll?

A. Yes, employees on a Leave of Absence need to re-enroll in health benefits during Open Enrollment. Re-enroll through Employee Space or by phone with Community's Benefits Department at (559) 459-1919 or by email at HRBenefits@communitymedical.org.

Q. Do I have to select a primary care provider (PCP) during Open Enrollment?

A. This is required only if choosing the Community Care Health Signature HMO Plan. Choose a primary care provider for yourself and applicable dependents online through Employee Space. **If you do not choose, a primary care provider will be auto-assigned to you effective January 1, 2024.** Please review the providers available at www.CommunityCareHealth.org.

The Value EPO (Exclusive Provider Organization), which replaces the Value HMO, does not require you to select a primary care provider to use benefits. With the EPO plan, you may self-refer within our Community Care Health network. Details about this plan are in the 'Medical Plan Questions' below. We encourage you to choose a primary care provider to have a partner with you in managing your health.

Q. I have a spouse and/or child who works at Community, can we dual cover on our medical, dental, vision and/or life insurance?

A. Dual coverage is not allowed on any Community Benefit plans (health, dental, vision, or life insurance.) Please note: If you choose to have PPO dual coverage through a spouse or parent who has a plan outside of Community's benefit plans, be aware that the two different insurance plans together will not mean you have 100% coverage. The two plans coordinate automatically and the secondary plan will only pay the difference up to what they would have paid. For example, if the Community plan is primary and covers at 80% and the secondary plan also covers at 80%, the secondary plan would not pay the 20% difference.

Q. Where can I find the Summary of Benefits Coverage (SBC) for our available medical plans?

A. You can find the Summary of Benefits Coverage on the Open Enrollment page of The Forum's HR department page.

Major Life Event FAQ

Q. If I opt out by 'Waiving Coverage," when can I next enroll into Community's Medical Plans?

A. You may enroll during the next Open Enrollment period in October of 2024, unless you have a major life event occur. Major life events include: a marriage, death, birth, or spouse's, or registered domestic partner's change in employment. You must notify Human Resources within 30 days of when the major life event/change occurs.

Dependent FAQ

Q. How long can my dependent stay on my benefits?

A. Dependents can be covered up until the age of 26. Coverage will automatically terminate at the end of the month following the day they turn 26.

Q. Can I enroll a dependent into only one plan or does the dependent have to be enrolled in all plans?

A. Yes, you can enroll a dependent into only one plan or into all plans. Medical, dental/vision, and life insurance and voluntary benefits from Community Extras are all separate elections. Please note: You may not dual cover dependents if they are enrolled themselves as an employee or through another parent on a Community medical, dental, or life insurance plan.

Q. What if I work out of the area and/or out of state or have a dependent out of state, does this limit the plan I can enroll in?

A. You have the option to enroll in either a PPO or HMO plan, as both plans offer out-of-area (Fresno, Madera, Kings counties) coverage within California. However, if you are a remote worker living out of state, then the PPO or Community's High Deductible Health Plan (HDHP) plan is the best medical plan to choose to ensure in-network coverage. All medical plans are available to those living in California, even if you have dependents living out of state (i.e. attending college.)

Flexible Spending Account FAQ

Q. Do I have to enroll in a Flexible Spending Account (FSA) each year through Open Enrollment?

A. If you want to have available funds for the upcoming calendar year, you must re-enroll annually to select a Flexible Spending Account for healthcare and for dependent care expenses.

Q. Am I required to be enrolled in a Community medical plan or have a dependent enrolled to elect or use FSA expenses for my dependent?

A. No, you and/or your dependent(s) don't have to be enrolled in a Community medical plan to participate in the FSA. If you are enrolled in a Community Medical plan, dependents don't have to be enrolled in this plan for you to use this money on their qualified medical expenses. However, the dependents have to be claimed as a dependent on your taxes and meet specific qualifications according to IRS publication #502.

Q. How do I access my current balance information?

A. There will be a change from Navia to Benepass for all FSA accounts in 2024. To review your current FSA balance information, go online to www.NaviaBenefits.com, or contact Navia Benefits Solutions at 1-800-669-3539 or download their mobile app.

Q. How long do I have to use my current Flexible Spending Account funds?

A. Health FSAs have a grace period until March 15 of the following calendar year to exhaust any remaining funds from the prior year. Dependent Care FSAs do not have a grace period and reimbursements end on December 31 of each year.

Q. What happens to my FSA funds if I don't use them by the deadline?

A. This is a "use it or lose it" benefit. According to IRS rules, any remaining funds you do not use are forfeited. For ideas on how to use your remaining health care FSA funds, visit www.FSAstore.com.

Q. May I change this election throughout the year?

A. Generally, no. However, if you experience a Major Life Event (i.e., you are enrolled in a daycare FSA and your child is no longer in daycare), then you may submit a Major Life Event form to have this account suspended. However, the use-it-or-lose-it rule still applies and you would not be issued any refunds for any previous payroll deductions. All future deductions would cease.

Health Savings Account FAQ

Q. What is a Health Savings Account (HSA)?

A. A health savings account offers you an easy way to lower your taxes and save money to pay for healthcare expenses. The account is fully funded by you to pay for qualified medical, pharmacy, dental, and vision expenses as they occur. Unlike FSA's, HSA contributions roll over from year to year.

Q. Who is eligible to contribute to an HSA?

A. To be eligible to contribute to an HSA, you must:

- Be covered by Community's High Deductible Health Plan (HDHP)
- Not be covered by any other health insurance that is not an HDHP
- Not be enrolled in Medicare
- Not claimed (or eligible to be claimed) as a dependent on someone else's tax return

Q. What are the HSA contribution limits?

A. The HSA maximum contribution limits for 2024 are $4,150 for employee only coverage and $8,300 for family coverage. If you are 55 and older, you can contribute an additional $1,000 as a catch-up contribution. All contributions must stop once an individual is enrolled in any type of Medicare.

Q. Can I withdraw funds from my Health Savings Account?

A. Yes! Withdrawals are tax-free as long as they are taken for "eligible healthcare expenses" incurred after on or after the date the HSA was established. You can use your HSA funds to pay for or reimburse yourself for your own qualified medical expenses, or those of your spouse and any dependents you claim on your tax return (even if they are not covered by the HDHP.)

Q. What happens to the remaining balance in my HSA at year-end?

A. Unlike Flexible Spending Accounts (FSA), the funds in your HSA will automatically roll over for use next year or whenever you may need it.

Q. If I leave Community, what will happen to the dollars in my HSA account?

A. Your HSA account will go with you. You have the following options to choose from:

- Leave your funds in the current HSA account.
- Transfer your funds to an HSA with your new employer.
- Transfer your funds to another qualifying account within 60 days.

Q. Can I have both an FSA and an HSA since Community offers both?

A. It depends. An HSA makes you ineligible for a general healthcare Flexible Spending Account (FSA). However, Community will offer a "limited purpose" FSA, so you may still be eligible to participate in both an HSA and limited purpose FSA if you meet qualifications.

Limited Purpose Flexible Spending Account FAQ

Q. What is a Limited Purpose Flexible Spending Account (LP-FSA)?

A. A limited purpose FSA (LP-FSA) is an account that lets you use pre-tax dollars to pay for eligible expenses for you, your spouse, and your eligible dependents. It's much like a typical, general-purpose health FSA, however, you may *only* use LP-FSA funds to pay for qualifying dental and vision expenses, not medical.

Q. Who is eligible to contribute to a Limited Purpose FSA?

A. Any full- or part-time employee who is contributing to an HSA and also enrolled in a high deductible health plan (HDHP).

Q. What are the Limited Purpose FSA contribution limits?

A. The minimum contribution limit is $130 and the maximum is $3,050.

Q. What if I don't use all of the funds in my LP-FSA?

A. Like the general purpose health flexible spending account, there is a "use-it-or-lose-it" rule to this benefit. Any funds remaining in the account beyond the March 15 grace period will expire and forfeit back into the employers account.

Q. What happens to the funds in my account if I leave Community?

A. You must incur all expenses while you are an active employee. Upon termination, your account will be deactivated; however, you have 90 days to submit receipts for reimbursements for expenses incurred while actively employed within the plan year.

Life Insurance FAQ

Q. How much group life insurance does Community provide?

A. Community purchases group life insurance for all full-time and part-time employees at *no cost* to you. The amount of coverage depends on your employee classification. Non-exempt (hourly) employees receive the equivalent of their annual base pay with a minimum of $25,000; a maximum up to $150,000. Exempt (salary) employees receive double their annual salary up to a maximum of $1,500,000.

Q. Can I purchase additional life insurance for myself and/or for my dependents?

A. Yes. During Open Enrollment you can elect supplemental employee life insurance up to six times your annual base salary or $500,000, whichever is less. You can elect life insurance for your spouse up to the total of your coverage or $250,000, whichever is less. You can elect life insurance for your child up to $10,000. Any amounts elected will be subject to medical questions and underwriting for the employee and spouse. Child life insurance increases do not require a personal health assessment.

Q. Do I have to complete a Personal Health Application (PHA) during Open Enrollment?

A. If you are requesting a higher amount, you will have to complete the Personal Health Application (PHA) in November. If the PHA is not completed/and or received, your request for additional coverage will be declined and your previous coverage in effect will rollover for 2024. Details on how to complete the PHA will be emailed directly to your Community email in November.

Q. Where can I view and/or update my life insurance beneficiary?

A. When completing your open enrollment elections through Employee Space, you will see a life insurance beneficiary section. You can make updates and confirm your designation and elections at that time. Also, you can change life insurance beneficiaries any time throughout the year through Employee Space.

Benefit Card information

Q. Will I receive new benefit cards?

A. Yes, for some plans and benefits but not for others:

Medical & Prescriptions: All medical plan members will receive a new card in 2024.

Flexible Spending Accounts (FSA): All participants who enroll in a FSA/LP-FSA will receive a new benefit card. This benefit, beginning in January 2024, will be managed by Benepass. However, keep your Navia card for any remaining health expenses left over to use for the rest of 2023 and during the 2½-month grace period, up until March 15.

HSA Account: A separate card will be issued by Benepass for this account beginning in January 2024.

Dental: If you are newly enrolled or have changed plans, you will receive a new dental card. Otherwise, continue to use your current dental card.

Vision: Vision Service Plan (VSP) is a paperless company and does not issue cards. You may visit any "choice" provider in the network, they can look up your benefits electronically using your social security number.

Medical Plan FAQ

Q. Are there any changes to the medical plans that I should be aware of?

A. Yes. This year we have more choices and two new medical plan options to fit your budget and healthcare needs. They differ not only on monthly premiums, but on co-pays and the share of medical costs you pick up. Be sure to use the Medical Benefits Cost Comparison tool on the Forum to help you choose a plan that best suits your needs. And please take advantage of the Health Benefits Fairs to talk to HR experts and benefits vendors.

Q. What is the new Community Care Health Value EPO and how does it work?

A. The new Value EPO (Expanded Provider Organization) replaces our Value HMO plan and features an expanded, exclusive network of doctors and offers lower monthly premiums and a reduced deductible. This may be a great option if you are seeking to keep your premiums to a minimum and have more flexibility in the care you receive.

Q. Do I have to select a Primary Care Provider (PCP) if I choose to enroll in the Value EPO?

A. Community Care Health does not require the selection of a PCP and referrals are not required to see a specialist. **Please note, some specialist's offices may still require a referral based on their office policy.*

Q. Which doctors, hospitals and other providers can I use under the Value EPO plan?

A. You must use providers within the Community Care Health network. To begin your search for primary care physicians and specialists, please visit www.CommunityCareHealth.org.

Q. What happens if I seek care out-of-network or have an out-of-network emergency on the HMO or EPO Plan?

A. If you receive care outside of the Community Care Health network, your insurance will not pay for any services unless you live outside of the service area and have prior approval by the insurance plan. However, all emergency and urgent care services would be covered. Please contact Community Care Health for additional questions on coverage.

Q. What is the new *High Deductible Health Plan (HDHP)* and how does it work?

A. An HDHP has a higher deductible than a typical health plan. That simply means you pay out of pocket for your medical expenses until you reach a certain amount. Then, your plan begins to pay.

Q. What are the benefits of an HDHP?

A. When paired with a pre-tax Health Savings Account (HSA), you can reduce your tax liability while managing your healthcare expenses.

Q. What network of providers can I see while enrolled in the HDHP or Core PPO plan?

A. You have access to BlueShield's large network of doctors and specialist. You may search providers at www.BlueShieldCA.com/networkPPO.

Q. How do I search for physicians within the Community Health Partner (CHP) network?

A. Go directly to www.CommunityHealthPartners.org/our-providers to find a doctor.

Core PPO FAQ

Q. Are there changes to our Core PPO?

A. There are some slight changes to the deductible and out-of-pocket maximum, but we've also made some improvements. This year, we've moved our PPO provider network from Anthem to BlueShield to provide the secure care you need while traveling out of the area, or out of state. We also have changed third party administrators from HealthComp to Compass Health Administrators. Search Blue Shield's provider network at www.BlueShieldCA.com/networkPPO.

Q. What's the difference between in-network and out-of-network?

A. Each time you seek medical care; you can choose your provider. You have the choice between an in-network and out-of-network doctor. When you visit an in-network doctor, you get in-network coverage and will have lower out-of-pocket costs. That's because participating health care providers have agreed to charge lower fees, and plans typically cover a larger share of the charges. If you choose to visit a doctor outside of the plan's network, your out-of-pocket costs will typically be higher or your visit may not be covered.

Q. What providers are considered within the "Tier One, In-Plan" under our PPO Plan?

A. **Community Facilities** include the following: Clovis Community Medical Center, Community Regional Medical Center, Fresno Heart & Surgical Hospital, Community Behavioral Health Center, and Community Subacute & Transitional Care Center.

Community Designated Providers include physicians under the BlueShield network. Facilities, labs, and radiology services are considered Out-of-Plan and covered under a reduced benefit in Tier 2.

Community Affiliates include Advanced Medical Imaging, California Imaging Institute, Quest Diagnostics for Laboratory Services, and Valley Children's Hospital.

Community Care Health Signature HMO FAQ

Q. Does my doctor take our Community Care Health Signature HMO Plan insurance?

A. You may search for primary care providers by visiting the Community Care Health's website at www.CommunityCareHealth.org for assistance in selecting a primary care provider. We also recommend calling to check if your doctor is taking your insurance after January 1 and/or taking new patients.

Q. Do I need a referral to see a specialist?

A. There are five specialties that do not require a referral to in-network providers: Allergy, Dermatology, OB/Gyn, Mental Health and Chiropractic care. All other specialties require a referral for network providers. Your Community Care Health primary care physician is the coordinator of your care and acts as the facilitator between you and your specialists. You can search for a provider by visiting the Community Care HMO Provider Directory www.CommunityCareHealth.org.

Dental and Vision FAQ

Q. What are my options for Dental Insurance?

A. You have the option to pick between the Delta Dental PPO or the DentalCare HMO plan. Please check with your current provider to make sure they take the plan you are choosing and/or verify coverage by going to www.DeltaDentalins.com.

New this year are enhanced benefits for the Dental PPO. Now, preventative care is covered even after the plan's maximum cost limits are reached. Added "SmileWay Wellness" benefits cover preventative care for people with chronic conditions such as diabetes, lupus, cancer, HIV/AIDS, Parkinson's, Rheumatoid arthritis, ALS and others. An extra periodontal scaling, teeth cleaning and periodontal maintenance is covered at 100%.

Q. What are my options for Vision?

A. We offer High Vision and Low Vision plans. The High Plan offers more comprehensive vision care. The Low plan is a great basic plan for those who may require less optical coverage. VSP offers exclusive member extras for savings on glasses, contact lenses, Lasik, and hearing aids for hearing loss treatment through TruHearing.

Q. Can I elect different medical and dental plans? (i.e., PPO Medical & HMO Dental)

A. Yes. All benefits are separate, allowing you to create the benefit package that best suits your needs.