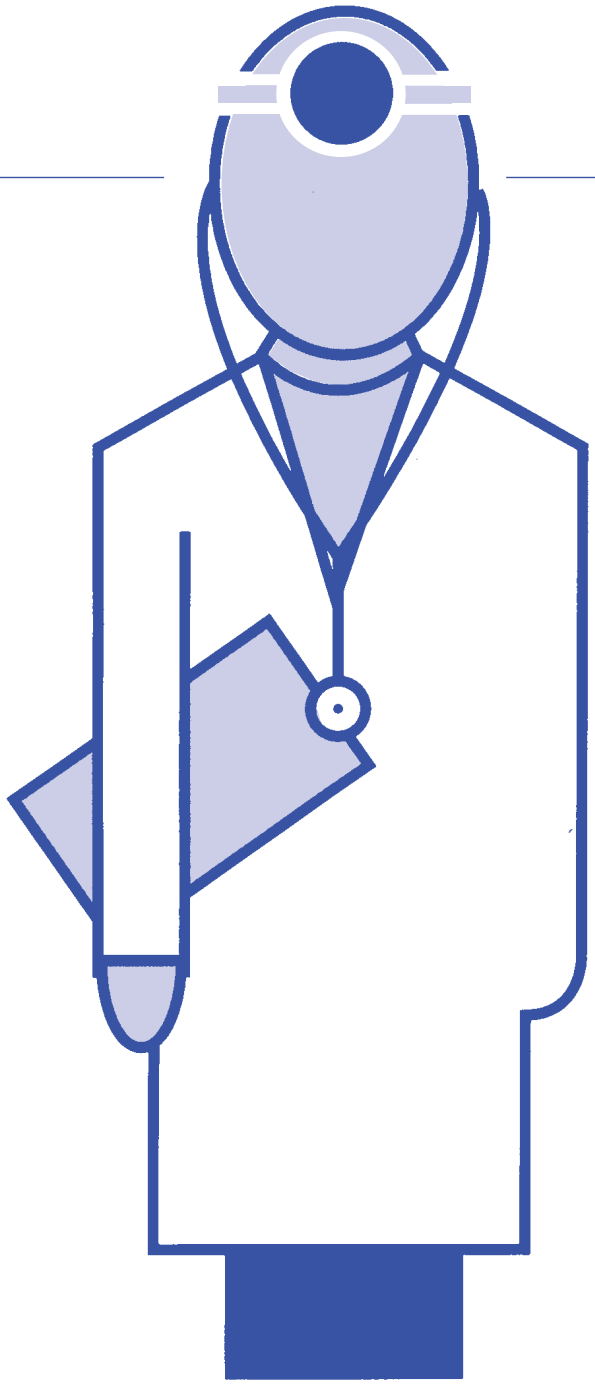
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

YOUR 2020 GUIDE TO CHOOSING A Health Plan



Once each year, you have an opportunity to review your health plan choice during the Fund's Open Enrollment period. If you choose a new plan, it will become effective for use on January 1st. New employees may make initial elections for Benefit Plans in accordance with their Employer's eligibility policy and current Collective Bargaining Agreements.

CHOICES CHOICES CHOICES CHOICES

HEALTHCARE CHOICE PLAN

AETNA

CIGNA

OXFORD FREEDOM ACCESS

OMNIA

TRADITIONAL PLAN
(CLOSED TO NEW EMPLOYEES)

CHOICES CHOICES CHOICES CHOICES

IMPORTANT POINTS TO REMEMBER

Carefully review all the information in this booklet.

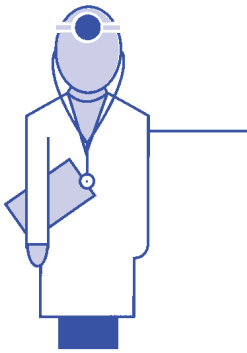
If you are changing plans or have chosen the HealthCare Choice Plan or one of the HMO's, you must select a Primary Care Physician for you and each of your eligible dependents.

Complete all required forms and return them to your Personnel Office no later than November 30, 2019. Remember, any changes you make will take effect on January 1, 2020.

If you are satisfied with your current health plan choice you do not need to complete any forms during this Open Enrollment.

Remember, your medical benefits are an important component of your overall compensation and benefits package. This is your annual opportunity to decide which plan is best for you and your family. Please review this information carefully.

HEALTH FUND INFORMATION FOR
2020 Open Enrollment



OPEN ENROLLMENT

Each year, you have an opportunity to review your health plan choices during the Fund's Open Enrollment period. This year's Open Enrollment period is November 1 through November 30, 2019. Any changes you make will take effect January 1, 2020. Open Enrollment dates may vary slightly depending on your employer's schedule. Please check with your Personnel Office to confirm the dates, and which plans are available.

You have several plans from which to choose. Each will have advantages as well as disadvantages. The more you learn about the plans, the easier it will be for you to decide what plan best fits your personal needs and budget.

CHOOSING YOUR HEALTH PLAN

What are my health plan choices?

Choosing the right health plan for you and your dependents may not seem as easy as it once was. Plans may differ in how much you have to pay and the ease at which you obtain certain services. Although no plan will pay for all the costs associated with your medical care, some plans will pay for a greater percentage of the cost than others.

Our Fund offers a variety of plans including: Traditional, HealthCare Choice and HMOs. This Open Enrollment guide includes highlights of each. For all the details of a particular plan, see the Summary Plan Document for that plan.

Not all plans are available to all employees in the Fund. Please check with your Personnel Office to confirm which options are available to you.

What is most important to me in a plan?

In choosing a plan, you have to decide what is most important to you. Ask yourself these questions:

- How comprehensive do I want coverage of health care services to be?
- How do I feel about limits on my choice of doctors or hospitals?
- How do I feel about a primary care doctor referring me to specialists for additional care?
- How convenient does my care need to be?
- How important is the cost of services?
- How do I feel about keeping receipts and filing claims?

You might also want to think about whether the services a plan offers meet your needs. Call the plan for details about coverage if you have questions. When making your choice consider the following:

- Lifestyle changes you may be thinking about, such as starting a family or retiring.
- Chronic health conditions or disabilities that you or family members have.
- Care for family members who travel a lot, attend college, or spend time at two homes.

SOURCES OF ADDITIONAL INFORMATION ABOUT HEALTH PLANS AND HEALTH ISSUES

America's Health Insurance Plans - Consumer Guide to Health Plans
http://www.ahip.org

NJ Department of Health and Social Services
http://www.nj.gov/health

NJ Department of Health and Senior Services - NJ HMO Consumer Rights & Complaint Procedures
http://www.state.nj.us/health/hmo/rights.htm

US Department of Health and Human Services - Gateway to general information on health issues
http://www.healthfinder.gov/

IMPORTANT ANNOUNCEMENTS F OR 2020

Summary of CHAPTER 78

Chapter 78 was signed into law on June 28, 2011 by Governor Christie. Among other requirements, Chapter 78 established a new contribution arrangement that requires public employees and certain retirees to contribute more towards the cost of their employer sponsored health insurance.

The amount of any required contribution and when the contributions will begin is based upon many factors including salary and bargaining unit representation. Please refer to "**The Medical Contribution Estimator"** on the MCJHIF Web Site in order to determine your estimated required contribution for 2020.

Further detail on Chapter 78 is found on the back page.

New Jersey Chapter 375 over-age Dependent Children up to 30 law and DU31 Coverage until Age 31

This regulation only applies to fully insured programs throughout New Jersey. Currently the Fund only maintains one program that is fully-insured falling within the Chapter 375 parameters; the Oxford Freedom program. Under these provisions certain qualified over age children may elect coverage under the fully insured plan offered by the Fund (Oxford Freedom) from the time their dependent coverage eligibility would normally end until their 31st birthday. The covered person/dependent is responsible for the full cost of this extended coverage and will be billed directly on a monthly basis.

It is important to note that any/all dependent children currently covered under the provisions of Chapter 375, P.L. 2005, will need to complete a new application to enroll as a dependent child under age 26 under Patient Protection and Affordable Care Act (PPACA).

Federal Health Coverage Law - Patient Protection and Affordable Care Act

Provisions of the federal Patient Protection and Affordable Care Act (PPACA) include the coverage of children until age 26.

Eligibility

- A "child" is defined as an enrollee's child until age 26, regardless of the child's marital, student, or financial dependency status — even if the young adult no longer lives with his or her parents.
- Medical and prescription drug coverage will be extended to eligible children through December 31 of the year they turn age 26.

Women's Health

Effective with prescriptions filled on or after January 1, 2013, the generic hormonal birth control pills and certain barrier contraceptive devices will be covered at 100%.

Verification

A photocopy of the dependent child's birth certificate that includes the covered parent's name must be submitted along with the application.

A photocopy of the dependent child's birth certificate showing the spouse/partner's name as a parent and a photocopy of marriage/partnership certificate showing the names of the employee and spouse/partner.

For a legal guardianship, grandchild, or foster child provide a photocopy of Affidavits of Dependency and a Final Court Order with the presiding judge's signature and seal attesting to the legal guardianship of the covered employee.

■ ■ ■ ■ ■ Further information will be available on the Fund's web-site at www.mcjhif.com

New Jersey Pension and Health Benefits Reform under Chapter 78, P.L. 2011

Sections 39 to 44: Required Active and Retired Employee Contributions towards Health Benefit Coverage

This law requires all public employees and certain public retirees to contribute toward the cost of health care benefits coverage based upon a percentage of the cost of coverage. All active public employees will pay a percentage of the cost of health care benefits coverage for themselves and any dependents. Lower compensated employees will pay a smaller percentage and more highly compensated employees will pay a higher percentage. In addition, the applicable percentage will vary based upon whether the employee has family, individual, or member with child or spouse coverage. These rates will be phased in over several years for employees employed on the contribution's effective date who will pay 1/4, 1/2, and 3/4 of the amount of the contribution rate during the first, second and third years, respectively. The law establishes a "floor" for employee contributions so that no employee will pay an amount that is less than 1.5% of the employee's compensation. The contribution commenced on January 1, 2012 for certain public employees and upon the expiration of a collective negotiation agreement for others.

Similar provisions in this law apply to retirees of units of local government. Retirees may be required to contribute a percentage of the cost of health care benefits coverage in retirement benefit. These provisions will not apply to public employees who, on the effective date of the law, have 20 or more years of service in one or more State or locally-administered retirement systems. A 1.5% "floor", for those retirees to whom the 1.5% contribution in current law applies, will also be applicable to these retirees.

Further information will be available on the Fund's web-site at www.mcjhif.com

Horizon Choice Out of Network Expenses

Below is a clarification of the Horizon Choice out of network benefit. This information is being provided as a convenience to all employees to assist in the evaluation of medical benefit options and does not represent any change in coverage.

Eligible out of network claims incurred outside the Horizon Choice network will be reimbursed at 80% after satisfaction of the $100 deductible. The maximum out of pocket cost per individual is $500 ($400 coinsurance plus $100 deductible) and $1,000 ($800 coinsurance and $200 deductible) per family.

Please be aware that out of network expenses eligible for reimbursement under Choice are limited to the overall allowable charge as determined by Horizon. It is possible that certain out of network expenses will not be allowed by Horizon. These expenses will not accumulate toward the maximum out of pocket cost as noted above. Providers may balance bill members for these expenses.

All members enrolled in Choice are encouraged to question their providers relative to balance billing prior to scheduling any procedure.

Assume for example that an Out of Network Surgeon's charge is $10,000 and the Horizon Choice allowance is $6,000. The deductible and coinsurance will be applied to the $6,000 allowance, not the $10,000 total charge. Of the $6,000, the employee will be responsible for $500 and Horizon will cover the $5,500 balance. The surgeon may balance bill the employee for $500 plus the difference between the $10,000 total charge and $6,000 allowance. Total out of pocket to the member will be $4,500 in this example.

THE CHOICE IS YOURS

- Review all the information in this Open Enrollment Guide.
- If you choose the HealthCare Choice Plan or one of the HMOs, you will have to pick a Personal/Primary Care Physician for you and each of your eligible dependents.
- Complete any required forms and return them to your Personnel Office by November 30, 2019 (please confirm this date with your Personnel Office, as it may vary with local needs). Any changes you make will take effect on January 1, 2020.
- County employees should login to the Employee Self Service website and go to the Open Enrollment Section.
- If you are satisfied with your current Health Plan, you do not need to complete any forms during this Open Enrollment.

	TRADITIONAL (Closed for new employees)	HORIZON POINT OF SERVICE (POS) IN-NETWORK	OUT-OF-NETWORK	HORIZON OMNIA Tier 1 (no coverage out-of-network)	Tier 2	AETNA HMO (no coverage out-of-network)	CIGNA HMO (no coverage out-of-network)	OXFORD FREEDOM ACCESS IN-NETWORK	OUT-OF-NETWORK
CUSTOMER SERVICE	Horizon Blue Cross Blue Shield of New Jersey 800-355-2583	Horizon Blue Cross Blue Shield of New Jersey 800-355-2583		Horizon Blue Cross Blue Shield of New Jersey 800-355-2583		1-800-370-4526	1-800-CIGNA24	888-201-4133	
WEBSITE	www.horizonblue.com	www.horizonblue.com		www.horizonblue.com		www.aetna.com	www.cigna.com	www.oxfordhealth.com	
HOSPITAL STAY BENEFITS HOSPITAL INPATIENT	100% for 365 days	100%	80% out of network allowance after deductible	100% after copay per admission	80% after deductible per admission	100%	100%	100%	60% after deductible
SKILLED NURSING FACILITY	100%	100% up to 100 days in-network facility per calendar year	80% out of network allowance after deductible max. up to 60 days per calendar year	100% after copay per admission	80% after deductible per admission	100%	100% up to 100 days per calendar year	100% up to 100 days per calendar year	Deductible and coinsurance up to 60 days per calendar year
HOSPITAL PREADMISSION TESTING	100%	100%	80% out of network allowance after deductible	100%	80% out of network after deductible	100%	100%	100%	60% after deductible
MEDICAL SERVICES PHYSICIAN (SURGERY)	Basic benefit at 100% balance at 80% after deductible	100%	80% out of network allowance after deductible	100% after copay	100% after copay	100%	100%	100%	60% after deductible
PHYSICIAN (OFFICE VISITS)	80% of network allowance after ductible	100% after copay	80% out of network allowance after deductible	100% after copay	100% after copay	100% after copay	100% after copay	100% after copay	60% after deductible
CHIROPRACTIC	80% of network allowance after deductible	100% after copay	80% out of network allowance after deductible	100% after copay	100% after copay	100%	100% after copay max. 20 visits per year	Copay no limit	60% after deductible - no limit
MATERNITY	Basic benefit at 100% balance at 80% of network allowance after deductible	100% after initial copay	80% out of network allowance after deductible	100% after initial copay	100% after initial copay	100% after initial copay	100% after copay	100% after copay	60% after deductible
PREVENTIVE SERVICES[1]									
PHYSICAL EXAMS	100%	100%	80% out of network allowance after deductible	100%	100%	100%	100%	100%	60% after deductible
IMMUNIZATIONS	100%	100%	80% out of network allowance after deductible	100%	100%	100%	100%	100%	60% after deductible
MAMMOGRAMS	100%	100%	80% out of network allowance after deductible	100%	100%	100%	100%	100%	60% after deductible
PAP SMEAR	100%	100%	80% out of network allowance after deductible	100%	100%	100%	100%	100%	60% after deductible
PROSTATE EXAM	100%	100%	80% out of network allowance after deductible	100%	100%	100%	100%	100%	60% after deductible
WELL BABY	100%	100%	80% out of network allowance after deductible	100%	100%	100%	100%	100%	60% after deductible
MISCELLANEOUS SERVICES RADIATION/CHEMOTHERAPY OUTPATIENT	Basic benefit at 100% balance at 80% after deductible	100%	80% out of network allowance after deductible	100%	80% after deductible	100%	100%	100%	60% after deductible
HOSPICE	100% (case management required)	100%	80% out of network allowance after deductible	100% after copay	100% after copay	100%	100%	210 day combined in and out of network limit	
PHYSICAL AND/ OR SPEECH THERAPY	Basic benefit at 100% balance at 80% after deductible	100% after copay	80% out of network allowance after deductible	100% after copay	100% after copay	100% over a 60 consecutive day period per illness or injury	100% after copay; max. 60 visits per calendar year	Copay 60 visits per calendar year	Deductible and coinsurance up to 60 visits per calendar year
DENTAL COVERAGE IN MEDICAL PLAN	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary	Limited payment for bony impacted molars, mouth tumors, accidental injury, if medically necessary
X-RAYS/LAB TESTS	Basic benefit at 100% balance at 80% of network allowance after deductible	100%	80% after deductible	100% after copay	80% after deductible	100%	100%	100%	60% after deductible
PRESCRIPTION DRUGS IN MEDICAL PLAN	Separate Plan [4]	Separate Plan [4]	Separate Plan [4]	Separate Plan	Separate Plan	Separate Plan	Separate Plan	Separate Plan	Separate Plan
VISION CARE IN MEDICAL PLAN	Not covered	$50 per calendar year includes exams, lenses, frames	$50 per calendar year includes exam, lenses, frames	Not Covered	Not Covered	100%, $100 lens reimbursement every 24 months	100% after copay for annual exam, $20 to $75 per year for hardware at participating provider	Copay for exam/$70 every 24 months for hardware	60% after deductible for exam/ $70 every 24 months for hardware
MENTAL HEALTH AND SUBSTANCE ABUSE ALCOHOL ABUSE (INPATIENT)	100% for first 120 days, balance covered at 80% after deductible, maximum combined hospital stay is 365 day	100%	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%	Same as any other illness	Same as any other illness
ALCOHOL ABUSE [2] (OUTPATIENT)	80% after deductible	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100% after copay	Same as any other illness	Same as any other illness
DRUG ABUSE (INPATIENT) [2]	100% for first 120 days, balance covered at 80% after deductible, maximum combined hospital stay is 365 day	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%	Same as any other illness	Same as any other illness
DRUG ABUSE (OUTPATIENT) [2]	80% after deductible	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100% after copay	Same as any other illness	Same as any other illness
MENTAL HEALTH [2] (INPATIENT)	100% for first 120 days, balance covered at 80% after deductible, maximum combined hospital stay is 365 day	100%	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%	Same as any other illness	Same as any other illness
MENTAL HEALTH [2] (OUTPATIENT)	80% after deductible	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100% after copay	Same as any other illness	Same as any other illness
EMERGENCY CARE EMERGENCY ROOM (ACCIDENTAL)	100%	100% after copay, copay waived if admitted	80% out of network allowance after deductible	100% after copay	Copay, then 80% after deductible	100% after copay, waived if admitted	100% after copay, waived if admitted	100% after copay waived if admitted	100% after copay waived if admitted
URGENT CARE	100%	100% after copay, copay waived if admitted	80% out of network allowance after deductible	100% after copay	Copay, then 80% after deductible	100% after copay	100% after copay	100% after copay	100% after copay
OUT-OF-POCKET EXPENSES DEDUCTIBLE (INDIVIDUAL)	100%	None	$100	None	$1,500	None	None	$0	$2,000
DEDUCTIBLE (FAMILY MAX.)	$200 (employee plus one)	None	$200	None	$3,000	None	None	$0	$6,000
MAX. OUT-OF-POCKET (INDIVIDUAL)	$400 plus [3] $100 individual deductible	$300 [3]	$400 plus [3] $100 individual deductible	$2,500	$4.500	$1,500 [3]	$1,500 [3]	$2,500 [3]	$7,200 [3]
MAX. OUT-OF-POCKET (FAMILY)	$400 per covered person [4] plus $200 family deductible	$600 [3]	$800 plus [3] $200 family deductible	$5,000	$9,000	$3,000 [3]	$3,000 [3]	$5,000 [3]	$21,600 [3]

This chart provides you with an outline of covered benefits. Keep in mind that the benefits outlined in this chart highlight features of your health benefit program. These outlines do not constitute a contract. Some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract.

[1] Preventive Service covered at 100% when coded as preventive care.

[2] All health plans cover Mental Health, Alcohol, and Substance Abuse as any other medical illness in accordance with the Federal Mental Health Parity and Addiction Equity Act of 2008.

[3] The Out of Pocket Maximum Cost for in network medical and prescription expenses (combined) in the 2020 plan year is limited to $6,550 per individual and $13,100 per family.

[4] Copay/Coinsurance is only reimbursed if incurred due to a free standing drug plan.