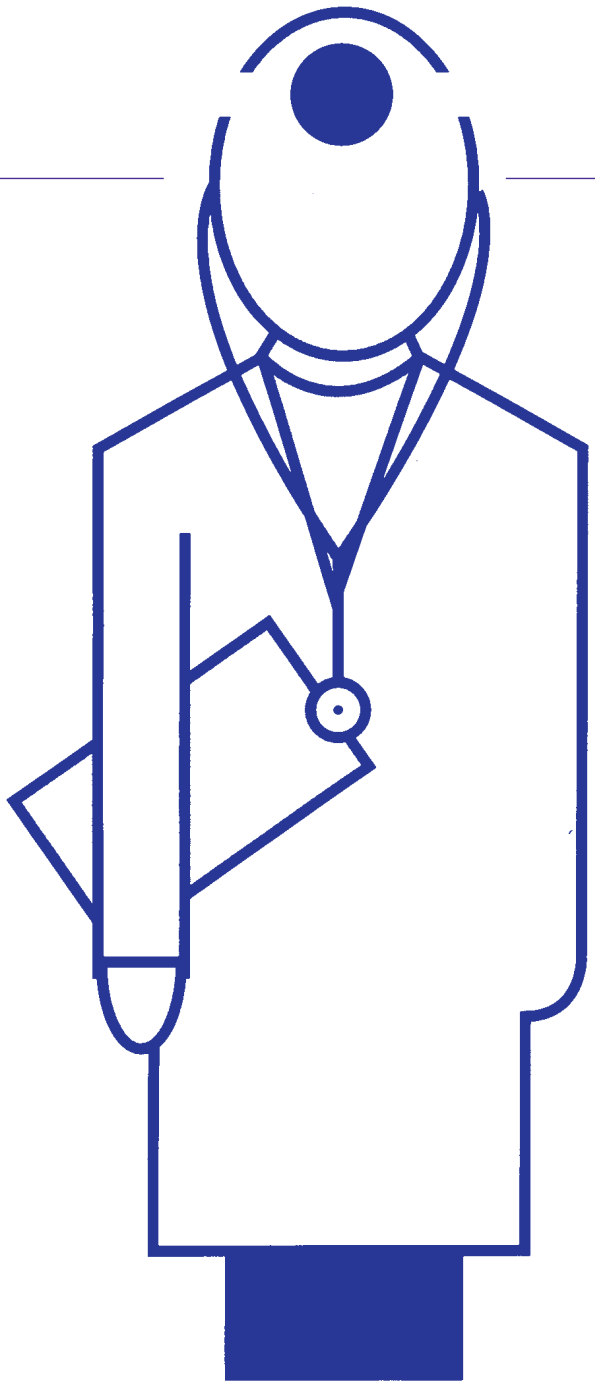
MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

MIDDLESEX COLLEGE

YOUR 2024 GUIDE TO CHOOSING A **Health Plan**



New employees may make initial elections for Benefit Plans in accordance with their Employer's eligibility policies and current Collective Bargaining Agreements.
You have an opportunity to review your health plan choice during the Fund's Open Enrollment period.

CHOICES CHOICES CHOICES CHOICES

HEALTHCARE CHOICE PLAN

OMNIA **Garden State**

AETNA **Educators**

CIGNA

These plans are only available to employess hired before 7/1/20. For the EHP and GSP, see the supplement to this guide.

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 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 the Human Resources Department by the deadline dates. Remember, any changes you make will take effect on January 1.

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

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
2024 Open Enrollment

OPEN ENROLLMENT

You have an opportunity to review your health plan choices each year during the Fund's Open Enrollment period.
Your first Open Enrollment period is in November with the changes effective January 1.
Dates will be announced by the Human Resources Department.

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: OMNIA, 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.

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

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

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

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

IMPORTANT ANNOUNCEMENTS FOR 2024

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 2024.

Summary of CHAPTER 44

Chapter 44 was signed into law on July 1, 2020 by Governor Murphy. Chapter 44 required certain school employers to create the equivalent of two new healthcare plans: the New Jersey Educators Health Plan (NJEHP) and the Garden State Health Plan (GSHP), along with a new employee contribution schedule specific to those enrolled in the new plans. Chapter 44 also restricted enrollment for employees hired on or after July 1, 2020 to only the NJEHP or GSHP. Plan details for the NJEHP and GSHP are available in a supplemental document, and contributions specific to those plans are available online.

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.
- 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.

	HEALTHCARE CHOICE PLAN*		HORIZON OMNIA		AETNA HMO	CIGNA HMO
	IN-NETWORK	OUT-OF-NETWORK	Tier 1	Tier 2	(no coverage out-of-network)	(no coverage 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		1-800-370-4526	1-800-CIGNA24
WEBSITE	www.horizonblue.com		www.horizonblue.com		www.aetna.com	www.cigna.com
HOSPITAL STAY BENEFITS HOSPITAL INPATIENT	100%	80% out of network allowance after deductible	100% after copay per admission	80% after deductible per admission	100%	100%
SKILLED NURSING FACILITY	100% up to 100 days in-network facility per calendar year	80% out of network allowance after deductible	100% after copay per admission	80% after copay per admission	100%	100% up to 100 days per calendar year
HOSPITAL PREADMISSION TESTING	100%	80% out of network allowance after deductible	100%	80% out of network after deductible	100%	100%
MEDICAL SERVICES PHYSICIAN (SURGERY)	100%	80% out of network allowance after deductible	100% after copay	100% after copay	100%	100%
PHYSICIAN (OFFICE VISITS)	Copay	80% out of network allowance after deductible	100% after copay	100% after copay	100% after copay	100% after copay
CHIROPRACTIC	Copay	80% out of network allowance after deductible	100% after copay	100% after copay	100%	100%, after copay, Max. of 20 visits without a referral
MATERNITY	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 initial copay
PREVENTIVE SERVICES**						
PHYSICAL EXAM	100%	80% out of network allowance after deductible	100%	100%	100%	100%
IMMUNIZATIONS	100%	80% out of network allowance after deductible	100%	100%	100%	100%
MAMMOGRAMS	100%	80% out of network allowance after deductible	100%	100%	100%	100%
PAP SMEAR	100%	80% out of network allowance after deductible	100%	100%	100%	100%
PROSTATE EXAM	100%	80% out of network allowance after deductible	100%	100%	100%	100%
WELL BABY	100%	80% out of network allowance after deductible	100%	100%	100%	100%
MISCELLANEOUS SERVICES RADIATION/CHEMOTHERAPY OUTPATIENT	100%	80% out of network allowance after deductible	100%	80% after deductible	100%	100%
HOSPICE	100%	80% out of network allowance after deductible	100% after copay	100% after copay	100%	100%
PHYSICAL AND/ OR SPEECH THERAPY	100%	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
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
X-RAYS/LAB TESTS	100%	80% after deductible	100% after copay	80% after deductible	100%	100%
PRESCRIPTION DRUG PLAN	Separate Plan	Separate Plan	Separate Plan	Separate Plan	Not covered	Separate Plan
VISION CARE IN MEDICAL PLAN	$50 per calendar year includes exam, 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
MENTAL DISORDERS AND SUBSTANCE ABUSE ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	100% after copay	80% after deductible	100%	100%
ALCOHOL ABUSE (OUTPATIENT)	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100% after copay
DRUG ABUSE (INPATIENT)	100%	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%
DRUG ABUSE (OUTPATIENT)	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%
MENTAL DISORDERS (INPATIENT)	100%	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%
MENTAL DISORDERS (OUTPATIENT)	100% after copay	80% out of network allowance after deductible	100% after copay	80% after deductible	100%	100%
EMERGENCY CARE EMERGENCY ROOM (ACCIDENTAL)	100% after copay, must be reported within 48 hours, copay waived if admitted	100% after copay, or 80% out of network allowance after deductible, if not reported within 48 hours	100% after copay	Copay, then 80% after deductible	100% after copay, waived if admitted	100% after copay, waived if admitted
URGENT CARE	100% after copay	100% after copay and deductible	100% after copay	Copay, then 80% after deductible	100% after copay, waived if admitted	100% after copay, waived if admitted
DEDUCTIBLE (INDIVIDUAL)	$100	$100	None	$1,500	None	None
DEDUCTIBLE (FAMILY MAX.)	$200	$200	None	$3,000	None	None
MAX. OUT-OF-POCKET (INDIVIDUAL)	$400 plus $100 individual deductible	$400 plus $100 individual deductible	$2,500	$4.500	$1,500	$1,500
MAX. OUT-OF-POCKET (FAMILY)	$800 (cumulative) not to exceed $400 per covered person	$400 per covered person, Family Unit $800 (cumulative) Plus $200 family deductible	$5,000	$9,000	$3,000	$3,000

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.
Some services are subject to precertification, second surgical opinion, and/or large case management guidelines. Failure to comply with these rules can result is a significant reduction in coverage. Please see the plan contracts for details.

*Remember, if you use the Horizon Network you will not be responsible for any balance bill or submission of claim forms.

**Preventive Services covered at 100% when coded as preventive

	HORIZON EDUCATORS PLAN* *with Blue Card*		HORIZON GARDEN STATE PLAN* *without Blue Card, NJ Only*	
	IN-NETWORK	OUT-OF-NETWORK	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	
WEBSITE	www.horizonblue.com		www.horizonblue.com	
HOSPITAL STAY BENEFITS HOSPITAL INPATIENT	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
SKILLED NURSING FACILITY	100% up to 120 days combined in and out of network	70% out of network allowance after deductible	100% up to 120 days combined in and out of network	70% out of network allowance after deductible
HOSPITAL PREADMISSION TESTING	100%	70% out of network allowance after deductible	100%	70% out of network after deductible
MEDICAL SERVICES PHYSICIAN (SURGERY)	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
PHYSICIAN (OFFICE VISITS)	100% after copay	70% out of network allowance after deductible	100% after copay	70% out of network allowance after deductible
CHIROPRACTIC	100% after copay	70% out of network allowance after deductible	100% after copay	70% out of network allowance after deductible
MATERNITY	100% after initial copay	70% out of network allowance after deductible	100% after initial copay	70% out of network allowance after deductible
PREVENTIVE SERVICES**				
PHYSICAL EXAM	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
IMMUNIZATIONS	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
MAMMOGRAMS	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
PAP SMEAR	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
PROSTATE EXAM	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
WELL BABY	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
MISCELLANEOUS SERVICES RADIATION/CHEMOTHERAPY OUTPATIENT	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
HOSPICE	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
PHYSICAL AND/ OR SPEECH THERAPY	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
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
X-RAYS/LAB TESTS	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
PRESCRIPTION DRUG PLAN	Separate Plan	Separate Plan	Separate Plan	Separate Plan
VISION CARE IN MEDICAL PLAN	100% after copay per calendar year includes exam only	Not Covered	100% after copay per calendar year includes exam only	Not Covered
MENTAL DISORDERS AND SUBSTANCE ABUSE ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness
ALCOHOL ABUSE (OUTPATIENT)	100% after copay	70% out of network allowance after deductible	100% after copay	70% out of network allowance
DRUG ABUSE (INPATIENT)	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
DRUG ABUSE (OUTPATIENT)	100% after copay	70% out of network allowance after deductible	100% after copay	70% out of network allowance after deductible
MENTAL DISORDERS (INPATIENT)	100%	70% out of network allowance after deductible	100%	70% out of network allowance after deductible
MENTAL DISORDERS (OUTPATIENT)	100% after copay	70% out of network allowance after deductible	100% after copay	70% out of network allowance after deductible
EMERGENCY CARE EMERGENCY ROOM (ACCIDENTAL)	100% after copay, must be reported within 48 hours, copay waived if admitted	100% after copay, must be reported within 48 hours, copay waived if admitted	100% after copay, must be reported within 48 hours, copay waived if admitted	100% after copay, must be reported within 48 hours, copay waived if admitted
URGENT CARE	100% after copay	100% after copay and deductible	100% after copay	100% after copay and deductible
DEDUCTIBLE (INDIVIDUAL)	None	$350	None	$350
DEDUCTIBLE (FAMILY MAX.)	None	$700	None	$700
MAX. OUT-OF-POCKET (INDIVIDUAL)	$500	$2,000	$500	$2,000
MAX. OUT-OF-POCKET (FAMILY)	$1,000 (cumulative) not to exceed $500 per covered person	$5,000 (cumulative) not to exceed $2,000 per covered person	$1,000 (cumulative) not to exceed $500 per covered person	$5,000 (cumulative) not to exceed $2,000 per covered person

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.
Some services are subject to precertification, second surgical opinion, and/or large case management guidelines. Failure to comply with these rules can result is a significant reduction in coverage. Please see the plan contracts for details.

*Remember, if you use the Horizon Network you will not be responsible for any balance bill or submission of claim forms.
**Preventive Services covered at 100% when coded as preventive care.

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 Human Resources Department by the deadline dates. Any change you make will take effect January 1.
- If you are satisfied with your current Health Plan, you do not need to complete any forms during this Open Enrollment.