

STATE OF NEW JERSEY
 DEPARTMENT OF THE TREASURY
 DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM
 PO BOX 299 TRENTON, NEW JERSEY 08625-0299

RESOLUTION

A RESOLUTION for Local Government Employers to limit the medical plans offered under the State Health Benefits Program. Employers must offer at least one plan from each category.

BE IT RESOLVED:

The _____
CORPORATE NAME OF EMPLOYER SHBP/SEHBP EMPLOYER LOCATION NUMBER

WILL NOT OFFER THE FOLLOWING PLAN(S) (CHECK THE PLANS YOUR LOCATION WILL NOT BE OFFERING – YOU MUST OFFER AT LEAST ONE PLAN FROM EACH CATEGORY.)

| CATEGORY 1 | | CATEGORY 2 | |
|--|--|---|--|
| <input type="checkbox"/> AETNA FREEDOM 10 | <input type="checkbox"/> NJ DIRECT10 | <input type="checkbox"/> AETNA FREEDOM 1525 | <input type="checkbox"/> NJ DIRECT1525 |
| <input type="checkbox"/> AETNA FREEDOM 15 | <input type="checkbox"/> NJ DIRECT15 | <input type="checkbox"/> AETNA FREEDOM 2030 | <input type="checkbox"/> NJ DIRECT2030 |
| <input type="checkbox"/> AETNA HMO | <input type="checkbox"/> HORIZON HMO | | |
| CATEGORY 3 | | CATEGORY 4 | |
| <input type="checkbox"/> AETNA LIBERTY PLAN | <input type="checkbox"/> OMNIA HEALTH PLAN | <input type="checkbox"/> AETNA FREEDOM 2035 | <input type="checkbox"/> NJ DIRECT2035 |
| CATEGORY 5 | | | |
| <input type="checkbox"/> AETNA VALUE HD 4000 | | <input type="checkbox"/> NJ DIRECT HD4000 | |
| <input type="checkbox"/> AETNA VALUE HD 1500 | | <input type="checkbox"/> NJ DIRECT HD1500 | |

Upon receipt of this resolution, the Health Benefits Bureau will schedule a Special Open Enrollment for active employees currently enrolled in any plan that will no longer be offered. These employees must submit a *Health Benefits Application* to change medical plans during the Special Open Enrollment or will otherwise be **terminated from coverage. Resolutions may be filed once in a calendar year.**

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the:

CORPORATE NAME OF EMPLOYER

on the _____ day of _____, 20 _____.

SIGNATURE

OFFICIAL TITLE

NUMBER OF EMPLOYEES

STREET ADDRESS

CITY STATE ZIP CODE

AREA CODE TELEPHONE NUMBER

EMPLOYER'S STATE SOCIAL SECURITY IDENTIFICATION NUMBER