HA-0992-0918

State of New Jersey • Division of Pensions & Benefits (NJDPB)

STATE HEALTH BENEFITS PROGRAM
P.O. BOX 299 TRENTON, NEW JERSEY 08625-0299

RESOLUTION

A RESOLUTION for Local Employers to offer an incentive under the State Health Benefits Program.

BE IT RESOLVED:

The _____ _____
CORPORATE NAME OF EMPLOYER — SHBP EMPLOYER LOCATION NUMBER

We agree to voluntarily participate in the Financial Incentive Program granting financial incentives to subscribers who select enrollment into tiered-network medical plans otherwise known as Horizon Blue Cross Blue Shield of New Jersey's OMNIA Plan or Aetna's Liberty plan. We agree that the management and administration of this incentive program shall be solely our responsibility.

The terms of the Incentive Program described above shall include:

- The Incentive Program shall be available to subscribers who are first time enrollees in a tiered-network medical plan beginning Plan Year 2019 and continuing for two plan years through December 31, 2020;
- The Incentive Program does not extend to participants enrolled under P.L. 2005, c. 375 (certain over-age adult children) and COBRA;
- Participation is voluntary at the option of the employer;
- The financial incentive for eligible employees shall be:
  - — $1,000 for **Single member coverage** when changing to a tiered-network plan.
  - — $1,250 for **Member/Spouse coverage** when changing to a tiered-network plan.
  - — $1,250 for **Parent/Child coverage** when changing to a tiered-network plan.
  - — $2,000 for **Family coverage** when changing to a tiered-network plan.
- The incentive amount shall be paid within the first quarter of Plan Year 2019 and is reportable income; and
- The incentive shall be forfeited and returned to the employer if the subscriber fails to remain enrolled for at least two plan years, except that if a subscriber is made ineligible for healthcare through layoff, involuntary separation, reduction to part-time status, or classification into an ineligible position. If a subscriber voluntarily retires or changes health plans due to a catastrophic or emergency health need as determined by the employer after a full year, then the incentive shall be forfeited on a pro-rata basis.

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

the: _____ on the _____ day of _____, 20_____.
CORPORATE NAME OF EMPLOYER

_____ _____
SIGNATURE — OFFICIAL TITLE

_____
STREET ADDRESS — CITY — STATE — ZIP CODE

_____
AREA CODE — TELEPHONE NUMBER

_____ _____
EMPLOYER'S STATE SOCIAL SECURITY IDENTIFICATION NUMBER — NUMBER OF EMPLOYEES