Memo

	Andrea Spalla – State Co-chair, SHBP PDC
To	Michael Zanyor – Public employee representative Co-chair, SHBP PDC
From	Aon Consulting, Inc.
Date	August 15, 2025
Re	Submission of SHBP Savings Proposals of State Representatives of the SHBP-PDC

This memo is in response to savings proposals provided by the State Representatives of the State Health Benefits Program Plan Design Committee ("SHBP-PDC") pursuant to the State of New Jersey Fiscal Year 2026 ("FY2026") Appropriations Act, P.L. 2025, c. 74, detailing cost saving plan design proposals for the New Jersey State Health Benefits Program ("SHBP") to achieve a total of $100 million in recurring State savings during the first six months of Plan Year ("PY") 2026.

Per the State of New Jersey Fiscal Year 2026 ("FY2026") Appropriations Act, P.L. 2025, c. 74, the plan actuary was asked to review the proposals submitted and determine whether they will result in recurring and actuarially verifiable savings. As such, Aon provided savings figures for plan design concepts that are verifiable based on the data and information available as of August 15, 2025. Strategies referenced within this document may achieve $100 million in savings during the first six months of Plan Year 2026. However, some strategies may require more information before they can be considered verifiable due to the nature of the program (i.e. retrospective analysis of a solution to evaluate verifiable efficacy, vendor administrative costs that may offset savings figures, etc.).

Below are the proposals provided by the State Representatives of the SHBP PDC. Savings assume each proposal is implemented effective January 1, 2026, or earlier, and are shown on a full calendar year basis. Savings for six months can be assumed to be equal to half of the full calendar year savings figures represented. Savings associated with each proposal are not additive due to the interrelatedness of certain plan changes:

1. Eliminate all current plans and replace with two plan options: a modified Unity PPO plan (referred to as a New PPO) and a modified Tiered Network plan. Each proposed scenario also includes modified prescription drug cost-share amounts.

a. Scenario 1: See additional proposal detail titled “Scenario 1.a Detail”
b. Scenario 2: See additional proposal detail titled “Scenario 1.b Detail”
c. Scenario 3: See additional proposal detail titled “Scenario 1.c Detail”
d. Scenario 4: See additional proposal detail titled “Scenario 1.d Detail”

Aon Response: The New PPO and modified Tiered Network plans will replace all current plan designs for State Actives and Early Retirees. This may generate plan savings through higher member cost sharing and provider steerage by directing care to the most appropriate setting.

The chart below illustrates the savings for each of these scenarios. Additional assumptions and methods are included in the back of this memo.

Plan Year 2026 Savings ($M)	State Actives	State Early Retirees
Scenario 1	$110M or 4.2%	$25M or 4.7%
Scenario 2	$185M or 7.0%	$37M or 7.0%
Scenario 3	$256M or 9.7%	$48M or 9.1%
Scenario 4	$203M or 7.7%	$40M or 7.6%

2. Modify prescription drug co-pays across all plans, in tandem with Proposal 11. See additional proposal detail titled “Proposal 2 Detail.”

Aon Response: In addition to plan savings through higher member cost sharing, increasing these copays could promote more appropriate use of care resulting in additional savings. Mandatory generics and mandatory mail order maintenance are assumed to apply to all plan options. The copay increases are assumed to apply to all plan options except the HDLow and HDHigh options.

- State Actives: $43M or 1.6%
- State Early Retirees: $4M or 0.8%

Note, this proposed scenario excludes GLP-1 drugs for weight-loss from accumulating toward the prescription drug out-of-pocket. While it is expected that this change would save the plan additional money, Aon is unable to assess the verifiable impact of this change within the requested time period, and it is excluded from the savings shown above.

3. Exclude coverage of GLP-1 drugs for weight loss only across all populations (active and retiree members) and in tandem with Proposal 11.

   Aon Response: If the plans were to exclude coverage of GLP-1 medications for weight-loss drugs, it is estimated the Plan would reduce State Active costs by $48M. Early retiree savings impact is unavailable within the requested time period. Under this scenario, coverage would only be available for Wegovy for cardiovascular risk for a member who has a BMI of 27+ and has a documented prior heart attack, stroke, or peripheral artery disease. The plan also would not collect any rebates for Wegovy under this scenario.

   Projected savings are based on projected PY2026 membership in the draft Rate Setting Analysis and PMPM impacts provided by Optum. Optum's estimates include estimated savings due to reductions in utilization.

4. Across all populations (active and retiree members) limit access to GLP-1 drugs for weight loss to members with a BMI at or greater than 35, all with higher member cost-share and in tandem with Proposal 11.

   Aon Response: Per Optum, this scenario would not produce savings and could potentially increase costs. Under this approach, the SHBP would receive lower rebates, and the reductions in projected utilization would not offset the rebate loss.

   Note, this feedback is based on Optum's analysis of projected utilization compared to the rebate loss and does not factor in potential savings that could be realized through the inclusion of a weight management program outlined in Proposal 11. A weight management program in addition to the changes referenced above, could result in savings for the State.

5. Retain all current SHBP State plans and increase the deductibles and out of pocket maximum amounts across all plans, for both in-network and out of network care. See additional proposal detail titled "Proposal 5 Detail."

   Aon Response: The In-Network (INN) and Out-of-Network (OON) deductibles are assumed to increase $1,000 and the INN medical Out-of-Pocket (OOP) max is assumed to increase $1,000 unless currently equal to $7,360. The OON medical OOP max is assumed to increase to $7,360. This provides savings through higher member cost sharing while also promoting in-network utilization.
   - State Actives: $182M or 6.9%
   - State Early Retirees: $31M or 5.9%

6. Implement spousal surcharge of $50/month for members with a spouse who has access to other health benefits coverage through their own employer but uses the SHBP plan.

   Aon Response: A surcharge for spouses with access to coverage through their own employer would be a monthly charge in addition to their regular medical coverage contribution/premium for a spouse. Since SHBP medical plans are self-insured and pay a portion of the member's medical coverage and actual claims, if the spouse moved to his/her employer's medical plan and utilizes that benefit instead, it saves the SHBP on future plan costs. If the spouse decides to elect the SHBP plan coverage rather than his/her employer plan, funds available through member contributions will increase.
   - State Actives: $24M or 0.9%, including $13M in estimated cost savings due to dropped spouse coverage and $11M in estimated surcharges paid
   - State Early Retirees: $2M or 0.4% including $1M in estimated cost savings due to dropped spouse coverage and $1M in estimated surcharges paid

7. Eliminate PPO10 and PPO15 plans and all other plans except the current Unity/ PPO and Tiered Network plan options; Unity PPO and Tiered Network plan designs remain unchanged.

   Aon Response: Eliminating these plan options would require members to enroll in the Unity PPO or Tiered Network plan option. These plans have lower costs and more highly managed networks, which would result in gross plan cost savings.
   - State Actives: $18M or 0.7%
   - State Early Retirees: $8M or 1.5%

8. Eliminate the Medicare Supplement plans and migrate State members to the Medicare Advantage PPO15 plan option.

   Aon Response: Elimination of all Medicare Supplement plans offered to Medicare enrollees, which will require retirees to elect one of the four Medicare Advantage options would result in gross plan cost savings.
   - State Medicare Retirees: $11M or 2.8%

9. Limit physical therapy and chiropractic visits for all plans to 30 per year, each.

   Aon Response: A cap on both physical therapy and chiropractic visits will not only limit visits for high utilizers, providing savings, but may also promote more appropriate use of care.
   - State Actives: $5M or 0.2%
   - State Early Retirees: $1M or 0.2%

10. Expand the pending Centers of Excellence pilot program to include two more covered procedures (routine colonoscopies and one other procedure from an included list of possible options) and change the member cost-share in years one and two of that pilot program to more effectively incentivize utilization of the Center of Excellence providers. See additional proposal detail titled "Proposal 10 Detail."

    Aon Response: The Division of Pensions and Benefits is in the process of conducting a Request for Quotation (RFQ) for a Surgical Center of Excellence partner.

    Pending completion of the RFQ, a surgical center of excellence cannot be prospectively evaluated for verifiable savings because the actual cost reductions and clinical outcomes depend on a multitude of variables that cannot be fully predicted in advance. Prospective evaluation of this type of program heavily relies on assumptions and projections on the utilization of services, and the reimbursement rates agreed upon by the selected vendor partner. Currently SHBP Resolution 2024-7 allows for voluntary participation in the Surgical COE making savings impacts highly dependent on utilization. As a result, retrospective analyses—using actual utilization and cost data—can reliably determine whether a surgical center of excellence has achieved measurable and verifiable savings.

11. In tandem with increased member cost share for GLP-1 drugs, require all members and dependents prescribed a GLP-1 drug for all diagnoses to also participate in a behavioral modification/lifestyle management co-therapy "point solution" program selected by the plan administrator to support drug adherence and enhance health outcomes. Failure to participate or adhere to the co-therapy program requirements results in loss of coverage of the GLP-1 except in the case of diabetes.

    Aon Response: The implementation of behavioral modification/lifestyle management co-therapy point solution focused on weight management can generate savings for the plan. Prospective evaluation of this type of program is heavily dependent on the potential point solution partner's technical and financial approach. As a result, retrospective analyses—using actual utilization and cost data—can reliably determine whether a point solution has achieved measurable and verifiable savings.

Plan Initiative Savings ($ Savings)

Plan Year 2026 ($ Millions)	State		
Savings Proposals	**Active**	**Early Retiree**	**Medicare Retiree**
Proposal 1a: PPO and TN with Minor Changes	$110	$25	N/A
Proposal 1b: PPO and TN with Moderate Changes	$185	$37	N/A
Proposal 1c: New PPO and Tiered Network	$256	$48	N/A
Proposal 1d: New PPO and Tiered Network with $0 PCP	$203	$40	N/A
Proposal 2: Modified Rx Copays	$43	$4	N/A
Proposal 3: Exclude GLP-1 Weight Loss	$48	N/A	N/A
Proposal 4: Weight Loss BMI Criteria	N/A	N/A	N/A
Proposal 5: Increase Deductible and OOP Max	$182	$31	N/A
Proposal 6: Implement Spousal Surcharge	$24	$2	N/A
Spousal Surcharge Cost Savings	*$13*	*$1*	*N/A*
Spousal Surcharge Amount	*$11*	*$1*	*N/A*
Proposal 7: Eliminate All Plans Except Unity PPO and TN	$18	$8	N/A
Proposal 8: Eliminate Medicare Supplement	N/A	N/A	$11
Proposal 9: Limit PT and Chiropractic Visits	$5	$1	N/A
Proposal 10: Expand COE	N/A	N/A	N/A
Proposal 11: GLP-1 Behavioral Modification/Lifestyle Management	N/A	N/A	N/A

Plan Initiative Savings (% Savings)

Plan Year 2026 (% Savings)	State		
Savings Proposals	**Active**	**Early Retiree**	**Medicare Retiree**
Proposal 1a: PPO and TN with Minor Changes	4.2%	4.7%	N/A
Proposal 1b: PPO and TN with Moderate Changes	7.0%	7.0%	N/A
Proposal 1c: New PPO and Tiered Network	9.7%	9.1%	N/A
Proposal 1d: New PPO and Tiered Network with $0 PCP	7.7%	7.6%	N/A
Proposal 2: Modified Rx Copays	1.6%	0.8%	N/A
Proposal 3: Exclude GLP-1 Weight Loss	1.8%	N/A	N/A
Proposal 4: Weight Loss BMI Criteria	N/A	N/A	N/A
Proposal 5: Increase Deductible and OOP Max	6.9%	5.9%	N/A
Proposal 6: Implement Spousal Surcharge	0.9%	0.4%	N/A
Spousal Surcharge Cost Savings	*0.5%*	*0.2%*	*N/A*
Spousal Surcharge Amount	*0.4%*	*0.2%*	*N/A*
Proposal 7: Eliminate All Plans Except Unity PPO and TN	0.7%	1.5%	N/A
Proposal 8: Eliminate Medicare Supplement	N/A	N/A	2.8%
Proposal 9: Limit PT and Chiropractic Visits	0.2%	0.2%	N/A
Proposal 10: Expand COE	N/A	N/A	N/A
Proposal 11: GLP-1 Behavioral Modification/Lifestyle Management	N/A	N/A	N/A

Savings Assumptions and Disclosures

Baseline Plan Year 2026 Total Costs are based on the Draft State Plan Year 2026 Rate Setting Analysis. The analysis assumes no additional migration between carriers outside of what is included in each proposal.

As part of this analysis, additional input provided by Horizon and Optum was considered and adjustments reflecting this information were made where appropriate. Additional, scenario specific assumptions include:

Proposal 1: Implement New PPO Plan & Modified Tiered Network Plan (Eliminate Remaining Plans)

- Assumes the State Active and Early Retiree PPO10, PPO15, HMO10, HMO15, PPO1525, HMO1525, PPO2030, HMO2030, PPO2035, Unity 2019 PPO, HDLow, and HDHigh plans are eliminated. Active employees have the option of electing either the New PPO plan or an alternative Tiered Network plan design with higher member cost sharing, which replace the current Unity/Unity 2019 and Tiered Network plans.

- For purposes of this scenario, employees who are currently enrolled in one of the PPO plans being eliminated are assumed to enroll in the New PPO. Employees currently enrolled in the HMO plans being eliminated are assumed to enroll in the alternative Tiered Network Plan. No additional new hire requirements adjustments are considered.

- Medical and prescription drug plan design savings are based on Aon's Actuarial Value model and out-of-network reimbursement impacts were provided by Horizon.
    - For purposes of this scenario, the prescription drug actuarial value of the alternative PPO plan and alternative Tiered Network plan reflect a weighted average of generic, brand preferred and brand non-preferred copays based on actual utilization provided by Optum.
    - The tiered network medical actuarial value reflects actual Tier 1 and Tier 2 utilization provided by Horizon.

- For purposes of this scenario, projected Plan Year 2026 prescription drug rebates as a percentage of claims are assumed to remain consistent with the Draft Plan Year 2026 Rate Setting results.

Proposal 2: Modified Rx Copays

- Impacts are based on Aon's Actuarial Value model.

- For purposes of this scenario, projected Plan Year 2026 prescription drug rebates as a percentage of claims are assumed to remain consistent with the Draft Plan Year 2026 Rate Setting results.

Proposal 3: Exclude GLP-1 Weight Loss Drugs

- Projected savings are based on projected PY2026 membership in the draft Rate Setting Analysis and PMPM impacts provided by Optum. Optum's estimates include estimated savings due to reductions in utilization.

Proposal 5: Increase Deductible and Out-of-Pocket Amounts

- Horizon provided savings amounts on a 2024 basis separately by plan. These savings were projected to Plan Year 2026 as a percentage of medical claims and are assumed to apply to both projected Horizon and Aetna plan costs.

- Impacts provided by Horizon are applicable to all plans except the Tiered Network, HDLow, HDHigh, HMO1525, and HMO2030. OON design changes do not apply to the Legacy HMO.

- The INN and OON deductibles are assumed to increase $1,000. The INN medical OOP max is assumed to increase $1,000 unless it is currently equal to $7,360. The OON medical OOP max is assumed to increase to $7,360.

- Factors provided by Horizon include adjustments for conservatism.

Proposal 6: Implement a $50 Monthly Spousal Surcharge

- Estimated cost impacts assume subscribers who elect EE + Spouse and EE + Family coverage will pay an additional $50 per month if their covered spouse has access to other coverage through their own employer.

- It is assumed that 50% of covered Active spouses and 25% of covered Early Retiree spouses are eligible for coverage through a separate employer and 5% of these spouses will drop coverage as a result of the surcharge (95% of spouses with eligible coverage will elect to remain in the plans and pay the surcharge). No impact is estimated for covered spouses assumed to have no eligible coverage through a separate employer. Spouses are assumed to have cost that is equal to the average member cost of the plan. Early Retiree impacts do not include split-family coverages.

Proposal 7: Eliminate All Plan Options

- Assumes the State Active and Early Retiree PPO10, PPO15, HMO10, HMO15, PPO1525, HMO1525, PPO2030, HMO2030, PPO2035, HDLow, and HDHigh plans are eliminated. Employees who are currently enrolled in one of the PPO plans being eliminated are assumed to enroll in the Unity PPO. Employees currently enrolled in the HMO plans being eliminated are assumed to enroll in the Tiered Network Plan.

- Medical and prescription drug plan design savings are based on Aon's Actuarial Value model and out-of-network reimbursement impacts were provided by Horizon.

- Projected Plan Year 2026 prescription drug rebates as a percentage of claims are assumed to remain consistent with the Draft Plan Year 2026 Rate Setting results.

Proposal 8: Eliminate the Medicare Supplement Plans

- Savings assume that all State Medicare Supplement plans are eliminated and members migrate to the Medicare Advantage PPO15 plan option.

- Estimated impacts also reflect the elimination of the Self-Insured Medicare ASO, medical capitation amounts and value-based charges, and impact of differences in Rx copays between the Medicare Supplement plans and the MA PPO15 plan. Rx impacts are based on Aon's actuarial value model. No adjustment has been made to aggregate projected Rx rebates or EGWP credits.

Proposal 9: Add Physical Therapy Limit Visits Across All Plans

- Horizon provided savings amounts on a 2024 basis separately by plan. These savings were projected to Plan Year 2026 as a percentage of medical claims and are assumed to apply to both projected Horizon and Aetna plan costs. Factors provided by Horizon include adjustments for conservatism.

Additional Disclosures

The estimates in this analysis are measured on an incurred basis and are consistent with the assumptions and methodology disclosed herein. Actual results and future projections may differ significantly from the current projections presented in this analysis due to (but not limited to) such factors as the following:

- Plan experience differing from what is anticipated by the economic or demographic assumptions;
- Changes in actuarial methods or in economic or demographic assumptions;
- Changes in plan provisions or applicable law.

This analysis contains the primary actuarial assumptions and methods used to develop the cost projections but may not include a comprehensive list of these methodologies and assumptions. Aon provided guidance with respect to these assumptions, and it is our belief that the assumptions represent reasonable expectations of anticipated plan experience.

Additional Proposal Detail - Proposal 1.a Detail

State Active 2026 Plan Designs	Proposal 1a: PPO and TN with Minor Changes Unity PPO	 Tiered Network
Actuarial Value	**93.9%**	**94.5%**
In-Network		
Deductible (Single / Family)	$200 / $500	Tier 1: $100 / $250 Tier 2: $1,750 / $3,500
OOP Max (Single / Family)[1]	$8,480 / $16,960	Tier 1: $2,500 / $5,000 Tier 2: $5,500 / $11,000
Coinsurance Max (Single / Family)	$1,000 / $2,500	N/A
Coinsurance[2]	10%	Tier 1: 5% Tier 2: 20%
PCP[4]	$15	Tier 1: $10 Tier 2: $25
Specialist	$35	Tier 1: $20 Tier 2: $40
Emergency Room	$150	Tier 1: $150 Tier 2: $150
Urgent Care	$50	Tier 1: $40 Tier 2: $75
Inpatient Stay	10%	Tier 1: $150 Tier 2: 20%
Outpatient Physical Therapy and Chriopractic[3]	$35	Tier 1: $20 Tier 2: $40
Outpatient Surgery Facility Charge	10%	Tier 1: $150 Tier 2: 20% Coins
Outpatient Advanced Radiology Facility Charge	10%	Tier 1: $20 Tier 2: 20% Coins
Ambulance	10%	Tier 1: 5% Tier 2: 20%
Out-of-Network (Single / Family)		
Deductible	$750 / $1,875	N/A
OOP Max	$6,500 / $13,000	N/A
Coinsurance	30%	N/A
Reimbursement Methodology	175% of CMS	N/A
Prescription Drug (Retail / Mail / Specialty)		
OOP Max (Single / Family)[1]	$2,120 / $4,240	$2,120 / $4,240
Generic Drugs	$10 / $20 / $30	$10 / $20 / $30
Preferred Brand Drugs	$20 / $40 / $50	$20 / $40 / $50
Non-Preferred Brand Drugs	$30 / $60 / $150	$30 / $60 / $150
Mandatory Generics	Yes	Yes
Mandatory Mail Order Maintenance	Yes	Yes

[1] Subject to yearly ACA limit adjustments

[2] For ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice

[3] Subject to 30 visit annual maximum for each

[4] PCP Copay is assumed to apply to PCP, Mental Health, and Telehealth Visits

Additional Proposal Detail - Proposal 1.b Detail

State Active 2026 Plan Designs	Proposal 1b: PPO and TN with Moderate Changes Unity PPO	 Tiered Network
Actuarial Value	**90.8%**	**92.8%**
In-Network		
Deductible (Single / Family)	$500 / $1,250	Tier 1: $200 / $500 Tier 2: $2,000 / $5,000
OOP Max (Single / Family)[1]	$8,480 / $16,960	Tier 1: $2,500 / $5,000 Tier 2: $6,500 / $13,000
Coinsurance Max (Single / Family)	$2,500 / $6,250	N/A
Coinsurance[2]	15%	Tier 1: 10% Tier 2: 25%
PCP[4]	$20	Tier 1: $10 Tier 2: $25
Specialist	$40	Tier 1: $20 Tier 2: $40
Emergency Room	$200	Tier 1: $200 Tier 2: $200
Urgent Care	$75	Tier 1: $50 Tier 2: $100
Inpatient Stay	15%	Tier 1: $150 Tier 2: 25%
Outpatient Physical Therapy and Chriopractic[3]	$40	Tier 1: $20 Tier 2: $40
Outpatient Surgery Facility Charge	15%	Tier 1: $175 Tier 2: 25% Coins
Outpatient Advanced Radiology Facility Charge	15%	Tier 1: $20 Tier 2: 25% Coins
Ambulance	15%	Tier 1: 10% Tier 2: 25%
Out-of-Network (Single / Family)		
Deductible	$1,500 / $3,750	N/A
OOP Max	$6,500 / $13,000	N/A
Coinsurance	40%	N/A
Reimbursement Methodology	175% of CMS	N/A
Prescription Drug (Retail / Mail / Specialty)		
OOP Max (Single / Family)[1]	$2,120 / $4,240	$2,120 / $4,240
Generic Drugs	$10 / $20 / $40	$10 / $20 / $40
Preferred Brand Drugs	$20 / $40 / $80	$20 / $40 / $80
Non-Preferred Brand Drugs	$40 / $80 / $200	$40 / $80 / $200
Mandatory Generics	Yes	Yes
Mandatory Mail Order Maintenance	Yes	Yes

[1] Subject to yearly ACA limit adjustments

[2] For ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice

[3] Subject to 30 visit annual maximum for each

[4] PCP Copay is assumed to apply to PCP, Mental Health, and Telehealth Visits

Additional Proposal Detail - Proposal 1.c Detail

State Active 2026 Plan Designs	Proposal 1c: New PPO and TN Unity PPO	 Tiered Network
Actuarial Value	**87.8%**	**91.4%**
In-Network		
Deductible (Single / Family)	$1,000 / $2,500	Tier 1: $250 / $625 Tier 2: $2,500 / $6,250
OOP Max (Single / Family)[1]	$8,480 / $16,960	Tier 1: $3,000 / $6,000 Tier 2: $6,500 / $13,000
Coinsurance Max (Single / Family)	$3,000 / $7,500	N/A
Coinsurance[2]	25%	Tier 1: 15% Tier 2: 25%
PCP[4]	$30	Tier 1: $15 Tier 2: $30
Specialist	$50	Tier 1: $25 Tier 2: $50
Emergency Room	$300	Tier 1: $300 Tier 2: $300
Urgent Care	$100	Tier 1: $75 Tier 2: $125
Inpatient Stay	25%	Tier 1: $150 Tier 2: 25%
Outpatient Physical Therapy and Chriopractic[3]	$50	Tier 1: $25 Tier 2: $50
Outpatient Surgery Facility Charge	25%	Tier 1: $200 Tier 2: 25% Coins
Outpatient Advanced Radiology Facility Charge	25%	Tier 1: $25 Tier 2: 25% Coins
Ambulance	25%	Tier 1: 15% Tier 2: 25%
Out-of-Network (Single / Family)		
Deductible	$2,000 / $5,000	N/A
OOP Max	$6,500 / $13,000	N/A
Coinsurance	50%	N/A
Reimbursement Methodology	175% of CMS	N/A
Prescription Drug (Retail / Mail / Specialty)		
OOP Max (Single / Family)[1]	$2,120 / $4,240	$2,120 / $4,240
Generic Drugs	$10 / $20 / $50	$10 / $20 / $50
Preferred Brand Drugs	$20 / $40 / $100	$20 / $40 / $100
Non-Preferred Brand Drugs	$50 / $100 / $250	$50 / $100 / $250
Mandatory Generics	Yes	Yes
Mandatory Mail Order Maintenance	Yes	Yes

[1] Subject to yearly ACA limit adjustments

[2] For ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice

[3] Subject to 30 visit annual maximum for each

[4] PCP Copay is assumed to apply to PCP, Mental Health, and Telehealth Visits

Additional Proposal Detail - Proposal 1.d Detail

State Active 2026 Plan Designs	Proposal 1d: New PPO and TN with $0 PCP Unity PPO	 Tiered Network
Actuarial Value	**89.9%**	**93.3%**
In-Network		
Deductible (Single / Family)	$500 / $1,250	Tier 1: $250 / $625 Tier 2: $2,000 / $5,000
OOP Max (Single / Family)[1]	$5,000 / $10,000	Tier 1: $2,000 / $5,000 Tier 2: $4,000 / $10,000
Coinsurance Max (Single / Family)	$2,000 / $5,000	N/A
Coinsurance[2]	25%	Tier 1: 5% Tier 2: 20%
PCP[4]	$0	Tier 1: $0 Tier 2: $30
Specialist	$75	Tier 1: $35 Tier 2: $60
Emergency Room	$200	Tier 1: $200 Tier 2: $200
Urgent Care	$125	Tier 1: $75 Tier 2: $125
Inpatient Stay	No Charge	Tier 1: $150 Tier 2: 20%
Outpatient Physical Therapy and Chriopractic[3]	$75	Tier 1: $35 Tier 2: $60
Outpatient Surgery Facility Charge	25%	Tier 1: $200 Tier 2: 20% Coins
Outpatient Advanced Radiology Facility Charge	25%	Tier 1: $25 Tier 2: 20% Coins
Ambulance	25%	Tier 1: 5% Tier 2: 20%
Out-of-Network (Single / Family)		
Deductible	$1,000 / $2,500	N/A
OOP Max	$6,500 / $13,000	N/A
Coinsurance	50%	N/A
Reimbursement Methodology	175% of CMS	N/A
Prescription Drug (Retail / Mail / Specialty)		
OOP Max (Single / Family)[1]	$2,120 / $4,240	$2,120 / $4,240
Generic Drugs	$10 / $20 / $50	$10 / $20 / $50
Preferred Brand Drugs	$20 / $40 / $100	$20 / $40 / $100
Non-Preferred Brand Drugs	$50 / $100 / $250	$50 / $100 / $250
Mandatory Generics	Yes	Yes
Mandatory Mail Order Maintenance	Yes	Yes

[1] Subject to yearly ACA limit adjustments

[2] For ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice

[3] Subject to 30 visit annual maximum for each

[4] PCP Copay is assumed to apply to PCP, Mental Health, and Telehealth Visits

Additional Proposal Detail - Proposal 2 Detail

State Active 2026 Prescription Drug Designs	Retail / Mail / Specialty
OOP Max (Single / Family)[1]	$2,120 / $4,240
Generic Drugs	$10 / $20 / $50
Preferred Brand Drugs	$30 / $60 / $150
Non-Preferred Brand Drugs	$120 / $240 / $600
Mandatory Generics	Yes
Mandatory Mail Order Maintenance	Yes

[1] Subject to yearly ACA limit adjustments; GLP-1 drugs for weight loss are excluded from OOP annual maximum

Additionally, require that all members and dependents prescribed a GLP-1 drug also participate in a lifestyle management co-therapy program, selected and engaged by the plan administrator, as a condition of plan coverage of the GLP-1 drug. Failure to participate or adhere to the co-therapy program requirements results in loss of coverage of the GLP-1 except in the case of diabetes.

Proposal 5 Detail

Retain all current SHBP State plans while increasing the deductibles and out of pocket maximum amounts across all plans, for both in-network and out of network care, as follows:

- Increase deductibles (single and family) both in-network and out-of-network by $1,000 above current levels in every plan; and
- Increase the annual out of pocket maximum (single and family) in-network by $1,000 above current levels in every plan, subject to annual adjustments tied to ACA limits; and
- Increase the annual out of pocket maximum (single and family for out-of-network services to equal the increased OOP maximum levels for in-network services.

Proposal 10 Detail

Expand the pending Centers of Excellence pilot program, which is being implemented pursuant to the SHBP PDC Resolution 2024-7 approved on July 24, 2024, as follows:

- Add routine colonoscopies and one other service or procedure in the program's Covered Procedures (as that term is defined in Resolution 2024-7); and
- change the member cost-share in years one and two of that pilot program to more effectively incentivize utilization of providers in the Center of Excellence network. Specifically, in years one and two of the pilot program, members who utilize a Center of Excellence network provider to obtain a Covered Service shall have no out of pocket cost share, but will not receive any gift card or other financial incentive. In addition, in year one of the pilot program, those members who obtain a Covered Service and choose not to utilize a Center of Excellence network provider but instead choose a provider in the

SHBP's TPA networks shall pay a co-payment of $400; and in year two of the pilot program, those members who have a Covered Service and choose not to utilize a Center of Excellence network provider but instead choose a provider in the SHBP's TPA networks shall pay a co-payment of $500.

- All other aspects of the pilot program as set forth in Resolution 2024-7 would remain unchanged.

For reference, Resolution 2024-7 can be found here:
www.nj.gov/treasury/pensions/documents/hb/Resolutions/SHBP-PDC/2024-7-centers-of-excellence.pdf