State of New Jersey
DEPARTMENT OF THE TREASURY
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PHILIP D. MURPHY
Governor

TAHESHA L. WAY
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ELIZABETH MAHER MUOIO
State Treasurer

July 31, 2025

By Electronic Mail
Jon Pipas, Vice-President
Aon Health Solutions
Via Quincy Charleston, Acting Secretary of SHBP-PDC
Quincy.Charleston@treas.nj.gov

Dear Vice-President Pipas:

RE: Submission of Recurring Savings Proposals of State Representatives of SHBP-PDC

Pursuant to the State of New Jersey Fiscal Year 2026 ("FY2026") Appropriations Act, P.L. 2025, c. 74, the State representatives of the State Health Benefits Program Plan Design Committee ("SHBP-PDC") hereby submit 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.

These plan design proposals will maintain the SHBP members' access to high-quality, affordable health care, while incentivizing more cost-effective health care decisions by members and bolstering the sustainability of the SHBP now and for years to come. To this end, most of the proposed plan design scenarios include: 1) scaling back the total number of available plan options to eliminate complexity for members that stifles rather than enhances choice, while also reducing SHBP costs; 2) more material differences between co-pays and co-insurance levels for higher and lower-cost services and prescription drugs; and 3) higher deductibles in tandem with increased out of pocket and co-insurance annual maximums. Several proposals would lower the actuarial values ("AVs") of the plans available to members when compared to the AVs of the most subscribed SHBP PPO plans, which have AVs in excess of 97%.

We think many of these plan design proposals, or some combination of them, will result in significantly more than $100 million in recurring SHBP plan cost savings during the first six months of Plan Year 2026, assuming implementation by, or soon after, January 1, 2026. We are hopeful that the SHBP-PDC can reach agreement on these legislatively mandated plan design proposals before September 30, 2025, given that more implementation time will allow maximum savings from a smaller number of proposals.

Proposals:

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 attachment titled "Scenario 1.a Detail."
    b. Scenario 2: See attachment titled "Scenario 1.b Detail."
    c. Scenario 3: See attachment titled "Scenario 1.c Detail."
    d. Scenario 4: See attachment titled "Scenario 1.d Detail."
2. Modify prescription drug co-pays across all plans, in tandem with Proposal 11. See attachment titled "Proposal 2 Detail."
3. Exclude coverage of GLP-1 drugs for weight loss only across all populations (active and retiree members) and in tandem with Proposal 11.
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.
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 attachment titled "Proposal 5 Detail."
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.
7. Eliminate PPO10 and PP015 plans and all other plans except the current Unity/ PPO and Tiered Network plan options; Unity PPO and Tiered Network plan designs remain unchanged.
8. Eliminate the Medicare Supplement plans and migrate State members to the Medicare Advantage PPO15 plan option.
9. Limit physical therapy and chiropractic visits for all plans to 30 per year, each.
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 attachment titled "Proposal 10 Detail."
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.

Please let us know if you need any more information to assess these proposals.

Sincerely,

Andrea Spalla

Andrea Spalla
State Co-chair, SHBP-PDC
For the State representatives

c: Michael Zanyor, Public employee representative Co-chair, SHBP-PDC

Proposal 1.a Detail:[1]

Replace all current plans with minor changes to Unity PPO (referred to as the New PPO) and Tiered Network plan options, as well as prescription drug cost share changes, as follows:

Modified (Platinum 1) New PPO (Target Actuarial Value: approx. 94%)

In-Network:
- Single/Family Deductible of $200/$500
- Single/Family Out of Pocket Annual Maximum of $8,480/$16,960 (subject to yearly ACA limit adjustments)
- Single/Family Co-insurance Annual Maximum of $1,000/$2,500
- In-network co-insurance of 10% (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice)
- Primary Care Physician Co-pay of $15
- Specialist Co-pay of $35
- Emergency Room Co-pay of $150
- Urgent Care Co-pay of $50
- Inpatient Stay Co-insurance of 10%
- Outpatient Physical Therapy and Chiropractic Co-pay of $35 (subject to 30 visit annual maximum for each)
- Outpatient Surgery Facility Charge of 10%
- Outpatient Advanced Radiology Facility Charge of 10%
- Ambulance Co-insurance of 10%

Out-of-Network:
- Single/Family Deductible of $750/$1,875
- Single/Family Out of Pocket Annual Maximum of $6,500/$13,000
- Co-insurance of 30%
- Reimbursement rate maximum of 175% CMS

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$30
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$50
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $30/$60/$150
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

Modified (Platinum 1) Tiered Network Plan (Target Actuarial Value: approx. 94.5%)

In-Network:
- Single/Family Deductible of $100/$250 in Tier 1; $1,750/$3,500 in Tier 2

[1] The SHBP Pharmacy Benefit Manager ("PBM") designates drugs as "preferred" or "non-preferred" via its Pharmacy and Therapeutic Committee and Management Committee based on a drug's clinical efficacy, safety, and cost-effectiveness. Preferred drugs typically offer the best balance of therapeutic value and net plan cost (after rebates), while non-preferred drugs are often more expensive to the plan and/or have less favorable clinical profiles.

- Single/Family Out of Pocket Annual Maximum of $2,500/$5,000 in Tier 1; $5,500/$11,000 in Tier 2
- Single/Family Co-insurance Annual Maximum: Not Applicable
- In-network co-insurance (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice) at 5% in Tier 1 and 20% in Tier 2
- Primary Care Physician Co-pay of $10 in Tier 1, $25 in Tier 2
- Specialist Co-pay of $20 in Tier 1, $40 in Tier 2
- Emergency Room Co-pay of $150, both tiers
- Urgent Care Co-pay of $40 in Tier 1, $75 in Tier 2
- Inpatient Stay Co-insurance of $150 in Tier 1, 20% in Tier 2
- Outpatient Physical Therapy and Chiropractic Co-pay of $20 in Tier 1, $40 in Tier 2 (and subject to 30 visit annual maximum)
- Outpatient Surgery Facility Charge of $150 in Tier 1, 20% in Tier 2
- Outpatient Advanced Radiology Facility Charge of $20 in Tier 1, 20% in Tier 2
- Ambulance Co-insurance of 5% in Tier 1, 20% in Tier 2

Out-of-Network:
- Single/Family Deductible – Not Applicable
- Single/Family Out of Pocket Annual Maximum – Not Applicable
- Co-insurance – Not Applicable
- Reimbursement rate – Not Applicable

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$30
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$50
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $30/$60/$150
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

Proposal 1.b Detail:[2]

Replace all current plans with moderate changes to the Unity PPO (referred to as New PPO) and Tiered Network plan options, as well as prescription drug cost share changes, as follows:

Modified (Platinum 2) New PPO (Target Actuarial Value: approx. 91%)

In-Network:
- Single/Family Deductible of $500/$1,250
- Single/Family Out of Pocket Annual Maximum of $8,480/$16,960 (subject to yearly ACA limit adjustments)
- Single/Family Co-insurance Annual Maximum of $2,500/$6,250
- In-network co-insurance of 15% (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice)
- Primary Care Physician Co-pay of $20
- Specialist Co-pay of $40
- Emergency Room Co-pay of $200
- Urgent Care Co-pay of $75
- Inpatient Stay Co-insurance of 15%
- Outpatient Physical Therapy and Chiropractic Co-pay of $40 (and subject to 30 visit annual maximum, each)
- Outpatient Surgery Facility Charge of 15%
- Outpatient Advanced Radiology Facility Charge of 15%
- Ambulance Co-insurance of 15%

Out-of-Network:
- Single/Family Deductible of $1,500/$3,750
- Single/Family Out of Pocket Annual Maximum of $6,500/$13,000
- Co-insurance of 40%
- Reimbursement rate maximum of 175% CMS

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$40
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$80
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $40/$80/$200
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

Modified (Platinum 2) Tiered Network Plan (Target Actuarial Value: approx. 93%)

In-Network:
- Single/Family Deductible of $200/$500 in Tier 1; $2,000/$5,000 in Tier 2

[2] The SHBP Pharmacy Benefit Manager ("PBM") designates drugs as "preferred" or "non-preferred" via its Pharmacy and Therapeutic Committee and Management Committee based on a drug's clinical efficacy, safety, and cost-effectiveness. Preferred drugs typically offer the best balance of therapeutic value and net plan cost (after rebates), while non-preferred drugs are often more expensive to the plan and/or have less favorable clinical profiles.

- Single/Family Out of Pocket Annual Maximum of $2,500/$5,000 in Tier 1; $6,500/$13,000 in Tier 2
- Single/Family Co-insurance Annual Maximum: Not Applicable
- In-network co-insurance (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice) at 10% in Tier 1 and 25% in Tier 2
- Primary Care Physician Co-pay of $10 in Tier 1, $25 in Tier 2
- Specialist Co-pay of $20 in Tier 1, $40 in Tier 2
- Emergency Room Co-pay of $200, both tiers
- Urgent Care Co-pay of $50 in Tier 1, $100 in Tier 2
- Inpatient Stay Co-insurance of $150 in Tier 1, 25% in Tier 2
- Outpatient Physical Therapy and Chiropractic Co-pay of $20 in Tier 1, $40 in Tier 2 (and subject to 30 visit annual maximum each)
- Outpatient Surgery Facility Charge of $175 in Tier 1, 25% in Tier 2
- Outpatient Advanced Radiology Facility Charge of $20 in Tier 1, 25% in Tier 2
- Ambulance Co-insurance of 10% in Tier 1, 25% in Tier 2

Out-of-Network:
- Single/Family Deductible – Not Applicable
- Single/Family Out of Pocket Annual Maximum – Not Applicable
- Co-insurance – Not Applicable
- Reimbursement rate – Not Applicable

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$40
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$80
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $40/$80/$200
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

Proposal 1.c Detail:[3]

Replace all current plans with modernized Unity PPO (referred to as New PPO) and Tiered Network plan options, as well as prescription drug cost share changes, as follows:

Modernized (High Gold) New PPO (Target Actuarial Value: approx. 88%)

In-Network:
- Single/Family Deductible of $1,000/$2,500
- Single/Family Out of Pocket Annual Maximum of $8,480/$16,960 (subject to yearly ACA limit adjustments)
- Single/Family Co-insurance Annual Maximum of $3,000/$7,500
- In-network co-insurance of 25% (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice)
- Primary Care Physician Co-pay of $30
- Specialist Co-pay of $50
- Emergency Room Co-pay of $300
- Urgent Care Co-pay of $100
- Inpatient Stay Co-insurance of 25%
- Outpatient Physical Therapy and Chiropractic Co-pay of $50 (and subject to 30 visit annual maximum each)
- Outpatient Surgery Facility Charge of 25%
- Outpatient Advanced Radiology Facility Charge of 25%
- Ambulance Co-insurance of 25%

Out-of-Network:
- Single/Family Deductible of $2,000/$5,000
- Single/Family Out of Pocket Annual Maximum of $6,500/$13,000
- Co-insurance of 50%
- Reimbursement rate maximum of 175% CMS

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$50
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$100
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $50/$100/$250
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

[3] The SHBP Pharmacy Benefit Manager ("PBM") designates drugs as "preferred" or "non-preferred" via its Pharmacy and Therapeutic Committee and Management Committee based on a drug's clinical efficacy, safety, and cost-effectiveness. Preferred drugs typically offer the best balance of therapeutic value and net plan cost (after rebates), while non-preferred drugs are often more expensive to the plan and/or have less favorable clinical profiles.

Modernized Tiered Network Plan (Target Actuarial Value: approx. 91%)

In-Network:
- Single/Family Deductible of $250/$625 in Tier 1; $2,500/$6,250 in Tier 2
- Single/Family Out of Pocket Annual Maximum of $3,000/$6,000 in Tier 1; $6,500/$13,000 in Tier 2
- Single/Family Co-insurance Annual Maximum: Not Applicable
- In-network co-insurance (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice) at 15% in Tier 1 and 25% in Tier 2
- Primary Care Physician Co-pay of $15 in Tier 1, $30 in Tier 2
- Specialist Co-pay of $25 in Tier 1, $50 in Tier 2
- Emergency Room Co-pay of $300, both tiers
- Urgent Care Co-pay of $75 in Tier 1, $125 in Tier 2
- Inpatient Stay Co-insurance of $150 in Tier 1, 25% in Tier 2
- Outpatient Physical Therapy and Chiropractic Co-pay of $25 in Tier 1, $50 in Tier 2 (and subject to 30 visit annual maximum)
- Outpatient Surgery Facility Charge of $200 in Tier 1, 25% in Tier 2
- Outpatient Advanced Radiology Facility Charge of $25 in Tier 1, 25% in Tier 2
- Ambulance Co-insurance of 15% in Tier 1, 25% in Tier 2

Out-of-Network:
- Single/Family Deductible – Not Applicable
- Single/Family Out of Pocket Annual Maximum – Not Applicable
- Co-insurance – Not Applicable
- Reimbursement rate – Not Applicable

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$50
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$100
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $50/$100/$250
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

Proposal 1.d Detail:[4]

Replace all current plans with modified Unity PPO (referred to as New PPO) and Tiered Network plan options that incentivize primary care physician visits, with prescription drug cost share changes, as follows:

Modified $0 PCP Co-Pay New PPO (Target Actuarial Value: approx. 90%)

In-Network:
- Single/Family Deductible of $500/$1,250
- Single/Family Out of Pocket Annual Maximum of $5,000/$10,000
- Single/Family Co-insurance Annual Maximum of $2,000/$5,000
- In-network co-insurance of 25% (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice)
- Primary Care Physician Co-pay of $0
- Specialist Co-pay of $75
- Emergency Room Co-pay of $200
- Urgent Care Co-pay of $125
- Inpatient Stay Co-insurance of 0% (no charge to member)
- Outpatient Physical Therapy and Chiropractic Co-pay of $75 (and subject to 30 visit annual maximum, each)
- Outpatient Surgery Facility Charge Co-insurance of 25%
- Outpatient Advanced Radiology Facility Charge Co-insurance of 25%
- Ambulance Co-insurance of 25%

Out-of-Network:
- Single/Family Deductible of $1,000/$2,500
- Single/Family Out of Pocket Annual Maximum of $6,500/$13,000
- Co-insurance of 50%
- Reimbursement rate maximum of 175% CMS

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$50
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$100
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $50/$100/$250
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

[4] The SHBP Pharmacy Benefit Manager ("PBM") designates drugs as "preferred" or "non-preferred" via its Pharmacy and Therapeutic Committee and Management Committee based on a drug's clinical efficacy, safety, and cost-effectiveness. Preferred drugs typically offer the best balance of therapeutic value and net plan cost (after rebates), while non-preferred drugs are often more expensive to the plan and/or have less favorable clinical profiles.

Modified $0 PCP Co-Pay Tiered Network Plan (Target Actuarial Value: approx. 93%)

In-Network:
- Single/Family Deductible of $250/$625 in Tier 1; $2,000/$5,000 in Tier 2
- Single/Family Out of Pocket Annual Maximum of $2,000/$5,000 in Tier 1; $4,000/$10,000 in Tier 2
- Single/Family Co-insurance Annual Maximum: Not Applicable
- In-network co-insurance (for ambulance, durable medical equipment, diagnostic tests and imaging, outpatient surgery facility fees, inpatient hospital facility and physician charges, skilled nursing, hospice) at 5% in Tier 1 and 20% in Tier 2
- Primary Care Physician Co-pay of $0 in Tier 1, $30 in Tier 2
- Specialist Co-pay of $35 in Tier 1, $60 in Tier 2
- Emergency Room Co-pay of $200, both tiers
- Urgent Care Co-pay of $75 in Tier 1, $125 in Tier 2
- Inpatient Stay Co-insurance of $150 in Tier 1, 20% in Tier 2
- Outpatient Physical Therapy and Chiropractic Co-pay of $35 in Tier 1, $60 in Tier 2 (and subject to 30 visit annual maximum each)
- Outpatient Surgery Facility Charge of $200 in Tier 1, 20% in Tier 2
- Outpatient Advanced Radiology Facility Charge of $25 in Tier 1, 20% in Tier 2
- Ambulance Co-insurance of 5% in Tier 1, 20% in Tier 2

Out-of-Network:
- Single/Family Deductible – Not Applicable
- Single/Family Out of Pocket Annual Maximum – Not Applicable
- Co-insurance – Not Applicable
- Reimbursement rate – Not Applicable

Prescription Drug Benefits:
- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments)
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$50
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $20/$40/$100
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $50/$100/$250
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

Proposal 2 Detail:[5]

Modify prescription drug co-pays across all plans, in tandem with Proposal 11, as follows:

Prescription Drug Benefits:

- Single/Family Out of Pocket Annual Maximum of $2,120/$4,240 (subject to yearly ACA limit adjustments); GLP-1 drugs for weight loss are excluded from OOP annual maximum
- Retail/Mail/Specialty Co-pays for Generic Drugs: $10/$20/$50
- Retail/Mail/Specialty Co-pays for Preferred Brand Drugs: $30/$60/$150
- Retail/Mail/Specialty Co-pays for Non-preferred Brand Drugs: $120/$240/$600
- Mandatory generics (member may choose brand name and pay the difference)
- Mandatory mail order for maintenance drugs

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.

[5] The SHBP Pharmacy Benefit Manager ("PBM") designates drugs as "preferred" or "non-preferred" via its Pharmacy and Therapeutic Committee and Management Committee based on a drug's clinical efficacy, safety, and cost-effectiveness. Preferred drugs typically offer the best balance of therapeutic value and net plan cost (after rebates), while non-preferred drugs are often more expensive to the plan and/or have less favorable clinical profiles.

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[6] 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

[6] Other services or procedures to consider adding to the pilot program are: infusion site of care steerage; cardio-metabolic services; surgical diagnosis for urology, ENT, gastroenterology, and pain management.