SHBP PDC RESOLUTION 2026-9

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO REDUCE AND MODERNIZE THE PLANS OFFERED BY STATE HEALTH BENEFITS PROGRAM

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, except for the Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, the costs for health and prescription drug benefits continue to increase exponentially, which has strained the budgets of the State and local employers and caused increased costs to members; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State and local employers to reduce and modernize the SHBP's plan offering to promote operational efficiency and incentivize members to choose the appropriate plan for their needs.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. Effective 1/1/2027, the State Health Benefits Program shall offer only three plans for all active employee members and their dependents: (1) the SHBP PPO; (2) the SHBP HDHP; and (3) the SHBP HMO.

   The plan design of the SHBP' plans shall be as follows:

	SHBP PPO	**SHBP HDHP**	**SHBP HMO**
In-Network			
In-network Deductible applicable to all services except preventative care, laboratory testing services, and services subject to co-payments.	Individual $500; Family $1,000; Individual in Family $500	The in-network deductible shall be $2,500 greater than the HDHP minimum deductible set by the IRS for each plan year for single coverage and $5,000 greater than the HDHP minimum	Individual $250; Family $500; Individual in Family $250

		deductible set by the IRS for each plan year for family coverage (i.e., the deductible for plan year 2027 will be $4,250 for single and $8,500 for family coverage and $8,500 individual in family).	
In-network Coinsurance applicable to **all** services except preventative care, laboratory testing services, and services subject to co-payments.	20%	20%	20%
Total In-network Out-of-Pocket Maximum (INNMOOP) (Copayments + Deductible + Coinsurance)	The out-of-pocket limit imposed by the federal Patient Protection and Affordable Care Act for the plan year for individual and family coverage respectively minus the pharmacy out-of-pocket maximum stated in the State Health Benefits Plan Design Committee Resolution #2025-11 (i.e., the INN MOOP for plan year 2027 will be $9,880 for single and $19,760 for family coverage).	The out-of-pocket limit imposed by the IRS and federal Patient Protection and Affordable Care Act for HDHPs for the plan year for individual and family coverage respectively (i.e., the INN MOOP for plan year 2027 will be $8,700 for single and $17,400 for family coverage and $12,000 for an individual in a family).	The out-of-pocket limit imposed by the federal Patient Protection and Affordable Care Act for the plan year for individual and family coverage respectively minus the pharmacy out-of-pocket maximum stated in the State Health Benefits Plan Design Committee Resolution #2025-11 (i.e., the INN MOOP for plan year 2027 will be $9,880 for single and $19,760 for family coverage).
In-Network Health Care Services			
Direct Primary Care	$10	N/A	N/A
Primary Care Office Visit	$20	20% after deductible	$20
Specialist Office Visit including	$40	20% after deductible	$40

Physical/Occupational/Speech Therapy and Chiropractic			
Diagnostic Radiology/Imaging Services	$50 (excluding for pregnancy)	20% after deductible	$50 (excluding for pregnancy)
Urgent Care	$75	20% after deductible	$75
Emergency Room	$150	20% after deductible	$150
Out-of-Network			
Out-of-network deductible	Individual $1,000 Family $2,000	Twice the in-network deductible	No out-of-network benefits
Out-of-Network Coinsurance after deductible applicable to all services	30%	40%	
Out-of-network reasonable and customary allowance	175% of CMS	175% of CMS	
Out-of-network Out-Of-Pocket Coinsurance Maximum	Twice the out-of-pocket limit imposed by the federal Patient Protection and Affordable Care Act for the plan year for individual and family coverage respectively (i.e., the out-of-network out-of-pocket coinsurance maximum for plan year 2027 will be $24,000 for single and $48,000 for family coverage).	Twice the out-of-pocket limit imposed by the federal Patient Protection and Affordable Care Act for the plan year for individual and family coverage respectively (i.e., the out-of-network out-of-pocket coinsurance maximum for plan year 2027 will be $24,000 for single and $48,000 for family coverage).	

2. Out-of-network physical therapy services shall be capped at 20 visits consistent with Resolution #2025-10.

3. The HSA contribution limit for the SHBP HDHP will be the HSA contribution limit set by the IRS for each plan year (i.e., the HSA contribution limit for plan year 2027 will be $4,500 for single and $9,000 for family coverage).

4. The HSA catch-up contribution limit for the SHBP HDHP for persons age 55 or older will be the amount set by the IRS for each plan year (i.e., the HSA catch-up contribution limit for plan year 2027 will be $1,000).

5. The HSA employer contribution for the SHBP HDHP may be a maximum of $500 for each plan year.

6. No plan offered by the SHBP may offer an employer-funder HRA.

7. The prescription drug copayments and out-of-pocket maximum for the SHBP PPO and SHBP HMO shall be as stated in State Health Benefits Plan Design Committee Resolution #2025-11. For the abundance of doubt, the SHBP will no longer offer an integrated prescription drug plan (i.e., MMRX).

8. For the SHBP HDHP, the prescription drugs are included in the plan and are subject to the plan deductible and coinsurance. This means that the member pays the full cost of the medications until the deductible is reached. Once the deductible is reached, the member pays 20% coinsurance until the out-of-pocket maximum is met.

DATED: September 1, 2026