Provider Conferences – 2008

Welcome and thank you for joining us –
We’re glad that you are here!
Agenda

• Updates and reminders
• House bills
• Improving member’s health
• Immunizations and medications
Updates & reminders
National provider identifier (NPI)

• As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Blue Cross and Blue Shield of North Carolina (BCBSNC) made the decision to comply with the National Provider Identifier (NPI) mandate on May 23, 2008.

• Under HIPAA, providers and health insurance carriers are considered covered entities and were instructed to comply with the NPI mandate effective May 23, 2008. As a result, electronic transactions received by BCBSNC on or after May 23, 2008, without an NPI will be rejected.
New member ID cards

• We’re redesigning our member ID card as part of an overall Blue Cross and Blue Shield Association effort to standardize ID cards for all Blue members nationwide.

• The Association wants to ensure that the benefit information on the cards is consistent and easy to find and understand.

• Additionally, a North Carolina senate bill, effective January 1, 2009, requires that all insurers list certain copayments on ID cards, as well as, the effective date of coverage or the issue date of the card.
New member ID cards – Sample drafts
New member ID cards

• The names for all dependents covered, as well as copayment amounts and helpful phone numbers, those will continue to be listed on the new ID cards.

• ID cards for our group and under 65 individual business that are printed on or after September 15, 2008, will reflect the new design and a thicker card stock. This includes all new enrollees, requests for additional ID cards and group maintenance changes.

• Everyone will receive a new ID card at the time of their renewal.
Enhanced explanation of payment (EOP)

- Beginning in mid-April, you may have noticed a new EOP message with a toll-free phone number and address you can use if you have questions about an EOP. Also, five new fields have been added on the EOP:
  - Number of days used to calculate the late payment interest
  - Two fields show the non-refunded principal and non-refunded interest amounts for an adjusted claim
  - Total non-refunded principal for the entire remittance
  - Total non-refunded interest for the entire remittance
**Enhanced explanation of payment (EOP)**

- Field to assist with tracking claims adjusted when the adjustment results in a negative balance. The newly created field will display text reading Balance Forward (beginning balance amount) and/or any Ending Balance (ending balance amount)

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>ID Number</th>
<th>Dates of Service</th>
<th>Patient Number</th>
<th>Medical Rec Number</th>
<th>Place</th>
<th>Remark Code</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Service</td>
<td>PC/Days</td>
<td>Prov ID</td>
<td>Billed Charges</td>
<td>Contracted Charges</td>
<td>Disallowed Amount</td>
<td>Deductible Amount</td>
<td>Copay/Coins Amount</td>
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<tr>
<td>SUBSCRIBER Mary WELNESS</td>
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<td>11/29/2006</td>
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<td>-20.00</td>
<td>11/29/2006</td>
<td>-5.00</td>
</tr>
<tr>
<td>HMO-BLUE CARE</td>
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<td>EFT BATCH #: 070012345</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Ending Balance -75.00**
Credentialing and re-credentialing update

• Recently BCBSNC updated the minimum liability insurance requirements for initial credentialing and re-credentialing of professional providers.
• The new minimum insurance liability limits are one-million dollars per occurrence / three-million dollars aggregate, over the previous one-million dollars per occurrence / one-million dollars aggregate.
• The limits increase went into effect May 1, 2008, for all new credentialing applications and will become effective on May 1, 2009 for all re-credentialing applications.
Blue Options 1-2-3™

• Blue Options 1-2-3™ is a new PPO plan that utilizes the same Blue Options™ network that our existing PPO plans use today.

• Blue Options 1-2-3™ promotes members’ enrollment with primary care physicians and encourages preventive health screenings and regular physical exams.

• Blue Options 1-2-3™ provides an affordable option for groups to offer to their employees because it gives employers the ability to design the benefits (deductible and coinsurance options) to meet their employee’s needs.

Became available January 1, 2008
You may have already seen this new member identification card presented by patients at your practice who are enrolled in Blue Options 1-2-3℠.
Blue Options 1-2-3™

1. Preventive and primary care
   - Copay
   - Lowest out-of-pocket

2. Inpatient hospital care
   - Coinsurance (following deductible)
   - Mid-level out-of-pocket

3. Outpatient care or specialist care
   - Coinsurance (following deductible)
   - Highest out-of-pocket
“Large Group” employer groups offering their employees a Blue Options HRA™ plan now have an option to elect “Pay Provider”.

The “Pay Provider” option gives providers the ability to file claims directly to BCBSNC for direct reimbursement by BCBSNC, instead of collecting payment from the member.
Blue Medicare HMO and PPO plans

Became available January 1, 2008

✓ Blue Medicare HMO and PPO ID cards are readily recognizable but remember that the cards include both BCBSNC and PARTNERS information. Therefore it’s important to review the cards carefully and take note of the Blue Medicare HMO or PPO alpha prefixes and PARTNERS National Health Plans of North Carolina, Inc (PARTNERS) information.
Blue Medicare HMO and PPO plans

• Blue Medicare is offered by PARTNERS National Health Plans of North Carolina, Inc., a BCBSNC company. Because of this, the following basic rules apply:
  - Only providers directly contracted with PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS) are considered as in-network for Blue Medicare HMO and Blue Medicare PPO. Participation with BCBSNC does not extend to Blue Medicare HMO and/or Blue Medicare PPO.
  - BCBSNC participating providers that are not contracted with PARTNERS can provide services to Blue Medicare PPO members as part of the member’s PPO out-of-network benefits.
  - Blue Medicare HMO members have no out-of-network benefits (except for emergency care).
Blue Medicare HMO and PPO plans

(continued)

- Claims submitted to BCBSNC for Blue Medicare HMO and PPO members in error will be returned to the submitting provider or electronic clearinghouse. This includes both paper and electronic claims.

- Providers participating with both BCBSNC and PARTNERS cannot use Blue e electronic transactions for Blue Medicare HMO and PPO claims and/or member information.

- BCBSNC health coaching services, claims processing, post adjudication review and medical policy do not apply to Blue Medicare HMO and Blue Medicare PPO. These services and functions are administered by PARTNERS at its Winston-Salem location.
Blue Book™ provider manual on the Web

March 2008
Now available
bcbsnc.com/providers/
Network Management regional offices

Greensboro
1-888-298-7567

Hickory
1-877-889-0002

Charlotte
1-800-754-8185

Raleigh
1-800-777-1643

Wilmington / Greenville
1-877-889-0001 / 1-888-291-1780
Your opinion matters

BCBSNC provider survey

bcbsnc.com/providers/

BlueCross BlueShield of North Carolina

BCBSNC Provider Survey

About you and your health care organization
Please begin by telling us about you and your health care organization.

1. Which of the following best describes your health care organization?

- Medical MD primary care practice
- Medical MD specialist care practice
- Mental health practice
- Urgent care practice
- Hospital system
- Ambulatory surgical center
- Ambulance service
- Durable medical equipment supplier
House bills
Elimination of the State Health Indemnity Plan (House Bill 1473)

- State Health Plan Indemnity coverage for State Health Plan retirees, employees and their enrolled dependents, will be eliminated as of midnight, June 30, 2008.

- All State Health Plan Indemnity members are transitioning to one of the three NC SmartChoice™ PPO plan options if electing State Health Plan coverage.

- Any State Health Plan member that did not elected a PPO plan option, will be enrolled in the 80/20 PPO plan beginning July 1, 2008 (if having State Health Plan coverage).
Elimination of the State Health Indemnity Plan (House Bill 1473)

• BCBSNC State Operations will continue to serve NC HealthChoice, the state's program for uninsured children.

• BCBSNC State Operations will handle the run-out on Indemnity claims for services rendered through June 30, 2008.

➢ As a result of all Indemnity membership making the transition to a NC SmartChoice® PPO plan, the member’s Indemnity ID cards will no longer be active as of July 1, 2008. Please ensure that a copy of the member’s new PPO plan membership card is obtained for your records and that any paper claims for services provided on or after 07/01 are sent to P.O. Box 30087.
Mental health parity (House Bill 973)

• Effective July 1, 2008, or upon a group's subsequent renewal date, the following nine mental illnesses will be covered under the same benefits as medical conditions:

<table>
<thead>
<tr>
<th>Bipolar Disorder</th>
<th>Schizoaffective Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>Paranoid and Other Psychotic Disorder</td>
<td>Anorexia Nervosa</td>
</tr>
<tr>
<td></td>
<td>Bulimia</td>
</tr>
</tbody>
</table>

- All other mental conditions are covered with current mental health benefits of 30 inpatient/outpatient days and 30 office visits.
  • Does not include parity for substance abuse.
  • Applies only to group coverage - does not apply to individual coverage.
Standard ID cards and prompt pay timelines
(House Bill 1032)

• Effective January 1, 2009, every insurer and the State Health Plan must provide an ID card to members with certain standard information, such as pertinent subscriber/member information, applicable copayments, contact information for the insurer, etc…

• Effective January 1, 2008, a two-year timeframe was placed for the time that (1) insurers can recover overpayments to physicians and facilities; and (2) physicians and facilities can seek underpayments.
  - The exception to the two-year period is in the case of health care fraud or when payments involve a government payor.
Coverage for prescriptions in emergencies (N.C. Department of Insurance Bill 748)

- Insurers will waive time restrictions on filling or refilling a prescription during a declared emergency or disaster.
- Insurers are still allowed to apply prior plan approval and quantity limitation requirements.
Thomas settlement
Discussion overview

- Thomas settlement Information
- BCBSNC compliance with Thomas Business Initiatives
- Identify opportunities to increase provider awareness about Thomas
Thomas settlement overview

• Agreement between physicians, various medical societies, the BCBSA, and the majority of Blue plans
• Resolves a series of issues between the Blue plans and physicians
• BCBSNC is committed to transparency and to working with physicians in tackling the major health care issues facing North Carolina
BCBSNC compliance with Thomas – 2007 Initiatives

• Establishment of the joint advisory group (JAG)
• Additional fee schedule disclosures
• Enhancement to the authorization notification process
• Updates to the overpayment/refund request process
BCBSNC compliance with Thomas – 2008 Initiatives

- Updates to physician agreements
- Significant claim edits posted on Blue e™
- Updates to member explanation of benefits (EOB) form
- Updates to the physician’s explanation of payment (EOP) form
- Enhancements to the HIPAA 835 transaction
BCBSNC compliance with Thomas 2008 – 2009 Initiatives

• Ability for providers to send certain clinical information to BCBSNC electronically
• Standardization of claims payment practices
• Full fee schedules available by practice (added to Blue eSM in 2009 with secure access)
• Additional prompt payment interest
BCBSNC compliance with Thomas
New post-service provider appeals process

• Post-service provider appeals process for billing and medical necessity disputes

• Filing fee associated with 2\textsuperscript{nd} level request for review by an external vendor
  
  \((2\textsuperscript{nd} \text{level only available for professional services})\)

• New process for filing provider appeals
  
  \(\text{− New provider appeal forms}\)
  
  \(\text{− Fax number for medical necessity and billing requests}\)
BCBSNC compliance with Thomas – Ongoing initiatives

• Disclosure and transparency
• Reduce precertification requirements
• Reduce overpayments
• Improve member eligibility information given to physicians
• Improve the Inter-Plan Programs (BlueCard®) system for providers
Where to find additional information

- BCBSNC external provider Web site
  - [http://www.bcbsnc.com/providers/thomas_love.cfm](http://www.bcbsnc.com/providers/thomas_love.cfm)
- Contact your Network Management representative
- Blue Book<sup>™</sup> provider manual
- Blue Link<sup>™</sup> provider newsletter
- Email blasts
Inter-Plan Programs Updates (BlueCard)
On April 1, 2008, Blue Cross of California changed its operating name to Anthem Blue Cross and California’s Blue Cross Life & Health subsidiary changed its name to Anthem Blue Cross Life and Health.

During the next few months, all California Anthem members will receive new ID cards with the Anthem Blue Cross brand.

For a period of several months, you may see both names.

The name change will be completed by August 31, 2008.
Wellmark Blue Cross and Blue Shield

- Wellmark Blue Cross and Blue Shield in cooperation with CatalystRx conducts quarterly drug utilization review (DUR) programs for Wellmark members.

- These programs primarily focus on patient safety, as example:
  - Members that have been prescribed a drug that has been recalled
  - To identify members who are receiving multiple prescriptions from several providers and/or pharmacies

- As a result of these programs, Wellmark may contact the prescribing physician to make them aware of potential concerns for their patients.
  - Communication with providers typically consists of an informational letter along with information on the patient in question
Medicare Advantage private fee for service

- MA PFFS is a health plan offered by an organization that pays physicians and providers on a fee-for-service basis.
- Patients can obtain services from any licensed physician or provider in the United States who is qualified to be paid by Medicare and accepts the health plan’s terms and conditions of payment.
- There is usually no contract or network that providers sign up for to provide service to PFFS patients.
- The Plan must provide the same coverage under PFFS as Medicare Part A and Part B, and may also offer additional benefits.
Medicare Advantage private fee for service

• Unlike coordinated care health plans, the MA PFFS plans are not required to contract with providers to participate.
• Providers need to know that the member is covered under a PFFS health plan, accept the health plan’s terms and conditions and provide care to be able to bill for services.
• PFFS plans call these providers “deemed providers.”
• If a provider does not agree to the terms and conditions, the provider should not provide services to the PFFS member (does not apply to emergency care situations).
Medicare Advantage private fee for service

• Ask the member for his or her ID card. Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card along with the following logo:

![Medicare Advantage PFFS logo]

• Use the same processes you use today to verify eligibility by calling 1-800-676-Blue (2583) and providing the alpha prefix or electronically with Blue e™
Medicare Advantage private fee for service

- Instructions for accessing PFFS terms and conditions are on the back of the member’s ID card.
- Terms and conditions are posted on the Web site of the member’s Plan.
- Terms and conditions for any Blue MA PFFS product can also be accessed through BCBSNC’s Web site at [https://www.bcbsnc.com/providers/edi/](https://www.bcbsnc.com/providers/edi/)
  - To view the terms and conditions for any MA PFFS member’s Blue health plan, from our Web site, enter the first three letters of the member’s identification number as listed on the member’s ID card and click “Go.” Your browser will then be directed to the appropriate terms and conditions for that member.
Medicare Advantage private fee for service

• Submit claims to BCBSNC

• Do not bill Medicare directly for any services rendered to a MA member. Payment will be made directly by BCBSNC.

• Reimbursements are the equivalent of the current Medicare payment amount for all covered services (i.e., the amount you would collect if the member was enrolled in original Medicare).
  
  ▪ Details are provided in the product terms and conditions.

• Providers can collect any applicable cost-sharing amount (i.e., co-pay, deductible).
Improving member’s health
Free resources to help your patients lose weight and manage diabetes

• Member Health Partnerships, provides your patients many tools and benefits for losing weight and managing diabetes including six free nutrition counseling visits per year and health coaching.

• By joining Member Health Partnerships, BCBSNC members can visit a credentialed registered dietitian six times per year with no copay if they see an in-network provider in an office-based setting.

• Members can call health coaches 24 hours per day with questions about weight loss, healthy eating and physical activity.

• BCBSNC commercial members (Blue Care, Blue Options, and Blue Advantage) can enroll in Member Health Partnerships by having them call 1-800-218-5295.
New tobacco cessation counseling codes

• BCBSNC, including the NC State Health Plan, is reimbursing for two new CPT codes for tobacco cessation counseling.

• Codes 99406 and 99407 should be used to report services provided face to face by a physician or other qualified health care professional, using "standardized, evidence-based screening instruments and tools with reliable documentation and appropriate sensitivity."
Tobacco cessation counseling codes

- Choice of code depends on time spent with the patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Time spent with patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
<td>Intermediate visit 3-10 minutes</td>
</tr>
<tr>
<td>99407</td>
<td>Intensive visit 10 or more minutes</td>
</tr>
</tbody>
</table>

These codes are payable in addition to other E & M services provided on the same day.
Free tobacco cessation resources

• North Carolina Quitline
  – Refer patients using a fax referral form or tell patients to call 1-800-Quit-Now (1-800-784-8669)
  – Available in multiple languages, 7 days a week from 8 a.m. - midnight

• BCBSNC Provider Toolkit
  – Free toolkits can be requested by completing fax form or calling 1-800-218-5295

• Member Health Partnerships – Tobacco Free
  – Quit kits available to most BCBSNC members by calling 1-800-218-5295
Colonoscopy standard benefit

• Colonoscopy is a covered benefit for all BCBSNC members. Colonoscopy screening in an office-based colonoscopy center can lead to significant out-of-pocket cost savings for members.

• The out-of-pocket cost of a colonoscopy done in an office-based center is a member’s specialty co-payment for Blue Care, Blue Options and Blue Advantage members.

• Members can have a colonoscopy in a hospital or ambulatory care center, subject to deductible and coinsurance.
Colonoscopy benefit information

• Colon cancer screening is an enhanced preventive benefit for Blue Options HSA members. Screening must take place in an office location to meet the Blue Options HSA preventive benefits.

• Physicians who do colonoscopies in an office based colonoscopy center are listed in the provider directory at bcbsnc.com, under Find a Doctor.

Members can check their benefit booklets or call BCBSNC Customer Service to determine their benefits.
Select your county and choose “Colonoscopy/office-based” under specialty
Immunizations & medication
Prior review for Remicade, Orenicia and Rituxan

• As of July 1, 2008, Remicade, Orenicia and Rituxan will require prior review in addition to the other drugs in the class (Enbrel, Humira, and Kineret) that already require prior review.

• These drugs are primarily used for the treatment of rheumatoid arthritis, crohn’s disease, ulcerative colitis, psoriasis and cancer and are IV medications covered under the medical benefits only.

• Rituxan will only require prior review when used for the treatment of rheumatoid arthritis. When it is used for cancer therapy it will not require prior review.
Removal of PA for anorexiant

• As of January 1, 2008, BCBSNC has removed the prior authorization (PA) requirement for weight loss drugs Xenical and Meridia.

• These agents have some long-term safety and efficacy data available and will continue to be covered on tier 3 of the formulary.

• During the Summer of 2007, a half-strength OTC version of Xenical called Alli was made available.
Prescription drug search

Use this simple tool to find information about prescription drugs. Enter the first few letters of the brand or generic drug name you would like to research below, then click the FIND DRUG button.

Medicare Prescription Drug Plan members: Learn which drugs are covered by your plan by reviewing the Medicare Prescription Drug Plan drug list. This drug list also includes drugs covered by Blue Medicare HMO and Blue Medicare PPO.

Retail Specialty Drug Network: Certain specialty drugs must be purchased at a BCBSNC retail specialty drug network pharmacy in order for your prescription to be covered (see your benefit booklet for any other requirements that might apply). Learn which specialty drugs are affected and which pharmacies are participating.

Your search results will include:

- Generic availability
- Tier classification
- Average cost
- Medication class
- Alternative options
- Important notes about the drug coverage

This search is based on the Tier 4 Formulary used by many of our plans. Drugs are assigned into one of four categories, or payment tiers, based on drug usage, cost and clinical effectiveness.

To find out if the Tier 4 Formulary applies to you, please refer to your benefit booklet or your BCBSNC member ID card.

The information on this page is current as of 02/21/08.
Medication Dedication℠

• Our Medication Dedication℠ program is designed to help members with chronic conditions improve their overall health and reduce their out-of-pocket prescription drug expenses. The program focuses on four chronic conditions:
  − Congestive heart failure (CHF)
  − High blood pressure
  − Diabetes
  − High cholesterol

• The program waives the copayment for specific generic drugs and moves more expensive brand-name drugs to the second lowest copayment tier.
Vaccine codes early release

• Three vaccine codes for products that pended FDA approval were implemented on January 1, 2008, but will not be published until CPT 2009:
  − 90681 Rotavirus vaccine, human, attenuated, two-dose schedule, live, for oral use
  − 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use
  − 90650 HPV vaccine, types 16 and 18, bivalent, three-dose schedule for intramuscular use
    • If billing HPV, use the current FDA approved code 90649
Vaccine safety

• Vaccines should always be transported and stored at their proper temperature.
• Vaccines can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered.
• BCBSNC members should never be asked to pick-up vaccines from the pharmacy for transport to a provider’s office, as this may result in unsafe temperature changes.
• Vaccines should only be obtained by the administering provider and never by a BCBSNC member.
Office-administered specialty drug network

- By taking advantage of the office administered specialty drug network, certain member specific and dose-specific injectable drugs can be delivered directly to your office and the network vendors will bill BCBSNC directly for the drug.

<table>
<thead>
<tr>
<th>The office-administered specialty drug network will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Improve access and simplify the process of obtaining select injectable drugs</td>
</tr>
<tr>
<td>- Remove financial risk that you may have incurred when supplying injectable drugs in the past</td>
</tr>
<tr>
<td>- Reduce paperwork for your office</td>
</tr>
<tr>
<td>- Verify eligibility with BCBSNC and inform the provider of prior approval requirements, when applicable</td>
</tr>
<tr>
<td>- Streamline the submission of injectable drug claims</td>
</tr>
</tbody>
</table>
Office-administered specialty drug network

• Use of the office-administered specialty drug network is voluntary.

• Network vendors will bill BCBSNC directly for the injectable drug.

• If you order a member-specific or dose-specific injectable drug from a network vendor, you do not file a claim with BCBSNC for the drug. The vendor will bill BCBSNC directly.
Office-administered specialty drug network

- Participating vendors include:
  - Caremark 1-800-571-3922
  - Medmark Inc. 1-888-884-8714
  - McKesson 1-888-456-7274
  - US Bioservices 1-800-816-7758
  - Hemophilia Resources of America 1-336-854-3128
    (Hemophilia Resources of America is the vendor to provide factor drugs only)
Office-administered specialty drug network

• During 2007, BCBSNC expanded the list of available network drugs to include:
  - Alglucosidase Alpha (Myozyme)
  - Decitabine (Dacogen)
  - Etonogestrel Implant (Implanon)
  - Idursulfase (Elaprase)
  - Naltrexone (Vivitrol)
  - Nelarabine (Arranon)
  - Panitumumab (Vectibix)
  - Ranibizumab (Lucentis)
  - Recombinant Hyaluronidase Human Injection (Hylenex)
  - Zoledronic Acid (Reclast)

• New additions effective January 1, 2008 include:
  - Histrelin acetate (Supprelin LA)
  - Lanreotide acetate (Somatuline Depot)
  - Protein C Concentrate (Ceprotin)
  - Temsirolimus (Torisel)
Office-administered specialty drug network

• Effective May 12, 2008, the following three vaccines were added to our office-administered specialty drug list:
  − Gardisil Human Papilloma Virus (HPV), vaccine for the prevention of diseases caused by HPV in girls and women age 9 to 26.
  − Zostavax Herpes Zoster Vaccine, for the prevention of herpes zoster in persons age 60 and older.
  − Adacel Tetanus, diphtheria toxoids and acellular pertussis vaccine, an active booster immunization for the prevention of tetanus, diphtheria and pertussis (whooping cough) as a single dose in persons 11 to 64 years of age.
Office-administered specialty drug network

• A complete listing of the current pharmaceuticals available to you and your patients under the office-administered specialty drug network, as well as, a listing of all additions or deletions (which will become effective at the beginning of the next quarter) can be viewed on our Web site at: bcbsnc.com/providers/injectable-drugs/available

• Note, Medicare Supplement and State Health PPO members are excluded from this program.
Thank you for attending!
May we answer your questions?