



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsnc.com](http://www.bcbsnc.com) or by calling 1-877-275-9787.

| Important Questions                                                   | Answers                                                                                                                                                                                                                                                                                                                                                                                                                  | Why this Matters:                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>What is the overall deductible?</b></p>                         | <p>In-Network- <b>\$3,500</b><br/>                     Individual/<b>\$6,850</b> Family Member/<b>\$7,000</b> Family Total.<br/>                     Out-of-Network- <b>\$7,000</b><br/>                     Individual/<b>\$14,000</b> Family Member/<b>\$14,000</b> Family Total.<br/>                     Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.</p> | <p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>.</p> |
| <p><b>Are there other deductibles for specific services?</b></p>      | <p>No.</p>                                                                                                                                                                                                                                                                                                                                                                                                               | <p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>                                                                                                                                                                                                                 |
| <p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>  | <p>Yes. In-Network- <b>\$3,500</b><br/>                     Individual/<b>\$6,850</b> Family Member/<b>\$7,000</b> Family Total. Out-of-Network- <b>\$7,000</b> Individual/<b>\$14,000</b> Family Member/<b>\$14,000</b> Family Total.</p>                                                                                                                                                                               | <p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>                                                                                                                                                             |
| <p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p> | <p>Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services</p>                                                                                                                                                                                                                                                                          | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>                                                                                                                                                                                                                                                                          |
| <p><b>Is there an overall annual limit on what the plan pays?</b></p> | <p>Yes.</p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.</p>                                                            |

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

|                                                          |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Does this plan use a <u>network of providers</u>?</b> | Yes. For a list of In-Network providers, see <a href="http://www.bcbsnc.com/content/providersearch/index.htm">www.bcbsnc.com/content/providersearch/index.htm</a> or please call 1-877-275-9787 | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| <b>Do I need a referral to see a <u>specialist</u>?</b>  | No. You don't need a referral to see a specialist.                                                                                                                                              | You can see the <u>specialist</u> you choose without permission from this plan.                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Are there services this plan doesn't cover?</b>       | Yes.                                                                                                                                                                                            | Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about <u>excluded services</u> .                                                                                                                                                                                                                                                                                             |



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

| Common Medical Event                                                 | Services You May Need                            | Your cost* if you use a |                         | Limitations & Exceptions |
|----------------------------------------------------------------------|--------------------------------------------------|-------------------------|-------------------------|--------------------------|
|                                                                      |                                                  | In-Network Provider     | Out-of-Network Provider |                          |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | 0% Coinsurance          | 20% Coinsurance         | ---none---               |
|                                                                      | Specialist visit                                 | 0% Coinsurance          | 20% Coinsurance         | ---none---               |

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

| Common Medical Event                                                                                                                                                                                                                                                                                                                                           | Services You May Need                  | Your cost* if you use a                    |                                                                              | Limitations & Exceptions                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                |                                        | In-Network Provider                        | Out-of-Network Provider                                                      |                                                                                                              |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                                                                                                                  | Other practitioner office visit        | 0% Coinsurance/<br>Chiropractic Visit      | 20%<br>Coinsurance/<br>Chiropractic Visit                                    | -Coverage is limited to 30 visits for Chiropractic care.                                                     |
|                                                                                                                                                                                                                                                                                                                                                                | Preventive care/screening/immunization | No Charge                                  | 20% Coinsurance                                                              | -Limits may apply                                                                                            |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                                                                                      | Diagnostic test (x-ray, blood work)    | 0% Coinsurance                             | 20% Coinsurance                                                              | -No coverage for tests not ordered by a doctor.                                                              |
|                                                                                                                                                                                                                                                                                                                                                                | Imaging (CT/PET scans, MRIs)           | 0% Coinsurance                             | 20% Coinsurance                                                              | -Prior authorization may be required for benefits to be provided                                             |
| <b>If you need drugs to treat your illness or condition</b><br>More information about prescription drug coverage is available at <a href="https://host1.medcohealth.com/consumer/site/openenrollment?accessCode=NATPLSNAPRF14&amp;pageName=oeinfo">https://host1.medcohealth.com/consumer/site/openenrollment?accessCode=NATPLSNAPRF14&amp;pageName=oeinfo</a> | Generic drugs                          | After deductible is met:<br>0% Coinsurance | After deductible is met: Coinsurance + charge over In-Network Allowed Amount |                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                | Preferred brand drugs                  | After deductible is met:<br>0% Coinsurance | After deductible is met: Coinsurance + charge over In-Network Allowed Amount |                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                | Non-preferred brand drugs              | After deductible is met:<br>0% Coinsurance | After deductible is met: Coinsurance + charge over In-Network Allowed Amount | No coverage for drugs in excess of quantity limits or therapeutically equivalent to an over the counter drug |
|                                                                                                                                                                                                                                                                                                                                                                | Specialty drugs                        | After deductible is met:<br>0% Coinsurance | After deductible is met: Coinsurance + charge over In-Network Allowed Amount | 30 day supply limit                                                                                          |

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

| Common Medical Event                                                          | Services You May Need                          | Your cost* if you use a       |                                   | Limitations & Exceptions                                         |
|-------------------------------------------------------------------------------|------------------------------------------------|-------------------------------|-----------------------------------|------------------------------------------------------------------|
|                                                                               |                                                | In-Network Provider           | Out-of-Network Provider           |                                                                  |
| <b>If you have outpatient surgery</b>                                         | Facility fee (e.g., ambulatory surgery center) | 0% Coinsurance                | 20% Coinsurance                   | ---none---                                                       |
|                                                                               | Physician/surgeon fees                         | 0% Coinsurance                | 20% Coinsurance                   | ---none---                                                       |
| <b>If you need immediate medical attention</b>                                | Emergency room services                        | 0% Coinsurance                | 0% Coinsurance                    | ---none---                                                       |
|                                                                               | Emergency medical transportation               | 0% Coinsurance                | 0% Coinsurance                    | ---none---                                                       |
|                                                                               | Urgent care                                    | 0% Coinsurance                | 0% Coinsurance                    | ---none---                                                       |
| <b>If you have a hospital stay</b>                                            | Facility fee (e.g., hospital room)             | 0% Coinsurance                | 20% Coinsurance                   | -Precertification may be required                                |
|                                                                               | Physician/surgeon fee                          | 0% Coinsurance                | 20% Coinsurance                   | ---none---                                                       |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services   | 0% Coinsurance/<br>outpatient | 20%<br>Coinsurance/<br>outpatient | -Prior Authorization may be required                             |
|                                                                               | Mental/Behavioral health inpatient services    | 0% Coinsurance                | 20% Coinsurance                   | -Precertification required                                       |
|                                                                               | Substance use disorder outpatient services     | 0% Coinsurance/<br>outpatient | 20%<br>Coinsurance/<br>outpatient | -Prior Authorization may be required                             |
|                                                                               | Substance use disorder inpatient services      | 0% Coinsurance                | 20% Coinsurance                   | -Precertification required                                       |
| <b>If you are pregnant</b>                                                    | Prenatal and postnatal care                    | 0% Coinsurance                | 20% Coinsurance                   | -No coverage for maternity for dependent children.               |
|                                                                               | Delivery and all inpatient services            | 0% Coinsurance                | 20% Coinsurance                   | -Precertification may be required                                |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                               | 0% Coinsurance                | 20% Coinsurance                   | -Prior authorization may be required for benefits to be provided |

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

| Common Medical Event                                                                             | Services You May Need     | Your cost* if you use a |                         | Limitations & Exceptions                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------|---------------------------|-------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                  |                           | In-Network Provider     | Out-of-Network Provider |                                                                                                                                                                                                                                                                                                                               |
| <b>If you need help recovering or have other special health needs other special health needs</b> | Rehabilitation services   | 0% Coinsurance          | 20% Coinsurance         | -Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy - \$40,000 maximum per benefit period for Adaptive Behavior Treatment for members ages 18 and younger. |
|                                                                                                  | Habilitation services     | 0% Coinsurance          | 20% Coinsurance         | -Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy - \$40,000 maximum per benefit period for Adaptive Behavior Treatment for members ages 18 and younger. |
|                                                                                                  | Skilled nursing care      | 0% Coinsurance          | 20% Coinsurance         | -Coverage is limited to 60 days per benefit period.-Precertification required                                                                                                                                                                                                                                                 |
|                                                                                                  | Durable medical equipment | 0% Coinsurance          | 20% Coinsurance         | -Prior authorization may be required for benefits to be provided-Limits may apply                                                                                                                                                                                                                                             |
|                                                                                                  | Hospice services          | 0% Coinsurance          | 20% Coinsurance         | -Precertification may be required                                                                                                                                                                                                                                                                                             |

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

| Common Medical Event                          | Services You May Need | Your cost* if you use a |                         | Limitations & Exceptions |
|-----------------------------------------------|-----------------------|-------------------------|-------------------------|--------------------------|
|                                               |                       | In-Network Provider     | Out-of-Network Provider |                          |
| <b>If your child needs dental or eye care</b> | Routine eye exam      | No Charge               | 20% Coinsurance         | -Limits may apply        |
|                                               | Glasses               | Not Covered             | Not Covered             | Excluded Service         |
|                                               | Dental check-up       | Not Covered             | Not Covered             | Excluded Service         |

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other [excluded services.](#))

- Acupuncture
- Long-term care, respite care, rest cures
- Cosmetic surgery and services
- Routine Foot Care
- Dental care (Adult)
- Weight loss programs

\*HSA/HRA funds, if available, may be used to cover eligible medical expenses

\*\*Self-funded groups may cover this service; check your benefit booklet for details

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Infertility treatment
- Routine eye care
- Chiropractic care
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See [www.bcbsnc.com](http://www.bcbsnc.com)
- Hearing aids
- Private duty nursing

\*\*\*Self-funded groups may not cover this service; check your benefit booklet for details

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or [mybcbsnc.com](http://mybcbsnc.com). You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), if applicable.

## Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

\*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.



## Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如需國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shiká'adoowoł nínzingo kwoji' hólné', naaltsoos áłts'ísí nantinígíí bine'déé' binámboo bikáá'.

-----*To see examples how this plan might cover costs for a sample medical situation, see the next page*-----

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,840
- You pay \$3,700

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$3,500        |
| Copays               | \$0            |
| Coinsurance          | \$0            |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$3,700</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,700
- You pay \$2,700

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,600        |
| Copays               | \$0            |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$2,700</b> |

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.

## Questions and answers about Coverage Examples:

---

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

---

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

---

### Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

---

### Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

---

### Can I use Coverage Examples to compare plans?

- ✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

---

### Are there other costs I should consider when comparing plans?

- ✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html> or call 1-877-275-9787 to request a copy.