2026 Summary of Benefits

MEDICARE ADVANTAGE PLANS WITH PART D PRESCRIPTION DRUG COVERAGE

NORTHEAST

Sapphire, Ruby, Diamond

BlueAdvantage (PPO)SM

of Tennessee

H7917_26DRSNESB_M (08/25)

SUMMARY OF BENEFITS

	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	**$0** per month. In addition, you must keep paying your Medicare Part B premiums.	**$46** per month. In addition, you must keep paying your Medicare Part B premiums.	**$89** per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: **No deductible** Prescription Drug Deductible: **$250** for Tiers 3-5.	Medical Deductible: **No deductible** Prescription Drug Deductible: **$250** for Tiers 3-5.	Medical Deductible: **No deductible** Prescription Drug Deductible: **$250** for Tiers 3-5.

Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • **$3,850** for services you receive from in-network providers. • **$5,750** for services you receive from in- and out-of-network providers combined. If you reach the limit on hospital and medical out-of-pocket costs, you can keep getting covered hospital and medical services and we will pay the full cost for those benefits for the rest of the year. Please note: you will still need to pay your cost-sharing for your Part D prescription drugs and any other supplemental benefits.	Your yearly limit(s) in this plan: • **$3,250** for services you receive from in-network providers. • **$5,750** for services you receive from in- and out-of-network providers combined. If you reach the limit on hospital and medical out-of-pocket costs, you can keep getting covered hospital and medical services and we will pay the full cost for those benefits for the rest of the year. Please note: you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs and any other supplemental benefits.	Your yearly limit(s) in this plan: • **$2,900** for services you receive from in-network providers. • **$5,750** for services you receive from in- and out-of-network providers combined. If you reach the limit on hospital and medical out-of-pocket costs, you can keep getting covered hospital and medical services and we will pay the full cost for those benefits for the rest of the year. Please note: you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs and any other supplemental benefits.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Health Benefits	**BlueAdvantage Sapphire Northeast**	**BlueAdvantage Ruby Northeast**	**BlueAdvantage Diamond Northeast**
Inpatient Hospital and Inpatient Services in a Psychiatric Hospital Our Plan covers an unlimited number of days for an inpatient hospital stay. Our Plan covers a maximum of **190 days in a psychiatric hospital in a lifetime**. The **190-day** limit does not apply to mental health services provided in a psychiatric unit of a general hospital. Prior authorization is required.	**In-Network:** Days 1-5: **$270** copay per day Additional days: **$0** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per stay	**In-Network:** Days 1-4: **$195** copay per day Additional days: **$0** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per stay	**In-Network:** Days 1-4: **$150** copay per day Additional days: **$0** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per stay

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Outpatient Surgical Services Prior authorization may be required.	**In-Network:** Ambulatory Surgical Center: **$200** copay Outpatient hospital: **$250** copay **Out-of-Network:** Ambulatory Surgical Center: **50%** of the Medicare-allowed amount Outpatient hospital: **50%** of the Medicare-allowed amount	**In-Network:** Ambulatory Surgical Center: **$175** copay Outpatient hospital: **$225** copay **Out-of-Network:** Ambulatory Surgical Center: **50%** of the Medicare-allowed amount Outpatient hospital: **50%** of the Medicare-allowed amount	**In-Network:** Ambulatory Surgical Center: **$125** copay Outpatient hospital: **$175** copay **Out-of-Network:** Ambulatory Surgical Center: **50%** of the Medicare-allowed amount Outpatient hospital: **50%** of the Medicare-allowed amount
Doctor Visits	**In-Network:** Primary Care Provider visit: **$0** copay Specialist visit: **$30** copay **Out-of-Network:** Primary Care physician visit: **50%** of the Medicare-allowed amount Specialist visit: **50%** of the Medicare-allowed amount	**In-Network:** Primary Care Provider visit: **$0** copay Specialist visit: **$25** copay **Out-of-Network:** Primary Care physician visit: **50%** of the Medicare-allowed amount Specialist visit: **50%** of the Medicare-allowed amount	**In-Network:** Primary Care Provider visit: **$0** copay Specialist visit: **$20** copay **Out-of-Network:** Primary Care physician visit: **50%** of the Medicare-allowed amount Specialist visit: **50%** of the Medicare-allowed amount
Preventive Care ***Our plan covers many preventive services, for example:*** • Bone density screenings	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
• Cardiovascular disease screenings • Cervical & vaginal cancer screenings • Colorectal cancer screenings • Diabetes screenings • Glaucoma tests • Mammogram screenings • Prostate cancer screenings • Vaccines: ‣ COVID-19 ‣ Flu ‣ Hepatitis B ‣ Pneumococcal Any additional preventive services approved by Medicare during the contract year will be covered			
Emergency Care Copay is waived if you are admitted to the hospital within 24 hours for the same condition. All emergency care is considered in network.	**Domestic:** **$150** copay per visit **Worldwide:** **$90** copay per visit	**Domestic:** **$150** copay per visit **Worldwide:** **$85** copay per visit	**Domestic:** **$150** copay per visit **Worldwide:** **$60** copay per visit
Urgently Needed Services Copay is waived if you are admitted to the hospital within 24	**Domestic:** **$25** copay per visit **Worldwide:** **$90** copay per visit	**Domestic:** **$25** copay per visit **Worldwide:** **$85** copay per visit	**Domestic:** **$25** copay per visit **Worldwide:** **$60** copay per visit

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
hours for the same condition.			
Diagnostic Services / Labs/ Imaging Prior authorization may be required.	**In-Network:** Diagnostic tests and procedures: **$0** copay at a Primary Care Provider's office **$30** copay at a Specialist's office **$40** copay at a Free-Standing Facility **$100** copay at an Outpatient Hospital **In-Network:** Lab services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$40** copay at an Outpatient Hospital **In-Network:** X-rays: **$0** copay at a Primary Care Provider's office **$30** copay at a Specialist's office **$40** copay at a Free-Standing Facility **$50** copay at an Outpatient Hospital **In-Network:**	**In-Network:** Diagnostic tests and procedures: **$0** copay at a Primary Care Provider's office **$25** copay at a Specialist's office **$40** copay at a Free-Standing Facility **$100** copay at an Outpatient Hospital **In-Network:** Lab services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$40** copay at an Outpatient Hospital **In-Network:** X-rays: **$0** copay at a Primary Care Provider's office **$25** copay at a Specialist's office **$40** copay at a Free-Standing Facility **$50** copay at an Outpatient Hospital **In-Network:**	**In-Network:** Diagnostic tests and procedures: **$0** copay at a Primary Care Provider's office **$20** copay at a Specialist's office **$30** copay at a Free-Standing Facility **$100** copay at an Outpatient Hospital **In-Network:** Lab services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$30** copay at an Outpatient Hospital **In-Network:** X-rays: **$0** copay at a Primary Care Provider's office **$20** copay at a Specialist's office **$30** copay at a Free-Standing Facility **$40** copay at an Outpatient Hospital **In-Network:**

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
	Advanced Imaging (such as MRI, CT Scan): **$225** copay **In-Network:** Therapeutic Radiology Services: **$60** copay **In-Network:** Coumadin Services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$10** copay at an Outpatient Hospital **In-Network:** Sleep Studies: **$10** copay for in-home **$40** copay at an Outpatient Facility **Out-of-Network:** **50%** of the Medicare-allowed amount	Advanced Imaging (such as MRI, CT Scan): **$200** copay **In-Network:** Therapeutic Radiology Services: **$40** copay **In-Network:** Coumadin Services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$10** copay at an Outpatient Hospital **In-Network:** Sleep Studies: **$10** copay for in-home **$40** copay at an Outpatient Facility **Out-of-Network:** **50%** of the Medicare-allowed amount	Advanced Imaging (such as MRI, CT Scan): **$175** copay **In-Network:** Therapeutic Radiology Services: **$30** copay **In-Network:** Coumadin Services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$10** copay at an Outpatient Hospital **In-Network:** Sleep Studies: **$10** copay for in-home **$40** copay at an Outpatient Facility **Out-of-Network:** **50%** of the Medicare-allowed amount
Hearing Services Cost-sharing for hearing aids does not count toward the maximum out-of-pocket amounts.	**In-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam (1 per year): **$0** copay at TruHearing® provider	**In-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam (1 per year): **$0** copay at TruHearing® provider	**In-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam (1 per year): **$0** copay at TruHearing® provider

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
	Hearing Aid: copay depends on model **$399** copay **(Standard)** **$599** copay **(Advanced)** **$899** copay **(Premium)** Limited to one per ear, per year. Benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. **Out-of-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam and Hearing aids: Not covered – must use designated vendor	Hearing Aid: copay depends on model **$199** copay **(Standard)** **$399** copay **(Advanced)** **$699** copay **(Premium)** Limited to one per ear, per year. Benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. **Out-of-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam and Hearing aids: Not covered – must use designated vendor	Hearing Aid: copay depends on model **$99** copay **(Standard)** **$299** copay **(Advanced)** **$599** copay **(Premium)** Limited to one per ear, per year. Benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. **Out-of-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam and Hearing aids: Not covered – must use designated vendor
Dental Services We cover diagnostic, preventive and treatment services until the annual allowance is met. These dental benefits do not count toward the maximum out-of-pocket amount.	**In-Network:** Medicare-covered: **$30** copay **Out-of-Network:** Medicare-covered: **50%** of the Medicare-allowed amount **$2,750** annual allowance for all of the covered	**In-Network:** Medicare-covered: **$25** copay **Out-of-Network:** Medicare-covered: **50%** of the Medicare-allowed amount **$2,750** annual allowance for all of the covered	**In-Network:** Medicare-covered: **$20** copay **Out-of-Network:** Medicare-covered: **50%** of the Medicare-allowed amount **$3,500** annual allowance for all of the covered

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
(Service limits and exclusions apply.) Included as covered benefits with service limits in this plan, but not limited to: **Diagnostic and Preventive:** • Standard diagnostic exams (limited to 2 per year) • Problem-focused oral evaluations • Cleanings (limited to 2 per year) • Bitewing x-ray (limited to 1 set per 12-month period) • Panoramic or full mouth x-ray (limited to 1 per 36-month period) **Endodontics:** • Root canals (limited to 1 per 60 month period) • Apicoectomy (limited to 1 per lifetime) • Retrograde filling (limited to 1 per lifetime) **Oral and Maxillofacial Surgery:** • Simple extractions and surgical	dental services listed below. **Diagnostic and Preventive** **In-Network:** **$0** copay through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Endodontics** **In-Network:** **$0** copay through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Oral and Maxillofacial Surgery:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Periodontics:** **In-Network:** **$0** copay through the annual allowance	dental services listed below. **Diagnostic and Preventive** **In-Network:** **$0** copay through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Endodontics** **In-Network:** **$0** copay through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Oral and Maxillofacial Surgery:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Periodontics:** **In-Network:** **$0** copay through the annual allowance	dental services listed below. **Diagnostic and Preventive** **In-Network:** **$0** copay through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Endodontics** **In-Network:** **$0** copay through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Oral and Maxillofacial Surgery:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Periodontics:** **In-Network:** **$0** copay through the annual allowance

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not covered by a medical plan **Periodontics:** • Periodontal exam (limited to 1 per 36 months) • Periodontal maintenance (limited to 2 per year) • Scaling and root planning (limited to 1 per 24 months for any quadrant) • Full mouth debridement (limited to 1 per lifetime) **Prosthodontics, removable and fixed:** • Complete dentures (limited to 1 in any 5 year period) • Partial dentures (limited to 1 in 5 years) • Denture restorations (limited to 1 in 5 years) **Restorative:**	**Out-of-Network:** **50%** of billed charges through the annual allowance **Prosthodontics:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Restorative:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance	**Out-of-Network:** **50%** of billed charges through the annual allowance **Prosthodontics:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Restorative:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance	**Out-of-Network:** **50%** of billed charges through the annual allowance **Prosthodontics:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance **Restorative:** **In-Network:** **20%** of the Plan-allowed amount through the annual allowance **Out-of-Network:** **50%** of billed charges through the annual allowance

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
• Fillings (limited to 1 per tooth surface per year) • Crowns (limited to 1 per tooth per 5 years) • Bridges (limited to 1 per 5 years) • Denture repair and adjustments (limited to 1 per 36 month period) Prior Authorization may be required.			
Vision Services Members are encouraged to use the defined vision care network to obtain routine eye exam and eyewear benefit coverage. Routine eye exams and eyewear copays and coinsurance do not apply to the maximum out-of-pocket.	**In- and Out-of-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: **$0** copay Routine eye exam (1 per year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **$0** copay Our plan pays a maximum of **$300** every two years for routine eyewear. If your total cost is more than **$300**, you will be required to pay the difference. For example: If your total cost for eyewear is **$350**, the Plan will pay **$300** and you will pay **$50**.	**In- and Out-of-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: **$0** copay Routine eye exam (1 per year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **$0** copay Our plan pays a maximum of **$300** every two years for routine eyewear. If your total cost is more than **$300**, you will be required to pay the difference. For example: If your total cost for eyewear is **$350**, the Plan will pay **$300** and you will pay **$50**.	**In- and Out-of-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: **$0** copay Routine eye exam (1 per year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **$0** copay Our plan pays a maximum of **$300** every two years for routine eyewear. If your total cost is more than **$300**, you will be required to pay the difference. For example: If your total cost for eyewear is **$350**, the Plan will pay **$300** and you will pay **$50**.

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Outpatient Mental Health Care Prior authorization is required.	**In-Network:** Outpatient group therapy visit: **$20** copay per visit Individual therapy visit: **$30** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** Outpatient group therapy visit: **$20** copay per visit Individual therapy visit: **$30** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** Outpatient group therapy visit: **$10** copay per visit Individual therapy visit: **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Skilled Nursing Facility (SNF) The amounts apply per benefit period. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you go into a SNF. The benefit period will accumulate one day for each day you are inpatient at a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.	**In-Network:** Days 1-20: **$0** copay per day Days 21-100: **$218** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per stay	**In-Network:** Days 1-20: **$0** copay per day Days 21-100: **$218** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per stay	**In-Network:** Days 1-20: **$0** copay per day Days 21-100: **$218** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per stay

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
There is no limit to the number of benefit periods. Prior authorization is required.			
Outpatient Rehabilitation Services (Physical Therapy) Prior authorization is required.	**In-Network:** Occupational therapy visit: **$15** copay per visit Physical therapy visit: **$15** copay per visit Speech and language therapy visit: **$15** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** Occupational therapy visit: **$10** copay per visit Physical therapy visit: **$10** copay per visit Speech and language therapy visit: **$10** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** Occupational therapy visit: **$10** copay per visit Physical therapy visit: **$10** copay per visit Speech and language therapy visit: **$10** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Ambulance Prior authorization is required for all non-emergency ambulance transport.	**Domestic:** Ground Ambulance: **$250** copay per one-way trip Air Ambulance: **20%** of the Medicare-allowed amount per one-way trip **Worldwide:** Ground Ambulance: **$250** copay per one-way trip Air Ambulance: **20%** of the Plan-allowed amount per one-way trip	**Domestic:** Ground Ambulance: **$175** copay per one-way trip Air Ambulance: **20%** of the Medicare-allowed amount per one-way trip **Worldwide:** Ground Ambulance: **$175** copay per one-way trip Air Ambulance: **20%** of the Plan-allowed amount per one-way trip	**Domestic:** Ground Ambulance: **$175** copay per one-way trip Air Ambulance: **20%** of the Medicare-allowed amount per one-way trip **Worldwide:** Ground Ambulance: **$175** copay per one-way trip Air Ambulance: **20%** of the Plan-allowed amount per one-way trip
Transportation	Not covered	Not covered	Not covered

Health Benefits	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Medicare Part B Drugs Prior authorization may be required.	**In-Network:** For Part B drugs such as chemotherapy drugs: **20%** of the Plan-allowed amount Other Part B drugs: **20%** of the Plan-allowed amount Part B insulin: **20%** of the Plan-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product **Out-of-Network:** For Part B drugs such as chemotherapy drugs: **50%** of the Medicare-allowed amount Other Part B drugs: **50%** of the Medicare-allowed amount Part B insulin: **20%** of the Medicare-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product	**In-Network:** For Part B drugs such as chemotherapy drugs: **20%** of the Plan-allowed amount Other Part B drugs: **20%** of the Plan-allowed amount Part B insulin: **20%** of the Plan-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product **Out-of-Network:** For Part B drugs such as chemotherapy drugs: **50%** of the Medicare-allowed amount Other Part B drugs: **50%** of the Medicare-allowed amount Part B insulin: **20%** of the Medicare-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product	**In-Network:** For Part B drugs such as chemotherapy drugs: **20%** of the Plan-allowed amount Other Part B drugs: **20%** of the Plan-allowed amount Part B insulin: **20%** of the Plan-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product **Out-of-Network:** For Part B drugs such as chemotherapy drugs: **50%** of the Medicare-allowed amount Other Part B drugs: **50%** of the Medicare-allowed amount Part B insulin: **20%** of the Medicare-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product

PRESCRIPTION DRUG BENEFITS

Deductible

Prescription Drug Deductible: $250 for Tiers 3, 4 and 5, excluding Tier 3 Insulins.

Initial Coverage

You pay the following until your total yearly drug costs reach **$2,100**.
Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Initial Coverage Stage	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Preferred Pharmacies	**Retail and Mail Order**	**Retail and Mail Order**	**Retail and Mail Order**
Tier	**30 / 100 Day Supply**	**30 / 100 Day Supply**	**30 / 100 Day Supply**
Tier 1: Preferred Generic	**$0 / $0**	**$0 / $0**	**$0 / $0**
Tier 2: Generic	**$10 / $10**	**$5 / $5**	**$5 / $5**
	30 / 90 Day Supply	**30 / 90 Day Supply**	**30 / 90 Day Supply**
Tier 3: Insulins	**$35 / $105**	**$28 / $70**	**$28 / $70**
Tier 3: Preferred Brand	**$42 / $105**	**$28 / $70**	**$28 / $70**
Tier 4: Non-Preferred Drugs (limited to a 30-day supply)	**50% coinsurance**	**50% coinsurance**	**50% coinsurance**
Tier 5: Specialty Drugs (limited to a 30-day supply)	**30% coinsurance**	**30% coinsurance**	**30% coinsurance**
Standard Pharmacies	**Retail and Mail Order**	**Retail and Mail Order**	**Retail and Mail Order**
Tier	**30 / 100 Day Supply**	**30 / 100 Day Supply**	**30 / 100 Day Supply**
Tier 1: Preferred Generic	**$6 / $15**	**$6 / $15**	**$6 / $15**
Tier 2: Generic	**$15 / $35**	**$10 / $25**	**$10 / $25**
	30 / 90 Day Supply	**30 / 90 Day Supply**	**30 / 90 Day Supply**

Tier 3: Insulins	**$35 / $105**	**$33 / $95**	**$33 / $95**
Tier 3: Preferred Brand	**$47 / $135**	**$33 / $95**	**$33 / $95**
Tier 4: Non-Preferred Drugs (limited to a 30-day supply)	**50% coinsurance**	**50% coinsurance**	**50% coinsurance**
Tier 5: Specialty Drugs (limited to a 30-day supply)	**30% coinsurance**	**30% coinsurance**	**30% coinsurance**
You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier.			
Catastrophic Coverage After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach the **$2,100** limit for the calendar year, your Part D-covered prescription drugs will be covered at no cost to you.			
Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at **1-800-772-1213** Monday–Friday, 7a.m.–7p.m. TTY users should call **1-800-325-0778**.			

ADDITIONAL HEALTH BENEFITS	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
24/7 NurseLine	**In-Network:** **$0** copay **Out-of-Network:** Not covered	**In-Network:** **$0** copay **Out-of-Network:** Not covered	**In-Network:** **$0** copay **Out-of-Network:** Not covered
Acupuncture for Chronic Low Back Pain We cover 12 visits in 90 days for Medicare-approved services. Prior authorization is required.	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Chiropractic Care Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) Prior authorization is required.	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit

ADDITIONAL HEALTH BENEFITS	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Diabetic Supplies and Services For Continuous Glucose Monitors (CGM): Brand restrictions apply. Prior authorization may be required for diabetic supplies and services.	Diabetes self-management training **In-Network:** **$0** copay **Out-of-Network:** **20%** of the Medicare-allowed amount Diabetic testing supplies: **In-Network:** Preferred: **$0** copay Non-Preferred: **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount Continuous Glucose Monitors (CGM): **In-Network:** Preferred: **20%** of the Plan-allowed amount Other: **50%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount Therapeutic shoes/inserts **In-Network:** **$10** copay **Out-of-Network:** **50%** of the Medicare-allowed amount	Diabetes self-management training **In-Network:** **$0** copay **Out-of-Network:** **20%** of the Medicare-allowed amount Diabetic testing supplies: **In-Network:** Preferred: **$0** copay Non-Preferred: **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount Continuous Glucose Monitors (CGM): **In-Network:** Preferred: **20%** of the Plan-allowed amount Other: **50%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount Therapeutic shoes/inserts **In-Network:** **$10** copay **Out-of-Network:** **50%** of the Medicare-allowed amount	Diabetes self-management training **In-Network:** **$0** copay **Out-of-Network:** **20%** of the Medicare-allowed amount Diabetic testing supplies: **In-Network:** Preferred: **$0** copay Non-Preferred: **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount Continuous Glucose Monitors (CGM): **In-Network:** Preferred: **20%** of the Plan-allowed amount Other: **50%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount Therapeutic shoes/inserts **In-Network:** **$10** copay **Out-of-Network:** **50%** of the Medicare-allowed amount

ADDITIONAL HEALTH BENEFITS	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Durable Medical Equipment Prior authorization may be required.	**In-Network:** **20%** of the plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **20%** of the plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **20%** of the plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount
Home Health Care Prior authorization is required.	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount
Meal Benefit This benefit provides 14 meals after discharge from an acute inpatient hospital, SNF, or observation stay to a home setting. Must use designated vendor.	**In-Network:** **$0** copay **Out-of-Network:** Not covered	**In-Network:** **$0** copay **Out-of-Network:** Not covered	**In-Network:** **$0** copay **Out-of-Network:** Not covered

ADDITIONAL HEALTH BENEFITS	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Outpatient Rehabilitation (Cardiac & Pulmonary) Prior authorization is required.	Cardiac (heart) rehab services **In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit Pulmonary (lung) rehab services **In-Network:** **$15** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	Cardiac (heart) rehab services **In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit Pulmonary (lung) rehab services **In-Network:** **$15** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	Cardiac (heart) rehab services **In-Network:** **$15** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit Pulmonary (lung) rehab services **In-Network:** **$15** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Over-the-Counter (OTC) items The plan pays a set amount per quarter (no roll-over) for certain OTC items such as vitamins, cough/cold/allergy medications, dental products and skin care items. Must use designated vendor.	**In-Network:** **$75** per quarter **Out-of-Network:** Not covered	**In-Network:** **$68** per quarter **Out-of-Network:** Not covered	**In-Network:** **$81** per quarter **Out-of-Network:** Not covered
Prosthetic Devices & Related Medical Supplies Prior authorization may be required.	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount

ADDITIONAL HEALTH BENEFITS	BlueAdvantage Sapphire Northeast	BlueAdvantage Ruby Northeast	BlueAdvantage Diamond Northeast
Renal Dialysis	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **20%** of the Medicare-allowed amount	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **20%** of the Medicare-allowed amount	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **20%** of the Medicare-allowed amount
Fitness Program This plan includes a free standard fitness center membership, tools and online resources.	**In-Network:** **You pay nothing.** **Out-of-Network:** Not covered	**In-Network:** **You pay nothing.** **Out-of-Network:** Not covered	**In-Network:** **You pay nothing.** **Out-of-Network:** Not covered

For more details, refer to the Evidence of Coverage (EOC) online at **bcbstmedicare.com/documents.**

DISCLAIMERS

This is a summary of drugs and health services covered by BlueAdvantage Preferred Provider Organization (PPO) Sapphire, Ruby and Diamond Northeast health plans January 1, 2026 through December 31, 2026.

BlueAdvantage is a PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, go to **bcbstmedicare.com** or call us and ask for the "**Evidence of Coverage**."

To join BlueAdvantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these Northeast counties in Tennessee:

Sapphire Northeast Tennessee: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington

Ruby Northeast Tennessee: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington

Diamond Northeast Tennessee: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington

This document is available in other alternate formats.

This document may be available in a non-English language. For additional information, call us at **1-800-292-5146**, TTY **711**.

BlueAdvantage plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross BlueShield of Tennessee members, except in emergency situations. Please call Member Service (see back cover) or see the "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions about this plan's benefits or costs,
please contact BlueCross BlueShield of Tennessee.

of Tennessee

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to our representative at **1-800-292-5146** TTY **711**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **bcbstmedicare.com** or call **1-800-292-5146** TTY **711** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium*, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ Effect on Current Coverage: If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

*Some BlueAdvantage (PPO)SM plans have a $0 plan premium. See the Evidence of Coverage for more information.

Note: BlueAdvantage Freedom (PPO)SM does not have Part D prescription drug coverage.

H7917_26PECL_C (08/25)

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance servicesto people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance").

For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; 423-591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), Monday through Friday, 8 a.m. to 6 p.m. ET. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (phone), Nondiscrimination_CoordinatorGM@bcbst.com (email), or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-831-2583 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-831-2583 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-831-2583 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-831-2583 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-831-2583（文本电话：711）或咨询您的服务提供商。

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-831-2583 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-831-2583 (TTY : 711) ou parlez à votre fournisseur.

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-831-2583 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-831-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-831-2583 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل على الرقم 1-800-831-2583 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس،به‌طور رایگان موجود می‌باشند. با شماره 1-800-831-2583 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-831-2583 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-831-2583（TTY：711）までお電話ください。
または、ご利用の事業者にご相談ください。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang a dispozisyon w gratis. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo a dispozisyon gratis tou. Rele nan 1-800-831-2583 (TTY: 711) oswa pale avèk founisè swen w lan.

ATENÇÃO: Se você fala [Português], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-831-2583 (TTY: 711) ou fale com seu provedor.

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-831-2583 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-831-2583 (TTY: 711) o makipag-usap sa iyong provider.

Notes

We're right here when you need us.

bcbstmedicare.com

If you're a member, call toll-free
1-800-831-2583 TTY **711**.
If you're not a member, call toll-free
1-800-292-5146 TTY **711**.
OCT. 1 TO MARCH 31, SEVEN DAYS A WEEK FROM 8 A.M. TO 9 P.M. ET. FROM **APRIL 1 TO SEPT. 30**, M-F FROM 8 A.M. TO 9 P.M. ET.

of Tennessee

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