HIGHMARK

Western New York

Senior Blue & BlueSaver (HMO)

Summary of Benefits

January 1, 2025 to December 31, 2025

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

This summary of benefits doesn't list every service, limitation, or special circumstance.

Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-329-2792** (TTY 711). We're available 8 a.m. to 8 p.m., 7 days a week.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Senior Blue & BlueSaver (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

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	Senior Blue Basic (HMO)	BlueSaver (HMO)
Premium	$0.00	$0.00
Part B Premium Reduction	$71.00	$4.00
Deductible	$0	$0
Max Out-Of-Pocket	$8,300	$6,900
Inpatient Hospital Stay*	Days 1 -6: $375 copay per day per admit & Days 7- 90: $0 copay per admit $2,250 OOP Max per year for IN	Days 1 - 6: $350 copay per day per admit & Days 7 - 90: $0 copay per admit $2,100 OOP Max per year for IN
Outpatient Hospital Coverage*	ASC[1]: $425 copay Facility: $475 copay	ASC[1]: $275 copay Facility: $375 copay
Doctor Office Visit	PCP: $10 copay Specialist: $50 copay	PCP: $0 copay Specialist: $30 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)	Covered in Full (Office visit copays may apply)
Emergency Room	$110 copay	$110 copay
Urgently Needed Services	$45 copay	$45 copay
Lab* & Diagnostic Tests*	Office Lab: $10 copay; Outpatient Lab: $10 copay Diagnostic Tests: $60 copay	Office Lab: $0 copay; Outpatient Lab: $0 copay Diagnostic Tests: $50 copay
X-Rays*/ Advanced Imaging*	X-ray: $50 copay Advanced Imaging: $225 copay	X-ray: $45 copay Advanced Imaging: $175 copay
Hearing Services	Medicare Covered: $50 copay IN Routine: Not Covered; TruHearing Advanced: Not Covered; TruHearing Premium; Not Covered	Medicare Covered: $30 copay. Routine: $45 copay (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year)
Dental Services	Medicare Covered: $50 copay. Routine Office Visit: $20 copay per service (1 per six months). Routine X-rays: $20 copay (1 per year). Comprehensive: 50% coinsurance with a maximum $1,000 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.	Medicare Covered: $30 copay. Routine Office Visit: $0 copay per service (1 per six months). Routine X-rays: $0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum $2,000 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: $50 copay. $0 diabetic retinal eye exam. Routine: $25 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery.	Medicare Covered: $30 copay. $0 diabetic retinal eye exam. Routine: $25 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $100 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 6: $335 copay per day per admit & Days 7 - 90: $0 copay per admit*; $2,010 OOP Max per year; Outpatient: $40 copay	Inpatient: Days 1 - 4: $395 copay per day per admit & Days 5 - 90: $0 copay per admit*; $1,580 OOP Max per year; Outpatient: $40 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $214 copay/day (days 21-100)	$0 copay/day (days 1-20), $214 copay/day (days 21-100)
Physical Therapy*	$40 copay	$30 copay
Ambulance (per one-way trip)*	$275 copay	$270 copay
Transportation	Not Covered	Not Covered
Medicare Part B Drugs*†	20% coinsurance	20% coinsurance
OTC	Not Covered	$140 allowance once per quarter
Flex Card	Not Covered	Not Covered
Durable Medical Equipment*	20% coinsurance $0 copay for compression stockings, diabetic shoes/inserts	20% coinsurance $0 copay for compression stockings, diabetic shoes/inserts
Formulary	Fundamental	Fundamental

	Senior Blue 651 (HMO)	Senior Blue Select (HMO)
Premium	$101.00	$40.00
Part B Premium Reduction	$0.00	$0.00
Deductible	$0	$0
Max Out-Of-Pocket	$6,700	$6,700
Inpatient Hospital Stay*	Days 1 - 7: $225 copay per day per admit & Days 8 - 90: $0 copay per admit $1,575 OOP Max per year	Days 1 - 5: $335 copay per day per admit & Days 6 - 90: $0 copay per admit $1,675 OOP Max per year
Outpatient Hospital Coverage*	ASC[1]: $225 copay Facility: $325 copay	ASC[1]: $300 copay Facility: $400 copay
Doctor Office Visit	PCP: $0 copay Specialist: $25 copay	PCP: $0 copay Specialist: $30 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)	Covered in Full (Office visit copays may apply)
Emergency Room	$125 copay	$125 copay
Urgently Needed Services	$55 copay	$55 copay
Lab* & Diagnostic Tests*	Office Lab: $5 copay; Outpatient Lab: $5 copay Diagnostic Tests: $40 copay	Office Lab: $0 copay; Outpatient Lab: $0 copay Diagnostic Tests: $50 copay
X-Rays*/ Advanced Imaging*	X-ray: $40 copay Advanced Imaging: $150 copay	X-ray: $45 copay Advanced Imaging: $175 copay
Hearing Services	Medicare Covered: $25 copay. Routine: $45 copay (1 Per Year). TruHearing Advanced: $499 copay; TruHearing Premium: $799 copay (2 Aids Every Year)	Medicare Covered: $30 copay. Routine: $45 copay (1 Per Year). TruHearing Advanced: $499 copay; TruHearing Premium: $799 copay (2 Aids Every Year)
Dental Services	Medicare Covered: $25 copay. Routine Office Visit: $0 copay (1 per six months). Routine X-rays: $0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum $2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits.	Medicare Covered: $30 copay. Routine Office Visit: $0 copay (1 per six months). Routine X-rays: $0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum $2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: $25 copay. $0 diabetic retinal eye exam. Routine: $25 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $200 annual eyewear allowance.	Medicare Covered: $30 copay. $0 diabetic retinal eye exam. Routine: $25 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $200 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 6: $215 copay per day per admit & Days 7 - 90: $0 copay per admit*; $1,290 OOP Max per year; Outpatient: $40 copay	Inpatient: Days 1 - 6: $260 copay per day per admit & Days 7 - 90: $0 copay per admit*; $1,560 OOP Max per year; Outpatient: $40 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $214 copay/day (days 21-100)	$0 copay/day (days 1-20), $214 copay/day (days 21-100)
Physical Therapy*	$15 copay	$25 copay
Ambulance (per one-way trip)*	$200 copay	$300 copay
Transportation	Not Covered	Not Covered
Medicare Part B Drugs*†	20% coinsurance	20% coinsurance
OTC	$60 allowance once per quarter	$70 allowance once per quarter
Flex Card	Not Covered	Not Covered
Durable Medical Equipment*	20% coinsurance $0 copay for compression stockings, diabetic shoes/inserts	20% coinsurance $0 copay for compression stockings, diabetic shoes/inserts
Formulary	Fundamental	Fundamental

	Senior Blue 601 (HMO)
Premium	$0.00
Part B Premium Reduction	$1.00
Deductible	$0
Max Out-Of-Pocket	$6,700
Inpatient Hospital Stay*	Days 1 - 7: $290 copay per day per admit & Days 8 - 90: $0 copay per admit $2,030 OOP Max per year
Outpatient Hospital Coverage*	ASC[1]: $225 copay Facility: $325 copay
Doctor Office Visit	PCP: $5 copay Specialist: $45 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)
Emergency Room	$125 copay
Urgently Needed Services	$55 copay
Lab* & Diagnostic Tests*	Office Lab: $0 copay; Outpatient Lab: $0 copay Diagnostic Tests: $45 copay
X-Rays*/ Advanced Imaging*	X-ray: $45 copay Advanced Imaging: $150 copay
Hearing Services	Medicare Covered: $45 copay. Routine: $45 copay (1 Per Year). TruHearing Advanced: $599 copay; TruHearing Premium: $899 copay (2 Aids Every Year)
Dental Services	Medicare Covered: $45 copay. Routine Office Visit: $0 copay (1 per six months). Routine X-rays: $0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum $2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: $45 copay. $0 diabetic retinal eye exam. Routine: $0 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $100 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 6: $260 copay per day per admit & Days 7 - 90: $0 copay per admit*; $1,560 OOP Max per year; Outpatient: $40 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $214 copay/day (days 21-100)
Physical Therapy*	$15 copay
Ambulance (per one-way trip)*	$200 copay
Transportation	Not Covered
Medicare Part B Drugs*†	20% coinsurance
OTC	$25 allowance once per quarter
Flex Card	Not Covered
Durable Medical Equipment*	20% coinsurance $0 copay for compression stockings, diabetic shoes/inserts
Formulary	Not Covered

*Indicates a service that requires prior authorization.

ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Senior Blue Basic (HMO)

DRUG

You pay the following until your total yearly drug costs reach $2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$12 Copay	$36 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	33% of the cost	33% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$17 Copay	$51 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	33% of the cost	33% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$30 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	33% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$17.50 Copay
		Tier 2 (Generic)	Not Applicable	$42.50 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	33% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

BlueSaver (HMO)

DRUG

You pay the following until your total yearly drug costs reach $2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$2 Copay	$6 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
		Tier 2 (Generic)	$17 Copay	$51 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$0 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	50% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$12.50 Copay
		Tier 2 (Generic)	Not Applicable	$42.50 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	50% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Senior Blue 651 (HMO)

DRUG

You pay the following until your total yearly drug costs reach $2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$10 Copay	$30 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$94 Copay	$282 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$15 Copay	$45 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$25 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$105 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$235 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$17.50 Copay
		Tier 2 (Generic)	Not Applicable	$37.50 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$117.50 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Senior Blue Select (HMO)

DRUG

You pay the following until your total yearly drug costs reach $2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$10 Copay	$30 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	40% of the cost	40% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$15 Copay	$45 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	40% of the cost	40% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$25 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	40% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	Not Applicable	$17.50 Copay
		Tier 2 (Generic)	Not Applicable	$37.50 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	40% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. The Blue Cross©, Blue Shield©, Cross, and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

This information is not a complete description of benefits. Call 1-866-682-7972 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

TruHearing is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.