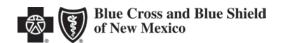
National Medicare Supplement - 2024



Medicare (Part A) Hospital Services — Per Benefit Period*

SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
Hospitalization*			
Semiprivate room and board, general nursing, an	d miscellaneous servi		
First 60 days	All but \$1,600	\$1,600 (Part A deductible)	\$0
61st through 90th day	All but \$400 a day	\$400 a day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
S	killed Nursing Facility	Care*	
You must meet Medicare's requirements, including h facility within 30 days after leaving the hospital	aving been in a hospital	for at least 3 days and entered a Medicar	e-approved
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$200 a day	Up to \$200 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

^{*}A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Medicare (Parts A and B)					
SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**		
Home Health Care					
Medicare-approved services					
Medically necessary skilled care services and medical supplies	100%	\$0	\$0		
Durable Medical Equipment First \$226 of Medicare-approved amounts	\$0	\$226 (Part B deductible)	\$0		
Remainder of Medicare-approved amounts	80%	20%	\$0		

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Medicare (Part B) Medical Services — Per Calendar Year*

SERVICES	MEDICARE PAYS	THIS PL	AN PAYS	YOU PAY**
Medical Expenses				
In or out of the hospital and outpatient hospital treatn				edical and surgical
services and supplies, physical and speech therapy,	diagnostic tests, durable me	dical equipment		
First \$226 of Medicare-approved amounts*	\$0	\$226 (Part	\$0	
Remainder of Medicare-approved amounts	Generally, 80%	Gener	\$0	
Medicare-covered preventive services	Generally, 75% or more of Medicare-approved amounts	Remainder of Medicare- approved amounts		\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%		\$0
Blood				
First 3 pints	\$0	All costs		\$0
Next \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)		\$0
Remainder of Medicare-approved amounts	80%	20%		\$0
Clinical Laboratory Services				
Blood tests for diagnostic services	100%	\$0		\$0
Immunosuppressive Drug Therapy				
	80%	20%		\$0
Mammography Screening				
As required by your physician	80%	2	20%	\$0
Other Benefits — Services Not Covered by Medic	are			
SERVICES	THIS PLAN PAYS		YOU PAY**	
Preventive Services Not Covered by Medicare	100% of the BCBSNM maximum allowable fee.		Amounts above the BCBSNM maximum allowable fee.	
Hearing/Vision Exams	100% of the BCBSNM maximum allowable fee; one exam per year.		Amounts above the BCBSNM maximum allowable fee.	
Care Outside Medicare Territorial Limits (see "NC	TE" below)			
Nonemergency Care	\$0		All expenses	
Emergency Care	100% of the BCBSNM allowable fee		Amounts above the BCBSNM maximum allowable fee	

^{*} Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

NOTE: The Medicare territorial limits are defined by Medicare as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

^{** &}quot;\$0" indicates your liability for covered charges. You are responsible for all other non-covered charges.

Other Benefits — Outpatient Prescription Drug Plan

You must use a participating pharmacy (except in an emergency). You pay the copayments listed, up to a maximum	Generic Drug Tier 1	Brand-Name Drug		
calendar year out-of-pocket limit of \$1000 per member for Tier 1, Tier 2 and Tier 3 drugs.		On Drug List Tier 2****	Not on Drug List Tier 3	
Retail/Specialty Pharmacy Programs: up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Shingles vaccines, for which you pay no copayment.	\$15	\$30	\$45	
Mail-Order Pharmacy Program: up to a 60- or 90-day supply or 540 units, whichever is less.	\$30	\$60	\$90	
Nonprescription Enteral Nutritional Products and Special Medical Foods: up to a 30-day supply per 30-day period; requires preauthorization.		\$45 retail/\$90 mail-or	der	

^{***} Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. Some prescription drugs require prior approval before coverage will be available.

NOTE: You must be enrolled in both Part A and Part B of Medicare to be eligible for this National Medicare Supplement coverage, which is offered by Los Alamos National Security to eligible retirees of Los Alamos National Laboratories (and Los Alamos National Security) and to their Medicare-eligible dependents. If you or your dependent does not have both Parts A and B of Medicare, the eligible person without Medicare may enroll in the medical program being offered by LANS to retirees/dependents without Medicare. Also, if you live outside the Medicare territorial limits, you may enroll in the medical program being offered by LANS to retirees/dependents without Medicare.

NOTE: BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.

^{****} If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.