<u>Provider Contact List</u>

New Mexico Retiree Health Care Authority
Main Number 1-800-233-2576 or Santa Fe 505-476-7340
www.nmrhca.org

Medical

Provider	Phone	Address / Website
Blue Cross Blue Shield of New Mexico (Medicare Supplement)	1-800-788-1792	5701 Balloon Fiesta Parkway Albuquerque, NM 87113 or PO Box 27630 Albuquerque, NM 87125 www.bcbsnm.com
Presbyterian Medicare Advantage (Medicare)	1-800-797-5343 ABQ: 505-923-6060 TTY: 1-888-625-8818	PO Box 27486 Albuquerque, NM 87125 7 days a week 8:00 am to 8:00 pm www.phs.org
BCBS Medicare Advantage (Medicare)	1-877-299-1008	5701 Balloon Fiesta Parkway Albuquerque, NM 87113 or PO Box 27630 Albuquerque, NM 87125 www.bcbsnm.com
UnitedHealthcare (Medicare) UHC Group Numbers: Plan I-13651; Plan II-13650	1-866-622-8014	www.uhcretiree.com
Humana Medicare Advantage (Medicare)	1-866-396-8810	Claims PO Box 14601 Lexington, KY 40512-4601 https://our.humana.com/nmrhca/

Prescription Drug (For all PPO Plans and BCBS Supplemental Medicare)

Provider	Phone	Address / Website
Express Scripts	Medicare: 1-800-551-1866 Non-Medicare: 1-800-501-0987	www.express-scripts.com

Dental

Provider	Phone	Address / Website
Delta Dental	1-877-395-9420 ABQ: 505-855-7111	2500 Louisiana Blvd. NE Ste 600 Albuquerque, NM 87110 www.deltadentalNM.com Monday—Friday 8:00am to 4:30pm
United Concordia	1-888-898-0370 *0	Claims PO Box 69421 Harrisburg, PA 17106 www.ucci.com

Vision

Provider	Phone	Address / Website
Davis Vision All prospective clients can use code 7587 when requesting a provider list or previewing plans.	1-800-999-5431	6301 Indian School Rd NE, Ste 200 Albuquerque, NM 87110 www.davisvision.com

Life Insurance

Provider	Phone	Address / Website
Standard Life Insurance	1-888-609-9763 opt 4 ā{ y s æ u t s æ r { w y	PO Box 225 Santa Cruz, NM 87567 www.standard.com/mybenefits/newmexico_rhca/

Plan Terms and Definitions

1. **Annual Deductible** – means the amount that must be paid (by you) each calendar year, toward covered services before health benefits for that member will be paid by the plan (except for certain services requiring only a copayment with deductible waived or preventive services).

2. **Annual Out-of-Pocket Limit** – means a specified dollar amount of covered services received during a benefit period that is the member's responsibility; after which the out-of-pocket limit is reached the plan pays 100 percent of benefits for the rest of the calendar year for covered charges.

3. **Calendar Year** (also referred to as benefit period) – means the period beginning January 1 and ending December 31 of the same year.

4. **Coinsurance** – means the amount, expressed as a percentage, of a covered health care expense that is partially paid by the plan and partially the member's responsibility to pay. The cost-sharing responsibility ends for most covered services in a particular calendar year when the out-of-pocket maximum has been reached.

5. **Copayment or Copay** – means the amount, expressed as a fixed-dollar figure required to be paid by a member in connection with health care services. Benefits payable by the plan are reduced by the amount of the required copayment for the covered service.

6. **Coverage GAP** (also referred to as donut hole) – is a period of consumer payment for prescription medication costs, which lies between the initial coverage limit and the catastrophic-coverage threshold. The Coverage GAP only applies to Medicare Part D prescription drug coverage.

7. **HMO** (Health Maintenance Organization) – you can only go to doctors, other health care providers, or hospitals on the plan's list except in an emergency or when treatment is not available through an in-network provider.

8. **In-Network Provider** – means physicians, hospitals, and other health care professionals, facilities, and suppliers that have contracted with the health plan as in-network providers.

9. **Medicare** – means the program of health care for the aged, end-stage renal disease (ESRD) patients and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

10. **Medicare Advantage Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contract with Medicare to provide you with all your Medicare Part A and Part B benefits.

11. **Medicare Supplemental Plan** – means health care coverage that provides supplemental benefits to Medicare coverage.

12. **Out-of-Network Provider** – means a duly licensed health care provider, including medical facilities, which has no agreement with the health plan for reimbursement of services to members.

13. **PPO** (Preferred Provider Organization) – a type of health plan that lets you choose where you go for care, without a referral from a primary care physician or having to only use providers in your plan's provider network.

NMRHCA
6300 Jefferson St NE, Suite 150
Albuquerque, NM 87109
1-800-233-2576

NMRHCA
33 Plaza La Prensa, Suite 101
Santa Fe, NM 87507
505-476-7340

Website: www.nmrhca.org

Hours of operation at both locations are 8 a.m. - 5 p.m., Monday through Friday.

Summary of NMRHCA Medicare Eligibility Guidelines

1. **Medicare Part A only and are not enrolled in Medicare Part B**
   a. Member is not eligible for any Medicare Advantage Plan.
   b. Member is only eligible for the Medicare Supplement Plan (BCBSNM's Medigap Policy).
   c. If a member does not initially enroll in Medicare Part B or voluntarily drops Medicare Part B, the member will be responsible for ALL Part B charges. BCBSNM Supplement will NOT pay any Part B charges.
   d. For Medicare Part A services, Medicare is primary and BCBSNM Supplement is secondary.
   e. NMRHCA participants who have not purchased their Medicare Part B are advised to make an appointment at their local Social Security Office to purchase Medicare Part B coverage. If not purchased during the initial enrollment period, Social Security has a general enrollment period January 1 through March 31 of each year.
2. **Medicare A and B based on End Stage Renal Disease (ESRD) only. Thirty (30) month coordination period starts from 1st dialysis or from date of transplant.**

Or

3. **Medicare A and B based on Dual Entitlement-ESRD eligibility and entitlement simultaneously with age or disability-based entitlement. Thirty (30) month coordination period starts from 1st dialysis or from date of transplant.**

Or

4. **Medicare A and B based on ESRD and then becomes entitled to Medicare A and B due to age. Thirty (30) month coordination period starts from 1st dialysis or from date of transplant.**
   a. Any non-Medicare, self-insured plan (BCBSNM or Presbyterian or New Mexico Health Connections) during the thirty (30) month coordination period.
   b. For Medicare Part A and Part B services, the non-Medicare, self-insured plan is primary and Medicare is secondary during the thirty (30) month coordination period. After the coordination period ends, the member must switch to the Medicare supplement plan (BCBSNM). Medicare becomes primary at that time.
5. **Medicare A and B based on age, covered under an active plan and becomes ESRD eligible. Member now eligible for NMRHCA benefits.**
   a. Any non-Medicare, self-insured plan (BCBSNM or Presbyterian or NM Health Connections, Premier or Value) during the thirty (30) month coordination period.
   b. For Medicare Part A and Part B services, the non-Medicare, self-insured plan is primary and Medicare is secondary during the thirty (30) month coordination period. After the coordination period ends, the member must switch to a Medicare supplement plan (BCBSNM) or Presbyterian Medicare Advantage plan (Presbyterian Advantage Plan I or II). Medicare becomes primary at that time.
   c. If a member is covered under an active group health plan and has Medicare Part A and B due to age, Medicare is secondary.
   d. If a member becomes ESRD eligible while covered under the active group plan, Medicare is secondary during the thirty (30) month coordination period.
   e. If a member enrolls with the NMRHCA, Medicare will continue to be secondary even under the NMRHCA plan until the end of the thirty (30) month coordination period.

Note: This is only a summary. For more details and clarification please contact NMRHCA at 1-800-233-2576.

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

Service Areas for the Medicare plans offered through NMRHCA

BCBSNM MEDICARE SUPPLEMENTAL PLAN
- Nationwide

UNITED HEALTHCARE MEDICARE ADVANTAGE PLAN
- Nationwide

HUMANA MEDICARE ADVANTAGE PLAN
- Nationwide

BCBS MEDICARE ADVANTAGE PLAN
- Statewide

PRESBYTERIAN MEDICARE ADVANTAGE PLAN
- Statewide