PVA Guide to Federal Health Programs

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This information is offered as a general guide to help you determine what federal health-care programs might be available to you. Everyone's situation is different, however, and depending on your situation, you may be eligible for other programs or there may be other ways to qualify for particular programs. You should contact the individual programs to obtain detailed information about eligibility and other program requirements.

Paralyzed Veterans of America

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A GUIDE TO FEDERAL HEALTH PROGRAMS FOR PVA MEMBERS

Most PVA members rely on at least one federal program for their health care. While most PVA members seek medical treatment in the VA health system, many are also eligible, as a result of their age, employment, or disability, for other federal health programs.

Federal health plans differ significantly in the benefits they provide, their cost-sharing requirements, and the flexibility they give enrollees in choosing doctors and hospitals. If one system does not meet all your health-care needs, you may be able to get what you need from another. We encourage you to use all of the health-care resources for which you are eligible. Drawing from different systems may help you obtain a more comprehensive array of services. For example, many PVA members are eligible for both VA and Medicare. They can use VA to obtain durable medical equipment or prescription medications that are not covered by Medicare. Members who live far from VA medical centers can use their Medicare coverage to see doctors who are closer to where they live and work.

If one system does not meet all your health-care needs, you may be able to get what you need from another.

Recognizing that information about health coverage is complicated and confusing, PVA has produced this guide to give you a brief overview of the federal programs for which you or your family may be eligible. The guide provides a short description of each federal program, its eligibility requirements, the coverage and benefits it provides, and sources for more information. It also includes a glossary of terms to help you better understand your health insurance coverage options.

After reading this guide, if you think you may be eligible for a federal health program that you do not currently use, you should contact the sources listed to obtain more information. Trained counselors are available to help you determine if you are eligible for particular federal programs.

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DEPARTMENT OF VETERANS AFFAIRS HEALTH SYSTEM

The Department of Veterans Affairs provides specialized medical care, primary care, and related medical and social support services for eligible veterans. The VA medical care system is administered by the Veterans Health Administration. It is the largest integrated health-care system, providing care to 3.4 million unique patients. In 1998, it operated 172 hospitals, 551 ambulatory clinics, 132 nursing homes, 40 domiciliaries, and 206 readjustment counseling centers, known as vet centers.

Eligibility

In 1996, Congress passed a law that requires VA to manage veterans' access to VA care by using a system of enrollment priorities. Veterans are enrolled according to seven priority groups and VA enrolls veterans from as many groups as possible given the resources that are available. The seven priority groups are the following:

1. veterans with service-connected disabilities rated 50% or higher;
2. veterans with service-connected disabilities rated 30% or 40%;
3. former prisoners of war, veterans with service-connected disabilities rated 10 or 20%, veterans discharged from active service for a compensable disability, and section 1151 waivers;
4. veterans who are receiving aid and attendance or house bound benefits, and other veterans who are catastrophically disabled;
5. nonservice-connected veterans and service-connected veterans rated 0 percent disabled whose income and net worth are below a specified dollar amount;
6. all other eligible veterans who are not required to make copayments for their care;
7. nonservice-connected veterans and noncompensable 0 percent service-connected veterans with income and net worth above a specified dollar amount.

In 1998, VHA opened enrollment to all seven priority groups. PVA members generally fall into priority group 1, if their spinal cord injury is service-connected, or into priority group 4, if their injury is not service-connected.

Benefits

Once enrolled in the system, veterans have access to a broad range of inpatient and outpatient services, including preventive and primary care. Services include, but are not limited to, diagnosis and treatment, rehabilitation, mental health and substance abuse treatment, home health, respite and hospice care, prosthetics, and pharmaceuticals. There are no limits on the days of care or outpatient visits VA will provide. Physicians determine what care is appropriate based on the veteran's individual situation and consistent with accepted medical practices.

There is no premium or deductible for VA care. Copayments are based on VA eligibility rating. Veterans with a service-connected disability rated 50% or higher, or who are being treated for a specific service-connected condition receive treatment free. All other copayment requirements are set by law and are dependent on the individual's or family's income.

Care in private facilities at VA expense is provided only when VA has contracted with another provider to deliver services or when a service-connected veteran is too far from a VA facility to receive care.

Emergency care is provided in VA facilities, in certain non-VA facilities with which VA has contracted, or in private facilities for veterans who are service-connected 50% or higher or who require emergency care for a service-connected condition.

For More Information

- Contact your nearest VA health-care facility. Call the Department of Veterans Affairs enrollment and information hotline tollfree at 1-877-222-VETS
- Visit the Department of Veterans Affairs web site at www.va.gov/health/elig
- Call PVA tollfree at (800) 424-8200

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CHAMPVA

CHAMPVA is a health-care benefits program administered by the Department of Veterans Affairs for dependents and survivors of veterans. Under CHAMPVA, VA shares the cost of covered health-care services and supplies with eligible beneficiaries. CHAMPVA is often confused with TRICARE, a Department of Defense program for military retirees and families of active duty, retired, and deceased service members. CHAMPVA and TRICARE are two different programs. TRICARE is discussed on page 11.

Eligibility

The following individuals are eligible for CHAMPVA benefits, provided they are not eligible for TRICARE or Medicare Part A as a result of reaching the age of 65:

- The spouse or child (under age 18) of a veteran who has been rated by VA as having a total and permanent service-connected disability. If the child of a veteran becomes permanently disabled before reaching age 18, the child's eligibility continues on a permanent basis. A child enrolled full-time at an approved educational institution can remain eligible until the age of 23.
- The surviving spouse or child of a veteran who died as a result of a VA-rated service-connected condition; or who, at the time of death, was rated permanently and totally disabled from a service-connected condition.
- The surviving spouse or child of a person who died in the line of duty and not due to misconduct.

Benefits

CHAMPVA covers most health-care services and supplies that are medically and psychologically necessary.

CHAMPVA functions as a secondary payer in cases where eligible members have other insurance plans. CHAMPVA will pay for CHAMPVA covered benefits that may not be covered by certain health plans. CHAMPVA serves as the primary payer for individuals who are eligible for Medicaid or State Victims of Crime Compensation, or who have no other insurance.

Under the CHAMPVA In-house Treatment Initiative (CITI), some CHAMPVA beneficiaries may receive free health care at participating VA facilities. However, veterans' care comes first in VA facilities. Only after veterans are taken care of can VA offer in-house services to CHAMPVA beneficiaries. Because of high demand by veterans, not all VA facilities can participate in the CITI program.

For More Information

- Call the VA Health Administration Center tollfree at (800) 733-8387
- Visit the web site www.va.gov/hac/champva.html

MEDICARE

Medicare is a federal program that provides health insurance to people 65 and older who have paid into the program with Social Security taxes and certain people with disabilities. The program, established in 1965, is administered by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services.

Eligibility

Generally you are eligible for Medicare if you are:

- 65 or older and receiving or eligible for Social Security, or
- Under 65 and have received Social Security disability benefits for 24 months, or
- A person (of any age) with end-stage renal disease.

Medicare provides health insurance to people 65 and older and certain people with disabilities.

Benefits

Medicare consists of two parts: Part A and Part B. Part A covers inpatient hospital services, skilled nursing facility care, home health care following a hospital or nursing home stay, and hospice care. If you are eligible, when you turn 65, you are

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automatically enrolled for Part A, which generally has no premiums, but requires de-ductibles and coinsurance payments.

Part B covers physician services and outpatient care. Part B is voluntary, but most (96%) Part A beneficiaries enroll in Part B. Part B has high monthly premiums, deductibles, and coinsurance; therefore, many Medicare beneficiaries choose to buy supplemental health insurance, called Medigap.

If you choose to join a Medicare managed care plan, you are still in Medicare.

The original Medicare plan is the traditional fee-for-service (or pay-per-visit) arrangement. You can go to any doctor, hospital, or other health-care provider who accepts Medicare. You pay the deductible, then Medicare pays its share, and you pay your share (coinsurance).

Original fee-for-service Medicare does not cover outpatient prescription drugs, routine physical exams, or long-term care. The only type of nursing home care original Medicare pays for is 100 days per calendar year of skilled nursing facility care for rehabilitation, such as recovery time after a hospital discharge. Medicare does not pay for personal assistance services.

Recently, more beneficiaries have opted to enroll in Medicare managed care plans. While Medicare managed care plans vary, they usually limit your choice of doctors and hospitals. Some plans require you to use only doctors and hospitals in their network, although others allow you to pay extra to see "out-of-network" doctors. Most managed care plans also assign you to a primary care doctor who is responsible for coordinating your care. Managed care plans typically require that you get approval from your primary care doctor before see you any specialists.

The advantages of Medicare managed care over original Medicare are the lower costs and increased benefits. Most Medicare managed care plans provide benefits, such as prescription drug coverage and routine physical exams, that original Medicare does not cover. If you are enrolled in a Medicare managed care plan, you do not pay Part A deductibles and coinsurance or Part B premiums, deductibles, and coinsurance. In most cases, Medicare managed care plans only require you to pay a copayment (usually $5 or $10) each time you receive a medical service. If you are enrolled in a managed care plan, you do not need to purchase Medigap supplemental insurance.

Expanding Options: Medicare+Choice

The Balanced Budget Act of 1997 (BBA) directed HCFA to establish the Medicare+Choice program. The Medicare+Choice program allows Medicare beneficiaries to choose among a broad range of health-care arrangements including:

- Original fee-for-service Medicare
- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Provider sponsored organizations (PSOs)
- Medical savings accounts (MSAs) (pilot test for 390,000 individuals)
- Medicare private fee-for-service plans (PFFS)

All states have programs to help beneficiaries with low incomes and limited resources defray the costs associated with Medicare.

These plans vary in the benefits they offer beneficiaries. However, all Medicare plans must offer at least the services covered by the original Medicare plan. They also vary in cost and how much choice you have among doctors, hospitals, and other health care providers. Not all types of plans are available in all states or all geographic areas. Your Medicare health-plan choices will depend on the health plans and health professionals that have agreed to participate as Medicare providers where you live.

If you are happy with the way you receive services under original Medicare, you do not have to change anything. If you choose to join a Medicare managed care plan, you are still in Medicare. The managed care plan is just another form of Medicare.

Filling in the Gaps in Medicare

Original Medicare requires you to pay coinsurance and deductibles, does not cap out-of-pocket expenses, and does not pay for outpatient prescription drugs. Consequently, it covers less than half of beneficiaries' total health expenses. To supplement Medicare coverage, most Medicare beneficiaries rely on health coverage through a former employer or union or purchase supplemental insurance, known as Medigap or Medicare SELECT. There are 10 standard Medigap policies offered in most states, and each provides a different combination of benefits. Some organizations, such as the American Association of Retired Persons (AARP), and some associations of

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military retirees, endorse Medigap policies offered by specific insurers.

Beneficiaries who are 65 or older must be accepted into the Medigap plan of their choice and charged standard premiums for Medigap if they enroll during their open enrollment period, which is generally the first six months after enrolling in Part B. However, once your open enrollment period ends, you may be forced to accept whatever Medigap policy an insurance company is willing to sell you. People with disabilities are not guaranteed the same federal Medigap protections as other Medicare beneficiaries. Many cannot purchase Medigap insurance because of pre-existing condition limitations and exclusions, exorbitantly high premiums, or refusal of insurers to sell them a policy.

All states have programs to help beneficiaries with low incomes and limited resources defray the costs associated with Medicare. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLIMB) program, and the Qualified Individual (QI) program. If your income is limited, your state may help pay your Medicare costs, such as your premiums and deductibles. To find out if you qualify for one of these programs, contact your state or local welfare, social service, or Medicaid agency.

For More Information

- Call tollfree (800) MEDICARE [(800) 633-4227]
- Refer to your Medicare hand book, *Medicare & You.* If you are a Medicare beneficiary, you should have received a copy in the mail. For free copies of the handbook or other Medicare publications, such as The Guide to Health Insurance for People with Medicare, call the Medicare Hotline tollfree (800) 638-6833
- Order *The Consumer's Guide to Medicare Supplement Insurance* by writing to:
  Health Insurance Association of America
  555 13th St., N.W., Ste 600 E
  Washington, DC 20004
- Visit the internet web site www.Medicare.gov which provides comprehensive information on Medicare, including important contacts to call for information, an interactive database with detailed information on Medicare's health plan options in your county, and answers to frequently asked questions about Medicare.

MEDICAID

Medicaid is the largest public program for providing health care and long-term care to people with low incomes and limited resources. The Medicaid program is administered by the states and financed jointly with federal and state dollars.

Eligibility

Only individuals who fall into particular categories, such as the elderly, people with disabilities who receive Supplemental Security Income (SSI), low-income children, and pregnant women, are eligible for Medicaid. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. Consequently, there are large variations in coverage. Most states include people who are "medically needy" in their Medicaid programs. This means individuals whose income or assets are too high to qualify for SSI, but who are being impoverished by medical costs.

Benefits

Medicaid covers a broad range of services. The federal government requires coverage of certain services: inpatient and outpatient hospital services; physician, midwife, and certified nurse practitioner services; laboratory and x-ray services; and nursing home and home health care. States may cover additional services. Optional services commonly offered include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, and intermediate care facilities for the mentally retarded.

Within broad federal guidelines, states determine the amount, duration, and scope of services offered under their Medicaid programs. For example, states may place limits on the number of covered physician visits.

Medicaid pays for almost half of all nursing home care provided in the United States. While most Medicaid spending for long-term care is on institutional services, all states cover some community-based services, such as case management, personal care services, respite care, adult day health services, and homemaker/home health aide services.

Medicaid Managed Care

Historically, Medicaid has paid for health care on a fee-for-service basis-reimbursing health-care providers for each procedure they perform. While this arrangement still predominates, states are enrolling more Medicaid beneficiaries in managed care to control costs.

For More Information

- Contact your State Medicaid Program Office for specifics on Medicaid eligibility and the health services offered in your state. All states have a Medicaid tollfree hotline for information on their Medicaid programs. You can look up the phone number for your state's Medicaid program in the government pages of your local telephone directory.

- The state Medicaid tollfree numbers are also listed on the web site: www.hcfa.gov/medicaid/obs5.htm If you do not have a computer, your local library or senior center may be able to help you access the website.

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TRICARE/CHAMPUS

TRICARE is the federal government's health insurance program for all seven of the uniformed services (Army, Navy, Air Force, Marines, Coast Guard, National Oceanic and Atmospheric Administration, and the Public Health Service). TRICARE was developed in 1995 in response to both rising health-care costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program and the closure of military bases and their hospitals. TRICARE offers three choices to eligible beneficiaries:

- TRICARE Standard, a fee-for-service option that is the same as CHAMPUS;
- TRICARE Extra, a preferred provider option that reduces both out-of-pocket expenses and choice of medical providers over Standard; and
- TRICARE Prime, which uses military treatment facilities (MTFs) as the principal provider of health-care services.

TRICARE is the federal government's health insurance program for all seven of the uniformed services.

Eligibility

Eligibility for TRICARE is limited to active duty service members, their qualified family members, non-Medicare-eligible military retirees and their family members (under age 65), and survivors (including spouses and dependent children as defined by law) of members of all seven uniformed services. Family members of active duty or retired members who are Medicare eligible because of a disability and enrolled in Medicare Part B are also eligible for TRICARE.

Veteran beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease can enroll in TRICARE if they are under 65 years of age and enrolled in Medicare Part B.

When they turn 65, military retirees and their spouses are no longer eligible for TRICARE/CHAMPUS and must enroll in Medicare. Although some retirees continue to receive health care at military treatment facilities on a space-available basis, the enactment of TRICARE and subsequent downsizing of the military have made it very difficult for military facilities to provide such care. In an effort to serve the over-65 retirees, DOD is participating in a

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limited pilot program called TRICARE Senior Prime. Under this program, a very limited number of over-65 retirees are enrolled in a Medicare HMO that operates at selected pilot sites. The members agree to receive all of their care through a case managed system at designated military treatment facilities. DOD is reimbursed for the cost of care at a discounted rate through the Medicare program.

TRICARE Options

TRICARE Standard is the fee-for-service option and is the same as the standard CHAMPUS benefit. Beneficiaries using this option have the greatest choice of civilian physicians, but at a higher cost. Beneficiaries are able to use any physician who will accept TRICARE fee-for-service patients. While TRICARE Standard beneficiaries do not pay premiums or enrollment fees, they must pay an annual deductible and coinsurance. Fees and charges under this option are higher than those of TRICARE Extra. As with TRICARE Extra, most TRICARE Standard beneficiaries buy supplemental health insurance to cover the higher costs of this option.

TRICARE Extra is similar to TRICARE Standard but it generally offers a 5 percent discount to patients when they use TRICARE Extra network providers. You can use TRICARE Extra and TRICARE Standard in combination on a case-by-case basis. For example, you can choose to see a doctor in the TRICARE Extra network and pay 5 percent less coinsurance or a doctor not on the TRICARE Extra network and pay more. You do not have to enroll in TRICARE Extra or pay an enrollment fee. However, under this option you generally pay the same deductibles as TRICARE Standard users. You do not have to file claim forms. Because out-of-pocket expenses under this option can be substantial, enrollees often subscribe to supplemental insurance to cover these charges.

Because of the high deductibles and coinsurance of TRICARE Standard and TRICARE Extra, many of the military associations, such as the Retired Officers Association and the Non Commissioned Officers Association, offer supplemental insurance to their members. Supplemental coverage plans vary in benefits and monthly premiums.

TRICARE Prime is a managed care plan similar to an HMO. It integrates military and civilian health care into a single delivery system. Under this option, you are assigned a primary care manager (PCM), who provides and manages your care or refers you to specialists if needed. A PCM can be an individual provider, a military treatment facility (MTF) physician, or a team within the MTF. The MTF commander may direct your assignment to a military PCM, if available, or you may choose a civilian network provider.

TRICARE Prime is the only TRICARE option that requires enrollment. Once enrolled, you are a member for one year. Active duty families enroll at no cost, but retirees and their families must pay an annual enrollment fee. TRICARE Prime does not have a deductible. Enrollees must pay a modest copayment for visits to civilian providers and for hospital stays. Under this option, you do not have to file claims. Enrollees in TRICARE Prime do not need to purchase supplemental insurance because the cost sharing is significantly lower than TRICARE Standard and TRICARE Extra. This option also offers additional wellness and preventive care services.

For More Information

- Call the nearest military hospital or clinic.
- Call the TRICARE help line at the TRICARE Service Center in your region. The telephone numbers for each region are in the table on the next page.

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IF YOU LIVE IN:	CALL:
Northern Virginia; Washington, DC; Maryland; Delaware; Pennsylvania; New Jersey; New York; Rhode Island; Connecticut; Massachusetts; Vermont; New Hampshire; Maine; and a small part of eastern West Virginia	Sierra Military Health Services, Inc. (Region 1) **1-888-999-5195**
North Carolina and most of Virginia	Anthem Alliance (Region 2) **1-800-931-9501**
Alabama; Florida; Georgia; Mississippi; South Carolina; Tennessee (except the Blanchfield Army Hospital catchment area) and the metropolitan area of New Orleans, including Baton Rouge in Louisiana	Humana Military Healthcare Services, Inc. (Regions 3 and 4) **1-800-444-5445**
Michigan; Wisconsin; Illinois; Indiana; Ohio, Kentucky; St. Louis area of Missouri; Clarksville area of Tennessee; and West Virginia	Anthem Alliance (Region 5) **1-800-941-4501**
Arkansas, (except the Millington, TN, Naval Hospital catchment area); Oklahoma; Louisiana (except the eastern third and New Orleans); and Texas (except the southwest corner)	Foundation Health Federal Services (Region 6) **1-800-406-2832**
Arizona; Nevada; New Mexico; Texas Alliance (El Paso area); Idaho; Utah; Montana; Wyoming; Colorado; North Dakota; South Dakota; Nebraska; Kansas; Minnesota; Iowa; and Missouri	TriWest Healthcare (Region 7 and 8) **1-888-TRIWEST**
California; Yuma, Arizona; Hawaii (in partnership with Queen's Health Care Plan); and Alaska	Foundation Health Federal Services (Regions 9, 10, & 12) **1-800-242-6788**
Washington, Oregon, and northern Idaho	Foundation Health Federal Services (Region 11) **1-800-982-0032**
Belgium; Germany; Italy; Iceland; the Netherlands; Portugal; Spain; Turkey; and the United Kingdom	TRICARE Europe **1-888-777-8343**
Guam; Korea; Japan (including Okinawa); and remote Western Pacific locations	TRICARE Pacific **1-888-777-8343**
Argentina; Barbados; Bolivia; Brazil; Chile; Colombia; Dominican Republic; Ecuador; El Salvador; Guatemala; Haiti; Honduras; Jamaica; Mexico; Nicaragua; Panama; Paraguay; Peru; Surinam; Venezuela; Belize; Costa Rica; Uruguay; Bahamas; Anguilla; Bermuda; Netherlands Antilles; Cuba; St. Lucia; Trinidad/Tobago; and Cayman Islands	TRICARE Latin America **1-888-777-8343**

GLOSSARY OF HEALTH CARE INSURANCE TERMS

Coinsurance: The amount, or percentage, you pay for medical care in a fee-for-service plan after you have met your deductible. For example, if the insurance company pays 80% of the claim, you pay a coinsurance of 20%

Copayment: A flat fee you pay each time you receive a medical service.

Deductible: The amount you pay each year to cover your medical expenses before your health insurer begins to pay.

Fee-for-service plan: Also known as an indemnity plan, "80/20," or traditional health insurance. Fee-for-service plans allow you to see any doctor at any time and reimburse doctors for each service they provide. Under a fee-for-service plan, you do not have to get approval to visit a specialist. Generally, your insurance pays 80% of the charge, and you pay the remaining 20%.

Health maintenance organizations (HMOs): HMOs receive a fixed payment to deliver services to you. Typically, your choices of doctors and hospitals are limited to those that have agreements with the HMO to provide care. In most HMOs, a primary care doctor provides most of your health care and must give approval before you can see a specialist. The main advantages of HMOs are their lower costs and extra benefits.

Managed care plan: Managed care plans negotiate discounts with certain doctors and hospitals to care for people enrolled in the plan. These doctors and hospitals are often referred to as being part of the managed care plan's "network" of providers. Some managed care plans require you to use only doctors and hospitals in their network, but others allow you to see "out-of-network" doctors if you pay extra. Most managed care plans assign you to a primary care doctor who coordinates your care. The plans typically require that you get approval from your primary care doctor before seeing any specialists.

Medical savings accounts (MSAs): Under an MSA, Medicare, an employer, or an individual would put aside money in a special savings account and purchase a fee-for-service health insurance policy with an extremely high deductible. Your deductible and out-of-pocket health-care expenses would be paid for out of the MSA until you meet the deductible limit. Once your health-care expenses exceed your deductible, then your insurance plan would start paying. You usually do not pay taxes on the money you put into the MSA, so you save on out-of-pocket expenses.

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Medicare private fee-for-service plans (PFFS): Under this type of arrangement, the insurance plan, rather than Medicare, decide how much to reimburse providers for medical services. Medicare pays the private plan a premium to cover traditional Medicare benefits. Providers are allowed to bill beyond what the plan pay (up to a limit), and the beneficiary is responsible for paying whatever the plan does not cover. The beneficiary may also be responsible for additional premiums.

Military retiree: Generally, a military retiree is defined as an individual who retires from military service after serving on active duty for 20 or more years. There are certain circumstances under which an individual can be medically retired from active duty and eligible for benefits as a military retiree.

Open enrollment period: The time during which you may obtain coverage under a health plan without presenting evidence of insurability. During this time, an insurer must allow you to purchase coverage at standard premium rates, regardless of your age and health status. They may not impose pre-existing condition limitations. When open enrollment ends, the insurer can refuse to sell you health coverage or charge higher rates for coverage.

Original fee-for-service Medicare: This is the traditional Medicare plan in which your doctors are reimbursed for each service they provide, and you can choose to see any doctor or hospital that accepts Medicare. You pay a deductible, then Medicare pays its share, and you pay your share (coinsurance).

Out-of-pocket expenses: The medical expenses that you must pay because they are not covered by insurance.

Pre-existing condition limitations: Restrictions that insurers place on payments for charges directly resulting from an injury or disease for which the insured received care or treatment within a specified time (e.g., three months) prior to the date of insurance.

Preferred provider organizations (PPOs): PPOs are similar to HMOs in that they have networks of doctors and hospitals that offer services at a discount to enrollees. The major difference is that you can use any doctor within the PPO network or pay a higher fee to use a doctor outside the PPO network.

Premium: A monthly or quarterly payment required to maintain insurance coverage.

Primary payer: In cases where an individual has more than one health insurer, the primary payer is the insurer that is responsible for paying a health claim first. The secondary payer is the insurer that pays for benefits that are covered under its insurance policy that are not covered by the primary insurer.

Provider sponsored organizations (PSOs): PSOs are a relatively new form of managed care that work much like an HMO except that they are formed by a group of hospitals and doctors who take on the financial risk of providing care to individuals who enroll in their plan.

Secondary payer: See primary payer.

Veteran: A person who served in the active military, naval, or air service, and who was honorably discharged or released from service.

ANOTHER RELATED PVA PUBLICATION

A Guide to Managed Care for People with Spinal Cord Injury or Disease

This guide helps people with SCI/D navigate the new health-care landscape dominated by managed care. The Guide explains the advantages and disadvantages of managed care and features a checklist of questions to ask and factors to consider when choosing a health plan. For a copy of *A Guide to Managed Care for People with Spinal Cord Injury or Disease*, call tollfree **(888) 860-7244**.

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