



THE USAA
EDUCATIONAL
FOUNDATION®

Good Information for Good Decisions.®

INSURANCE

HEALTH INSURANCE



OUR MISSION

The mission of The USAA Educational Foundation is to help consumers make informed decisions by providing information on financial management, safety concerns and significant life events.



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2 DETERMINING YOUR HEALTH INSURANCE NEEDS

The health insurance plan that is right for one family may be wrong for another. It is important to understand how health insurance works and which coverage fits your needs.

Identify Your Needs

Are you employed? Do you work full- or part-time? Are you single or married? If you are married, is at least one spouse employed? The answers to these questions make a significant difference when it comes to health insurance.

- Employer-sponsored group health insurance is generally less expensive than a privately purchased, individual plan and easier to obtain for those with pre-existing health conditions.
- Some small businesses do not provide group health plans and many companies do not cover part-time employees. In this case, your best choice may be group coverage obtained through a professional organization, club or alumni association.
- An individual health insurance plan may be your only option if you are between jobs, in school, self-employed or work for an employer who does not provide health insurance.
- If you and your spouse are both employed and are eligible for group coverage through different employers, review each plan. It may be less expensive to have separate, individual policies through your respective employers.

Shopping For Health Insurance

Carefully evaluate the insurer and the policy.

- Research the company's financial strength through an independent rating agency: Standard & Poor's, Weiss Ratings, A.M. Best and Moody's.
- Read the contract carefully. It explains which services are covered and which are excluded.
- If you are considering managed care, check the organization's accreditation.
- Do your homework. The Agency for Healthcare Research and Quality at www.ahrq.gov or the National Committee for Quality Assurance at www.ncqa.org are good places to begin.
- For information about companies doing business in your state, call the National Association of Insurance Commissioners at (816) 842-3600 or visit www.naic.org.
- Make sure the policy has a "free look" clause. Examine the policy during this period. Return the policy for a refund if it does not meet your needs.
- Choose a policy that offers guaranteed renewal. Although your premiums may increase, the insurer will not be able to cancel the policy as long as you pay them.
- Check policy exclusions carefully, because most contracts exclude pre-existing conditions for a period of time. Verify that your pre-existing conditions, if any, are covered.
- If a health plan — or its providers — is not convenient for your family, look elsewhere.

Health Insurance Options

Employers may offer several types of health insurance policies, giving you the freedom to choose one that fits your needs and lifestyle. If you are shopping for an individual policy, you will also have options to evaluate.

<p>Fee-For-Service Plan</p>	<ul style="list-style-type: none"> • You may obtain treatment from a physician or receive a medical service without a referral from a primary-care physician. • You, or you and your employer, pay monthly premiums. Once you meet an annual deductible, the plan generally pays a percentage (often 80%) of “reasonable and customary charges.” You pay the remaining amount, which is known as the “coinsurance” cost. Note: If your provider charges more than the reasonable and customary charges, you must pay the difference. • Some plans pay hospital expenses in full; others pay a percentage or require you to meet an additional deductible. • Most plans have an out-of-pocket maximum, or “cap.” Once your out-of-pocket medical expenses for covered charges reach a certain level during the plan year, the plan typically pays 100% of the full reasonable and customary charges for additional covered care. • The plan may have a lifetime limit on total benefits paid. If you are seeking coverage through an individual plan, look for a limit of at least \$1 million.
<p>High Deductible Health Plan</p>	<ul style="list-style-type: none"> • Monthly premiums may be lower than traditional health plan premiums, but annual out-of-pocket maximums may be higher. • An annual deductible must be met before plan benefits are paid, although exceptions are sometimes made for preventive care services. • When combined with a health savings account or health reimbursement account, you can build savings for future medical expenses and enjoy flexibility in using your health-care dollars.

Health Maintenance Organization (HMO)	<ul style="list-style-type: none"> • Controls the cost, amount, location and types of treatment to manage plan costs. • Participating health-care providers — including physicians, hospitals, skilled nursing facilities and intensive care facilities — accept a predetermined fee in exchange for their services. • Patients may pay a co-payment for each visit and, sometimes, a deductible. • You may be required to choose or be assigned a primary-care physician (PCP) whom you will see for all routine care. The PCP's approval is needed for referrals to specialists or if non-routine care is needed. • Generally, you do not have to file any claims or paperwork, but most managed care plans require preauthorization and approval for hospitalization unless it is an emergency. Preauthorization for emergencies is usually required within 24 or 48 hours of being admitted to the hospital. • If you use a nonparticipating provider, you will pay the entire cost of medical services charged.
Preferred Provider Organization (PPO)	<ul style="list-style-type: none"> • Combines managed care with a traditional fee-for-service arrangement. If your health-care providers belong to the PPO network, the plan works essentially like an HMO. • You may pay a co-payment or coinsurance for some services. • Although you may use providers who are not part of the plan, doing so may mean a higher deductible, co-payment or coinsurance. • The plan may have a lifetime limit on total benefits paid. If you are seeking coverage through an individual plan, look for a limit of at least \$1 million.
Point-Of-Service (POS) Plan	<ul style="list-style-type: none"> • Allows you to choose from different types of providers when service is rendered. • Similar to a PPO, except most POS plans use primary-care providers to coordinate patient care, while PPOs usually do not. • Often offered as an option by HMOs, at a higher monthly premium and with higher co-payments. • You may receive service from a network provider at a discount or no out-of-pocket cost, while service from a non-network provider will cost more.

Medicare

Once you reach age 65 — or if you have certain disabilities — you may be eligible for Medicare. Medicare helps pay for health care and is divided into four parts.

Part A	<ul style="list-style-type: none"> • Free to eligible recipients. • Helps pay for in-hospital care; provides services associated with hospital and hospice care; limited coverage for skilled nursing and home health care.
Part B	<ul style="list-style-type: none"> • Covers physician services and outpatient hospital care. • Enrollees pay a monthly premium and sometimes a deductible, co-payment or coinsurance, and pay amounts doctors may charge that are in excess of what Medicare covers.
Part C	<ul style="list-style-type: none"> • Known as Medicare Advantage and allows participants to purchase coverage from a private health insurance company that has contracted with the federal government to offer Medicare benefits. • Participating insurers may offer Medicare beneficiaries coverage through fee-for-service plans, managed care plans (such as HMOs) and preferred provider organization (PPO) plans.
Part D	<ul style="list-style-type: none"> • Optional prescription coverage purchased through a private health insurance company that has contracted with the federal government. • Enrollees pay a monthly premium and deductibles; co-payments or coinsurance may also apply. • Coverage may end at a certain point, only to begin again if your prescription expenses reach significant levels. • Coverage limits are set each year by the federal government.

Note: For additional information about Medicare coverage, call the Medicare Choices Helpline at (800) 633-4227.

WHAT IS A MEDIGAP POLICY?

Medicare beneficiaries often are asked to pay out-of-pocket costs to cover gaps in the coverage provided by the federal government's health insurance program. Many rely on Medicare supplement insurance, or a "Medigap" policy, to cover some or all of those gaps. However, you may not need a gap policy if your employer or former employer is still providing you health benefits as that health plan may already act as a Medigap policy. Check with that plan to find out. If you are paying premiums for that plan, you may want to compare the benefits and cost of that plan against a Medigap policy.

Medicaid

Medicaid is for individuals with limited incomes and resources. Medicaid is a joint federal and state public assistance program and the rules vary widely from state to state. Check with your state to learn about the rules in your area. For more information about Medicaid, visit www.cms.hhs.gov.

State Children's Health Insurance Program (SCHIP)

Your children may be eligible for health insurance under Medicaid or the State Children's Health Insurance Program (SCHIP), which provides health insurance for children whose family incomes are too high to qualify for Medicaid but who cannot afford private health insurance.

For little or no cost, the program pays for physician visits, immunizations, hospitalizations and emergency room visits.

States have different eligibility rules, but in most states, uninsured children under the age of 19 whose families earn up to \$36,200 annually (for a family of four) are eligible.

To find out more about your state's program, call (877) 543-7669, or visit www.insurekidsnow.gov/states.asp.

THE USAA EDUCATIONAL FOUNDATION'S PUBLICATION, *MAKING MEDICARE CHOICES*, OFFERS MORE INFORMATION. SEE "RESOURCES" ON THE INSIDE BACK COVER OF THIS PUBLICATION TO ORDER A FREE COPY.

Health insurance — whether it is provided by a group policy, an individual plan or a government program — does not cover every eventuality. Often, a specialized policy may provide the extra income protection you seek.

<p>Long-Term Care Insurance</p>	<p>Most health insurance and government programs do not provide coverage if you are chronically ill or disabled for an extended period of time. Long-term care insurance gives you control over how and where you receive services — at home, in a community program or in a nursing home, for example. When evaluating policies, you will have many options, including the daily benefit, the length of the benefit period and the length of the waiting period before coverage begins.</p>
<p>Disability Insurance</p>	<p>If an illness or injury prevents you from working, disability insurance will provide you with an income. Many employers offer group disability insurance at little or no cost to employees. However, the coverage might not replace all of your income, so you may want to consider supplemental coverage to fill the gap. You will pay federal income tax on some or all of the benefits if your employer pays for the plan.</p>
<p>Hospital Indemnity Insurance</p>	<p>An extended hospital stay could quickly wipe out your savings. Hospital indemnity insurance is a source of income — it pays you a specific amount for each day you are hospitalized.</p>
<p>Critical Illness Insurance</p>	<p>These policies are very specific — you receive benefits only if you are diagnosed with the specific disease or diseases named in the plan. Critical illness insurance generally covers cancer, heart attack, stroke or Alzheimer’s disease.</p>

WHEN SHOULD YOU REVIEW YOUR HEALTH INSURANCE COVERAGE?

At least once each year, or when there is a change in your personal life, financial situation or medical needs. Your health insurance policy is a key element of your ongoing financial security.

8 HEALTH CARE FOR MILITARY SERVICEMEMBERS

It is important to protect your assets from unexpected health-care costs. As long as you are active duty, health care for you and your family is provided by the military.

TRICARE COVERAGE	
OPTIONS	DESCRIPTION
TRICARE Prime	<ul style="list-style-type: none">• Active duty servicemembers are automatically covered at no cost and are seen in a military treatment facility (MTF). Family members may also be seen in an MTF if space is available.• No enrollment fee, annual deductible or co-payments for care by TRICARE network providers for family members of active duty servicemembers enrolled in Prime.• Co-payments still remain for those with TRICARE Prime for prescription drugs and Prime Point of Service claims.
TRICARE Extra	<ul style="list-style-type: none">• Allows participants to select a physician, hospital or other medical provider listed in the TRICARE Provider Directory.• No requirement to enroll.• Expenses include deductibles and co-payments.
TRICARE Standard	<ul style="list-style-type: none">• Allows military retirees to seek an authorized provider of choice.• No requirement to enroll.• Greatest flexibility in the choice of providers.• Most expensive of the three options.
TRICARE For Life	<ul style="list-style-type: none">• Requires enrollment in Medicare Part B.• Provides lifetime health care for those retired from military service who are Medicare-eligible (age 65 and older) and their Medicare-eligible family member.• Covers most out-of-pocket costs after Medicare has paid its share.

Separating From The Military

If you leave the military before retirement, you can purchase health insurance similar to TRICARE for up to 18 months for servicemembers and up to 36 months for family members. Group health-care coverage is usually available through civilian employers. Individual health insurance can be expensive. If you cannot get insurance through your employer and you are not eligible for TRICARE or VA medical care, investigate group health insurance obtained through a professional organization, club or alumni association.

When you retire from the military, health care from military facilities may be limited and most retirees will turn to the TRICARE program.

TRICARE Supplements

TRICARE supplements are available to pickup expenses that may remain after TRICARE pays its share of covered benefits. TRICARE coverage generally leaves little that is uncovered that a supplement plan would have to pickup, so review your benefits closely to understand whether paying for a supplement makes sense for you.

FOR MORE INFORMATION ABOUT TRICARE, VISIT WWW.TRICARE.MIL.

THE USAA EDUCATIONAL FOUNDATION'S PUBLICATIONS, *LIFE AFTER THE MILITARY AND SEPARATING FROM THE NATIONAL GUARD AND RESERVES*, OFFER ADDITIONAL INFORMATION. SEE "RESOURCES" ON THE INSIDE BACK COVER OF THIS PUBLICATION TO ORDER FREE COPIES.

10 IF COVERAGE OR PLANS CHANGE

If you leave your job, you can continue health coverage under your employer's plan for 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. You will have to pay the entire premium for coverage up to 102 percent of the cost to the plan, but the cost may be less than an individual plan and you cannot be turned down for health reasons or pre-existing conditions.

If you do not qualify for coverage under COBRA, consider short-term health insurance coverage. These plans are usually less expensive than an individual health plan and provide coverage for up to 6 months. You may also be able to convert your group health coverage to individual coverage.

For more information on COBRA, visit the U.S. Department of Labor Web site at www.dol.gov.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects you from losing health insurance coverage when you move from one plan to another. Before you leave a job, get a "certificate of creditable coverage" from your employer. This provides proof of your health coverage to your new employer and ensures your rights under HIPAA:

- If you have had health coverage for 12 continuous months and switch to a new group health plan, the new plan cannot limit coverage of pre-existing conditions.
- If you have not been covered for 12 months, a group health plan can deny coverage for pre-existing conditions, but only up to 12 months. The plan has to deduct any previous health coverage you had from the exclusion period.
- Group health plans cannot deny coverage based solely on your health status.

HIPAA does provide some protection from pre-existing exclusions for individuals buying individual health coverage, but the rules are stricter than for group health plans. To qualify, you:

- Must have had 18 months of continuous coverage under a group health plan.
- Must not be eligible for coverage under a group health plan, Medicare or Medicaid.
- Cannot have other health insurance.
- Must have used up all options for continued coverage, such as COBRA.
- Must not have had coverage canceled for nonpayment of premiums or fraud.

COMPARE, CONTRAST, CONSIDER 11

Use this work sheet to compare health insurance plans.

COMPARING HEALTH INSURANCE PLANS			
	PLAN A	PLAN B	PLAN C
Can I choose a primary care provider (PCP) or will I be assigned to one?			
Can I self-refer to a specialist, or must my PCP refer me?			
Is preauthorization required before going to the hospital or for tests or procedures?			
Do I have to file my own claims?			
If applicable, will the plan treat my pre-existing conditions?			
Will the plan cover me if I am traveling?			
Can I choose a hospital or will one be assigned?			
CHECK ALL INCLUDED COVERED SERVICES	PLAN A	PLAN B	PLAN C
Physical exams, health screenings, preventive care and immunizations			
Prenatal and maternity care			
Laboratory tests, X-rays, CAT scans, MRIs and other diagnostics			
Prescription medications			
Vision care, eye exams and eyeglasses or contacts			
Mental health or drug and alcohol abuse treatment and counseling			
Hearing exams and hearing aids			
Extended care at home, in a rehabilitation facility, adult day care or hospice			
Home medical equipment			
Physical or speech therapy			
Experimental or alternative treatments (acupuncture, chiropractic)			
CHECK ALL INCLUDED COVERED HOSPITAL SERVICES	PLAN A	PLAN B	PLAN C
Emergency care			
Ambulance services			
Outpatient surgery			
Transplant surgery			

COMPARING HEALTH INSURANCE PLANS (CONTINUED)

	PLAN A	PLAN B	PLAN C
1. What is the annual deductible? For an individual			
For a family			
2. What is the monthly premium? For an individual			
For individual and spouse			
For individual and child(ren)			
For a family			
3. What is your co-payment each time you use a service? (To estimate your annual cost, multiply the co-payment by the number of times you expect to use the service during the plan year.) Physician visit co-payment			
Hospital visit co-payment			
Prescription co-payment			
Other services co-payment			
4. What is the maximum amount you may pay out-of-pocket each year?			
5. What percentage of the cost will you be responsible for after you reach your deductible?			
6. What will you pay if you use providers outside the health plan's network?			
7. What is the lifetime benefit amount?			

RESOURCES



The USAA Educational Foundation offers the following publications.

LIFE INSURANCE (#507)

LONG-TERM CARE (#537)

MAKING MEDICARE CHOICES (#582)

THE EFFECTS OF AGING ON DRIVING SKILLS (#535)

PREPARING FOR PARENTHOOD (#563)

CHOOSING A HEALTHY LIFESTYLE (#546)

PLANNING AHEAD FOR YOUR SENIOR YEARS (#527)

ELDER CARE DECISIONS (#586)

IDENTITY THEFT (#520)

LIFE AFTER THE MILITARY (#539)

SEPARATING FROM THE NATIONAL GUARD AND RESERVES (#581)

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