VA Health Care Overview

Department of Veterans Affairs

inside

Building on over 50 years of providing quality health care services to our nation's veterans

This guide is designed to provide veterans and their families with the information they need to understand VA's health care system—its enrollment process, including enrollment priority groups, required copays (if applicable), and what services are covered. In addition to a narrative description, we have added frequently asked questions to each segment. If we have not addressed your specific questions, additional help is available at the following sources:

- Your local VA health care facility's Enrollment Office
- The eligibility page on our web site **www.va.gov/healtheligibility**
- Veterans Health Benefits Service Center **1-877-222-VETS (8387)**

Overview

Today's veterans have a comprehensive medical benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure that health care benefits are readily available to all enrolled veterans (see Enrollment Priority Groups on page 8).

Complementing the expansion of benefits and improved access is our ongoing commitment to providing the very best in quality service. Our goal is to ensure that our patients receive the finest quality of health care regardless of the treatment program, regardless of the location. In addition to our ongoing quality assurance activities, we've made it easier for veterans to get the health care they need. Additional locations continue to be added to the VA health care system—bringing the total number of treatment sites to over 1,600 nationwide.

As explained further in this guide, most veterans must be enrolled to receive VA health care. While some veterans are not required to enroll due to their special eligibility status, all veterans—including those who have special eligibility—are encouraged to apply for enrollment. Enrollment helps us to determine the number of potential veterans who may seek VA health care services, and is a very important part of our planning efforts.

Enrollment in the VA health care system provides veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period. In addition to the assurance that services will be available, enrolled veterans will appreciate not having to repeat the application process—regardless of where they seek their care or how often.

Veterans Choose the VA Facility

As part of the enrollment process, a veteran may select any VA health care facility or Community Based Outpatient Clinic (CBOC) to serve as his/her primary treatment facility.

Benefits on the Go

VA enrollment also allows health care benefits to become completely portable throughout the entire VA system. Enrolled veterans who are traveling or who spend time away from their primary treatment facility may obtain care at any VA health care facility across the country without the worry of having to reapply. Please note that VA health care is **not** considered a health care insurance plan.

Notice of Privacy Practices

Veterans who are enrolled for VA health care benefits are afforded various privacy rights under federal law and regulations including the right to a notice of privacy practices. The Veterans Health Administration (VHA) issued the VA Notice of Privacy Practices, IB 10-163, in April 2003. All veterans enrolled for health care benefits have a right to a copy of the VA Notice of Privacy Practices, IB 10-163. The VA Notice of Privacy Practices provides enrolled veterans with information on how VHA may use and disclose personal health information. The Notice also advises enrolled veterans of their rights to know when and to whom their health information may have been disclosed, request access to or receive a copy of their health information on file with VHA, request an amendment to correct inaccurate information on file, and file a privacy complaint. The VA Notice of Privacy Practices, IB 10-163, may be obtained through the Internet at **www.va.gov/vhapublications/viewpublication.asp?pub_id=1089** or through the mail by writing the VHA Privacy Office (19F2), 810 Vermont Avenue NW, Washington, DC 20420.

Frequently Asked Questions

Do I have to enroll to receive VA health care?

While most veterans must be enrolled to receive VA health care, some veterans are not required to enroll due to meeting special eligibility criteria. If you fall into one of the following categories, you are not required to enroll:

- If you are seeking care for a VA-rated service-connected disability
- If VA has rated you with a service-connected disability of 50% or more
- If less than one year has passed since you were discharged for a disability that the military determined was incurred or aggravated in the line of duty, but that VA has not yet rated

Why does VA encourage enrollment from those veterans who are not required to enroll?

The reason we encourage all potential VA health care patients to enroll is for planning and budgeting purposes. Enrollment numbers help to identify the potential demand for VA services. By including all potential patients in the enrollment count, including those who are not required to enroll, we are in a much better position to identify necessary funding levels to Congress.

What if the demand for VA services exceeds its budget?

When the demand for services exceeds our ability to provide quality and timely health care, decisions will be made to ensure that the level of services for enrolled veterans is not compromised. Those decisions may include suspending enrollment of veterans in lower priority groups (such as VA's decision to restrict higher income veterans who fall into Priority Groups 8e and 8g if they apply for care after January 16, 2003) or, in more drastic times, may include removing (disenrolling) lower priority group veterans from our enrollment system.

How can I verify my enrollment?

If you are uncertain of your enrollment status, check with the Enrollment Coordinator at your local VA health care facility. For a current telephone list of VA facilities, visit **www.va.gov/directory** or you may call the VA Health Benefits Service Center at 1-877-222-VETS (8387) to get the facility's telephone number.

VA Health Care Enrollment

Veterans can apply for enrollment in the VA health care system by completing VA Form 10-10EZ, APPLICATION FOR HEALTH BENEFITS. The application form can be obtained by visiting, calling, or writing any VA health care facility or veterans' benefits office. Forms can also be requested toll-free from VA's Health Benefits Service Center at 1-877-222-VETS (8387) or accessed from our web site at **www.va.gov/1010ez.htm**. Completed applications must be signed and dated and may be returned in person or by mail to any VA health care facility. If you apply in person at a VA health care facility, VA staff will do a preliminary assessment of your priority group. Even before your enrollment is confirmed, you may request an appointment for medical care at the time you apply in person, or if mailing your application, by checking 'yes' to the question asking if you want an appointment with a VA doctor or provider as soon as one becomes available. After your application is processed, the VA Health Eligibility Center in Atlanta will confirm your enrollment status and priority group and will notify you via mail of your enrollment status.

Enrollment Restriction

Effective January 17, 2003, VA suspended NEW enrollment of veterans assigned to Priority Groups 8e and 8g (VA's lowest priority group consisting of higher income veterans). These veterans will not be eligible for enrollment at this time. Veterans assigned to Priority Groups 8e and 8g is based on the following:

- The veteran does not have any special qualifying eligibility such as a compensable service-connected disability
- The veteran's household income exceeds the current year VA income threshold and the geographic income threshold for the veteran's residence
- Veterans who decline to provide their financial information

Veterans enrolled in Priority Groups 8a and 8c **on or before** January 16, 2003, will remain enrolled and continue to be eligible for the full-range of VA health care benefits.

Changes in VA's available resources may affect the number of priority groups VA can enroll in a given year. If that occurs, VA will publicize the enrollment changes and notify affected enrollees.

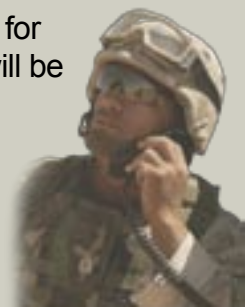
Recently Discharged Combat Veterans

The National Defense Authorization Act (NDAA) of Fiscal Year 2008, (Public Law 110-181), was signed into law January 28, 2008. It extended the period of enhanced enrollment opportunity for health care eligibility provided a veteran who served in a theater of combat operations after November 11, 1998 as follows:

- Currently enrolled combat veterans will have their enhanced enrollment period automatically extended to 5 years from their most recent discharge.
- New enrollees discharged from active duty on or after January 28, 2008 are eligible for this enhanced enrollment health benefit for 5 years after their date of their most recent discharge from active duty.
- Combat veterans who never enrolled and were discharged from active duty between November 11, 1998 and January 27, 2003 may apply for this enhanced enrollment opportunity through January 27, 2011.

As before, combat veterans will be assigned to Enrollment Priority Group 6, unless eligible for a higher Priority Group, and will not be charged copays for medication and/or treatment of conditions that are potentially related to their combat service. Veterans who enroll with VA under this enhanced authority will continue to be enrolled even after their enhanced eligibility period ends, although veterans enrolled in Priority Group 6 may be shifted to Priority Group 7 or 8, depending on their income level, and required to make applicable copays.

Note: Combat veterans who applied for enrollment after January 16, 2003, but were not accepted for enrollment based on the application being outside the previous post-discharge two year window will be automatically reviewed and notified of the enrollment decision under the new authority.



Financial Assessment (Means Testing)

While many veterans qualify for enrollment and cost-free health care services based on a compensable service-connected condition or other qualifying factor, most

veterans will be asked to complete a financial assessment as part of their enrollment application process. Otherwise known as the Means Test, this financial information will be used to determine the applicant's enrollment priority group (see Enrollment Priority Groups section) and whether he/she is eligible for cost-free VA health care. Higher-income veterans may be required to share in the expense of their care by paying copays (Refer to the Copay section of this booklet). Veterans who choose not to complete the financial assessment must agree to pay the required copays as a condition of their eligibility. Due to VA's restricting enrollment of new Priority Group 8e and 8g veterans who apply on or after January 17, 2003, veterans who decline to provide financial information, who agree to pay copays and who do not have any other special eligibility qualifying factors will not be accepted for enrollment.

Income Verification

The VA Health Eligibility Center Income Verification (IV) program verifies earned and unearned total gross household income provided by nonservice-connected veterans and veterans rated noncompensable 0% service-connected by VA who are required to complete a financial assessment means test.

The financial assessment is based on the veteran's previous year total gross household income and is used to determine veterans' eligibility for VA health care benefits and priority group assignment. The income information provided by the veteran is verified by matching records from the Internal Revenue Service and the Social Security Administration.

If through the IV process it is determined that the veteran's household income exceeds the established VA national income (means test) threshold, the veteran may be responsible for copays for health care provided since the date of completion of the initial financial assessment. In addition, if the veteran enrolled on or after the effective date of the January 17, 2003 "Enrollment Restriction Decision", the veteran's enrollment status could be rejected and as a result, will no longer eligible for VA health care. (For more information, refer to the Enrollment Restriction section of this booklet.)

Veterans Identification Card

VA provides eligible veterans a Veterans Identification Card (VIC) for use at VA health care facilities. Once the veteran's eligibility for VA medical benefits is verified and the veteran has his or her photo taken at their local VA medical facility, the card is mailed to the veteran, usually within five to seven days. Veterans may contact 877-222-VETS (8387) to check on the status of their card. In the event the card is lost or destroyed, a replacement card may be requested by contacting the VA where the picture was taken. NOTE: VICs cannot be used as a credit or an insurance card and it does not authorize or pay for care at non-VA facilities.

The VIC does not contain any sensitive, identifying information such as a veteran's Social Security number or date of birth on the face of the card. The VIC now displays the following special eligibility indicators: Service Connected, Purple Heart Medal, and Former POW.

Updating Your Information

VA Form 10-10EZR, Health Benefits Renewal Form, is for veterans who are currently enrolled and need to update or report changes to their address, phone number, name, health insurance, and financial information. Veterans who are required to update their income information on an annual basis will have this form automatically mailed to them each year.

If you are not charged copay for medications or health care or if you are charged a reduced inpatient copay, you should update and report your financial information to VA each year to prevent your status from lapsing. VA will remind you when it is time to renew the information.

It is not necessary to wait for the annual renewal period to provide VA your updated information. You may update your information whenever your financial or personal information changes. You will need to complete the form and mail it to your **local facility** for processing (you can find your local facility address online at **www.va.gov/directory**). Be sure to sign and date the form. If the form is not signed and dated properly, VA will return it to you for completion.

The 10-10EZR can be requested from VA's Health Benefits Service Center by calling toll-free 1-877-222-VETS (8387) or obtained at **www.va.gov/vaforms/medical/pdf/vha-10-10ezr-fill.pdf**.

Geographically-Based Means Testing

Recognizing that the cost of living can vary significantly from one geographic area to another, Congress added income thresholds based upon geographic locations to the existing VA national income thresholds for financial assessment purposes. This change assists lower-income veterans who live in high-cost areas by providing an enhanced enrollment priority and reducing the amount of their required inpatient copay.

Please note that the geographically-based copay reductions apply ONLY to INPATIENT SERVICES. Outpatient services, long-term care, as well as medication copays are NOT affected by this change.

Private Health Insurance

Since VA health care depends primarily on annual congressional appropriations, VA encourages veterans to retain any health care coverage they may already have—especially those in the lower enrollment priority groups as further described on pages 8 & 9, Enrollment Priority Groups. Veterans with private health insurance or with federally funded coverage through the Department of Defense (TRICARE), Medicare, or Medicaid, may choose to use these sources of coverage as a supplement to their VA benefits. It is important to note that VA health care is NOT considered as a health insurance plan.

By law, VA is obligated to bill health insurance carriers for services provided to treat nonservice-connected conditions. To ensure that current insurance information is on file—including coverage through employment of the veteran's spouse—VA staff is required to ensure that veterans' health insurance information is updated during each visit. Identification of insurance information is essential to VA since collections received from insurance companies help supplement the funding available to provide services to veterans. Veterans are asked to cooperate by disclosing all relevant health insurance information. Eligible veterans are not responsible for payment of VA medical services billed to their health insurance company that are not paid by their insurance carrier.

CAUTION! Before canceling insurance coverage, enrolled veterans should carefully consider the risks.

- There is no guarantee that in subsequent years Congress will appropriate sufficient funds for VA to provide care for all enrollment priority groups.
- Non-veteran spouses and other family members generally do not qualify for VA health care.
- If participation in Medicare Part B is cancelled, it cannot be reinstated until January of the next year and there may be a penalty for the reinstatement.

Insurance Collections

Since the start of insurance collections in 1986, veterans' health care services have been supplemented by funds collected from private health insurance companies. This supplement has allowed VA to provide services to numerous additional veterans.

Medicare Part D Prescription Drug Coverage

If you are eligible for Medicare Part D prescription drug coverage, you need to know that enrollment in the VA health care system is creditable coverage for Medicare Part D purposes. This means that VA prescription drug coverage is at least as good as the Medicare Part D coverage. Additional information can be found online at **www.va.gov/healtheligibility/costs/medicared.asp** or the Medicare website at **www.cms.hhs.gov**.

Frequently Asked Questions

Must I reapply every year and will I receive an enrollment confirmation?

If you have previously enrolled, your enrollment will be reviewed annually without any action necessary on your part. Veterans who are required to update their financial information are still required to provide their income information on an annual basis or when their income changes, using VA Form 10-10EZR. Depending on your priority group and the availability of funds for VA to provide medical benefits to all enrollees, your enrollment will be automatically renewed without any action on your part. Should there be any change to your enrollment status, you will be notified in writing.

Can I request an appointment before my enrollment is confirmed?

Yes. If you are applying in person at any VA medical center, you can request an appointment for medical care at the same time you apply for enrollment – there is no need to wait to request an appointment before your enrollment is confirmed. Additionally, you can indicate on the VA Form 10-10EZ if you desire an appointment and when your application is processed at the medical center, an appointment will be scheduled for you. You will be notified in writing of your appointment and your eligibility for medical care. For veterans requesting care for a service-connected disability, those appointments have a higher priority (see below) and will be scheduled within 30 days of the desired date.

If enrolled, must I use VA as my exclusive health care provider?

While there is no requirement that VA become your exclusive provider of care, please be aware that our authority to pay for non-VA care is extremely limited (see page 15). You may, however, elect to use your private health insurance benefits as a supplement for your VA health care benefits.

What income is counted for the Financial Assessment (Means Test) & is family size considered?

VA considers your previous calendar year's total household income and net worth. This includes the earned and unearned income and net worth of your spouse and dependent(s). Earned income is usually wages you receive from working. Unearned income can be interest earned, dividends received, money from retirement funds, Social Security payments, annuities or earnings from other assets. The number of persons in your family will be factored into the calculation to determine the applicable income threshold—both the VA national income threshold and the income threshold for your geographic region.

What is a Geographic Threshold?

By law, VA is required to identify veterans who are required to defray the cost of medical care. Those veterans whose income falls between the VA means test limits and the HUD low-income limits will have their inpatient medical care copays reduced by 80%. The remaining higher income veterans will continue to pay the full inpatient medical care copays and will be assigned the means test status "MT Copay Required". This law has no effect on outpatient and medication copays.

For those veterans who have more than one residence, which address is used for means testing under the geographically-based income thresholds?

The address used to determine your geographically-based income threshold is your permanent address and typically is the location where you declare residency for voting and tax purposes. To view geographic income thresholds, visit **www.va.gov/healtheligibility/library/pubs/gmtincomethresholds**.

How frequently are the income thresholds updated?

Income thresholds, used for the Financial Assessment as well as for geographic adjustments for high cost-of-living areas, are updated annually. To view the current income thresholds, visit **www.va.gov/healtheligibility/library/pubs/vaincomethresholds**.

VA Health Care Enrollment Priority Groups

Upon receipt of a completed application (must include signature and date), the veteran's eligibility will be verified. Based on his/her specific eligibility status, he/she will be assigned to one of the following priority groups. The priority groups range from 1 through 8 with Priority Group 1 being the highest priority and Priority Group 8 the lowest.

Priority Group 1

- Veterans with service-connected disabilities rated 50% or more disabling
- Veterans determined by VA to be unemployable due to VA service-connected conditions

Priority Group 2

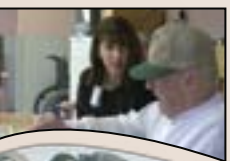
- Veterans with VA service-connected disabilities rated 30% or 40% disabling

Priority Group 3

- Veterans who are former POWs
- Veterans awarded the Purple Heart Medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with VA service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving VA aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled



Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6

- World War I veterans
- Compensable 0% service-connected veterans
- Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Project 112/SHAD participants
- Veterans who served in a theater of combat operations after November 11, 1998 as follows:
  - Veterans discharged from active duty on or after January 28, 2003, who were enrolled as of January 28, 2008 and veterans who apply for enrollment after January 28, 2008, for 5 years post discharge
  - Veterans discharged from active duty before January 28, 2003, who apply for enrollment after January 28, 2008, until January 27, 2011

Priority Group 7

Veterans with income and/or net worth ABOVE the VA national income threshold and income BELOW the geographic income threshold who agree to pay copays

Priority Group 8

Veterans with income and/or net worth ABOVE the VA national income threshold and the geographic income threshold who agree to pay copays

- Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

Enrollment Restriction for Veterans Assigned to Priority Groups 8e & 8g

Effective January 17, 2003, VA suspended NEW enrollment of veterans assigned to Priority Group 8e or 8g (VA's lowest priority group consisting of higher income veterans). Veterans assigned to these groups are NOT eligible for enrollment at this time. Priority Group 8e or 8g assignment is based on the following:

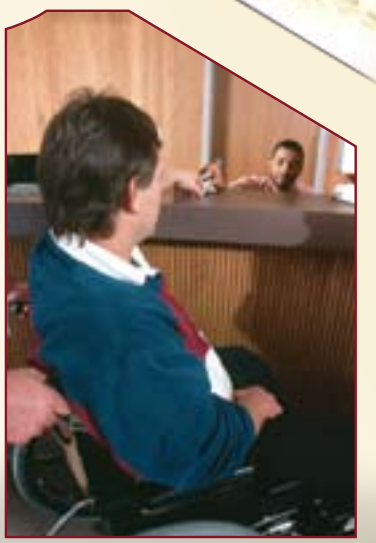
- Either the veteran's household income exceeds both the current year VA national income threshold and the geographic income threshold for the veteran's residence, or
- The veteran declined to provide his/her household information, and
- The veteran does not have any special qualifying eligibilities such as compensable VA service-connected disability

Veterans enrolled in Priority Group 8a or 8c **on or before** January 16, 2003 remain enrolled and continue to be eligible for the full-range of VA health care benefits.

Frequently Asked Questions

How does application of the geographically-based income thresholds change the financial assessment process and the enrollment priority groups?

While the financial assessment procedures do not change, application of the geographically based income thresholds results in a division of the original Priority Group 7 into two separate priority groups. Priority Group 7 is now limited to nonservice-connected veterans and 0% noncompensable service-connected veterans whose combined income and net worth exceed VA's annually established national income (means test) threshold BUT whose income is below the geographically-adjusted threshold.



What is a VA service-connected rating and how do I establish one?

A compensation and/or a service-connected rating is an official ruling by VA Regional Office that your illness or condition is directly related to your active military service. VA Regional Offices are also responsible for administering educational benefits, vocational rehabilitation, and other benefit programs including home loans. To obtain more information or to apply for any of these benefits, contact your nearest VA Regional Office at 1-800-827-1000 or visit us online at **www.va.gov**.

Who does the VA consider to be "catastrophically" disabled?

To be considered catastrophically disabled, you must have a severely disabling injury, disorder, or disease which permanently compromises your ability to carry out the activities of daily living. The disability must be of such a degree that you require personal or mechanical assistance to leave home or bed, or require constant supervision to avoid physical harm to yourself or others. To request an evaluation, contact the Enrollment Coordinator at your local VA health care facility. If it is determined by a VA health care provider that you are catastrophically disabled, your priority will be upgraded to Priority Group 4. If, however, you were previously required to make copays, that requirement will continue until your financial situation qualifies you for cost-free services.

Priority Group 8 has subpriority groups a, c, e, and g. Are there subpriority groups b, d, and f?

Although the subpriority group designations (a, c, e, and g) are in descending order based on highest priority to lowest, they deliberately were not put in consecutive order. Since these designations are used exclusively for internal tracking purposes, we reserved b, d, and f for future use in the event of additional changes to the priority groups.

Copays

While many veterans qualify for cost-free health care services based on a compensable service-connected condition or other qualifying factor, most veterans are required to complete an annual financial assessment, also known as a Means Test, to determine if they qualify for cost-free services. Veterans whose income and net worth exceed the established income threshold as well as those who choose not to complete the financial assessment must agree to pay required copays to become eligible for VA health care services. Note that new high income veterans with no special eligibility who apply for enrollment on or after January 17, 2003, and veterans who decline to provide income information are not eligible for enrollment. These veterans are assigned to Priority Groups 8e and 8g (see Enrollment Restriction). Along with their enrollment confirmation and priority group assignment, enrollees will receive via mail information regarding their copay requirements, if applicable.

Types of Copays

Outpatient Copays*—based on the highest of two levels of service on any individual day.

- Primary Care Services–Services provided by a primary care clinician (lower level of service)
- Specialty Care Services–Services provided by a clinical specialist such as:
  - surgeon
  - radiologist
  - audiologist
  - optometrist
  - cardiologist
  - and specialty tests such as:
    - magnetic resonance imagery (MRI)
    - computerized axial tomography (CAT) scan
    - nuclear medicine studies (highest level of service)

**There is no copay requirement for preventive care services such as screenings, immunizations, and other services that do not require the immediate presence of a physician.*

Medication Copays*—applicable to each prescription including each 30-day supply or less of maintenance medications.

**Includes an annual cap for enrollment priority groups 2 through 6.*

Inpatient Copays—in addition to a standard copay charge for each 90 days of care within a 365-day period regardless of the level of service (such as intensive care, surgical care, or general medical care), a per diem (daily) charge will be assessed for each day of hospitalization.

Long-Term Care Copays*—based on three levels of care (see Long-Term Care Benefits on page 18 for definitions).

- Nursing Home Care/Inpatient Respite Care/Geriatric Evaluation
- Adult Day Health Care/Outpatient Geriatric Evaluation/Outpatient Respite Care
- Domiciliary Care

**Copays for Long-Term Care services start on the 22nd day of care during any 12-month period—there is no copay requirement for the first 21 days. Actual copay charges will vary from veteran to veteran depending upon financial information submitted on VA Form 10-10EC.*

Annual Changes To Copay Rates

Because of the annual changes to the copay rates—including the annual cap on medication copays—they are published separately. Current year rates can be obtained at any VA health care facility or on the eligibility page on our web site **www.va.gov/healtheligibility/costs**.

Which Veterans Are Not Required to Make Copays?

Many veterans qualify for cost-free health care and/or medications based on

- Receiving a Purple Heart Medal, or
- Former Prisoner of War Status, or
- Compensable VA service-connected disabilities, or
- Low income, or
- Other qualifying factors including treatment related to their military service experience.

Some of the Services Exempt from Inpatient and Outpatient Copays

- Special registry examinations offered by VA to evaluate possible health risks associated with military service
- Counseling and care for military sexual trauma
- Compensation and pension examination requested by the Veterans Benefits Administration (VBA). This is a physical exam to determine service-related injuries for determination of a veteran's entitlement to compensation and pension benefits.

- Care that is part of a VA approved research project
- Care related to a VA-rated service-connected disability
- Readjustment counseling and related mental health services
- Emergency treatment at other than VA facilities
- Care for cancer of head or neck caused from nose or throat radium treatments given while in the military
- Publicly announced VA public health initiatives e.g. health fairs
- Care related to service for veterans who served in combat or against a hostile force during a period of hostilities after November 11, 1998
- Laboratory and other services such as flat film radiology services and electrocardiograms

Frequently Asked Questions

I am a recently discharged combat veteran. Must I pay VA copays?

If the services are provided for the treatment of a condition that may be potentially related to your military service in a theater of combat operations, you will not be charged any copays. Currently enrolled combat veterans have an enhanced enrollment health benefit period of five years from their most recent discharge. New enrollees discharged from active duty on or after January 28, 2008 are eligible for this enhanced enrollment health benefit for five years after the date of their most recent discharge from active duty. Combat veterans who never enrolled and were discharged from active duty between November 11, 1998 and January 27, 2003 may apply for this enhanced enrollment opportunity through January 27, 2011.

Recently discharged combat veterans will be asked to complete the applicable financial assessments (means test or medication copay tests) to determine if they qualify for a higher enrollment priority assignment, whether they will be charged copays for care and/or medication provided for treatment of non-combat related conditions, as well as their potential eligibility for beneficiary travel.

Note: Combat veterans who applied for enrollment after January 16, 2003, but were not accepted for enrollment based on the application being outside the previous post-discharge two year window will be automatically reviewed and notified of the enrollment decision under the new authority.

How many copay charges may be assessed during a single day?

For outpatient services, you will be charged one copay, regardless of the number of health care providers you see in a single day. The amount of the outpatient copay will be based on the highest level of service you received that day. For example,

if you have a specialty care visit and a primary care visit on the same day, you will be charged only for the specialty care visit since it is a higher level of care. The number of medication copays charged as a result of your outpatient visit depends on the number of each 30-day supply or less of medication filled. Inpatient copays are based on both a standard charge for each 90 days of care within a 365-day period as well as a per diem (daily) charge. Together, the inpatient copay charges cover all services including medications. With the exception of medication copays for outpatients, long-term care copays are a single, all-inclusive charge.

Who qualifies for the annual cap on medication copays?

The annual cap on medication copays applies to Priority Groups 2 through 6 (Priority Group 1 is exempt from ALL copays). Because of their higher financial status, veterans in Priority Groups 7 and 8 do NOT qualify for the medication copay annual cap. For those that qualify, once the annual limit is reached, all subsequent prescriptions filled during the calendar year will be free of the copay requirement.

What if I am Unable to Pay the Copays?

If there has been a significant decrease in your earned income from the previous year, your current projected income may be used on a case-by-case basis (VA calls this the Hardship Determination process). To apply for a Hardship Determination, consult your Enrollment Coordinator at your local VA medical facility. Hardship Determinations apply only to future copay responsibility. For copay debt that has already been established, you may apply for a waiver by contacting the Enrollment Coordinator at the VA Medical Center where you received your care.

What is the copay for a 90-day supply of medication?

Even though the prescription is written for 90-days, each 30-day or less supply is subject to that year's applicable medication copay rate. A 90-day supply would cost three times the medication copay rate.

Covered Services/Acute Care Benefits

Standard Benefits

The following acute care services are available to all enrolled veterans:

Preventive Care Services

- Immunizations
- Physical Examinations (including eye and hearing examinations)
- Health Care Assessments
- Screening Tests
- Health Education Programs

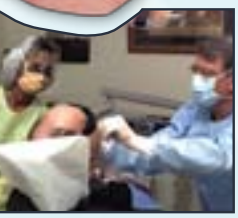
Ambulatory (Outpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

Hospital (Inpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

Prescription Drugs (when prescribed by a V physician)



Limited Benefits

The following care services (partial listing) have limitations and may have special eligibility criteria:

- Ambulance Services
- Dental Care
- Durable Medical Equipment
- Eyeglasses
- Hearing Aids
- Home Health Care
- Maternity and Parturition Services—usually provided in non-VA contracted hospitals at VA expense, care is limited to the mother (costs associated with the care of newborn are not covered)
- Non-VA Health Care Services

General Exclusions (partial listing)

- Abortions and abortion counseling
- Cosmetic surgery except where determined by VA to be medically necessary for reconstructive or psychiatric care
- Gender alteration
- Health club or spa membership, even for rehabilitation
- In-vitro fertilization
- Drugs, biological, and medical devices not approved by the Food and Drug Administration unless part of formal clinical trial under an approved research program or when prescribed under a compassionate use exemption.
- Medical care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to provide the care or services.
- Services not ordered and provided by licensed/accredited professional staff
- Special private duty nursing

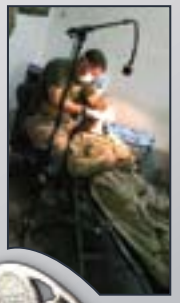
Frequently Asked Questions

Hearing aids & eyeglasses are listed as "limited" benefits. Under what circumstances do I qualify?

VA will provide hearing aids and eyeglasses to veterans who receive increased pension based on the need for regular aid and attendance or being permanently housebound, receive compensation for a service-connected disability or are former POWs. Otherwise, hearing aids and eyeglasses are provided only in special circumstances, and not for normally occurring hearing or vision loss. For additional information, contact the prosthetic representative your local VA health care facility.

Am I eligible for dental care?

You are eligible for dental services if your dental care is for either a compensable service-connected condition, a dental condition resulting from service-connected trauma, if you have a service-connected rating of 100 percent or rated unemployable due to service-connected conditions. You also qualify if you are a former POW, a participant in a VA vocational rehabilitation program, an enrolled homeless veteran participating in specific health care programs, or if your dental condition is aggravating a medical problem under VA treatment.



Effective January 28, 2008, recently discharged veterans with a service-connected non-compensable dental condition or disability who served on active duty 90 days or more and who apply for VA dental care within 180 days of separation from active duty, may receive a one time treatment for dental conditions if the dental condition is shown to have existed at the time of discharge or release and the veteran's certificate of discharge does not indicate that the veteran received necessary dental care within a 90-day period prior to discharge or release. This includes veterans who reentered active military, naval, or air service within 90 days after the date of a prior discharge, and veterans whose disqualifying discharge or release has been corrected by competent authority.

Note: Veterans discharged between August 1, 2007, and January 27, 2008, are eligible

for the dental benefit by making application within 180 days of their discharge. Veterans previously denied this one time dental benefit because application was made outside of the previously mandated 90 day period after separation will be contacted to review and correct, as appropriate, your application denial. Affected veterans may also contact their local medical center to review and correct, as appropriate, their denied application.

Note: Veterans awarded a temporary total disability rating by the Veterans Benefits Administration are not eligible for comprehensive outpatient dental services.

Am I limited to a specific number of inpatient days or outpatient visits during a given period of time?

For acute care services (inpatient days of care & outpatient visits) there are no limits.

Do I qualify for routine health care at non-VA facilities at VA expense?

To qualify for routine care at non-VA facilities at VA expense (otherwise known as Fee Basis care), you must first be given specific authorization by your VA provider. Included among the factors in determining whether such care will be authorized is your medical condition and availability of VA services within your geographic area.

Am I eligible for emergency care at non-VA facilities?

If you are being treated at a VA health care facility and need emergency care that VA cannot provide, and VA refers you to a non-VA facility for care, VA will pay for that care.

When you go directly to a non-VA facility for emergency care, there are three ways you may be eligible for the care. In all cases, the care must have been provided in a medical emergency, VA health care facilities were not feasibly available, and payment may only be made until you are stable for transfer to VA or discharge.

The first way you may be eligible is:

- When the nearest VA health care facility is notified of the emergency within 72 hours of either inpatient or outpatient treatment, and you meet one of the eligibility requirements given below. Notification can be made by you, a family member, or the provider, if:
  - You are treated for a service-connected disability
  - You have been rated by VA as permanently and totally disabled due to a service-connected disability
  - You receive care for a disability for which you were discharged from active duty
  - You receive care for a nonservice-connected disability that is associated with and aggravating a service-connected disability
  - You are participating in a rehabilitation program under 38 U.S.C. chapter 31
  - You are a woman veteran
- When the nearest VA health care facility is notified of outpatient emergency room treatment within 72 hours, and you meet one of the eligibility requirements given below. Notification can be made by you, a family member, or the provider, if:
  - You have a service-connected rating of 50 percent or more
  - You are a veteran of the Mexican border period or WWI
  - You are receiving VA aid and attendance or housebound benefits
  - You require emergency medical care during authorized travel
  - You are receiving VA contract nursing home care



The second way you may be eligible is:

When VA is not notified within 72 hours, or notified after you have been discharged and you meet one of the eligibility requirements given below:

- You are treated for a service-connected disability
- You have been rated by VA as permanently and totally disabled due to a service-connected disability
- You receive care for a nonservice-connected disability that is associated with and aggravating a service-connected disability
- You are participating in a rehabilitation program under 38 U.S.C. chapter 31

The third way you may be eligible is:

- When you are not eligible under the first two ways listed above & you meet all of the following criteria:
  - The emergency services were provided in a hospital emergency department
  - The condition treated was of such nature that a delay in seeking treatment would have been hazardous to life or health
  - VA facilities were not feasibly available
  - You are enrolled in the VA health care system
  - You received medical services from VA within the 24-month period preceding the emergency treatment
  - You are financially liable for the treatment
  - You have no coverage under a health plan for payment of the treatment
  - You have exhausted all claims against a third party without success


Is VA approval needed before I obtain non-VA emergency services?

While approval is not required, you or another responsible person should notify the nearest VA health care facility as soon as possible. Since VA payment is limited to the point your condition is stable for transportation to a VA facility, notification allows VA to make transfer arrangements as soon as possible.

Does the VA offer compensation for travel expenses to and from a VA facility?

If you meet specific criteria (see next question), you are eligible for travel benefits. In most cases, travel benefits are subject to a deductible. Exceptions to the deductible requirement are: 1) travel for a compensation and pension examination; and 2) travel by an ambulance or a specially equipped van. Because travel benefits are subject to annual mileage rate and deductible changes, we publish a separate document detailing these amounts each year. You can obtain a copy at any VA health care facility.

Do I qualify for travel benefits?

You may qualify for beneficiary travel payments if you fall into one of the following categories:

- You have a service-connected rating of 30 percent or more
- You are traveling for treatment of a service-connected condition
- You receive a VA pension
- You are traveling for a scheduled compensation or pension examination
- Your income does not exceed the maximum annual VA pension rate
- You are in an authorized Vocational Rehabilitation Program
- Your medical condition requires an ambulance or a specially equipped van, you are unable to defray the cost, and the travel is pre-authorized (authorization is not required for emergencies if a delay would endanger your life or health)

Long-Term Care Benefits

Standard Benefits

The following long-term care services are available to all enrolled veterans.

Geriatric Evaluation

Geriatric evaluation is the comprehensive assessment of a veteran's ability to care for him/herself, his/her physical health, and social environment, which leads to a plan of care. The plan could include treatment, rehabilitation, health promotion, and social services. These evaluations are performed by inpatient Geriatric Evaluation and Management (GEM) Units, GEM clinics, geriatric primary care clinics, and other outpatient settings.

Adult Day Health Care

The adult day health care (ADHC) program is a therapeutic day care program, providing medical and rehabilitation services to disabled veterans in a combined setting.

Respite Care

Respite care provides supportive care to veterans on a short-term basis to give the caregiver a planned period of relief from the physical and emotional demands associated with providing care. Respite care can be provided in the home or other non institutional settings.

Home Care

Skilled home care is provided by VA and contract agencies to veterans that are home bound with chronic diseases and includes nursing, physical/occupational therapy, and social services.

Hospice/Palliative Care

Hospice/palliative care programs offer pain management, symptom control, and other medical services to terminally ill veterans or veterans in the late stages of the chronic disease process. Services also include respite care as well as bereavement counseling to family members.

Financial Assessment for Long-Term Care Services

For veterans who are not automatically exempt from making copays for long-term care services (see Copays on page 11), a separate financial assessment (VA Form 10-10EC, APPLICATION FOR EXTENDED CARE SERVICES) must be completed to determine whether they qualify for cost-free services or to what extent they are required to make long term care copays. For those veterans who do not qualify for cost-free services, the financial assessment for long term care services is used to determine the copay requirement. Unlike copays for other VA health care services, which are based on fixed changes for all, long-term care copay charges are individually adjusted based on each veteran's financial status.

Limited Benefits

Nursing Home Care

While some veterans qualify for indefinite nursing home care services, other veterans may qualify for a limited period of time. Among those that automatically qualify for indefinite nursing home care are veterans whose service-connected condition is clinically determined to require nursing home care and veterans with a service-connected rating of 70% or more. Other veterans—with priority given to those with service-connected conditions—may be provided short-term nursing home care if space and resources are available.

Domiciliary Care

Domiciliary care provides rehabilitative and long-term, health maintenance care for veterans who require some medical care, but who do not require all the services provided in nursing homes. Domiciliary care emphasizes rehabilitation and return to the community. VA may provide domiciliary care to veterans whose annual income does not exceed the maximum annual rate of VA pension or to veterans who have no adequate means of support.






Frequently Asked Questions

I already provided financial information on my initial VA application, why is it necessary to complete a separate financial assessment for long-term care?

Unlike the information collected from the financial assessment, which is based on your previous year's income, the 10-10EC is designed to assess your current financial status, including current expenses. This in-depth analysis provides the necessary monthly income/expense information to determine whether you qualify for cost-free long-term care or a significant reduction from the maximum copay charge.

Once I submit a completed VA Form 10-10EC, who notifies me of my long-term care copay requirements?

The social worker or case manager involved in your long-term care placement will provide you with an annual projection of your monthly copay charges.

Assuming I qualify for nursing home care, how is it determined whether the care will be provided in a VA facility or a private nursing home at VA expense?

Generally, if you qualify for indefinite nursing home care, that care will be furnished in a VA facility. Care may be provided in a private facility under VA contract when there is compelling medical or social need. If you do not qualify for indefinite care, you may be placed in a community nursing home—generally not to exceed six months—following an episode of VA care. The purpose of this short-term placement is to provide assistance to you and your families while alternative, long-term arrangements are explored.

For veterans who do not qualify for indefinite nursing home care at VA expense, what assistance is available for making alternative arrangements?

When the need for nursing home care extends beyond the veteran's eligibility, our social workers will help family members identify possible sources for financial assistance. Our staff will review basic Medicare and Medicaid eligibility and direct the family to the appropriate sources for further assistance, including possible application for additional VA benefit programs.

Additional VA Health Care

Veterans

In addition to the VA health care system, which administers benefits to veterans residing within the United States, VA also provides benefits to service-connected veterans outside the country.

VA Foreign Medical Program—a health care benefits program for US veterans with VA-rated service-connected conditions who are living or traveling abroad. Foreign benefits are administered by two separate offices (as indicated on the following page) depending on where the health care services are obtained.

Veterans in the Philippines

Address
VA Outpatient Clinic (358/00)
2201 Roxas Blvd.
Pasay City 1300
Republic of the Philippines

Email
manlopc.inqry@vba.va.gov

Fax
011-632-838-4566

All other countries

Address
Foreign Medical Program
PO Box 65021
Denver CO 80206-9021

Telephone
303.331.7590

Fax
303.331.7803

Email
www.va.gov/hac/contact
(see Foreign Medical Program)

Website
www.va.gov/hac

Dependents & Survivors

CHAMPVA—a health care benefits program for:

- Dependents of veterans who have been rated by VA as having a total and permanent disability;
- Survivors of veterans who died from VA-rated service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a VA-rated service-connected condition; and
- Survivors of persons who died in the line of duty and not due to misconduct and not otherwise entitled to benefits under DoD's TRICARE program.

Address
CHAMPVA
PO Box 65023
Denver CO 80206-9023

Telephone
800.733.8387

Fax
303.331.7804

Email
www.va.gov/hac/contact
(see CHAMPVA)

Website
www.va.gov/hac

Children of Women Vietnam Veterans Health Care Benefits—a program designed for women Vietnam veterans' birth children who are determined by a VA Regional Office to have one or more covered birth defects.

Address
Children of Women Vietnam Veterans
PO Box 469027
Denver CO 80246-9027

Telephone
888.820.1756

Fax
303.331.7807

Email
www.va.gov/hac/contact
(see CWVV)

Website
www.va.gov/hac

Spina Bifida Health Care Benefits—a program designed for Vietnam veterans' birth children diagnosed with spina bifida and who are in receipt of a VA Regional Office award for spina bifida benefits.

Address
Spina Bifida Health Care
PO Box 65025
Denver CO 80206-9025

Telephone
888.820.1756

Fax
303.331.7807

Email
www.va.gov/hac/contact
(see Spina Bifida)

Website
www.va.gov/hac

For more information on VA health care,
call toll-free 1-877-222-VETS (8387)
Or online at **www.va.gov/healtheligibility**
To download a copy of this brochure, go to:
www.va.gov/healtheligibility/library/pubs/healthcareoverview

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Veterans Health Administration

Chief Business Office

March 2008

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