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Eligibility for VA Health Services

In October 1996, Congress passed Public Law 104-262, the *Veterans' Health Care Eligibility Reform Act of 1996*. This legislation paved the way for the creation of a Medical Benefits Package - a standard enhanced health benefits plan available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services.

VA places a priority on improved veteran satisfaction. Our goal is to ensure the quality of care and service you receive is consistently excellent, in every location, in every program. Under the Medical Benefits Package, VA offers you, the veteran, a comprehensive health care plan that provides the care you need.

What are the Priority Groups?

Once you apply for enrollment, your eligibility will be verified. Based on your specific eligibility status, you will be assigned a priority group.

The priority groups are as follows, ranging from 1-7 with 1 being the highest priority for enrollment. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans.

Priority Group 1

Veterans with service-connected disabilities rated 50% or more

Priority Group 2

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

Priority Group 3

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

Priority Group 4

- Veterans who are receiving 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 dollar thresholds

Priority Group 6

All other eligible veterans who are not required to make [copayments](#) for their care, including:

- World War I and Mexican Border War veterans
- Veterans seeking care solely for disorders associated with: exposure to herbicides while serving in Vietnam; or exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or for disorders associated with service in the Gulf War; or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998
- [Compensable](#) 0% service-connected veterans

Priority Group 7

Nonservice-connected veterans and [noncompensable](#) 0% service-connected veterans with income and net worth above the established dollar thresholds and who agree to pay specified [copayments](#)

Enrollment

You are now eligible for a comprehensive health care package that is completely portable across the entire VA health care system. To receive health care, most veterans must be enrolled first.

Do I have to enroll to receive health care?

You are *NOT* required to apply for enrollment if you fall into one of the following categories:

- VA has rated you as 50% or more service-connected;
- Less than one year has passed since you were discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but VA has not yet rated;
OR
- You are seeking care from VA for a service-connected disability only (even if the rating is only 0%).

How do I apply?

You can apply for VA health care by completing VA form 10-10EZ. The 10-10EZ may be obtained by visiting, calling, or writing any VA health care facility or veterans' benefits office. You can also call toll-free 1-877-222-VETS (1-877-222-8387) or access the form on the internet at <http://www.va.gov/1010ez.htm>

Enrollment is an ongoing process. You can apply for enrollment at any VA health care facility.

An important aspect of enrollment is for you to identify which VA health care facility you choose as your [preferred facility](#).

The preferred facility is where you receive your primary care. If for any reason a selected facility is unable to provide the health care needed by an enrolled veteran, then that facility will make arrangements for referral to another VA health care facility or to one of VA's private sector affiliates to provide the required care.

What is the re-enrollment process?

Once enrolled, most veterans will remain enrolled from year to year without further action on their part. However, certain veterans are required to provide income information to determine their priority level. Those veterans will be requested to update a 10-10EZ on an annual basis.

You may choose not to be re-enrolled, or changes in VA funding may reduce the number of priority groups VA can enroll in a given fiscal year. Any veteran who is affected will be notified in writing.

Should you have any changes in address, preferred facility, or other status information, you simply need to notify the VA location that has provided the care, the nearest VA health care facility, or call the toll-free number 1-877-222-VETS (1-877-222-8387).

Benefits

What is the Medical Benefits Package?

In October 1996, Congress passed Public Law 104-262, the *Veterans' Health Care Eligibility Reform Act of 1996*. This legislation paved the way for the creation of a Medical Benefits Package - a standard enhanced health benefits plan generally available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services.

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What does it cover?

The Medical Benefits Package will generally be provided to all enrolled veterans regardless of your priority group.

Public Law 104-262 calls for VA to provide you hospital care and outpatient care services that are defined as "[needed](#)". VA defines "needed" as care or service that will promote, preserve, and restore health. This includes treatment, procedures, supplies, or services. This decision of need will be based on the judgement of your health care provider and in accordance with generally accepted standards of clinical practice.

The following three categories contain a list of health care services that are provided under the Medical Benefits Package, a list of some that are not covered by VA, and a list of other services that are provided under special authority.

Services Covered Under the Medical Benefits Package

Basic care

1. Outpatient medical, surgical, and mental health care, including care for substance abuse.
2. Inpatient hospital, medical, surgical, and mental health care, including care for substance abuse.
3. Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.
4. Emergency care in VA facilities.
5. Emergency care in non-VA facilities in certain conditions: This benefit is a safety net for veterans requiring emergency care for a service connected disability or enrolled veterans who have no other means of paying a private facility emergency bill. If another health insurance provider pays all or part of a bill, VA cannot provide any reimbursement. To qualify for payment or reimbursement for

non-VA emergency care service for a service-connected disability, you must meet all of the following criteria:

1. It must be for a Medical Emergency.
2. Department of Veterans Affairs or other Federal facilities are not feasibly available at time of emergency event.
3. The emergency was for a service-connected disability.

To qualify for payment or reimbursement for non-VA emergency care services for a nonservice-connected condition, you must meet all of the following criteria:

4. You are enrolled in the VA Health Care System.
 5. You have been provided care by a VA clinician or provider within the last 24 months.
 6. You were provided care in a hospital emergency department or similar facility providing emergency care.
 7. You have no other form of health insurance.
 8. You do not have coverage under Medicare, Medicaid, or a state program.
 9. You do not have coverage under any other VA programs.
 10. Department of Veterans Affairs or other Federal facilities are not feasibly available at time of emergency event.
 11. A reasonable layperson would judge that any delay in medical attention would endanger your health or life.
 12. You are financially liable to the provider of the emergency treatment for that treatment.
 13. You have no other contractual or legal recourse against a third party that will pay all or part of the bill.
6. Bereavement counseling.
 7. Comprehensive rehabilitative services other than vocational services.
 8. Consultation, professional counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran.
 9. Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids.
 10. Home health services.

11. Reconstructive (plastic) surgery required as a result of a disease or trauma but not including cosmetic surgery that is not medically necessary.

12. Respite, hospice, and palliative care.

13. Payment of travel and travel expenses for eligible veterans.

1. A veteran or other person traveling in connection with treatment for a service-connected disability (irrespective of percent of disability).
2. A veteran with a service-connected disability rated at 30 percent or more, for treatment of any condition.
3. A veteran receiving VA pension benefits.
4. A veteran whose annual income does not exceed the maximum annual rate of pension, which would be payable if the veteran were eligible for pension, or who is unable to defray the expenses of travel.

14. Pregnancy and delivery service, to the extent authorized by law.

15. Completion of forms.

1. This coverage includes completion of forms such as Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, and non-VA disability program forms by health care professionals based on an examination or knowledge of the veteran's condition. This does not include the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

Preventive care

1. Periodic medical exams.
2. Health education, including nutrition education.
3. Maintenance of drug-use profiles, drug monitoring, and drug use education.
4. Mental health and substance abuse preventive services.

Services Not Covered Under the Medical Benefits Package

The "medical benefits package" does not include the following:

1. Abortions and abortion counseling.
2. In vitro fertilization.
3. Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.
4. Gender alterations.
5. Hospital and outpatient 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 give the care or services.
6. Membership in spas and health clubs.
- 7.

Services With Limited Coverage

1. Commonwealth Army veterans and new Philippine Scouts may receive hospital and outpatient care provided for in the Medical Benefits Package.
2. A veteran may receive certain types of VA hospital and outpatient care not included in the Medical Benefits Package such as humanitarian emergency care for which the individual will be billed, compensation and pension examinations, dental care, readjustment counseling, care as part of a VA-approved research project, seeing-eye or guide dogs, sexual trauma counseling and treatment, special registry examinations.
3. A veteran may receive an examination to determine whether the veteran is catastrophically disabled and therefore eligible for inclusion in priority category 4.
4. Non-enrolled veterans
 1. A veteran rated for service-connected disabilities at 50 percent or greater will receive VA hospital and outpatient care.
 2. A veteran who has a service-connected disability will receive VA hospital care for that service-connected disability.
 3. A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty will receive VA

hospital and outpatient care for that disability for the 12-month period following discharge or release.

4. When there is a compelling medical need to complete a course of VA treatment started when the veteran was enrolled in the VA health care system, a veteran will receive that treatment.
5. A veteran participating in VA's vocational rehabilitation will receive VA hospital and outpatient care.
6. A veteran may receive VA hospital and outpatient care based on factors other than veteran status e.g., a veteran who is a private-hospital patient and is referred to VA for a diagnostic test by that hospital under a sharing contract; a veteran who is a VA employee and is examined to determine physical or mental fitness to perform official duties; A Department of Defense retiree under a sharing agreement.
7. A veteran may receive VA hospital and outpatient care outside the United States, without regard to the veteran's citizenship, if necessary for treatment of a service-connected disability, or any disability associated with and held to be aggravating a service-connected disability or if the care is furnished to a veteran participating in a VA rehabilitation program.

Financial Information

Most [nonservice-connected](#) veterans and [noncompensable](#) 0% service-connected veterans are required to complete an annual [means test](#) or to agree to pay VA the applicable copayment. The means test is based on their family's income and net worth. Some veterans are required to make copayments for their care and medications.

Veterans are requested to provide health insurance information. VA is required to submit claims to insurance carriers for treatment of all nonservice-connected conditions. Reimbursement received from insurance carriers are retained at the VA health care facility where treatment was received. These funds are used to provide additional health care services to all veterans.

Means Testing

Certain [nonservice-connected](#) veterans are required to fill out the financial worksheet, which we refer to as the "Means Test." A means test is a gathering of financial information by which VA determines your priority group for enrollment, and whether or not you are required to make [copayments](#) for the service you receive. The means test is based on prior year income and net worth. However, you can apply for an exemption from paying those copayments to avoid a hardship if projections of your income for the current year will be substantially below the applicable income threshold.

Should you decline to complete the Financial Worksheet, you must agree to pay the applicable copayment unless you are otherwise eligible for VA care. We would be unable to determine your priority and therefore could not offer you enrollment. It is

possible, if you do not want to complete the Financial Worksheet, to declare yourself as a Discretionary Veteran. This means that you would accept placement in priority group 7 for enrollment and if enrolled you would be accepting responsibility for making the required copayments.

Hardship Determination

A Hardship Determination is a process by which veterans enrolled in Priority Group 7 may request a change in their enrollment priority group if their projected income for the current year will be substantially lower than their income from the previous year. Circumstances that might warrant hardship determination would be the loss of employment, business bankruptcy, or out-of-pocket medical expenses.

Prescriptions

If you are being provided treatment, necessary prescriptions will be provided. For more information on the current [copayment](#) rates, go to <http://www.va.gov/revenue>. Service-connected veterans rated 50% or more, service-connected veterans receiving medications for a service-connected condition, or [nonservice-connected](#) veterans who meet the low-income criteria are exempt from the prescription copayment. This income threshold changes annually.

Copayments

Four Basic Types of Charges

There are four basic types of charges:

- Medication – Prescription [copayment](#) charges were established by Congress. The charge is \$7 for each 30 day or less supply of medications provided on an outpatient basis for [nonservice-connected](#) conditions.
- Outpatient – The copayments will be based on primary care visits (\$15), specialty care visits (\$50) and no copayment designations.
- Inpatient – Congress determined the appropriate inpatient copayment should be the current inpatient Medicare Deductible Rate plus \$10 for the first 90 days that you remain in the hospital.
- Nursing Home – Congress determined the copayment should be the current Medicare deductible rate plus \$5.00 for each day.

The Debt Collection Improvement Act of 1996 (Public Law 104-134) requires the Department of Veterans Affairs (VA) to refer any unpaid bills over 180 days old to the Treasury Department for potential offset. The Treasury Department or other authorized representatives will offset all or a portion of what you owe VA against almost any monies paid to you by the Federal Government. This could include, but is not limited to, social security benefits, federal income tax refunds and federal salary, or retirements benefits. Referral of your bills to Treasury may result in processing fees being charged to you. Processing fees will be charged for the referral and for each offset made.

If you can't afford to make [copayments](#) there are two options:

1. The first option is to request a waiver for paying your current debt. If you request a waiver, you must submit sufficient proof that you can not financially afford to make payment to VA. This process could take several months; please contact the Revenue Coordinator at the VA health care facility where you receive care.
2. The second option is to request a hardship determination to avoid future debts. You will need to submit specific financial information about your current year income. A decision will be made based on information you provide.

Which Veterans Pay for Which Services

Which veterans pay for which services at VA health care facilities?

Priority Group 1

If care is provided to priority group 1 veterans for a nonservice-connected condition, VA will bill the health insurance company.

Priority Groups 2, 3, and 4

Veterans in priority groups 2, 3, or 4 are required to pay a prescription copayment if they are less than 50% service-connected and the medication is for a nonservice-connected condition. VA will bill the health insurance company of veterans receiving treatment for nonservice-connected conditions in priority groups 2, 3, or 4.

Priority Group 5

VA will bill the health insurance company of the priority group 5 veterans who are receiving treatment for nonservice-connected conditions.

Priority Group 6

WWI, Mexican Border, and [compensable](#) 0% Service Connected veterans

Priority Group 6 veterans are not required to pay copayments or medication copayments when they are receiving care for exposure/experience related conditions. The insurance carrier will not be billed for treatment provided to related conditions. If care is provided to priority group 6 veterans for a nonservice-connected condition not related to their exposure/experience, VA will bill the insurance carrier. All applicable copayments will be assessed to veterans when the care is for conditions not related to their exposure or experience .

Priority Group 7

Priority group 7 veterans are required to pay inpatient copayment, outpatient copayment, prescription copayment, and nursing home copayment. VA will bill the health insurance company of priority group 7 veterans.

Special Categories of Veterans

Agent Orange, Ionizing Radiation, Gulf War, and women veterans receiving sexual trauma counseling are subject to [means test](#) copayments when the treatment they are receiving is not related to their exposure or experience. The initial registry examination and first follow-up visit to receive results of the examination are not billed to the health insurance carrier. However, VA will bill your insurance carrier for subsequent care of nonservice-connected disabilities that is not related to exposure.

Prescription Copayment Exemption

Service-connected veterans rated 50% or more or nonservice-connected veterans who meet the low income criteria are exempt from the prescription copayment.

Non-veteran Care

VA does not have the authority to bill insurance carriers for care provided to employees or to non-veterans. Emergency medical care provided to a non-veteran will be billed directly to the person receiving the care.

TRICARE Recipients

TRICARE recipients are required to pay a prescription copayment. VA will bill private health insurance first and TRICARE second. TRICARE recipients are billed deductibles and copayments as required by TRICARE and will be collected by VA at the time treatment is provided. However, VA will not collect any deductibles and copayments that may be required by the third party health insurance carrier.