Health insurance coverage through Veteran or Veteran's spouse provided by employer, Veteran or other non-federal sources.

VA health care is NOT considered a health insurance plan.

VA is required to bill private health insurance providers for medical care, supplies, and prescriptions provided for treatment of Veterans' nonservice-connected conditions. Generally, VA cannot bill Medicare but can bill Medicare supplemental health insurance for covered services.

All Veterans applying for VA medical care are required to provide information on their health insurance coverage, including coverage provided under policies of their spouses. Veterans are not responsible for paying any remaining balance of VA's insurance claim not paid or covered by their health insurance, and any payment received by VA may be used to offset "dollar for dollar" a Veteran's VA copay responsibility.

The video below, entitled "Private Health Insurance: How it Helps You", addresses the importance of Veterans providing private health insurance information when receiving care for non-service connected conditions.

What's in it for me for providing health insurance information?

You will not be responsible to pay for any unpaid balance that your third-party health insurance carrier does not cover. Depending on your Priority Group, however, you may be required to pay a VA copayment for non-service connected care.

Payments made to VA by your private health insurance carrier may allow VA to offset part or all of your VA copayment.

Many private health insurance companies apply VA healthcare charges toward your annual deductible. Contact your private health insurance carrier for specific details concerning your coverage. For billing questions about your VA patient statement, contact the number listed on your patient statement for billing inquiries.

Funds that VA receives from your third-party health insurance carrier go directly back to your VA Medical Center's operational budget. That money can be used to hire more staff or buy medical equipment to improve Veterans healthcare.

Insurance Coverage and Eligibility for VA Health Care

Your insurance coverage or lack of insurance coverage does not determine your eligibility for treatment at a VA health care facility.

Emergency Medical Care

During a medical emergency, Veterans should immediately seek care at the nearest medical facility. A medical emergency is an injury, illness or symptom so severe that without immediate treatment, you

believe your life or health is in danger. If you believe your life or health is in danger, call 911 or go to the nearest emergency department right away.

Veterans do not need to check with VA before calling for an ambulance or going to an emergency department. During a medical emergency, VA encourages all Veterans to seek immediate medical attention without delay. A claim for emergency care will never be denied based solely on VA not receiving notification prior to seeking care.

It is, however, important to promptly notify VA after receiving emergency care at a community emergency department. Notification should be made within 72 hours of admission to a community medical facility. This allows VA to assist the Veteran in coordinating necessary care or transfer, and helps to ensure that the administrative and clinical requirements for VA to pay for the care are met. IMPORTANT: An emergency department (ED) is a facility that is staffed and equipped to provide emergency treatment and does not include community facilities that provide medical treatment in situations other than emergencies.

Risks of Giving Up Your Private Insurance

What should you do with your private health insurance if you are accepted into VA health care program? You could save a lot of money if you dropped the insurance, but there are some things you should consider.

What about your non-Veteran family members?

VA does not normally provide care for family members of Veterans enrolled in VA's health care program. If you drop your private health insurance, they may have no health care coverage.
What would happen if you are disenrolled from VA's health care program?

There is no guarantee that in subsequent years Congress will appropriate sufficient funds for VA to provide care for all enrollment Priority Groups. This could happen if you are enrolled in one of the lower Priority Groups. This would leave you with no health care coverage.

What would happen if you drop your Medicare Part B coverage?

If you cancel your Medicare Part B Coverage, you need to know that you cannot be reinstated until January of the following year, AND you may be penalized for reinstatement.

For these reasons, VA encourages you to keep your private health insurance.

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. VA bills TRICARE for non-service connected medical treatment.

Health Plan Costs

Your health care costs are different based on who you are and your health plan option. In some cases, you may have to pay a portion of the cost for a health service or prescription in the form of a cost-share or copaymentA fixed dollar amount you may pay for a covered health care service or drug.. For plan costs, use the TRICARE Compare Cost Tool.

Dental Care

Dental coverage is separate from TRICARE's medical coverage. Your dental coverage is based on who you are:

- Active Duty Service Members: Covered by active duty dental benefits
- Active Duty Family Members: Can purchase the TRICARE Dental Program
- Guard/Reserve Members: Coverage changes based on sponsor's military status, learn more
- Guard/Reserve Family Members: Can purchase the TRICARE Dental Program
- Retired Service Members and Families: Can purchase the TRICARE Retiree Dental Program
- Survivors: Covered by either TRICARE Dental Program or TRICARE Retiree Dental Program, learn more

Note: Adult children enrolled in TRICARE Young Adult don't qualify for dental benefits.

Pharmacy

The TRICARE Pharmacy Program provides the prescription drugs you need, when you need them, in a safe, easy, and affordable way.

TRICARE's prescriptions are managed through the pharmacy contractor, Express Scripts.

- Sign up for secure services with Express Scripts
- Download the free Mobile App
- Search the TRICARE Formulary
- Check Pharmacy Costs
- Special Needs

TRICARE offers several services under the basic TRICARE benefit for beneficiaries with special needs: Applied Behavioral Analysis

- Cancer Clinical Trials
- Durable Medical Equipment
- Home Health Care
- Hospice Care
- Mental Health Care
- Skilled Nursing Facility Care

TRICARE also has several special programs that provide services beyond the basic TRICARE benefit for beneficiaries with special needs.

Are you moving?

Talk to your child's case manager and regional contractor before you move. They can help you find a new doctor and other resources so the transition is smooth with no interruptions in coverage.

Long Term Care Not Covered

Long term care (provides services that assist in the activities of daily living,) is not covered by TRICARE (or Medicare). You may purchase long term care insurance from a private insurer, and you may qualify for the Federal Long Term Care Insurance Program.

Vision Care

Your vision benefits, including eye exams, depend on:

- Who you are
- Your TRICARE plan
- Your age
- You may need a referral and/or prior authorization for vision care. Learn more in the following pages:
- Eye Exams
- Glasses and Contacts
- Vision Coverage through FEDVIP Starting in 2019

You may have the option to enroll in vision coverage through the Federal Employees Dental and Vision Insurance Program (FEDVIP). The first opportunity to enroll will be during the 2018 Open Season. For more information, visit https://tricare.mil/FEDVIP.

Did you know?

Some military hospitals and clinics may offer vision procedures that are not covered by TRICARE. Contact a military hospital or clinic near you to see what programs are offered.

Medicare

Medicare is a federally funded health insurance for people 65 or older, under 65 with certain disabilities and any age with End-Stage Renal disease.

Medicaid

Medicaid is a state-administered health insurance provided to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Usually, Veterans who qualify for Medicaid will not pay copays for VA health care.

Should I give up my private health insurance or other insurance (like TRICARE or Medicare) if I'm accepted into the VA health care program?

This is your decision. You can save money if you drop your private health insurance, but there are risks. We encourage you to keep your insurance because:

We don't normally provide care for Veterans' family members. So, if you drop your private insurance plan, your family may have no health coverage.

We don't know if Congress will provide enough funding in future years for us to care for all Veterans who are signed up for VA health care. If you're in one of the lower priority groups, you could lose your VA health care benefits in the future. And, if you don't keep your private insurance, this would leave you with no coverage.

If you have Medicare Part B (coverage for doctors and outpatient services) and you cancel it, you won't be able to get it back until January of the following year. And, you may have to pay a penalty to get your coverage back.

If I already have VA health care benefits, should I still sign up for Medicare when I turn 65?

Yes. We encourage you to sign up for Medicare as soon as you can. This is because:

- We don't know if Congress will provide enough funding in future years for us to provide care for all Veterans who are signed up for VA health care. If you're in one of the lower priority groups, you could lose your VA health care benefits in the future.
- Having Medicare means you're covered if you need to go to a non-VA hospital or doctor—so you have more options to choose from.
- If you delay signing up for Medicare Part B (coverage for doctors and outpatient services) and then need to sign up later because you lose your VA health care benefits or need more choice in care options, you'll pay a penalty. This penalty gets bigger each year you delay signing up—and you'll pay it every year for the rest of your life.
- If you sign up for Medicare Part D (coverage for prescription drugs), you'll be able to use it to get medicine from non-VA doctors and fill your prescriptions at your local pharmacy instead of through the VA mail-order service. But you should know that VA prescription drug coverage is better than Medicare coverage—and there's no penalty for delaying Medicare Part D.

If I'm signed up for VA health care, and I also have Medicare, what's covered by each?

You'll need to choose which benefits to use each time you receive care.

To use VA benefits, you'll need to get care at a VA medical center or other VA location. We'll also cover your care if we pre-authorize you (meaning we give you permission ahead of time) to get services in a non-VA hospital or other care settings. Keep in mind that you may need to pay a VA copayment for non-service-connected care.

If you go to a non-VA care setting, Medicare may pay for your care. Or, if we only authorize some services in a non-VA location, then Medicare may pay for other services you may need during your stay. Check your Medicare plan so you know which care locations and services you're covered for.

Can I use my Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) to help pay for VA care for non-service-connected conditions?

Yes. We may bill and accept reimbursement from High Deductible Health Plans (HDHPs) for medical care and services to treat your non-service-connected conditions. If you have an HDHP linked to an HSA, you can use your HSA to pay your VA copayments for non-service-connected care. We may also accept reimbursement from HRAs for the care we provide to treat your non-service-connected conditions.

Why VA Bills Your Health Insurance

VA is required by law to bill any health insurance carrier that provides coverage for you, including policies held by your spouse. Only Veterans treated for non-service connected conditions should see their insurance company billed for their treatment. Veterans who are treated for service-connected conditions should not have their insurance company billed for treatment. VA does not bill Medicare or Medicaid.

VA may bill and accept reimbursement from High Deductible Health Plans (HDHPs) for medical care and services provided to Veterans for non-service connected conditions. (HDHPs are usually linked to a Health Savings Account, which can be used to make VA copayments.) VA may also accept reimbursement from Health Reimbursement Arrangements (HRAs) for care provided for non-service connected conditions.

Most non-service connected Veterans without a special eligibility such as a Purple Heart, are required to complete a financial assessment at the time of enrollment. A financial assessment consists of the Veteran's household income (including spouse and dependents if applicable).

If your total gross household income is below VA income limits, you will not be charged a copay for medical services, however, you may be responsible for medication or extended care copays. If you have insurance VA will bill your insurance carrier for your non-service connected care.

If your total gross household income is over the VA income limits, VA will bill your health insurance carrier for your nonservice-connected medical services and you will be responsible for copays for nonservice-connected medical services, medications and extended care services that are not covered by your health insurance.

Financial Assessment

A financial assessment is a means of collecting the Veteran's household income information which is used to determine whether a Veteran is eligible for enrollment and whether or not the Veteran would be required to pay copays for care or prescription medication. VA is required by law to collect this information.

There is no change in VA's long-standing policy to provide no-cost care to Veterans who cannot afford to pay for their care, Veterans with catastrophic medical conditions, Veterans with a disability rating of 50 percent or higher, or for conditions that are officially rated as "service-connected."

Veterans Required to Provide a Financial Assessment

Not all Veterans are required to provide their income information to VA when applying for enrollment. Only certain Veterans who do not have a VA-rated service connected disability, who do not receive a VA pension payment or have a special eligibility, such as a recently discharged Combat Veteran or a Purple Heart recipient, must provide their gross household income (which includes spouse/partner and dependent children, if applicable) for the previous year when applying for enrollment for VA health care. This part of the application process is called an 'income assessment or financial assessment" (also formerly called a means test) and is used to determine if these Veterans are eligible for enrollment and whether or not they have to pay copays for their health care or prescription medication.

Financial Assessments are not Required to be Updated Yearly

Enrolled Veterans are no longer required to provide their financial assessment on an annual basis if they had a current financial assessment on file as of March 24, 2014. This means Veterans can enjoy their VA health care benefits without worrying about having to submit updated income information to VA every year.If the enrolled Veteran does not have a financial assessment on file as of March 24, 2014, the Veteran will be required to provide updated income information. Veterans may update their financial assessment when they visit their VA facility at their next appointment. Veterans may also update their information by submitting VA Form 1010EZR, which is available online, at their local VA medical center or by contacting 1-877-222-VETS (8387), to have the form mailed. This form is available online at https://www.1010ez.med.va.gov

Income Updates from IRS and SSA

VA securely receives income information from the IRS and SSA to confirm Veterans' continued enrollment eligibility. VA will contact the Veteran (and spouse/partner and dependents, if applicable) only if the income information received from IRS and SSA indicates a change in the Veteran's eligibility or copay requirements. Veterans will still have access to care during the period of review should they do not agree with the information VA receives from IRS and SSA.

Exceptions:

Veterans applying for enrollment must provide income information by using VA Form 1010EZ. This form is available online at https://www.1010ez.med.va.gov/ and can also be obtained at any VA medical center, Veteran Service Office, or by contacting 1-877-222-VETS (8387), to have the form mailed. Enrolled Veterans who are eligible because their household income is below the VA income limit (e.g., NSC and 0% SC Veterans without any special eligibility) will:

- Not be required to update their income on a yearly basis.
- Be required to complete a financial assessment at their next health care visit if they do not have a current financial assessment on file as of March 24, 2014.

- Veterans Required to Provide Yearly Income Updates
- Veterans who complete a financial assessment to determine their eligibility for cost-free medications or for Beneficiary Travel only are required to submit their income yearly.

Recent Combat Veterans

Combat Veterans who served in combat after the Gulf War or in combat against a hostile force after November 11, 1998, are eligible for free care for five years for any illness that may be related to their military service beginning on the date of the Veteran's discharge. These Veterans are now eligible for an additional year of eligibility based on the Clay Hunt Act. For more information, please visit the Clay Hunt webpage.

These Combat Veterans are not required to provide their income for care related to their service in the theater of operations; however, they may complete the financial assessment to determine their eligibility for a higher priority status in the VA health care system, eligibility for beneficiary travel benefits, or for cost-free care for treatment not related to their military service.

Veterans Exposed to Agent Orange, Ionizing Radiation or Environmental Contaminants
Veterans who were exposed to Agent Orange in Vietnam, ionizing radiation, or exposed to environmental contaminants in the Persian Gulf receive free care for treatment related to their exposure. These Veterans are not required to provide their income; however, they may complete the financial assessment to determine if they are required to pay copays for care not related to their exposure.

Veterans who Decline to Provide Income Information

Veterans who decline to provide their income information and agree to pay copays for their care are not required to provide their income information; however, unless otherwise eligible (e.g. Compensable service-connected, former POW, Combat Veterans, served in the Republic of Vietnam, service during certain periods in Southwest Asia) the Veteran's enrollment may be denied based on the enrollment restriction.

Information from IRS and SSA

If the information received from IRS and SSA may result in a change in the Veteran's eligibility or copay requirement, VA will notify the Veteran and give the Veteran an opportunity to provide input. For more information about the income verification process, see the "Income Verification" section below.

Changes to Income and Personal Information

VA encourages Veterans to continue to report changes in their income information, as well as their personal information, such as address, phone numbers, dependents, next of kin and health insurance, using VA Form 1010EZR available online or at their local medical center. These changes can be submitted at any time.

Income Verification Tables

VA is required by law to verify Veterans' self-reported household income (including spouse/partner and dependents, if any) with the Internal Revenue Service (IRS) and Social Security Administration (SSA).The Income Verification (IV) process is used to confirm the accuracy of Veterans eligibility for VA health care, copay status and enrollment priority group assignment. Because of the timeframe for taxpayers to report income to the IRS, the IV process typically begins in July of the following year of reported income. For example, income for the year 2015 is available from IRS/SSA in July of 2016.

Veterans Included in the Income Verification Process

VA does not verify all enrolled Veterans' income. Only Veterans who receive free medical care and/or medications based on their self-reported household income are included in the income verification process.

Income Verification Process

If a Veteran's income is below VA's income limits (see income limits table), but the income information received from the IRS/SSA indicates the Veteran's household income is above VA's income limits, the Veteran and spouse/partner, if applicable, will be notified by letter and given an opportunity to verify or dispute this information.

If no response is received after 45 days, a reminder letter is mailed, offering the opportunity for the Veteran to verify or dispute the income reported by IRS/SSA and to submit additional deductible expenses, if any.

If no response is received within 75 days, it is assumed the IRS/SSA information is correct and a letter will be sent informing the Veteran his/her copay status will be changed and of their copay responsibility. This may also impact the Veteran's eligibility for enrollment. The Veteran will also receive information on how to appeal the decision.

When VA receives a response, an IV case manager will be assigned to work with the Veteran and/or the Veteran's representative. The IV case manager will provide assistance and guidance to the Veteran through the income verification process, and will assist the Veteran in identifying any authorized deductions that may reduce the Veterans' total gross household income below VA's income limits. It is our goal to work closely with the Veteran to resolve and close the income verification case within 75 days.

If after the review process the information does not reduce the Veteran's income below VA's income limits, a final letter is mailed to the Veteran explaining that the Veteran will be responsible for copays and required to pay copays for care received during the income year under review. The letter also contains information on how to appeal the decision.

Financial Hardship

VA has programs that may help if the Veteran is unable to pay the copay charges. For more information, visit http://www.va.gov/HEALTHBENEFITS/cost/financialhardship.asp.
For more Information about the Income Verification program or financial assessments, contact the Income Verification office at 1-800-929-VETS (8387).

Medication Copays and Income Screening

The Medication Copay applies to each prescription, including each 30-day supply or less of maintenance medications prescribed on an outpatient basis for nonservice-connected conditions. This copay may change annually.

Medication copays are charged for all over-the-counter medications such as aspirin, cough syrup, vitamins, etc., that are dispensed from a VA pharmacy. Therefore, you may want to consider purchasing over-the-counter medications on your own.

Veterans who have a Service Connection rating of 40% or less and whose income is at or below the applicable pension thresholds may wish to complete a medication copay exemption test.

Billing Questions: If you receive a bill that you believe to be in error, please contact the toll-free number that is listed on your billing statement.

- Types of Copays
- Outpatient
- Inpatient
- Extended Care
- Medication Copay

You may be responsible for one or more of the federally mandated copays VA is required to charge. Veterans who are Service-Connected 10% or greater are not required to pay a copay for inpatient or outpatient care medical care.

Health Savings Accounts (HSAs) can be used to make VA first-party copayments.

Because copay rates may change annually, they are published separately. Current year rates can be obtained at any VA health care facility or at our website:

www.va.gov/healthbenefits/cost/copays.asp.

You are not responsible for the balance of your insurance company's bills, deductibles or cost shares.

Health Benefits Copays

While many Veterans qualify for free healthcare services based on a VA compensable service-connected condition or other special eligibilities, most Veterans are required to complete a financial assessment or

means test at the time of enrollment to determine if they qualify for free health care services. Veterans whose income exceed VA income limits as well as those who choose not to complete the financial assessment at the time of enrollment, must agree to pay required copays for health care services to become eligible for VA healthcare services.

VA health care, how to pay a copayment and how to address copayment debts

Outpatient Copays
Primary Care Services: $15

Services provided by a primary care clinician.

Specialty Care Services: $50

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, and nuclear medicine studies.

Medications:

Veterans in Priority Group 1 do not pay for medications.
Inpatient Services

There are two inpatient copay rates, the full rate and the reduced rate.
Priority Group 7 and certain other Veterans are responsible for paying 20 percent of VA's inpatient copay rate.

- Inpatient Copay for the first 90 days of care during a 365-day period. $257
- Inpatient Copay for each additional 90 days of care during a 365-day period. $128
- Daily Charge $2/day
- Priority Group 8 and certain other Veterans are responsible for VA's full inpatient copay rate.
- Inpatient Copay for the first 90 days of care during a 365-day period. $1,288
- Inpatient Copay for each additional 90 days of care during a 365-day period. $644
- Daily Charge $10/day

Veterans living in high cost areas may qualify for a reduced inpatient copay rate. For more information contact VA toll-free at 877-222-VETS (8387).

Veterans can use the Health Benefits Explorer to see what copays may apply to their health care plan. Click here for Health Benefits Explorer.

Effective February 27, 2017

Veterans in Priority Groups 2-8, are required to pay for each 30-day or less supply of medication for treatment of nonservice-connected condition (unless otherwise exempt).

Medications

- Effective February 27, 2017
- Veterans in Priority Groups 2-8, are required to pay for each 30-day or less supply of medication for treatment of nonservice-connected condition (unless otherwise exempt).
- 30-day or less supply for Tier 1 (Preferred Generics) Medications for certain Veterans: $5
- 30-day or less supply for Tier 2 (Non-Preferred Generics & some OTCs) Medications for certain Veterans: $8
- 30-day or less supply for Tier 3 (Brand Name) Medications for certain Veterans: $11
- (Veterans in Priority Groups 2 through 8 are limited to $700 annual cap)
- Click here to view the Tier 1 Copay Medication List
- Click here to view the Tiered Medication List

Geriatrics and Extended Care

Long term care copays are based on three levels of care:

- Inpatient: Up to $97 per day (Community Living (Nursing home), Respite, Geriatric Evaluation)
- Outpatient: $15 per day (Adult Day Health Care, Respite, Geriatric Evaluation)
- Domiciliary: $5 per day**

Copayments for Long-Term Care services start on the 22nd day of care during any 12-month period — there is no copayment requirement for the first 21 days. Actual copayment charges will vary from Veteran to Veteran depending upon financial information submitted on VA Form 10-10EC.
Geriatrics and Extended Care provides services for Veterans who are elderly and have complex needs, and Veterans of any age who need daily support and assistance. Veterans can receive care at home, at VA medical centers or in the community.

Hospice Services

Hospice is a comfort based form of care for Veterans who have a terminal condition with 6 months or less to live. Hospice Care provides treatment that relieves suffering and helps to control symptoms in a way that respects your personal, cultural, and religious beliefs and practices. Hospice also provides grief counseling to your family.

Respite Care

Respite Care is a service that pays for a person to come to a Veteran's home or for a Veteran to go to a program while their family caregiver takes a break. While a Veteran gets Respite Care, the family caregiver can run errands or go out of town for a few days without worrying about leaving the Veteran alone at home. Depending on the Respite Care services in your area, you can choose which options are best for you and your family caregiver. For example: If your caregiver has lots of errands to run or appointments, you could have a Home Health Aide come to your home while your caregiver is out of the house. If your caregiver needs time at your home alone, you could attend an Adult Day Health Care center for the day. Or, if your caregiver is out of town for a few days, you could stay at a Community

Living Center (VA Nursing Home) during the time they are away. Respite Care services may be available up to 30 days each calendar year.

Domiciliary Care

VA offers two distinct types of Domiciliary Care: short-term rehabilitation and long-term health maintenance care. This program also provides a clinically appropriate level of care for homeless Veterans whose health care needs are not severe enough to require more intensive levels of treatment.

Medical Foster Homes

Medical Foster Homes are private homes in which a trained caregiver provides services to a few individuals. Some, but not all, residents are Veterans. VA inspects and approves all Medical Foster Homes. A Medical Foster Home can serve as an alternative to a nursing home. It may be appropriate for Veterans who require nursing home care but prefer a non-institutional setting with fewer residents. Contact your assigned VA social worker or case manager for further information on Medical Foster Home care.

State Veterans Homes

State Veterans Homes are facilities that provide nursing home, domiciliary or adult day care. Your eligibility for State Veterans Homes is based on clinical need and setting availability. Each State establishes eligibility and admission criteria for its homes. For more information about your State Veterans Home, contact Social Work Service at your local VA facility.

How to Apply for Long Term Care

Complete VA Form 10-10EC on paper and apply in person or mail the application to your local VA health care facility.

Call VA toll-free at 877-222-VETS (8387), Monday through Friday between 8am to 8pm Monday through Friday, EST.

Veterans Not Required To Make Copays

Some Veterans qualify for free healthcare and/or prescriptions based on special eligibility factors including but not limited to:

- Former Prisoner of War status
- 50% or more compensable VA service-connected disabilities (0-40% compensable service-connected may take copay test to determine prescription copay status)
- Veterans deemed catastrophically disabled by a VA provider
- 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 examinations.
- Care that is part of a VA research projectCare related to a VA-rated service-connected disability
- Readjustment counseling and related mental health services
- Care for cancer of head or neck caused by nose or throat radium treatments received while in the military
- Individual or Group Smoking Cessation or Weight Reduction services
- Publicly announced VA public health initiatives, for example, health fairs
- Care potentially related to combat service for Veterans that served in a theater of combat operations after November 11, 1998.
- Laboratory and electrocardiograms