



Advocate



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VA Assisting Veterans with Health Care Costs

For veterans struggling financially due to a job loss or decreased income, the Department of Veterans Affairs (VA) offers an assortment of programs that can relieve the costs of health care or provide care at no cost. Veterans whose previous income was ruled too high for VA health care may be able to enter the VA system based upon a hardship if their current year's income is projected to fall below federal income thresholds due to a job loss, separation from service or some other financial setback. Veterans determined eligible due to hardship can avoid copays applied to higher-income veterans. Qualifying veterans may be eligible for enrollment and receive health care at no cost.

Also eligible for no-cost VA care are most veterans who recently returned from a combat zone. They are entitled

to five years of free VA care. The five-year "clock" begins with their discharge from the military, not their departure from the combat zone.

Each VA medical center across the country has an enrollment coordinator available to provide veterans information about these programs. Veterans may also contact VA's Health Benefits Service Center at 1-877-222 VETS (8387) or visit the VA health eligibility website at www.va.gov/healtheligibility. *



REPORT from the HILL

by Chuck Partridge
Government Relations

111th Congress Begins Work

With the convening of the 111th Congress on January 6th, the military community can expect and, in fact, has already faced several new challenges and resurrection of old fights from previous years.

Every two years at the beginning of each Congress, the Congressional Budget Office publishes a list of budget options for use by the members of the Senate and House. The options provide ideas for legislative action and describe the impact of the actions on the budget and the agency affected.

Several budget options provided in the latest edition would create serious problems for retirees, members on active duty, the reserve, National Guard and their family members.

TRICARE for Life

One option would introduce out-of-

pocket requirements under TRICARE-for-Life. Far from being minimum, the changes proposed would seriously undermine the military medical care promise and create hardships for retirees.

Here is the option: It would impose a \$525 deductible then it would require the beneficiary to pay 50 percent of the next \$4,725 in Medicare cost sharing. Therefore, the potential out-of-pocket cost to a retiree and spouse would be \$5,776 per year. To that add a minimum of \$96.10 per month for the Medicare Part B premium for the retiree and spouse or \$2,313.60 per year. This would total \$8,089.60 per year for a Medicare eligible couple or \$4,044.80 per individual. In addition, the proposal would link these fees to annual medical inflation. Therefore, a retiree could receive a 3 percent COLA for their retired pay while, based on recent experience, co-pays and deductibles for medical care could go up 11 or 12 percent over the year.

When you consider that a typical military retired couple might draw \$20,000 in retired pay (and many draw less), their medical care under this scheme could cost them 40 percent of

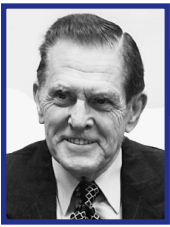
their retired pay. You can see what a catastrophic impact this could have on retirees. Further the impact is even worse on military widows whose Survivor Benefit Plan (SBP) or Dependency and Indemnity Compensation (DIC) payments are significantly less.

Proposals such as this represent a significant threat to AMS members and the entire retiree community. AMS plans to respond quickly if such draconian measures are recommended by the Administration or introduced by a member of Congress. We will need your help to inform your representative and senators that such a proposal is unacceptable and would jeopardize the livelihood of thousands of retirees and widows.

TRICARE for Retirees Under 65

There is also an option to impose increased medical fees on retirees not yet eligible for Medicare. This proposal would raise the TRICARE Prime annual fee for single coverage from \$230 to \$550 and for family coverage increase the fee from the current \$460 to \$1100 annually. It would also increase the co-payment for a visit to the doctor

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PRESIDENT'S COLUMN

Douglas Russell

This is my first column since the change of guard at the Department of Veterans Affairs, so I want to use it to wish farewell to departing VA Secretary Dr. James Peake. Dr. Peake had the very unenviable job of taking over the second largest department in the federal government knowing he would only be in the position for about a year. Given the size of the VA, it was very hard to expect to accomplish much in that short period of time.

If nothing else, he turned morale among the VA employees around and won praise from veterans groups. Rightly or wrongly, his predecessor, James Nicholson, was seen as nothing but a political appointee whose job was to hold back, or even cut, VA spending. As a result, morale among career employees plummeted and Nicholson's relationships with members of Congress, especially the new chairmen of the House and Senate VA committees, was very contentious.

In addition to improving morale, Secretary Peake also made great strides in moving forward the effort to improve the Information Technology in the VA. So I thank him for his service to veterans of our nation and wish him the very best in his future endeavors.

I also want to welcome the new VA Secretary, General Eric Shinseki. Secretary Shinseki had an outstanding career in the Army and I think all veterans are very pleased that President Obama selected him to head the Department of Veterans Affairs.

Secretary Shinseki has proved to everyone that he will stand up for what he believes is right and will not buckle under to political pressure. You may recall that he was Army Chief of Staff from 1999 to 2003. In the period just preceding the invasion of Iraq, General Shinseki

testified before Congress that it would take several hundred thousand troops to control Iraq after the invasion. As a result of his testimony, he was publicly repudiated by then Defense Secretary Donald Rumsfeld who said Shinseki was "far off the mark." Rumsfeld publicly humiliated Shinseki and undercut him during his remaining months as Army Chief of Staff by naming Shinseki's replacement 15 months before his retirement.

The irony, of course, is that Shinseki was right and had Rumsfeld followed his advice, things in Iraq may have been much different than they turned out. That fact was implicitly recognized by members of the Senate during Shinseki's confirmation hearing. Shinseki never said a word for an hour and a half after the beginning of his hearing because Senators from both parties took up all the time praising him.

Secretary Shinseki said he plans to develop a 2010 budget within his first 90 days that realizes the vision of President Obama to transform VA into an organization that is people-centric, results-driven and forward-looking.

Key issues on his agenda include smooth activation of an enhanced GI Bill education benefit that eligible Veterans can begin using next fall, streamlining the disability claims system, leveraging information technology to accelerate and modernize services, and opening VA's health care system to Veterans previously unable to enroll in it, while facilitating access for returning Iraq and Afghanistan Veterans.

AMS congratulates Secretary Shinseki and we greet his term of office with great anticipation.

Douglas Russell

VA Ramps Up Job Search for Injured Vets

Thirty percent of employees of the Department of Veterans Affairs (VA) are veterans – the second highest ranking among cabinet departments after the Department of Defense -- and nearly 8 percent of VA employees are service-connected disabled veterans. But the VA intends to increase the number of disabled veterans who obtain employment in its workforce.

All severely injured veterans of the wars in Iraq and Afghanistan will be contacted by VA's Veterans Employment Coordination Service to determine their interest in -- and qualifications for -- VA jobs. So far, that office has identified

2,300 severely injured veterans of those wars, of whom 600 expressed interest in VA employment.

The coordination service was established a year ago to recruit veterans into VA, especially those seriously injured in the current wars. It has nine regional coordinators working with local facility human resources offices across the country not only to reach out to potential job candidates but to ensure that local managers know about special authorities available to hire veterans. For example, qualified disabled veterans rated by the Defense Department or VA as having a 30 percent or more service-connected

disability can be hired non-competitively.

"Our team is spreading the message that VA is hiring, and we want to hire disabled veterans," said Dennis O. May, director of VA's Veterans Employment Coordination Service. VA coordinators participate in military career fairs and transition briefings, and partner with veterans organizations, the Department of Labor's Veterans Employment and Training Service, as well as VA's Vocational Rehabilitation and Employment Service, the Marine Corps' Wounded Warrior Regiment and the Army's Warrior Transition Units. ✨

Report from the Hill

continued from page 1

from \$12 to \$28.

For TRICARE Standard and Extra the annual deductible would go to \$350 single and \$700 for family coverage. In addition, for the first time since CHAMPUS/TRICARE was established, an annual enrollment fee of \$50 for single coverage and \$100 for family coverage would be imposed.

TRICARE for Active Duty Service Members

In addition to these budget options for retirees, active duty families could face changes. The proposal provides for providing active duty military families with a \$500 annual cash allowance for health expenses. TRICARE fees would be imposed and they would be charged to use the Military Treatment Facilities as well. As an alternative, family members could take the \$500 and opt out of military health care if they had health care through another employer. Under all of the options, the service member would continue to be eligible for military health care in MTFs or TRICARE as is currently the case.

The Budget Option study quotes a DoD estimate that among TRICARE Prime enrollees, inpatient use is 58% higher and outpatient visits 39% higher than a civilian HMO comparison group. The CBO analyst believes that imposing TRICARE and MTF fees would reduce military families' use of these services. This is probably true. The study also admits that these measures could result in families not getting the treatment they need. Military leaders know that such policies would create more problems for young military

families away from home, many separated from their spouses who are on one of their repetitive tours to Iraq or Afghanistan or another garden spot requiring a military presence. To suggest these changes, especially in time of war, reflects a lack of knowledge of the need for military community and the support families receive from the tradition that the military takes care of its own. These proposals undermine this concept and ultimately will not save money.

Other Options

Neither the new Administration nor the new Congress has endorsed any of these options. We hope that they will not. There are many other options. As AMS has pointed out before, part of the problem of health care cost growth has been the elimination of uniformed medical professionals and the reduction of federal civilian medical personnel strength. In the past, military medical personnel working in MTFs have served as protection against the high medical inflation rates affecting the private sector. However, severe medical manpower reductions, downgraded hospitals and clinics have pushed more care to the commercial sector and opened DoD to more of the same inflationary forces that affect civilian medical providers. Rebuilding this medical capability could save significant costs.

In addition, authorizing military hospitals to bill Medicare for treatment of Medicare eligible retirees and families could save Medicare billions of dollars while providing patient loads for efficient MTF operation. Before accepting the measures outlined in this article, AMS urges its friends in Congress to explore these and other avenues of cost reduction and efficiencies. ✨

One Million Vets Share \$320 Million in VA Insurance Dividends

One million veterans are in line to share \$319.8 million in annual insurance dividends during 2009, according to the Department of Veterans Affairs (VA). VA operates one of the nation's largest life insurance programs, providing more than \$1 trillion in coverage to seven million service members, veterans and family members. The dividend payments are being sent to an estimated one million holders of VA insurance policies on the anniversary date of their policies. Sent automatically through different payment plans, the amounts vary based on the age of the veteran, the type of insurance, and the length of time the policy has been in force.

The dividends come from the earnings of trust funds into which veterans have paid insurance premiums over the years, and are linked to returns on

investments in U.S. government securities.

VA officials caution veterans about a long-running scam in which various groups charge fees to "locate" veterans who are eligible for the dividends. Veterans eligible for the dividends have had VA life insurance policies in effect since they left the military and have received annual notifications from VA about the policies.

Dividends are paid each year to veterans who served between 1917 and 1956 and who hold certain government life insurance policies. The policies are known by letters that appear at the beginning of each policy's identification number.

World War II veterans holding National Service Life Insurance ("V") policies comprise the largest group receiving 2009 insurance dividend

payments. They are expected to receive total payments of \$243.8 million.

An additional group of World War II-era veterans, those who have Veterans Reopened Insurance ("J", "JR" and "JS") policies, will in total receive dividends of \$8.1 million. Korean War era veterans who have maintained Veterans Special Life Insurance ("RS" and "W") policies can expect to receive dividends totaling \$67.2 million.

Dividends totaling \$725,000 will be paid to veterans who served after World War I until 1940 who hold U.S. Government Life Insurance ("K") policies.

Veterans who have questions about their policies may contact the VA insurance toll-free number at 1-800-669-8477 or send an email to VAinsurance@va.gov. They may also visit the Internet at www.insurance.va.gov. ✨

Pilot Program Helps Streamline Disability Evaluation Process for Wounded Service Members

The Department of Defense (DoD) is working with the Department of Veterans Affairs (VA) to expand a pilot program that simplifies the current disability evaluation process for wounded, injured and ill service members.

The Disability Evaluation System (DES) pilot program is aimed at assisting wounded service members obtain faster access to TRICARE, other healthcare, and VA benefits by developing a single medical examination used by both DoD and VA, with a single source disability evaluation done by VA and accepted by DoD.

The pilot, implemented in November 2007 in the National Capitol Region, is slated to expand to 19 additional installations through June 1, 2009.

Currently, a wounded warrior's branch of service evaluates the member for conditions that may make him or her unfit for duty. This evaluation initiates the medical examination board process. Following separation or retirement from service, the member is again evaluated by the VA for disability and compensation. The pilot process streamlines and makes more transparent both processes through concurrent rather than sequential processing, more information for the member during the process, and comprehensive information regarding entitlements from both agencies at the time of the

separation.

Under the pilot, only one evaluation is necessary after a member is referred for a service medical evaluation board. The single evaluation also helps service members get comprehensive information about their benefits, including TRICARE.

The pilot is a result of the President's Commission on Care for America's Returning Wounded Warriors. The goal is to simplify healthcare and treatment for injured service members and veterans and deliver benefits as quickly as possible.

The pilot was initially tested at three Military Treatment Facilities in the National Capitol Region – Malcolm Grow Medical Center at Andrews Air Force Base, MD., Walter Reed Army Medical Center in Washington, D.C., and National Naval Medical Center in Bethesda, MD.

Since the pilot program began, the VA indicates more than 700 service members have participated in the pilot. To collect and evaluate data from other geographic regions, 19 more installations have been added to the study.

For more information about how TRICARE works for medically retired service members, visit <http://www.tricare.mil>. For more information about VA benefits, visit <http://www.vba.va.gov/VBA>. ✨

New Tool Improves Search Feature on TRICARE Web Site

Looking for information on the TRICARE Web site? Thanks to a new custom search tool, TRICARE beneficiaries can experience improved results on the TRICARE benefit information portal at <http://www.tricare.mil>. The Google Custom Search technology directs users to the information they need with a few key words and the click of a mouse.

By using the world's largest and most accessed search engine, TRICARE users can more easily find a wealth of information on topics such as finding providers, the various TRICARE healthcare plans, "what's covered," plan costs and much more.

"We want our beneficiaries to have a Web site that is easy to search and accessible," said Army Maj. Gen. Elder Granger, Deputy Director, TRICARE Management Activity (TMA). "This should be another major improvement for them."

The new search technology optimizes the TRICARE Web site experi-

ence for beneficiaries, providing more accurate results during a search for general TRICARE information.

The TRICARE beneficiary portal was also improved in 2007 with the implementation of a tool that delivers customized information. By entering a simple profile detailing duty status, location and plan, beneficiaries can receive a tailored Web site with the topics that most directly apply to them.

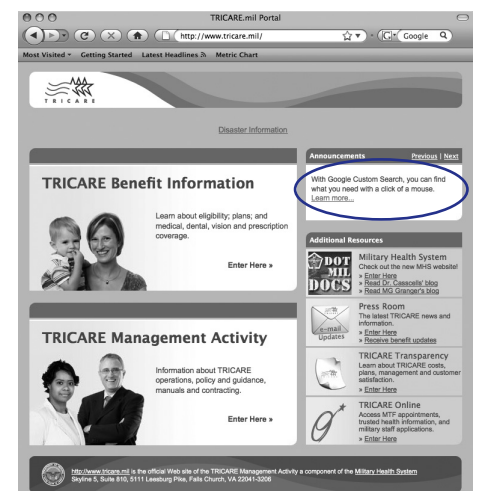
Improvements equal results.

According to 2008 E-Government Satisfaction results from the American Customer Satisfaction Index, TRICARE's Web site was the most improved government news or information site – up seven points over 2007.

"This is quite an accomplishment considering the complexity of the TRICARE benefit and the depth of information on our Web site," said Granger. "The TRICARE Web team has made great strides in responding to beneficiary needs. As more and more military families use the Web to find

benefit information, we must seek new ways to deliver targeted information, quickly and more accurately."

Plans also call for implementing the Google Custom Search tool on the TMA corporate portal also located on the front page of <http://www.tricare.mil>. The corporate portal features a wealth of information about TMA such as studies and surveys, reimbursement rates, TMA policies and other programs under TMA. ✨



VA-NIH Study Offers Hope for Parkinson's Patients

Study Says Deep-Brain Stimulation Has Benefits

Electrical stimulation of the brain -- a treatment in which a pacemaker-like device sends pulses to electrodes implanted in the brain -- is riskier than drug therapy but may hold significant benefits for those with Parkinson's disease who no longer respond well to medication alone. That is the conclusion of researchers from the Department of Veterans Affairs (VA) and National Institutes of Health (NIH) who conducted a six-year study comparing deep-brain stimulation (DBS) to medication, along with speech, physical or occupational therapy, given as needed. The results of the trial, the largest of its kind to date, appear in the January 7 *Journal of the American Medical Association (JAMA)*.

The study included 255 Parkinson's patients at seven VA medical centers and six university hospitals. The VA sites were Portland, Ore., Seattle, San Francisco, Los Angeles, Houston, Richmond, Va., and Philadelphia, all members of VA's network of Parkinson's Disease Research, Education and Clinical Centers. The *JAMA* article also noted VA's nationwide system of hospitals and specialized centers of excellence make the Department uniquely capable of conducting such large, multi-site trials of new therapies and medical devices. VA's patient population is especially suited for trials of treatments for chronic disease in the elderly.

Patients who took part in the study were on medication but are no longer seeing improvements in symptoms such as tremors or stiffness. Many were also developing side effects from the drugs, such as involuntary face, arm or leg movements.

Researchers followed the patients for six months, finding:

- Patients who received DBS gained an average of 4.6 hours per day of good motor control and few or no involuntary movements, compared with no gain for those on medical therapy alone;
- 71 percent of DBS patients showed significant gains in motor function, compared with only 32 percent of drug therapy patients; and
- Serious adverse side effects were nearly four times more common in the DBS group, but almost all of these effects in both groups were resolved during the six-month study. The most common side effects from DBS were infections, falls, depression, gait and balance problems, and pain.

Lead authors and study co-chairs were Frances Weaver, PhD, a researcher with the Center for Management of Complex Chronic Care at the Hines VA Hospital near Chicago, and Dr. Kenneth Follett, a neurosurgeon at the Omaha VA Medical Center and University of Nebraska. They emphasize that besides the higher likelihood of serious side effects with DBS compared with drug therapy, another drawback of the procedure is that, although it generally improves movement, it does little to help other Parkinson's symptoms such as depression, decline in mental ability, gait and balance problems, and trouble with gastrointestinal, urinary or sexual

function.

"The results of the study should not be over or understated," said Dr. Michael Kussman, VA's Under Secretary for Health. "Still, there are many good candidates for DBS among patients with Parkinson's disease whom we treat in VA."

The trial was sponsored by VA's Cooperative Studies Program and the National Institute of Neurological Disorders and Stroke, part of the National Institutes of Health. Additional support came from Medtronic, which makes the DBS system used in the study. Parkinson's disease, a progressive neurological disorder, affects some 1.5 million Americans, with 50,000 new cases diagnosed annually. VA treats at least 40,000 veterans with the disorder each year. Most patients are over age 50, but some forms of the disease can strike younger adults. ✿

VA To Offer Health Care to Previously Ineligible Veterans

The Department of Veterans Affairs (VA) has announced plans to re-open enrollment in its health care system by July 2009 to about 265,000 veterans whose incomes exceed current limits. The change affects veterans whose incomes exceed the current VA means test and geographic means test income thresholds by 10 percent or less. Congress provided funds in VA's fiscal year 2009 budget to support the new enrollment.

In 1996, Congress established a priority-based enrollment system for VA and a uniform package of medical benefits for all enrollees. The legislation opened enrollment in VA's health care system to all eligible veterans and required that each year the Secretary of Veterans Affairs assess veterans' demand for services and determine if the necessary resources are available to provide timely, quality care to all enrollees.

Enrollment for the lowest priority of the eight groups—veterans who are not being compensated for a military-related disability and who have incomes above a set threshold—was suspended on January 18, 2003, although veterans in that priority group who were already enrolled for care were permitted to remain enrolled.

VA originally suspended enrollment for Priority 8 veterans because it was unable to provide all enrolled veterans with timely access to its health care due to a tremendous growth in the number of veterans then seeking enrollment. VA now plans to reopen enrollment for a portion of these veterans without compromising the Department's ability to provide high quality health care services to all enrolled veterans who are eligible for care.

VA's computer systems are being modified to accommodate the changes, and the Department is preparing communication and education materials to ensure that Congress, veterans service organizations, and the public are aware of the coming changes. ✿

TRICARE Reserve Select Announces Lower Premiums for Health Care Coverage

The monthly premiums for TRICARE Reserve Select (TRS) member coverage officially dropped Jan. 1, 2009, by 42 percent, from \$81 to \$47.51. TRS member and family coverage dropped 29 percent, from \$253 to \$180.17

In response to the 2009 National Defense Authorization Act, Section 704, TRICARE analyzed Reserve Select costs from 2006 and 2007 and adjusted TRS premium rates for 2009.

“TRS premiums are billed a month in advance, so members started seeing reductions in early December, 2008” said Army Maj. Gen. Elder Granger, Deputy Director of TRICARE Management Activity. “This is good timing considering these challenging economic times.”

“TRS offers an opportunity for our members and families to have comprehensive, affordable health care coverage,” said Col. Marty Wong, head

of the joint family program for the National Guard Bureau. “This is great news.”

Granger also noted the benefits of purchasing coverage in the relatively new health plan open to qualified members of the Selected Reserve. “TRS has only been around since 2005,” he said. “Now is one of the best times in the short history of TRS to sign up and start receiving health care benefits.”

The TRS program was greatly streamlined in October 2007. Since then, the number of members has more than doubled. “TRS covered about 35,000 National Guard and Reserve members and families in late 2007,” said Granger. “Now we have over 80,000.”

TRS delivers coverage similar to TRICARE Standard and Extra to qualified members who purchase the coverage and pay monthly premiums. TRS also features continuously open

enrollment.

To qualify, candidates must be members of the Selected Reserve and cannot be enrolled in or eligible for the Federal Employee Health Benefits (FEHB) program. For instance, National Guard or Reserve personnel are not eligible to purchase TRS if their spouses have family plans under FEHB and the members are covered (enrolled) under FEHB.

Once a member’s qualifications are established by the services, the member can go to the TRICARE Reserve Select page at <http://www.tricare.mil/trs> and follow the instructions to purchase coverage through the Guard and Reserve Web portal found on the page. The direct link to the Guard and Reserve portal is <https://www.dmdc.osd.mil/appj/trs/index.jsp>

For more information about TRS visit the TRICARE Web site at <http://www.tricare.mil/trs>. *

VA Announces \$22 Million for Rural Veterans

The Department of Veterans Affairs (VA) has provided \$21.7 million to its regional health care systems to improve services specifically designed for veterans in rural areas.

Within the last year, VA has launched a major rural health initiative. The Department has already created a 13-member committee to advise the VA secretary on issues affecting rural veterans, opened three rural health resource centers to better understand rural health issues, rolled out four new mobile health clinics to serve 24 predominately rural counties, announced the opening of 10 new rural outreach clinics in 2009 and launched a fleet of 50 new mobile counseling centers.

The extra funding is part of a two-year VA program to improve the access and quality of health care for veterans in geographically isolated areas. The program focuses on several areas, including access to health care, providing world-class care, the use of the latest technology, recruiting and retaining a highly educated workforce and collaborating with other organizations.

More specifically, the new funds will be used to increase the number of mobile clinics, establish new outpatient clinics, expand fee-based care, explore collaborations with federal and community partners, accelerate the use of telemedicine deployment, and fund innovative pilot programs. The new

funds will be distributed according to the proportion of veterans living in rural areas within each VA regional health care system, called VISNs, for “Veterans Integrated Service Networks.”

VISNs with less than 3 percent of their patients in rural areas will receive \$250,000. Those with population of rural veterans between 3 percent and 6 percent will receive \$1 million each. And VISNs with more than 6 percent of their veterans population in rural areas will receive \$1.5 million. *

VISN Headquarters / Extra Funds

Boston, MA, \$1 million	Chicago, IL, \$1 million
Albany, NY, \$1 million	Kansas City, MO, \$1.5 million
New York, NY, \$250,000	Jackson, MS, \$1.5 million
Pittsburgh, PA, \$1 million	Dallas, TX, \$1 million
Baltimore, MD, \$250,000	Phoenix, AZ, \$1 million
Durham, NC, \$1.5 million	Denver, CO, \$1 million
Deluth, GA, \$1.5 million	Portland, OR, \$1 million
Bay Pines, FL, \$1 million	San Francisco, CA, \$1 million
Nashville, TN, \$1.5 million	Long Beach, CA, \$250,000
Cincinnati, OH, \$1 million	Minneapolis, MN, \$1.5 million
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