RAO Bulletin
15 November 2008

Note: Anyone receiving this who does not want it request click on the automatic delete tab at the end of the Bulletin or hit reply and place the word "Remove" in the subject line!!!!!!!!!!!!!!

THIS BULLETIN CONTAINS THE FOLLOWING ARTICLES

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VET JOBS UPDATE 06: OPM also announced that they are moving forward with President Bush's Military Spouse Hiring Authority. In the next few weeks the proposed regulations will be published in the Federal Register for public comment. This has been incorrectly reported in the press to be a hiring preference. It is not. It is a "non-competitive authority to hire." They also announced that the new Time in Grade regulations were just published. They will take effect on 9 MAR 09. What this change means is that someone who is hired into a federal job does not have to wait 52 weeks in that job before a promotion. This should be a great help for some new veterans and retirees who are being hired. Their superior can take into account their military experience to move they up in pay grade. It does not remove job qualification standards which often still require 1 year in the previous job. [Source: TREA Washington Update 11 Nov 08 ++]

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TRICARE AFTER HOURS CARE: Accidents happen. Babies get sick. Complications occur. And it seems they never happen at a convenient time. Certainly not always during the typical 9 a.m. to 5 p.m. work day. Tricare knows this, which is why it's important to know your options for after-hours care.

Emergency Care: Of course, if you are having an emergency, always call 911 or go to the nearest emergency room. Tricare defines emergency care as the care you receive for a medical, maternity or psychiatric condition that would lead a "prudent lay person" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists, or that the absence of immediate medical attention would result in a threat to life, limb or eyesight, or when the person has painful symptoms requiring immediate attention to relieve suffering. This includes situations where a person is in severe pain or is at immediate risk to self or others. What's important is to know what you must do following your visit. In general, take a look at these steps:

- Tricare Standard/Extra: If you have Tricare Standard/Extra, you manage your own care. However, you should contact your regional contractor if you are admitted due to a psychiatric emergency. The notification should be made within 24 hours of admission or the next business day. In general, the admission should be reported within 72 hours.
- Tricare Prime: In most cases, if you have Tricare Prime (including Tricare Prime Remote, Tricare Prime Overseas or Tricare Global Remote Overseas) you need to contact your primary care manager within 24 hours or the next business day after receiving emergency care, so that ongoing care can be coordinated and to ensure you receive proper authorization for care, if necessary.
- Tricare For Life (TFL): In the case of an emergency, Tricare For Life beneficiaries should go to the closest emergency room or call 911. TFL comes into play when the covered services have been exhausted under Medicare or are otherwise not a Medicare benefit. To remain eligible for TFL, you must have Medicare Part B and follow the Medicare rules.

Since there are so many variables to consider within Tricare's options, it is a good idea to visit the informative beneficiary Web site and enter your profile to determine your covered services, and what steps you need to take before an emergency arises.

Urgent Care: Tricare defines urgent care as the care you receive for an illness or injury that would not result in

further disability or death if not treated immediately, but does require professional attention within 24 hours. Urgent care has the potential to develop into an emergency if treatment is delayed longer than 24 hours. Again, with the number of variables to consider, we recommend visiting the beneficiary Web site to learn exactly what you need to do before the need for urgent care arises. In general, the following information applies:

- Tricare Standard/Extra: As mentioned above, when using Tricare Standard and Extra, you manage your own health care. While you'll never require referrals for any type of care, some services may require prior authorization. It's also important for you to understand the type of provider you are seeing. You can visit any Tricare-authorized provider, network or non-network, but the type of provider you see determines your out-of-pocket costs.
- Tricare Prime: You may schedule an appointment with your primary care manager (PCM) for URGENT care, for conditions such as a sprain, sore throat or rising temperature, by making a "same-day" appointment. If you are a registered user on the Tricare Online Web Portal, you may be able to schedule some appointments at military treatment facilities online. Active duty service members should obtain care in accordance with service guidance. You should be able to receive an urgent care appointment within 24 hours (one day), even if you are traveling. If you do not coordinate urgent care with your PCM, the care will be covered under the point of service option, resulting in higher out-of-pocket costs. If you are away from home, contact your regional contractor for assistance in obtaining urgent care: West Region: TriWest, 1-888-874-9378; North Region: Health Net, 1-877-TRICARE; South Region: Humana, 1-800-444-544.
- Tricare For Life: When using TFL, you manage your own health care. To get your urgent care, simply make an appointment with your Medicare provider. To remain eligible for TFL, you must have Medicare Part B and follow the Medicare rules.

Overseas: There are a number of resources available for beneficiaries living or traveling overseas who encounter an emergency or need urgent care. Check out the Tricare passport for detailed information on how to proceed with your health care needs while overseas. Also, Tricare has been working to expand emergency and urgent care options for our overseas active duty service members and their family members. For example, all active duty service members and active duty family members enrolled in Tricare Prime are now able to access the Tricare Global Remote Overseas (TGRO) Alarm Center for assistance. Previously, only beneficiaries enrolled in TGRO had access to these services. For more updates, refer to :
http://www.tricare.mil/pressroom/news.aspx?fid=399 and
http://www.tricare.mil/pressroom/news.aspx?fid=468.
[Source: The Tricare Blog Major General Elder Granger article 10 Nov 08 ++]

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RACHAP/RHAPP UPDATE 01: The Retiree-At-Cost Hearing Aid Program (RACHAP) for Air Force and/or Retiree Hearing Aid Purchase Program (RHAPP) are available to military retirees from active duty, Guard, and Reserve units who have hearing loss and/or tinnitus. Retired Commissioned Officers of the US Public Health Service are also eligible for this program. This is not a Tricare benefit. Advances in technology now make hearing aids into high-tech medical devices. The best hearing aids ever made are now in production. Retirees can obtain hearing aids at significant savings by using the programs. Two hearing aids can usually be purchased for less than $2,000. Exact costs are variable and subject to change at any time without notice. Contact your nearest audiology clinic for further details. Not every medical facility is able to provide these programs. Care of active duty members takes precedent at all MTFs. It is recommended that you contact the appropriate facility before incurring significant travel expenses. A list of stateside and overseas facilities currently participating

with telephone numbers can be found at http://militaryaudiology.org/site/rachaprhapp-locations/ . Facilities may discontinue this program for any reason without notice. Retirees can use any facility which will accept them; you don't need to return to your service affiliation to participate. Dependents of military retirees are ineligible to participate in this program throughout the US. Overseas travel is required. [Source: NAUS Weekly Update 14 Nov 08 ++]

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TRICARE PI FEE SCHEDULE: A new Tricare provider fee schedule for medical services and procedures is in effect in the Philippine Islands. Tricare officials expect the new fee schedule to better reflect actual medical costs. There are no changes in payments for laboratory, radiology, pathology services and procedures. Tricare beneficiaries and providers in the Philippines who filed Tricare claims during the past two years are receiving letters from Tricare Management Activity (TMA) notifying them of the fee schedule change, which went into effect 1 NOV 08. The new allowable charges and inpatient per diem rates are available on the Tricare Web site at http://www.tricare.mil/CMAC. Tricare Standard deductibles and cost-shares will not change for beneficiaries in the Philippines under the new fee schedule. Annual out-of-pocket caps for active duty family member costs will continue at $1,000 and $3,000 for retirees and their eligible family members. Tricare beneficiaries living in, or traveling to, the Philippines should be aware that they must use Tricare certified providers to receive claims reimbursement. A list of certified providers for the Philippines is available on the Pacific Area Office page in the TMA portal at http://www.tricare.mil. [Source: Tricare News Release 13 Nov 08 ++]

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BARCODE BASICS: A European Article Number (EAN) is a barcoding standard which is a superset of the original 12-digit Universal Product Code (UPC) system developed in North America. Check the barcode if you are interested in knowing the country that the item you are considering purchasing came from. The first two or three digits of an EAN-13 barcode identify the country in which the manufacturer's identification code was assigned. For example the EAN: 4 710088 412539 is assigned to Taiwan. This may or may not be the country in which the goods were manufactured but in many cases is. Following are some EAN identifiers of countries consumers might want to consider prior to making their decision whether to buy or not. For a complete listing refer to http://www.makebarcode.com/specs/ean_cc.html:

00 to 13 (USA & Canada)
400 to 440 (Germany)
45 + 49 (Japan)
460 to 469 (Russian Federation)
471 (Taiwan)
480 (Philippines)
489 (Hong-Kong)
626 (Iran)
690 - 695 (China)
867 (North Korea)
880 (South Korea)
893 (Vietnam)
[Source: The Barcode Software Center, Inc Nov 08 ++]

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MOBILIZED RESERVE 11 NOV 08: The Army, Air Force and Marine Corps announced the current number of reservists on active duty as of 11 NOV 08 in support of the partial mobilization. The net collective result is 192 more reservists mobilized than last reported in the Bulletin for 1 NOV 08. At any given time, services may mobilize some units and individuals while demobilizing others, making it possible for these figures to either increase or decrease. The total number currently on active duty in support of the partial mobilization of the Army National Guard and Army Reserve is 96,023; Navy Reserve, 6,041; Air National Guard and Air Force Reserve, 10,399; Marine Corps Reserve, 6.946; and the Coast Guard Reserve, 848. This brings the total National Guard and Reserve personnel who have been mobilized to 120,257 including both units and individual augmentees. A cumulative roster of all National Guard and Reserve personnel, who are currently mobilized, can be found at http://www.defenselink.mil/news/Nov2008/20081111ngr.pdf . [Source: DoD News Release 948-0811 NOV 08 ++]

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VA HEALTH CARE FUNDING UPDATE 17: President-elect Barack Obama promised days before the 4 NOV election that his administration would support the idea of approving veterans' funding one year in advance in an effort to avoid disruptions in critical programs. His pledge, made in a 28 OCT letter to the American Federation of Government Employees, puts him on record as supporting what a coalition of veterans organizations sees as the answer to a perennial problem: funding for veterans programs that comes in fits and starts — and, in the process, diminishing the quality of health care."First and foremost, the way our nation provides funding for VA health care must be reformed," Obama says in the letter. "My administration will recommend passage of advance appropriation legislation for the [fiscal] 2010 appropriations cycle, instead of yearly continuing resolutions that lead to delays in hiring and facility construction. I will also work to fully fund veterans care." Nine veterans' groups, united in what they call the Partnership for Veterans Health Care Budget Reform, have been calling for reform because only twice in the last 14 years — and only three times in the last 20 — has the Veterans Affairs Department budget been approved by the start of the fiscal year on Oct. 1. This has been one of the years when the budget passed on time.

The nine groups proposed that Congress pass a budget for veterans programs a full year ahead of time, which would mean that in 2009 lawmakers would need to pass both a fiscal 2010 budget and a fiscal 2011 budget. Obama's letter indicates support for that idea. Delayed budgets hurt veterans because they make it harder for VA to plan capital improvements and buy major medical equipment, and also delays hiring, said Joseph Violante, national legislative director of Disabled American Veterans. Another benefit to advanced funding is that veterans programs would get a first slice of the federal budget, without having to directly compete with other federal programs, Violante said. The day after his election, Obama pledged as president to fully fund VA and establish a "world-class VA planning division" so that future budgets were more accurate, according to a transition agenda that was briefly placed on the president-elect's transition Web site. The transition agenda has since been removed. [Source: NavyTimes Rick Maze article 12 Nov 08 ++]

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VET JOBS UPDATE 05: The number of veterans working for the federal government rose slightly in fiscal 2007, according to a new report from the Office of Personnel Management. Between fiscal 2006 and 2007, the number of veterans in the civilian workforce increased by 4,779, or 0.1 percent. In fiscal 2007, there were

462,744 veterans working for Uncle Sam, accounting for 25.5% of the total government workforce. Those figures represent a 0.5% gain from fiscal 2003. Disabled veterans also boosted their ranks in government between fiscal 2003 and 2007, growing 1.3% during that time to 103,180. In fiscal 2007, the number of disabled federal employees fell to 0.92%, down from 1.2% in fiscal 1996, according to the Equal Employment Opportunity Commission. The disability categories that cover veterans are determined by VA, and can include conditions like burns, post-traumatic stress disorder and traumatic brain injury. Civilians who apply for federal employment are considered to have targeted disabilities if they suffer from deafness, blindness, paralysis, amputation, mental illness, retardation, convulsive disorders, and spine or limb distortion, among a number of other conditions. Some veterans who are considered disabled by VA might not be considered to have targeted disabilities.

The report said veterans overall made up 22.9% of new federal hires in fiscal 2007, up from 22.1% in fiscal 2006. In the 43 departments and agencies that OPM studied, 52,452 of the new hires in fiscal 2007 were vets. Despite the modest hiring gains, veterans were underrepresented slightly in promotions, OPM found. While vets comprise 25.5% of the workforce, they received 23.2% of the 290,855 promotions granted to federal employees in fiscal 2007. Disabled veterans received 5.5 % of all promotions, while they make up 5.7% of the workforce. And 30% disabled veterans received 3% of promotions, though they are 3.1% of the overall workforce. OPM also found that agencies used their special hiring authority -- for veterans who are more than 30% disabled -- less in fiscal 2007 than in fiscal 2006. Agencies hired 1,265 of veterans in that category with that authority in fiscal 2006; in fiscal 2007, the government took advantage of the special provision to hire 1,068 veterans deemed 30% or more disabled, 197 less than the previous year. Disability advocates have said agencies must do more for all disabled employees if they hope to accommodate disabled veterans and help them to succeed. [Source: GovExec.com Alyssa Rosenberg article 11 Nov 08 ++]

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HYPERTENSION UPDATE 01: The lives of nearly 8,000 black Americans could be saved each year if doctors could figure out a way to bring their average blood pressure down to the average level of whites, a surprising new study found. The gap between the races in controlling blood pressure is well-known, but the resulting number of lives lost startled some scientists. The study, released 10 NOV in the Annals of Family Medicine, is being called the first to calculate the lives lost due to racial disparities in blood pressure control. The lead author, Dr. Kevin Fiscella of the University of Rochester School of Medicine & Dentistry said he believes steps can be taken to erase that gap. But a second article in the same journal found that racial differences in blood pressure treatment persisted in England despite a national health system that provides equal access to care. Doctors may not be providing proper care, but some black patients may not be taking prescribed medicines or following medical advice, said Christopher Millett of the Imperial College of London.

High blood pressure -- often called the "silent killer" because it has no symptoms -- increases a person's chances for heart disease, stroke and other serious problems. But it's easy to check for and usually can be controlled through exercise, diet and medication. For decades, doctors have noted that a higher percentage of black Americans have high blood pressure than whites. The reasons for that include poverty and cultural habits. Both can prevent people from exercising, eating healthy foods and getting in to see a good doctor. The study suggesting 8,000 black lives are lost because of uncontrolled blood pressure is based on earlier research that finds that about 40% of black adults have high blood pressure, compared with about 30% of whites. Fiscella and his colleague, Kathleen Holt, made a series of calculations. They took estimates of how each point of increased blood pressure affects the likelihood of death, and put it in a formula that included the difference in black and

white blood pressure readings. Those differences caused about 5,500 extra deaths from heart disease and about 2,200 deaths from stroke each year. The second study, done in England, looked at the electronic medical records of about 8,900 patients in southwest London, who are covered by that country's national health insurance system. Researchers found black patients with high blood pressure had significantly higher readings than white or Asian patients, even though blacks were prescribed more medications.

The researchers also looked at patients who were sick with one or more conditions like heart disease, kidney disease and diabetes. They found that blood pressure control was much worse in blacks than whites. Patients' failure to regularly take their medicine may be one factor. Another may be that certain medications work better for blacks, but some doctors may be overlooking that difference, said Millett, a consultant in public health for Imperial College. Former U.S. Surgeon General Dr. David Satcher said changes need to be made to make sure minority patients can get good medical care when they need it. But there also needs to be more done to make sure patients understand medical directions and feel comfortable asking questions when they don't. "It's very clear we need to target our efforts to differences in" how well patients follow medical advice, said Satcher, who is now an administrator at Atlanta's Morehouse School of Medicine.

Once hypertension develops, it becomes a lifetime condition. Hypertension is an increased pressure on the walls of the arteries when the heart pumps blood to the different part of the body. A sphygmomanometer is the instrument used in measuring the blood pressure aided by a stethoscope to check the sound from the arteries. A blood pressure is measured in "biphasic" number-e.g. 120/80. There are two phases when taking blood pressure readings. One is the systolic pressure in which the heart pumps blood from the left side of the heart to the major arteries. The other phase is the diastolic pressure or the pressure in filling up of blood in the chambers of the heart (ventricles). A normal blood pressure is below 140/90 millimeter per mercury (mm/hg) in a sphygmomanometer reading. An increase in blood pressure connotes hypertension. Anything more than 140/90 mm/hg but less than 160/90 mm/hg is diagnosed as "borderline hypertension." If the reading is more than 160/90 mm/hg, it is considered as "definite hypertension." Being hypertensive can greatly affect the normal condition of the heart and circulation of the blood. There is still no known reason why this mechanism fails. [Source: CNN.com/Health article 10 Nov 08 ++]

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VA/DOD RESUME REVIEW: Following is an excerpt taken from an editorial written by Bruce Coulter, editor of the Burlington Union and a retired, disabled veteran. He may be reached at 978-371-5775, or by e-mail at bcoulter@cnc.com. Reproduction in the Bulletin is to provide insight into some of the president elect's options related to veterans and should not be considered an endorsement of the content:

"During the course of a 21- month presidential campaign, President-elect Barack Obama said he would derail the amount of legislation passed on behalf of Washington, D.C. lobbyists, many of whom are former government officials. Although he's taken a step back from that posture, he hopes to limit the role and influence of special interest groups. Still, jobs, according to Politico.com, would still be available to lobbyists, but not within the sphere of their private practice. In other words, an energy industry lobbyist would not likely be hired to work for the Department of Energy. Given that position, Obama should take a hard look at Department of Veterans Affairs Secretary James Peake, who earlier this year proposed outsourcing the administration of new Post-9/11 G.I Bill benefits. The VA has since reversed course, announcing last month it would rely upon its own workforce to set up the information technology programs needed to implement the educational benefits of the G.I. Bill. The plan was not well received by veterans' groups, who loudly protested against the proposal.

Peake was an executive with California-based QTC Management, Inc, a private corporation that provides compensation and pension examinations for the VA. The chairman of QTC is former VA secretary Anthony Principi.

If Obama is serious about limiting the influence of special interests, he should consider nominating Tammy Duckworth, a decorated and disabled veteran of the Iraq War, and now, the director of the Illinois Department of Veterans Affairs. Duckworth was serving as co-pilot of a Black Hawk helicopter in Iraq that was struck by a rocket-propelled grenade. As a result of the attack, she lost both legs and partial use of one arm. Despite what could have been a major personal setback, Duckworth has moved forward with her life, making an unsuccessful bid for Congress in 2006 and still serving as a major in the Illinois National Guard, despite being offered a medical retirement. Duckworth may also be a sentimental favorite as a "hometown" pick given that she, like Obama, represents the Land of Lincoln. John Raughter, a spokesman for the American Legion, when asked for a comment regarding Duckworth's possible nomination, said the group's bylaws do not allow endorsements for any offices. "So we always focus on positions, rather than personalities," he said. ... Other candidates being considered for the position is the incumbent, Peake, and Max Cleland, a former U.S. Senator from Georgia and a disabled veteran of the Vietnam War.

And while he's taking applications Obama should consider sending David Chu, the undersecretary of defense for personnel and readiness packing. Chu, a career federal service employee, is no friend of veterans. In a 2005 interview with the Wall Street Journal, Chu said Congress had gone too far in expanding military retiree benefits. "The amounts have gotten to the point where they are hurtful. They are taking away from the nation's ability to defend itself," said Chu. Now he's at it again. The Department of Defense has instituted a policy, based on a memorandum written by Chu, according to Disabled American Veteran Magazine, "Limits the number of injured and disabled servicemembers who would not have to repay their military disability severance pay before they could receive disability compensation from the Department of Veterans Affairs."Chu's memo redefines what qualifies as a combat-related injury, despite the intent of Congress's passage of the 2008 Defense Authorization act, which allows combat-related special compensation for injuries received in a combat zone or duty performed in combat-related operations. In his memo, Chu defined combat-related injuries as "a disease or injury incurred in the line of duty as a direct result of armed conflict." In short, by changing Congress's policy, Chu has cheated a large group of veterans out of compensation they earned the hard way, including many who would be eligible for combat-related special compensation. By the way, the pensions earned by veterans after 20 or more years of service are likely to be dwarfed by the federal pension Chu will receive. It's time for him to update his resume..."
[Source: Concord MA Burlington Union editorial 10 Nov 08 ++]

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VA INTERIM BENEFIT LAWSUIT: Two veterans' groups have filed a suit in an effort to get a federal court to order interim benefits for veterans if a claim for disability compensation takes longer than 90 days to be processed. Vietnam Veterans of America and Veterans of Modern Warfare want an interim payment equal to what is paid for a 30 percent disability rating — between $356 and $497 a month, depending on the number of dependents — if an initial claim takes more than 90 days or an appeal of a denied claim takes longer than 180 days. The suit, filed 10 NOV in the U.S. District Court for the District of Columbia, is an attempt to use the federal court system to tackle the Department of Veterans Affairs claims processing bureaucracy, said Robert Cattanach, one of the attorneys handling the case. VA officials had no immediate comment. Spokesman Phil Budahn said VA officials learned about the suit only after it was filed, and are working on a response.

"Veterans need prompt action and they need it now," Cattanach said. "The Department of Veterans Affairs is failing miserably."

It is no coincidence that the suit was filed one day before Veterans Day. John Rowan, president of the Vietnam Veterans of America, said more than half a million veterans "will wake up on Veterans Day still awaiting their benefits" because VA takes, on average, 182 days to process an initial claim and 4½ years or more to an appeal. "These unacceptable and excessive delays cause veterans and their families irreparable harm," he said. "Financial hardship can become extremely dire while waiting." Donald Overton, Veterans of Modern Warfare's executive director, called it a "terrible irony" that today's military has sophisticated weapons of war but the VA claims system remains antiquated. "All of us should be outraged," Overton said. The lawsuit asks the court to require the VA to present a plan within 30 days for speedier claims processing. If the VA fails to come up with such a plan, the suit asks the court to order an "equitable remedy," which the veterans' groups believe would be interim payments equal to what someone would receive if they had a 30% disability rating. The interim payments would continue until the claim is resolved. Cattanach said interim payments "are not a lot of money" but would be enough for "basic support."

The 90-day and 180-day standards sought by the lawsuit are the groups' estimates of what is reasonable. Federal law does not include any specific requirement about how long claims processing can take. Providing interim benefits while awaiting claims decisions is an idea that has bounced around veterans' groups and Congress for several years as the backlog of pending claims has grown. There has been some reluctance to endorse the idea because of concern that the promise of quick payments might encourage veterans to file unsubstantiated claims and deliberately make them complicated so they would take longer than 90 days to complete. Cattanach said faster claims processing is more important now than ever. "Disabled vets have a very difficult time finding jobs, especially in this economy," Cattanach said. While veterans eventually received backdated payments if claims are decided in their favor, veterans suffer in the meantime. "Providing back pay whenever the VA gets around to it" does not make up for the hard times, he said. "Under the law, excessive delays amount to the same thing as benefits denied." [Source: NavyTimes Rick Maze article 10 Nov 08 ++]

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CHANGING MEDICARE HEALTH PLANS: You are limited as to when you can change your Medicare health plan during the year (this is known as lock-in). Changes can only be made during ACEP, OEP, or SEP periods/circumstances:

Annual Coordinated Election Period (ACEP): You can switch once during the ACEP which runs from 15 NOV thru 31 DEC of every year. Your new coverage will start 1 JAN. During this period you can change your choice of health coverage, and add, drop or change Medicare drug coverage. You can make as many changes as you need during this period, but only your last coverage choice will take effect on 1 JAN. To avoid enrollment problems, it is best to make as few changes as possible. If you are changing plans to join a Medicare Medical Savings Accounts (MSA), you can only do so during the ACEP. If you are enrolling in the Medicare drug benefit for the first time, you may face a penalty if you had not previously had coverage as good as Medicare's

Open Enrollment Period (OEP): You can switch once during the OEP which runs from 1 JAN through 31 MAR of every year. Your new coverage starts the first of the month after you make your selection. During the OEP you cannot decide to add or drop Medicare drug coverage (Part D). Your options are:

- If you have a Medicare private health plan with drug coverage you can switch to another Medicare private health plan with drug coverage or original Medicare and a stand-alone drug plan.
- If you have Original Medicare and a stand-alone drug plan you can switch to a Medicare private health plan with drug coverage.
- If you have a Medicare private health plan without drug coverage you can switch to another Medicare private health plan without drug coverage or original Medicare alone (no stand-alone drug plan).
- If you have original Medicare alone (no stand-alone drug plan) you can switch to a Medicare private health plan without drug coverage.
- If your Medicare private health plan leaves your area or you move out of your plan's service area, you can switch to another private health plan or to Original Medicare.

Special Enrollment Period (SEP): Under certain circumstances, you may be eligible for a SEP to change your drug coverage and/or health plan. If you get an SEP, your new coverage will start the first of the month after you sign up for or disenroll from a Medicare private health plan. If you do not enroll in the Medicare drug benefit (Part D) when you are first eligible, and you do not have other drug coverage that is at least as good as Medicare's (i.e. creditable) for 63 days or more, you will likely have to pay a premium penalty if you later enroll in a Medicare drug plan. Most SEPs allow you to enroll in the drug benefit outside a standard enrollment period, but you will still owe a premium penalty. You can get the penalty waived if you qualify for Extra Help—a federal program that helps pay for most of the costs of the Medicare drug benefit—and enroll in a Medicare drug plan in 2007 or 2008 if you show that you received inadequate information about the creditability of your drug coverage. SEP eligibility could apply if:

1. You lose creditable drug coverage through no fault of your own or you want to disenroll from Medicare drug coverage to keep or enroll in other creditable coverage programs such as VA, TRICARE or a state pharmaceutical assistance program (SPAP) that offers creditable coverage. This does not include losing your drug coverage because you do not pay, or cannot afford, your premiums.
2. You join or drop employer/union drug coverage regardless of whether it is creditable. Employer coverage may be current or former (retiree plan).
3. You are institutionalized. i.e. You move into, reside in, or move out of a qualified institutional facility: a skilled nursing facility, nursing home, psychiatric hospital or unit, Intermediate Care Facility for the Mentally Retarded—ICF/MR, rehabilitation hospital or unit, long-term care hospital, or swing-bed hospital
4. You are enrolled in a qualified State Pharmaceutical Assistance Program (SPAP), or lose SPAP eligibility.
5. You have Extra Help whether you applied or automatically qualified because you have Medicaid, a Medicare Savings Program or receive Supplemental Security Insurance.
6. You want to disenroll from your FIRST Medicare private health plan with drug coverage (MA-PD).
7. You enroll in/disenroll from PACE.
8. You move (permanently change your home address).
9. You have had Medicare eligibility issues.
10. You are eligible to join a Special Needs Plan (SNP) or you lose SNP eligibility.
11. You experience contract violations, misleading marketing or enrollment errors.
12. Your plan no longer offers Medicare coverage.
13. You experience an exceptional circumstance not covered in the foregoing.

[Source: Medicare Rights Center 10 Nov 08 ++]

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DFAS 1099R FOR 2008: Below is the schedule for viewing your tax statement on myPay for the tax year 2008:

December 10, 2008	Retiree Account Statement
December 15, 2008	Retired 1099R
December 15, 2008	Annuitant Account Statement
December 15, 2008	Annuitant 1099R

[Source: DFAS Newsletter 13 Nov 08 ++]

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EXPRESS SCRIPTS DATA BREACH: One of the nation's largest processors of pharmacy prescriptions said this week that extortionists are threatening to disclose personal and medical information about millions of Americans if the company fails to meet payment demands. St. Louis-based Express Scripts said 6 NOV that in early OCT it received a letter that included the names, birth dates, Social Security numbers and, in some cases, prescription data on 75 of its customers. The authors threatened to expose millions of consumer records if the company declined to pay up, Express Scripts said in a statement. Chief executive George Paz said in the statement that Express Scripts has no intention of paying and that his company is working with the FBI to track down those responsible for the scam. Express Scripts is the third-largest U.S. pharmacy benefit management firm, which processes and pays prescription drug claims. Working with more than 1,600 companies, it handles roughly 500 million prescriptions a year for about 50 million Americans.

Express Scripts has notified its clients of the threat. Fairfax County Public Schools yesterday sent a letter to employees alerting health-plan participants who use Express Scripts to the breach. The letter was delivered by mail, said company spokesman Steve Littlejohn. He declined to say how much money the extortionists were demanding. He added that the company is trying to determine how the data were stolen. "We know where the data came from by looking at it, but precisely how it was accessed is still part of the investigation," Littlejohn said. The company last week set up a Web site to give consumers tips on how to protect their identity. While Express Scripts does not interact with consumers directly, the company's name is printed on prescription cards of health-care plans that use its services, Littlejohn said. The 75 people listed in the letter have been notified. Billy Cox, special agent for the FBI's St. Louis field office, confirmed that the bureau was contacted by Express Scripts, but declined to comment on the case. ESI has offered a $1 million reward for information leading to the arrest and conviction of the perpetrator and is offering free identity restoration services if any customer becomes a victim of identity theft because of this incident. A dedicated website has been established at www.esisupports.com which members and beneficiaries can use for further information and guidance

Alan Paller, director of research for the SANS Institute, a Bethesda-based computer-security training group, said many companies, especially in the financial industry, have already paid to keep their customers' data from being released. Some receive more than one extortion threat a day. Paller said that in some ways, the health-care industry is the perfect target. "Nobody is going to want to go to a health-care provider if they think their private medical history is going to be revealed to the world online," he said. "Hospitals wouldn't have to think too hard about that before paying off an extortion demand." Last month, the FBI arrested an Indiana man accusing him of stealing 900,000 policyholder records from a medical provider and trying to extort $208,000 from its parent, American International Group. Graham Cluley, a senior technology consultant for Sophos, a British computer security company, said Express Scripts was right to go to the FBI. "Data extortion is not like if your daughter gets kidnapped: Even if something is returned to you, you can never be sure they're not going to carry on taking advantage of the situation," Cluley said. "The bad guys can always just make a copy of what they've stolen, and

they can keep on coming back and asking for money, or they can still go and sell the data online." [Source: Washington Post Brian Krebs article 8 Nov 08 ++]

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MEDICARE REIMBURSEMENT UPDATE 01: Doctors across California, Nevada, and Hawaii are owed millions of dollars in backlogged Medicare reimbursements, leading some physicians to turn away elderly patients and pushing others to the brink of bankruptcy. In the most extreme cases, doctors have not been paid since FEB 08. Others are owed hundreds of thousands of dollars. Doctors who serve high numbers of Medicare patients say they are defaulting on rent, laying off staff and begging drug suppliers not to stop shipments. One cardiologist said she's even resorted to doing the office laundry to cut costs. The holdup is twofold. By May, doctors were supposed to be using a new universal identification number assigned by the Centers for Medicare and Medicaid Services. Without the new number, which is like a Social Security number, doctors can't get reimbursed. Then, as scores of doctors still waited for those numbers, in September the federal agency switched to a new claim processor for its 90,000 California providers. The move to Palmetto GBA in South Carolina, part of a national effort to reform Medicare contractors, compounded the billing issues and left even doctors who had their universal identification numbers waiting months for reimbursement.

In some cases, the problem is as simple as a change of address not being processed. Dr. Daniel Marcus moved from Suite 404 to 414 in his Marina del Rey office and as a result has not been paid since May. "This is just a complete disaster," said Dr. Dev Gnanadev, medical director and chairman of the Department of Surgery at Arrowhead Regional Medical Center in Colton and president of the California Medical Assn. "I know people who have turned down their office to minimal size. Some are even considering closing temporarily. If you don't get paid, then you're in deep trouble." Rep. Henry Waxman (D-Beverly Hills), whose office was contacted by at least two dozen doctors, called the transition to the new contractor "marred by missteps." Palmetto has also been the subject of complaints from doctors in Nevada, which switched to the processing firm in August. The state has the fastest-growing Medicare population in the nation. So far, Medicare patients have been largely insulated from the reimbursement fight, though they may have difficulty making new appointments. Some doctors, particularly those with specialties that get minimal Medicare reimbursements, say this could be the tipping point that makes them abandon their participation in Medicare altogether. This could have a ripple effect on TFL and Tricare Standard users

Mike Barlow, a Palmetto vice president who oversees California, Nevada and Hawaii, said company officials are aware of the issues and have acted to address them. The company has hired and trained more people to field calls. Teams are in place to fast-track the most severe cases. Palmetto has taken the brunt of the doctors' ire. The cover of Southern California Physician magazine that hit mailboxes this week features a huge picture of a cockroach, also called a Palmetto bug, with the word "INFESTATION!" stripped across the front. The article opens with one doctor telling Barlow, "I wish I had a tomato," as he stood before an angry crowd at a California Medical Assn. meeting last month. Critics of the switch say the federal Medicare agency is also to blame for undertaking two major transitions within months of each other. In an effort to cut costs, the agency picked a contractor that was not equipped or prepared to handle California's Medicare providers, they contend. But federal officials defend the choice. Torris Smith, an associate regional administrator for the agency, said Palmetto has more than 40 years of experience as a Medicare contractor and was selected after a "full and open competition."

Officials of both Palmetto and the federal agency said they expect the backlog of applications will be eased by 31 DEC. Claims, meanwhile, are being paid, they said. Medicare's regional office is also trying to assist

doctors with serious problems, Smith said, and Palmetto will advance emergency payments. But change isn't coming soon enough for doctors and their staffs, who have wasted hours on hold with no relief. The California Medical Assn. has fielded calls from more than 1,000 doctors seeking help with delayed reimbursements. Palmetto officials said they receive about 4,500 calls per day -- that's down from the 45,000 calls on the first day when they had been expecting only 2,500. Through SEP, callers were met with a busy signal 90% of the time. With added phone lines, only 10% of the callers should be getting busy signals now, Barlow said. Dr. Sally Davis of Walnut Creek-based Cardiology Associates, who is doing the office laundry along with her two partners, said, "It's unbelievably embarrassing that we've reached that point." Dirty linens, though, is the least of her problems. Roughly 80% to 85% of her patients are on Medicare, and the practice is owed more than $700,000. [Source: Los Angeles Times Kimi Yoshino article 8 Nov 08 ++]

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MEDICAD FUNDING UPDATE 01: In the first of an expected avalanche of post-election regulations, the Bush administration on 7 NOV narrowed the scope of services that can be provided to poor people under Medicaid's outpatient hospital benefit. The new rule conflicts with efforts by Congressional leaders and governors to increase federal aid to the states for Medicaid as part of a new economic action plan. President-elect Barack Obama has endorsed those efforts. At a news conference he said that legislation to stimulate the economy should include "assistance to state and local governments" so they would not have to lay off workers or increase taxes. In a notice published 7 NOV in the Federal Register, the Bush administration said it had to clarify the definition of outpatient hospital services because the current ambiguity had allowed states to claim excessive payments. "This rule represents a new initiative to preserve the fiscal integrity of the Medicaid program," the notice said. But John W. Bluford III, the president of Truman Medical Centers in Kansas City, Mo., said: "This is a disaster for safety-net institutions like ours. The change in the outpatient rule will mean a $5 million hit to us. Medicaid accounts for about 55% of our business."

Alan D. Aviles, the president of the New York City Health and Hospitals Corporation, the largest municipal health care system in the country, said: "The new rule forces us to consider reducing some outpatient services like dental and vision care. State and local government cannot pick up these costs. If anything, we expect to see additional cuts at the state level." Carol H. Steckel, the commissioner of the Alabama Medicaid Agency, said the rule would reduce federal payments for outpatient services at two large children's hospitals, in Birmingham and Mobile AL. Richard J. Pollack, the executive vice president of the American Hospital Association, said these concerns were valid. "The new regulation," Mr. Pollack said, "will jeopardize important community-based services, including screening, diagnostic and dental services for children, as well as lab and ambulance services." Herb B. Kuhn, the deputy administrator of the Centers for Medicare and Medicaid Services, defended the rule. "We are not trying to deny services," Mr. Kuhn said. "We want to pay for them more accurately and appropriately. Payments for some services were way higher than they should be."

The rule narrows the definition of outpatient hospital services to exclude those that could be provided and covered outside a hospital. In May, the White House said it wanted to avoid the rush of "midnight regulations" that had occurred at the end of other administrations. But Bush administration officials said this week that they still intended to issue, or relax, many economic, environmental, health and safety rules before they leave office on 20 JAN. Medicaid, financed jointly by the federal government and the states, provides health insurance to more than 50 million low-income people. Services can often be billed at a higher rate if they are performed in the outpatient department of a hospital rather than in a doctor's office or a free-standing clinic. Hospitals generally have higher overhead costs. Matt D. Salo, a health policy specialist at the National Governors

Association, said, “The new rule is consistent with the administration’s effort to squeeze, shrink and flatten Medicaid spending.” In a recent letter, the governors urged Congress to increase the federal share of Medicaid for at least two years. With state tax revenues plunging, many governors are considering cuts in Medicaid and other programs. Such cuts, they say, would further depress economic activity.

Ann Clemency Kohler, the executive director of the National Association of State Medicaid Directors, said: “The new rule is a pretty sweeping change from longtime Medicaid policy. Since the beginning of the program, states have been allowed to define hospital outpatient services. We have to question why the rule is being issued now, three days after the election, with a new administration coming in.” The rule was proposed in SEP 07. It takes effect on 8 DEC, six weeks before Mr. Bush leaves office. Ms. Kohler said the rule would cut “money going to the states, to safety net providers, at a time when states are really being stressed. More and more people are coming onto Medicaid. People are losing their jobs and running out of unemployment benefits. Some employers can no longer afford to provide health insurance to their workers.” In the last 18 months, Congress has imposed moratoriums on six other rules that would have cut Medicaid payments. But the administration says Congress did not block this rule. Larry S. Gage, the president of the National Association of Public Hospitals, said, “We will urge Congress to extend the moratorium to this rule, and we will ask the Obama administration to withdraw it.” [Source: New York Times Robert Pear article 7 Nov 08 ++]

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MISSING IN AMERICA PROJECT UPDATE 01: Eleven veterans from three branches of the military were laid to rest 7 NOV at a state veterans cemetery, thanks to the efforts of a project that matches records of those who served their country with unclaimed remains in funeral homes. In this case, the cremated remains of all 11 came from a single funeral home in north Idaho. The veterans had served in three different wars. One of them, Sgt. James Overton, served in World War I and died Nov. 14, 1939. "It's sad to think they were lost in some funeral home," said Sharon Bowman, a 57-year-old state employee with the Idaho Department of Health and Welfare in Nampa. Bowman was among a small crowd that gathered at the Idaho State Veterans Cemetery to honor the veterans, who were identified through the Missing in America Project, a nonprofit organization that locates the unclaimed remains of veterans with assistance from state and federal agencies. The unclaimed remains of 50 service members have been found since 2005 in Idaho, where efforts at the state veterans cemetery inspired the creation of the nationwide Missing in America Project, Fred Salanti, a 60-year-old Vietnam veteran and director of the organization, said in a telephone interview.

Nationwide, the Missing in America Project has coordinators in 45 states who have identified the cremated remains of nearly 500 solders. About 350 have been laid to rest in veterans cemeteries. "We are their family," Salanti said. "We stand in and sign documents at the national cemeteries and the state cemeteries so they can receive those honors." The 11 veterans honored in Boise were from Idaho, California and Washington state, said Zach Rodriguez, director of the Idaho State Veterans Cemetery. The servicemen have been identified as veterans from the U.S. Army, Air Force and Marine Corps. They served in the Vietnam War, World War I and World War II. The remains were identified earlier this year at a Lewiston funeral home. "Once they've been abandoned for more than a year, there's a state statute that allows us to go recover the remains," Rodriguez said. Members of the Missing in America Project crosscheck data on U.S. service members from a national data center with names and birthdates on unclaimed remains at funeral homes. For more info on the Missing in America Project refer to www.miap.us. [Source: AP Jessie L. Bonner article 7 Nov 08 ++]
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TOMB OF THE UNKNOWNS UPDATE 02: A proposal to replace the cracked and weathered white marble monument that crowns the Tomb of the Unknowns at Arlington National Cemetery has stirred up a years-long controversy. The always-guarded tomb to the nation's war dead is a potent symbol of sacrifice and patriotism and the above-ground monument, which has cracks running 48 feet around it, is the most visible part of it. Congress authorized the tomb in 1921 as a memorial to honor the unknown dead of World War I, which had ended three years earlier. On 11 NOV that year — then known as Armistice Day and now Veterans Day — an unidentified American soldier from the war was interred in an underground vault. For years, Army officials have studied the idea of building a replica because of concerns that the damage, which is getting worse despite repairs, is distracting from the monument's solemn appearance. Moreover, officials say, replacement marble is becoming scarce and should be secured now. An August report said the Army would again repair the monument while a final decision is being made. The repairs would cost about $65,000, and a replica monument would cost about $2.2 million. "The importance of preserving that tomb as long as possible is paramount," said Tom Sherlock, the cemetery historian. "The decision has been made to repair as much as possible and to only ultimately replace it if that becomes a necessity in the future."

Preservationists and others argue that repairs should continue since the authentic monument conveys a symbolism that a replica cannot duplicate. The sarcophagus-shaped monument is a solid block of marble, weighing 36 tons and topped with a 12-ton cap and resting on a 16-ton base, according to the U.S. Army Military District of Washington. Four other pieces of marble are used in the sub-base. In the years since 1921, unknown service members from World War II, the Korean War and Vietnam were added, with their tombs marked by marble slabs in the tomb's plaza. The Vietnam soldier's remains were later exhumed and identified, and that tomb remains vacant, although a new plaque was added to honor the nation's missing service members from 1958 to 1975. The Army's new report said the cracks are not compromising the stone's structural integrity and are repairable, but the monument's condition will continue to deteriorate. Repeated repairs will leave the monument looking "patched, worn and shabby," counter to the cemetery's purpose of maintaining a dignified memorial to the nation's war dead, the report said. The Army has support for its position of repairing the monument now but keeping the option open to replace it in the future. The Veterans of Foreign Wars and American Legion also support the Army's strategy. [Source: Gannett News Service Dennis Camire article 7 Nov 08 ++]

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DISABILITY EVALUATION SYSTEM: Wounded service members leaving the military will have easier, quicker access to their veterans benefits due to the expansion of a pilot program that will offer streamlined disability evaluations that will reach 19 military installations, representing all military departments. The Department of Veterans Affairs (VA) announced 7 NOV the expansion of the Disability Evaluation System (DES) pilot which started in the National Capitol Region in coordination with Departments of Defense (DoD). The pilot is a test of a new process that eliminates duplicative, time-consuming and often confusing elements of the two current disability processes of the departments. The initial phase of the expansion started on 1 OCT with Fort Meade, Md. and Fort Belvoir , Va. The remaining 17 installations will begin upon completion of site preparations and personnel orientation and training, during an 8-month period from NOV 08 to May 09. "The decision to expand the pilot was based upon a favorable review that focused on whether the pilot met its timeliness, effectiveness, transparency, and customer and stakeholder satisfaction objectives," said Sam Retherford, Director, officer and enlisted personnel management, Office of the Under Secretary of Defense for Personnel and Readiness. "This expansion extends beyond the national capital region, so that more diverse data from other geographic areas can be evaluated, prior to rendering a final decision on worldwide

implementation."

The remaining installations to begin the program are: Army: Fort Carson, Colo.; Fort Drum, N.Y.; Fort Stewart, Ga.; Fort Richardson, Alaska; Fort Wainwright, Alaska; Brooke Army Medical Center, Texas; and Fort Polk, La. Navy: Naval Medical Center (NMC) San Diego and Camp Pendleton, Calif. ; NMC Bremerton , Wash. ; NMC Jacksonville , Fla. ; and Camp Lejeune , N.C. Air Force: Vance Air Force Base, Okla.; Nellis Air Force Base, Nev.; MacDill Air Force Base, Fla.; Elmendorf Air Force Base, Alaska.; and Travis Air Force Base, Calif. In November 2007 VA and DoD implemented the pilot test for disability cases originating at the three major military treatment facilities in the national capitol region. To date, over 700 service members have participated in the pilot over the last ten months. The single disability examination pilot is focused on recommendations from the reports of the Task Force on Returning Global War on Terrorism Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (the Dole/Shalala Commission), and the Commission on Veterans' Disability Benefits. [Source: VA Media relations 7 Nov 08 ++]

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ARIZONA MEMORIAL: Aging, frail survivors of the 1941 Japanese attack on Pearl Harbor gingerly sifted dirt as they helped to break ground on a new visitor's center for the Arizona Memorial. The current visitor's center — across the harbor from the submerged battleship — is sinking because it was built on reclaimed land, causing water to seep into its basement. Engineers estimate the building will last only a few more years. The center is where visitors board ferries taking them to the white memorial straddling the sunken hull of the Arizona. It's also where they learn about the attack through exhibits and films, making it vital for conveying the history of the day that launched the U.S. into World War II. The National Park Service, which runs the memorial, and the Arizona Memorial Museum Association, which supports it, have spearheaded the effort to build a replacement visitor's center so they can continue to tell the story of Pearl Harbor.

Sen. Daniel K. Inouye, D-Hawaii, a World War II veteran, told the several hundred people gathered for the groundbreaking 5 NOV that walking through the visitor's center exposes people to the devastation and despair Americans felt during the attack. It also instills in them unwavering resolve, he said. "We must always remember our history. While there were painful lessons learned, it is also the source of our inner strength and our spirit," Inouye said. "We must never allow that torch to flicker out." Inouye, 84, witnessed Japanese fighter planes flying over Oahu on Dec. 7, 1941, when he was a 17-year-old high school student living in Honolulu. He served as a first-aid volunteer, helping to treat civilians wounded when misfired U.S. anti-aircraft shells fell on homes and businesses. In 1943, he joined the 442nd Regimental Combat Team, a highly decorated unit of mostly Japanese-Americans. In 2000, President Clinton presented him with the Medal of Honor.

Herb Weatherwax, a 91-year-old attack survivor, said the new visitor's center would help survivors and the park service tell the story of the attack. "I just hope that I live long enough for it," he said. The building is due to be completed by December 2010. The Pearl Harbor Memorial Fund has raised nearly $54 million of the estimated $58 million cost of the center. Donations from individuals will cover more than $22 million of it, while the federal government is putting up $29.6 million and the state of Hawaii is paying $2 million. The current center, built in 1980, was designed to accommodate about 2,000 visitors a day. But more than 4,000 people have been visiting daily on average since the 1980s, straining its resources. The Arizona sank nine minutes after a being hit by an aerial bomb dropped by a Japanese plane. It is an underwater grave for more than 1,000 sailors and Marines unable to escape. There were 1.4 million gallons of fuel on the USS Arizona when

she sank. Over 60 years later, approximately two quarts a day still surfaces from the ship. Some Pearl Harbor survivors have referred to the oil droplets as "Black Tears."

There is no charge for admission to the memorial. Complementary tickets are distributed on a first-come, first-served basis (these tickets are not reservable) for timed programs to the memorial. Timed programs include a 23-minute documentary film about the attack on Pearl Harbor and the boat trip to the USS Arizona Memorial. Programs begin at 7:45 a.m. The last program each day begins at 3:00 p.m. Tickets are issued on a first-come, first-served basis. The wait time for a program may be as much as three hours depending on the season. There is a female and male restroom facility on-site. Visitors may want to use restroom facilities in the parking lot or at the Bowfin Submarine Memorial and Museum during busy times. Both restrooms have diaper changing tables. There is no shower or locker room. The minimum dress attire for the USS Arizona Memorial is footwear, shorts and shirt. Sandals and Flip Flops are permissible, but bathing suits or profane T-shirts are not allowed on-site. The minimum dress attire for military personnel is dress whites or better, or service equivalent. BDU'S are not allowed on the memorial. There are no age restrictions at the national memorial. Pets are not permitted. Service animals are not considered pets and are allowed. [Source: AP Audrey McAvoy article 6 Nov 08 ++]

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TRICARE PHARMACY POLICY UPDATE 03: When Express Scripts (ESI) was chosen to administer the Tricare pharmacy benefit, they committed to doing their part to provide a quality benefit that DOD beneficiaries can count on for years to come. One way they do this is by effectively managing their retail pharmacy networks. Recently, Walgreens had been unable to reach a contractual agreement with Express Scripts, the Tricare Pharmacy Contractor. Therefore, as of 1 JAN 09, Walgreens would have no longer be in the network used by the Tricare pharmacy plan. That meant that if any beneficiary filled a prescription at Walgreens after 31 DEC 08, they would have had to pay 100% of the cost and then file a paper claim for non- network benefit reimbursement. For more information on cost shares when using a non-network pharmacy refer to: http://member.express-scripts.com/dodCustom/benefitSummary.do#3. There are three easy ways to transfer your prescriptions:

1. Have the medications you take on an ongoing basis safely and conveniently delivered through Home Delivery from the Tricare Mail Order Pharmacy (TMOP). Visit www.express-scripts.com/Tricare to switch your eligible prescriptions to Home Delivery today.
2. Transfer the prescriptions you take on an ongoing basis to TMOP by asking your doctor to fax your eligible prescription(s) to 1-877-895-1900. This fax number is for healthcare providers only.
3. Have your prescription bottles ready and call or visit the network pharmacy of your choice. You may fill your prescriptions at other major pharmacies and independent drug stores that remain part of the network used by Tricare. For a complete list of local pharmacies in the network used by the Tricare pharmacy plan, refer to www.express-scripts.com/Tricare. If you have questions, call Express Scripts anytime at 1-877-425-1139.

There are 756,000 Tricare beneficiaries who use Walgreens that were sent letters advising them of this change. ESI was hopeful that Walgreens would ultimately decide to continue their service to Tricare beneficiaries and strike a deal after the beneficiary letters had been sent. That is exactly what happened. Beneficiaries who received letters from Express Scripts concerning Walgreens will receive another letter from Express Scripts stating that Walgreens is still a viable retail option in 2009. ESI exceeds all Tricare Pharmacy contractual access and size requirements. The current network has 60,149 stores. Access standards are:
a. Urban (1 pharmacy in 2 miles) 96.1%

b. Suburban (1 pharmacy in 5 miles) 99.8%
c. Rural (1 pharmacy in 15 miles) 99.0%
[Source: EANGUS Minuteman Update 6 & 13 Nov 08 ++]

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VA CATEGORY 8 CARE UPDATE 07: President-elect Barack Obama has vowed to reverse or sharply modify many of the Bush administration's policies. Based on his campaign promises he wants to expand VA health care for veterans. Congress voted in 1996 to do that, but the agency has exercised its authority to suspend enrollments as needed. Obama has said that led to 1 million veterans being turned away, and he has promised to reverse the policy. He also said he would improve screening and treatment for mental health conditions and traumatic brain injury; expand the number of housing vouchers and start a program to help veterans at risk of being homeless; add more rural veterans centers; create an electronic system to transfer medical records from the military; and improve preventative health options. The Senate Veterans Affairs Committee is also expected to push for changes at the VA. CongressionaL Quarterly reports, "As the new president moves to bring troops home from Iraq and fortify" the US presence in Afghanistan, the Senate Veterans Affairs Committee "will be spurring" the VA to "ramp up its capacity to provide medical, readjustment, disability and housing benefits to veterans and their families." The committee "is likely to try to rebuild the VA compensation system from the ground up. That could include creating a uniform information technology system to manage VA claims and figuring out what should be included in claims notification letters." [Source: AP Kimberly Hefling & GC Jonsom articles 6 Nov 08 ++]

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TSP UPDATE 11: The Thrift Savings Plan weathered another difficult month in October as every fund except the government securities option lost ground.

- The G Fund -- the plan's most stable offering -- rose 0.31% in OCT, following a 0.31% increase in SEP. The fund is up 3.18% since JAN and 3.95% since OCT 07. It is the only offering that has posted positive returns in 2008, and one of only two funds to make gains during the past 12 months.
- The F Fund is the only other fund that is up since OCT 07. It is a portfolio of fixed-income bonds. That offering has grown 0.52% in the past 12 months, though it fell 2.4% in OCT and is down 1.59% for 2008.
- The S Fund, which invests in small- and mid-size U.S. companies and tracks the Dow Jones Wilshire 4500 Index, posted the largest OCT loss: its value fell 20.99%. The fund is down 33.69% since the beginning of 2008, and 37.69% for the past 12 months.
- The I fund, which invests in European, Asian and Australian companies and suffered the largest losses of any TSP fund in SEP, was close behind the S Fund in OCT, falling 20.59%. The I Fund has dropped 42.67% in 2008 and 46.05% since OCT 07. Those are the largest 2008 and 12-month losses of any TSP offering.
- The C Fund, which tracks Standard & Poor's 500 Index, was down 16.83% in October, and 32.84% since the beginning of 2008. The fund has fallen 36.08% since OCT 07.

All the life-cycle funds, which make riskier but more aggressive investments for younger workers and shift to more conservative allocations as employees approach retirement, lost more in OCT than in SEP. The L 2040 Fund fell 15.4%, the L 2030 Fund lost 13.4%, the L 2020 Fund dropped 11.1%, the L 2010 Fund slid 5.41% and the L Income Fund for investors closest to retirement fell 3.44%. Those losses deepened the overall declines for the life-cycle funds both in 2008 and for the past 12 months. The L 2040 Fund is down 29.82% in 2008 and

32.73% for the past year, the L 2030 Fund is down 26.11% in 2008 and 28.73% for the past 12 months. The L 2020 Fund has declined 21.83% since the beginning of the year and 24.06% since OCT 07. The L 2010 Fund is down 10.57% this year and 11.77% from the same time a year ago, while the L Income Fund has fallen 5.43% in 2008 and 5.78% during the past 12 months. [Source: GovExec.com Alyssa Rosenberg article 3 Nov 08 ++]

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IMMUNIZATIONS UPDATE 01: Feeling woozy after your latest round of immunization shots then you're probably a male airman. Ten years of records showed that 2,612 service members passed out cold — and fell down — after a nurse slowly inserted a thin half-inch of steel into their biceps or buttocks. Data from the Armed Forces Health Surveillance Center shows that the rate of airmen who fell out was twice that of soldiers and sailors — Marines fall in between — and that twice as many men as women were among the fainthearted. The overall numbers also are rising; today's service members are 2½ times more likely to faint from getting a shot than they were in 1998. Possibly worse than the risk of ridicule is the risk of injury, the report states, "particularly when collapse leads to forceful contact between the face or skull ... and a sharp or solid object nearby." Researchers found 150 examples of fractures, brain injuries, open wounds, contusions, sprains and strains. Fainting occurs when blood vessels dilate and blood pressure decreases among people who stand for too long, don't like the sight of blood or fear pain, experts say. [Source: Navy Times Staff Report 3 Nov 08 ++]

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VA RADIATION UNDER DOSING: Nearly six months after a physicist at the Veterans Affairs Medical Center in Philadelphia discovered that a patient being treated for prostate cancer had received lower-than-prescribed radiation doses, inspectors with VA's National Health Physics Program have found more than 100 similar cases at four facilities. VA officials have declined repeated requests for information about the department's brachytherapy programs, in which radioactive seeds are implanted into the prostate. In October, the Nuclear Regulatory Commission, which licenses VA's radiation programs, announced that the department had suspended treatment at hospitals in Cincinnati; Jackson, Miss., and Washington. The Philadelphia program was suspended earlier. VA spokeswoman Laurie Tranter said on 15 OCT that officials would not discuss the program suspensions or any aspect of the investigation until the department issues a press release. VA still had not issued a release by 3 NOV. "It's not any particular person" delaying the statement, she said. "It's the process." Nonetheless, reports filed with NRC and recently made public shed some light on the investigation.

VA is required by law to notify the commission whenever it discovers radiation dosing errors that vary by 20% or more from the prescribed dose. Reports filed through October show that VA investigators had found 92 cases of improper dosing at the Philadelphia center as of 2 OCT. Nine cases had been identified at the Jackson Medical Center as of 30 OCT; six cases at the Cincinnati Medical Center as of 7 OCT; and three at the Washington Medical Center as of 26 SEP. NRC records are made public within 30 days of filing. The initial discovery of under dosing at Philadelphia stemmed from a brachytherapy procedure that took place 5 MAY. "Seeds of a lower apparent activity than intended were mistakenly ordered and implanted," according to the initial VA report to NRC on 16 MAY. As the investigation unfolded, the Philadelphia report was updated as new cases of improper dosing were discovered. The most recent update was 2 OCT, when investigators reported the discovery of an additional 37 patients for whom "medical events" had been identified. That brought the total number of patients receiving incorrect doses at Philadelphia to 92.

According to the report filed with NRC, "35 of the additional medical events involve doses to organs or

tissues other than the treatment site." The other two newly identified patients received doses to the treatment site (the prostate) that were below 80% of what was prescribed. None of the reports filed with NRC is considered "emergency events," but NRC has hired an independent consultant to assess the effect of the errors on patients' health. That assessment is ongoing. Viktoria Mitlyng, a spokeswoman with NRC's regional office in Lisle Illinois said the commission is monitoring VA's investigation of programs at 13 hospitals that perform brachytherapy, including the four whose programs were suspended. It is possible programs at other hospitals will be suspended, depending on what investigators find there, Mitlyng said. "We don't have a timeline" for the investigation of all 13 hospitals, she said. "We want to make sure it's done properly." [Source: GovExec.com Katherine McIntire Peters article 3 Nov 08 ++]

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NPRC SCAM: The below email was received by myself and a number of other vets who are asking if it i legitimate. A review of the website provided in the message revealed that it contains a number of veteran related informational items but does not provide any information on who the owner/sponsors of this site are or any background that would attest to the legitimacy of the site. Since this web site ends in dot.com vice dot.gov it is not a government site and could possibly be a scam to get personal information. Readers are advised to exercise caution before providing any personal information or records.

"HOUSTON , TX (October 21, 2008) In order to alleviate the strain on the National Personnel Records Commission (NPRC), and Veterans Affairs (VA), U.S. Veteran Compensation Programs introduced today that veterans can permanently store their service medical records (SMR), legal records, or military records in their new, user-friendly, Records Archive Division (RAD). http://www.veteranprograms.com"
[Source: CA DVBE Advocate Ted Puntillo msg 3 Nov 08 ++]

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WARTS: Other than being a nuisance, most warts are harmless and go away on their own. They are normally non-cancerous skin growths caused by a viral infection in the top layer of the skin. However, in some cases they can become cancerous. Warts are usually skin-colored and feel rough to the touch, but they can be dark, flat and smooth. These skin infections, which are more common in kids than in adults, are caused by viruses of the human papillomavirus (HPV) family. They can affect any area of the body, but tend to invade warm, moist places, like small cuts or scratches on the fingers, hands, and feet. They are usually painless unless they're on the soles of the feet or another part of the body that gets bumped or touched all the time. Kids can pick up HPV and get warts from touching anything someone with a wart has used, like towels and surfaces. The appearance of a wart depends on where it is growing. There are several different kinds of warts including:

- Common warts usually grow on the fingers, around the nails and on the backs of the hands. They are more common where skin has been broken, for example where fingernails are bitten or hangnails picked. These are often called "seed" warts because the blood vessels to the wart produce black dots that look like seeds.
- Foot warts are usually on the soles (plantar area) of the feet and are called plantar warts. When plantar warts grow in clusters they are known as mosaic warts. Most plantar warts do not stick up above the surface like common warts because the pressure of walking flattens them and pushes them back into the skin. Like common warts, these warts may have black dots. Plantar warts have a bad reputation because they can be painful, feeling like a stone in the shoe.
- Flat warts are smaller (about the size of a pinhead) and smoother than other warts. They tend to grow in

large numbers - 20 to 100 at any one time. They may be pink, light brown, or yellow. They can occur anywhere, but in children they are most common on the face. In adults they are often found in the beard area in men and on the legs in women. Irritation from shaving probably accounts for this.

- Filiform warts. These have a finger-like shape, are usually flesh-colored, and often grow on or around the mouth, eyes, or nose.

Warts are passed from person to person, sometimes indirectly. The time from the first contact to the time the warts have grown large enough to be seen is often several months. The risk of catching hand, foot, or flat warts from another person is small. Some people get warts depending on how often they are exposed to the virus. Wart viruses occur more easily if the skin has been damaged in some way, which explains the high frequency of warts in children who bite their nails or pick at hangnails. Some people are just more likely to catch the wart virus than are others, just as some people catch colds very easily. Patients with a weakened immune system also are more prone to a wart virus infection. In children, warts can disappear without treatment over a period of several months to years. However, warts that are bothersome, painful, or rapidly multiplying should be treated. Warts in adults often do not disappear as easily or as quickly as they do in children. Dermatologists are trained to use a variety of treatments, depending on the age of the patient and the type of wart.

- Common warts: Young children can be treated at home by their parents on a daily basis by applying salicylic acid gel, solution or plaster. There is usually little discomfort but it can take many weeks of treatment to obtain favorable results. Treatment should be stopped at least temporarily if the wart becomes sore. Warts may also be treated by "painting" with cantharidin in the dermatologist's office. Cantharidin causes a blister to form under the wart. The dermatologist can then clip away the dead part of the wart in the blister roof in a week or so. For adults and older children cryotherapy (freezing) is generally preferred. This treatment is not too painful and rarely results in scarring. However, repeat treatments at one to three week intervals are often necessary. Electrosurgery (burning) is another good alternative treatment. Laser treatment can also be used for resistant warts that have not responded to other therapies.
- Foot warts: Difficult to treat because the bulk of the wart lies below the skin surface. Treatments include the use of salicylic acid plasters, applying other chemicals to the wart, or one of the surgical treatments including laser surgery, electrosurgery, or cutting. The dermatologist may recommend a change in footwear to reduce pressure on the wart and ways to keep the foot dry since moisture tends to allow warts to spread.
- Flat warts: Often too numerous to treat with methods mentioned above. As a result, "peeling" methods using daily applications of salicylic acid, tretinoin, glycolic acid or other surface peeling preparations are often recommended. For some adults, periodic office treatments for surgical treatments are sometimes necessary.
- Laser therapy. Lasers are more expensive and require the injection of a local anesthesia to numb the area treated.
- Injection. Each wart is injected with an anti-cancer drug called bleomycin. The injections may be painful and can have other side effects.
- Immunotherapy. Attempts to use the body's own rejection system. Several methods of immunotherapy are being used. With one method the patient is made allergic to a certain chemical which is then painted on the wart. A mild allergic reaction occurs around the treated warts, and may result in the disappearance of the warts. Warts may also be injected with interferon, a treatment to boost the immune reaction and cause rejection of the wart.

There are some wart remedies available without a prescription. However, you might mistake another kind of skin growth for a wart, and end up treating something more serious as though it were a wart. If you have any questions about either the diagnosis or the best way to treat a wart, you should seek your dermatologist's advice.

Many people, patients and doctors alike, believe folk remedies and hypnosis are effective. Since warts, especially in children, may disappear without treatment, it's hard to know whether it was a folk remedy or just the passage of time that led to the cure. Since warts are generally harmless, there may be times when these treatments are appropriate. Medical treatments can always be used if necessary. Sometimes it seems as if new warts appear as fast as old ones go away. This may happen because the old warts have shed virus into the surrounding skin before they were treated. In reality new "baby" warts are growing up around the original "mother" warts. The best way to limit this is to treat new warts as quickly as they develop so they have little time to shed virus into nearby skin. A check by your dermatologist can help assure the treated wart has resolved completely. Research is moving along very rapidly. There is great interest in new treatments, as well as the development of a vaccine against warts. [Source: Familydoctor.org May 08 ++]

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WARTS UPDATE 01: The U.S. Centers for Disease Control (CDC) and Prevention reported 3 NOV that the human wart virus HPV caused 25,000 cases of cancer a year in the United States between 1998 and 2003, including not only cervical cancer but also anal and mouth cancers. The study suggests a broad need for screening both men and women for human papillomavirus, or HPV. This virus category includes about 100 different viruses, and they are the leading cause of cervical cancer. The viruses, transmitted sexually and by skin-to-skin contact, can also cause anal and penile cancers, as well as cancers of the mouth and throat. Both Merck and Co. and GlaxoSmithKline make vaccines against some of the strains of HPV most strongly linked with cervical cancer. They are recommended for girls and young women who have not begun sexual activity. Dr. Maura Gillison of Johns Hopkins University in Baltimore, who has studied the link between HPV and oral cancers, said the findings suggest a wider use of the cervical cancer vaccines may be justified. "Currently available HPV vaccines have the potential to reduce the rates of HPV-associated cancers, like oral and anal cancers, that are currently on the rise and for which there is no effective or widely applied screening programs," Gillison said in a statement. Last month researchers said their computer model indicated that vaccinating women as old as 45 could prevent some cases of cervical cancer, even though the vaccines do not protect anyone who has already been infected with one of the strains of HPV. An estimated 11,070 new cases of cervical cancer will be diagnosed in 2008 in the United States, and 3,870 women will die of it. Cervical cancer is even more widespread globally where regular Pap smear and HIV tests are not available. An estimated 500,000 women globally are diagnosed with cervical cancer each year and 300,000 die of it. The CDC survey of 38 states and Washington, D.C., found nearly 7,400 cancers of the mouth and throat that could be linked with HPV -- nearly 5,700 among men and about 1,700 among women. "There were more than 3,000 HPV-associated anal cancers per year -- about 1,900 in women and 1,100 in men," the CDC said. [Source: Reuters Maggie Fox article 3 Nov 08 ++]

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TFL NEED-TO-KNOWS: If you're nearing retirement, transitioning health care coverage shouldn't be a hassle. As you're preparing to switch to TRICARE for Life (TFL), the following facts and tips will help you make a seamless transition to TRICARE for Life (TFL) coverage.

1. Enroll in Medicare Part B when first eligible. TFL enrollment hinges on enrollment in Medicare Part B. You must remain enrolled in Medicare Part B (medical care) in order to maintain TRICARE eligibility.

2. Keep DEERS up to date. Although Medicare provides data to DEERS, you must maintain your TRICARE

eligibility by keeping DEERS up to date any time there is a life changing event, like becoming eligible for Medicare. Contact DEERS online at www.dmdc.osd.mil/rsl or call toll-free 1-800-538-9552.

3. Enrollment in TFL is seamless. If you are receiving Social Security benefits, you will transition smoothly to TFL upon your 65th birthday; if you are not receiving Social Security benefits at the time of your 65th birthday, you will need to visit the nearest Social Security office and enroll in Medicare.

4. Medicare authorized providers are also TRICARE authorized. You can visit any Medicare provider for care since all Medicare providers are also TRICARE authorized. Simply show your Medicare card and Uniformed Services ID card at your appointment.

5. Claims are paid automatically between Medicare and TFL. As a TFL beneficiary, you will not need to submit a paper claim when you have a doctor's visit (in most cases). The provider will submit the claim to Medicare. Medicare will then submit the claim to TRICARE once the Medicare portion is paid.

6. TFL is considered a second payer to Medicare. For services covered by Medicare and TRICARE, Medicare will pay its portion of the claim and TRICARE will pay the remainder. For services that are covered by Medicare and not by TRICARE (such as chiropractic care) TRICARE will not make a payment and the beneficiary will be responsible. Services covered by TRICARE but not Medicare (such as overseas claims) may be billed directly to Wisconsin Physicians Services (WPS) and TRICARE will pay as primary insurer. You will be responsible for any cost shares. Payments for services that are not covered by either program remain your sole responsibility.

7. Other health insurance (OHI) coordinates differently with TFL and Medicare. TFL beneficiaries who have OHI need to submit their Medicare Summary Notice with a paper claim and OHI explanation of benefits (EOB) to Wisconsin Physician Services. The paper claims may be sent to: Wisconsin Physician Services, TRICARE for Life, P.O. Box 7890, Madison, WI 53707-7890

8. Enrollment in Medicare Part D is not necessary. The TRICARE pharmacy benefit is considered creditable coverage and pays equally to Medicare.

9. TFL beneficiaries may continue to use any of the TRICARE pharmacy programs. You may fill prescriptions at any military treatment facility pharmacy, through the TRICARE Mail Order Pharmacy or through any TRICARE network or non-network pharmacy.

10. TRICARE coverage continues for eligible family members after the death of a sponsor.
Surviving spouses remain eligible for TRICARE unless they remarry. If they remarry, they lose TRICARE eligibility and cannot regain eligibility later, even in cases of divorce or death of the new spouse. Unmarried surviving children remain eligible for TRICARE until their 21st birthday (or 23rd birthday if enrolled in college full time and if at the time of the sponsor's death, the sponsor provided more than 50 percent of the child's financial support.) For more information on TRICARE for Life, please visit www.tricare4u.com or call Wisconsin Physicians Services toll-free at 1-866-773-0404.
[Source: USDR Action alert 30 Oct 08 ++]

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UNIFORM WEARING UPDATE 01: On October 31st of each year, small children (and some not-so-small "children") dress up in costumes and go door-to-door begging strangers for candy. Some of these folks, both small and tall will be wearing replicas of United States Military Uniforms. Is that legal? Can you dress up your little Rambo to look like a United States Army Officer? What about your big Rambo? It would seem, on the surface, that the law is pretty plain, right? None of the categories of 10 USC, Subtitle A, Part II, Chapter 45, Sections 771 and 772 state cover Halloween. Or, do they? Section 772 (f) allows the uniform to be worn in a theatrical production. Is Trick or Treat a "theatrical production?" Nobody knows, because no court has ever defined this. The closest a court has come is the Supreme Court, who used a very liberal interpretation of "theatrical production" in SCHACHT v. UNITED STATES, 398 U.S. 58 (1970). In this case, the court said:

"Our previous cases would seem to make it clear that 18 U.S.C. 702, making it an offense to wear our military uniforms without authority is, standing alone, a valid statute on its face. See, e. g., United States v. O'Brien, 391 U.S. 367 (1968). But the general prohibition of 18 U.S.C. 702 cannot always stand alone in view of 10 U.S.C. 772, which authorizes the wearing of military uniforms under certain conditions and circumstances including the circumstance of an actor portraying a member of the armed services in a "theatrical production" 10 U.S.C. 772 (f). The Government's argument in this case seems to imply that somehow what these amateur actors did in Houston should not be treated as a "theatrical production" within the meaning of 772 (f). We are unable to follow such a suggestion. Certainly theatrical productions need not always be performed in buildings or even on a defined area such as a conventional stage. Nor need they be performed by professional actors or be heavily financed or elaborately produced. Since time immemorial, outdoor theatrical performances, often performed by amateurs, have played an important part in the entertainment and the education of the people of the world. Here, the record shows without dispute the preparation and repeated presentation by amateur actors of a short play designed to create in the audience an understanding of and opposition to our participation in the Vietnam war. Supra, at 60 and this page. It may be that the performances were crude and [398 U.S. 58, 62] amateurish and perhaps unappealing, but the same thing can be said about many theatrical performances. We cannot believe that when Congress wrote out a special exception for theatrical productions it intended to protect only a narrow and limited category of professionally produced plays. Of course, we need not decide here all the questions concerning what is and what is not within the scope of 772 (f). We need only find, as we emphatically do, that the street skit in which Schacht participated was a "theatrical production" within the meaning of that section."

Notable is in making this decision, the Supreme Court also struck the words, "if the portrayal does not tend to discredit that armed force," from the statute as unconstitutional. The court said: "This brings us to petitioner's complaint that giving force and effect to the last clause of 772 (f) would impose an unconstitutional restraint on his right of free speech. We agree. This clause on its face simply restricts 772 (f)'s authorization to those dramatic portrayals that do not "tend to discredit" the military, but, when this restriction is read together with 18 U.S.C. 702, it becomes clear that Congress has in effect made it a crime for an actor wearing a military uniform to say things during his performance critical of the conduct or [398 U.S. 58, 63] policies of the Armed Forces. An actor, like everyone else in our country, enjoys a constitutional right to freedom of speech, including the right openly to criticize the Government during a dramatic performance. The last clause of 772 (f) denies this constitutional right to an actor who is wearing a military uniform by making it a crime for him to say things that tend to bring the military into discredit and disrepute. In the present case Schacht was free to participate in any skit at the demonstration that praised the Army, but under the final clause of 772 (f) he could be convicted of a federal offense if his portrayal attacked the Army instead of praising it. In light of our earlier finding that the skit in which Schacht participated was a "theatrical production" within the meaning of 772 (f), it follows that his conviction can be sustained only if he can be punished for speaking out against the role of our Army and our country in Vietnam. Clearly punishment for this reason would be an unconstitutional abridgment of freedom of

speech. The final clause of 772 (f), which leaves Americans free to praise the war in Vietnam but can send persons like Schacht to prison for opposing it, cannot survive in a country which has the First Amendment. To preserve the constitutionality of 772 (f) that final clause must be stricken from the section."

So, is it illegal for your kid to dress up as an Air Force officer for Halloween? Unknown for sure, but very probably not. Separate from technical legality is whether or not it really matters. If your kid wears the uniform, would that result in arrest and prosecution? Almost certainly not. Under our legal system, district attorneys have are given a wide latitude of what law violations to prosecute and which ones to ignore. [Source: About.com: US military 28 Oct 08 ++]

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VA PRESUMPTIVE ATOMIC VET DISEASES UPDATE 01: The Department of Veterans Affairs presumes that specific disabilities diagnosed in certain veterans were caused by their military service. If one of these conditions is diagnosed in Vietnam Vet, VA presumes that the circumstances of his/her service (i.e. exposure to agent Orange) caused the condition, and disability compensation can be awarded. This includes DIC education and CHAMPVA for spouses of veterans rated 100% or surviving spouses late-veterans that died from discussed medical problems. The following disabilities may be presumed for those who participated in atmospheric nuclear testing; occupied or was a POW in Hiroshima or Nagasaki; service before 1 FEB 92 at a diffusion plant in Paducah, KY, Portsmouth, OH, or Oak Ridge, TN; or service before 1 JAN 74 at Amchitka Island, AK:

- All forms of leukemia (except for chronic lymphocytic leukemia)
- Cancer of the thyroid, breast, pharynx, esophagus, stomach, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary tract (renal pelves, ureter, urinary bladder and urethra), brain, bone, lung, colon, ovary
- Bronchiolo-alveolar carcinoma
- Multiple myeloma
- Lymphomas (other than hodgkin's disease)
- Primary liver cancer (except if cirrhosis or hepatitis B is indicated)

[Source: County of Humboldt Veterans Service office 12 Oct 08 ++]

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DOD PDBR UPDATE 02: Service members who have been medically separated since 11 SEP 01 will have the opportunity to have their disability ratings reviewed to ensure fairness and accuracy. The new Physical Disability Board of Review (PDBR) will examine each applicant's medical separation, compare DoD and VA ratings, and make a recommendation to the respective Service Secretary (or designee). A disability rating cannot be lowered and any change to the rating is effective on the date of final decision by the Service Secretary. To be eligible for PDBR review, a service member must have been medically separated between 11 SEP 01 and 31 DEC 09 with a combined disability rating of 20% or less, and not found eligible for retirement. There are significant differences between this new PDBR review and a Board for Correction of Military (or Naval) Record (BCMR/BCNR) review. These differences are outlined at http://www.health.mil/Content//docs/COMPARISON.pdf and will also be on the application.

While the Air Force is the lead for the PDBR process, case tracking and reporting, a joint service board will conduct the evaluation and review of each case. Applicants will not be able to appear in person, but may include any statements, briefs, medical records or other supporting documents with their application. After the

document review is completed and a final decision is made, each applicant will be notified of the decision and any further information regarding a change of rating. Pending final approval, the application form should be available on the MHS Web Site (http://www.health.mil/) on or about1 DEC 08. Applications will be accepted immediately thereafter. For more information about the PDBR refer to the FAQ document at. http://www.health.mil/Content//docs/PDBR%20Question%20and%20Answers.pdf. You can contact the PDBR intake unit at SAF/MRBR, 550 C Street West, Suite 41, Randolph AFB, Texas 78150-4743. Keep in mind that this office cannot discuss the merits of your application. You may wish to contact your local veterans' service organization for advice or guidance. The DoD Instruction on the PDBR process is available at: http://www.dtic.mil/whs/directives/corres/pdf/604044p.pdf . [Source: DoD Military Health System News 3 Nov 08 ++]

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VA CLAIM SHREDDING UPDATE 01: The Department of Veterans Affairs is finalizing a sweeping new records policy to prevent the destruction of claims documents in benefits offices around the nation. The policy comes as the VA continues to investigate improper shredding at a St. Petersburg veterans benefits office and 56 other regional offices in nearly every state. It calls for the appointment of a records control team in Washington, D.C., to oversee the handling of documents. It also would lead to the hiring of records officers in each benefits office to do the same on a local level. And before shredding any document, two VA employees, including a supervisor, would have to sign off, according to a draft of the policy obtained by the St. Petersburg Times. The VA said it also notified members of Congress on 28 OCT about the pending policy; parts of which the agency said have already been implemented.

The new policy came about after the discovery last month of nearly 500 veterans' claims documents improperly set aside for shredding in 41 VA benefits offices. The documents, which had no duplicates in VA files, could have been crucial in deciding if an individual veteran received a pension or disability payment. That total includes 13 documents found in shredding bins in the VA's busiest benefits office at Bay Pines in St. Petersburg, where the agency's inspector general is still conducting an audit. Bay Pines is the home benefits office for Florida's 1.8-million veterans and the 330,000 who live in the Tampa Bay area. The total also includes 95 records which were erroneously dumped in a shredder bin at the VA office in Columbia SC. Forty-six of the records -- or about half discovered in the shredder bin at the Columbia office -- were either new claims for benefits or supporting documents. Other claims included burial and death benefits, notices of clients' disagreements with VA rulings, and documents for education benefits. Veterans Affairs officials are investigating why and an unidentified employee at that office is under investigation for mishandling the documents, which include new benefits claims and other personal files. On 28 OCT VA leaders met with representatives of the largest veterans' service groups in the nation Friday and told them they expect to enact this new policy within 10 days, perhaps with minor revisions. In the meantime, a national ban on all shredding in VA benefits offices remains in effect.

Some veterans' representatives' question if the policy will go beyond the shredding bin to assure paperwork is not lost or destroyed in other ways, such as when workers bring documents home. "This solves a problem," said Dave Autry, a spokesman for Disabled American Veterans. "I'm not sure it solves the entire problem." A VA spokeswoman said she could not comment on the new document policy because she had not yet been told about it. Improper shredding is "a big problem, and we've got to take care of it," said Alison Aikele, a VA spokeswoman. "Even one document is too many." The chairman of the House Committee on Veterans Affairs plans to hold a hearing later this month to examine the destruction of veterans claims documents. In some cases,

the VA says, employees may have deliberately and improperly set aside claims documents for shredding.

Two VA employees, neither in St. Petersburg, have been placed on paid leave pending further investigation. At one of the VA's busiest benefits office in New York City, four VA management employees have been placed on administrative leave, the VA has confirmed. That office's director and assistant director also have been transferred. The VA first denied any of these leaves were related to shredding but reversed itself when presented with information obtained by the Times. The agency now says one of those suspensions was because of shredding allegations. The VA said other suspensions were because employees may have doctored records indicating they more timely process claims than they actually did. Veterans with concerns about their files and claims are asked to call the U.S. Department of Veterans Affairs, (800) 827-1000. [Source: St. Petersburg times William R. Levesque article 1 Nov 08 ++]

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VA TINNITUS CARE: Hearing loss is presently the most common veterans' disability with tinnitus (i.e. persistent ringing in the ear) ranking second. In fiscal 2007, VA dispensed nearly 350,000 hearing aids to veterans. Nearly 850,000 veterans receive compensation for service-connected hearing disabilities. Tinnitus is the number one service-connected health condition for Iraq and Afghanistan veterans, with nearly 70,000 diagnoses. Defective hearing ranks third, with almost 60,000 cases. One of VA's 14 Centers of Excellence, the National Center for Rehabilitative Auditory Research (NCRAR) at the Portland OR VA Medical Center, conducts research to support hearing rehabilitation, education, professional training, and technology development. NCRAR researchers are working on more than 30 hearing loss and tinnitus projects, including the connection between traumatic brain injuries and hearing loss. Researchers are also working with engineers to develop a portable ototoxicity measuring device. The hope is that this device will improve the ability to detect and monitor hearing loss among soldiers in the field and that resulting from treatment with some medications. [Source: VCFL Michael Isam article 30 Oct 08 ++]

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VA DIABETES MELLITUS CARE UPDATE 04: The occurrence of Type 2, or adult onset, diabetes is increasing, particularly for the Vietnam Era veteran. For veterans of Vietnam, there is a statistically higher incidence of Type 2 diabetes. Because of this, the Veterans Affairs Department declared a link between Vietnam service and the disease. This means that if you have served in Vietnam and now have Type 2 diabetes, you are eligible for service-connected disability compensation and health care connected with this condition through the VA. The term "service in Vietnam" means that at some time between 9 JAN 62, and 7 MAY 75, you were in Vietnam. Service in the waters offshore or in the air does not qualify you unless during that time you set foot in Vietnam and have some way to prove it. For most veterans who served in Vietnam, their service is clearly shown on their separation papers, the DD-214.

If you have qualifying service, you should obtain a statement from your treating doctor that you are currently being treated for the disease. The more detail you provide, the easier it will be for the VA to handle your claim, so try to get a copy of your treatment records for the past year. A successful claim could entitle you to monetary compensation and treatment for your diabetes. The evaluation will be assessed through a VA examination, during which a VA doctor will evaluate your current condition. The VA will then assign an evaluation through the rating process. The evaluation could be as little as zero percent disabling to 100% disabling, which would result in monthly compensation for your condition. Service connection can also be granted for secondary

conditions directly related to the diabetes, for example, diabetic retinopathy. Once service connection has been established, you can reopen your claim if the condition progresses or other secondary conditions are discovered. In addition, if service connection is established, you are entitled to care for this condition at any VA medical facility. Medical care includes prescription drugs required to treat the condition. Both the medical care and prescription drugs are provided without cost for veterans service connected for the condition. If you've never filed a claim with the VA before, or you know someone who may benefit from this information, contact your local Veterans Service office. [Source: The trasure coast Palm Paul Hiott article 1 Nov 08 ++]

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UNIFORM WEARING UPDATE 02: The military services do care if civilians wear the uniform or parts of the uniform. Although district attorneys have are given wide latitude of what law violations to prosecute and which ones to ignore the military might they be willing to persuade a local district Attorney to prosecute. Some of the services have gone out of their way to include restrictions in their dress and appearance regulations (which are not enforceable against civilians, but tend to show that service's view on the subject). Army Regualtion 670-1, paragraph 1-4 states: d. In accordance with chapter 45, section 771, title 10, United States Code (10 USC 771), no person except a member of the U.S. Army may wear the uniform, or a distinctive part of the uniform of the U.S. Army unless otherwise authorized by law. Additionally, no person except a member of the U.S. Army may wear a uniform, any part of which is similar to a distinctive part of the U.S. Army uniform. This includes the distinctive uniforms and uniform items listed in paragraph 1–12 of this regulation.

Paragraph a.1–12 goes on to define Distinctive uniforms and uniform items: The following uniform items are distinctive and will not be sold to or worn by unauthorized personnel:
(1) All Army headgear, when worn with insignia.
(2) Badges and tabs (identification, marksmanship, combat, and special skill).
(3) Uniform buttons (U.S. Army or Corps of Engineers).
(4) Decorations, service medals, service and training ribbons, and other awards and their appurtenances.
(5) Insignia of any design or color that the Army has adopted.
[Source: About.com: US military 28 Oct 08 ++]

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HAVE YOU HEARD: The Company Commander and the First Sergeant were in the field. As they hit the sack for the night, the First Sergeant said, "Sir, look up into the sky and tell me what you see?"

The CO said, "I see millions of stars."

1st Sgt.: "And what does that tell you, sir?"

CO: "Astronomically, it tells me that there are millions of galaxies and potentially billions of planets. Theologically, it tells me that God is great and that we are small and insignificant. Meteorologically, it tells me that we will have a beautiful day tomorrow. What does it tell you, Top?"

1st Sgt.: "Well sir, it tells me that somebody stole our tent."

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VETERAN LEGISLATION STATUS 13 NOV 08: Congress will reconvene 17 NOV for a lame duck session and most likely adjourn by 21 NOV. This will be their last session prior to the start of the 111th Congress in JAN 09. Refer to the Bulletin’s House & Senate attachments for or a listing of Congressional bills of interest to

the veteran community that have been introduced in the 110th Congress. Support of these bills through cosponsorship by other legislators is critical if they are ever going to move through the legislative process for a floor vote to become law. A good indication on that likelihood is the number of cosponsors who have signed onto the bill. A cosponsor is a member of Congress who has joined one or more other members in his/her chamber (i.e. House or Senate) to sponsor a bill or amendment. The member who introduces the bill is considered the sponsor. Members subsequently signing on are called cosponsors. Any number of members may cosponsor a bill in the House or Senate. At http://thomas.loc.gov you can also review a copy of each bill's content, determine its current status, the committee it has been assigned to, and if your legislator is a sponsor or cosponsor of it. To determine what bills, amendments your representative has sponsored, cosponsored, or dropped sponsorship on refer to http://thomas.loc.gov/bss/d110/sponlst.html. The key to increasing cosponsorship on veteran related bills and subsequent passage into law is letting our representatives know of veteran's feelings on issues. At the end of some listed bills is a web link that can be used to do that. You can also reach his/her Washington via the Capital Operator direct at (866) 272-6622, (800) 828-0498, or (866) 340-9281 to express your views. Otherwise, you can locate on http://thomas.loc.gov who your representative is and his/her phone number, mailing address, or email/website to communicate with a message or letter of your own making. Refer to http://www.thecapitol.net/FAQ/cong_schedule.html for future times that you can access your representatives on their home turf. [Source: RAO Bulletin Attachment 13 Nov 08 ++]

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Lt. James "EMO" Tichacek, USN (Ret)
Director, Retiree Assistance Office, U.S. Embassy Warden & IRS VITA Baguio City RP
PSC 517 Box RCB, FPO AP 96517
Tel: (951) 238-1246 in U.S. or Cell: 0915-361-3503 in the Philippines.
Email: raoemo@sbcglobal.net Web: http://post_119_gulfport_ms.tripod.com/rao1.html
AL/AMVETS/DAV/FRA/NAUS/NCOA/MOAA/USDR/VFW/VVA/CG33/DD890/AD37 member