

I think I have written and talked this topic into the ground. I must, however, reemphasize this subject because it continues to cause untold problems to many of our Health Fund members. It is time consuming, expensive and if you are trapped into this dilemma, there is little the Health Fund can do to save you from having to pay costs that the Health Fund cannot cover.

PRE-CERTIFICATION. This is one of the most important provisions of the Plan Document. The reason for pre-certification is to determine two things: first and foremost is to determine if the procedure is covered, and secondly to ascertain if the provider or providers are "in-network."

In emergency cases, the Health Fund will pay the charges as if they were in-network. The Fund, however, will not pay above the usual and customary fees whether in-network or not. A provider not in-network can charge fees that are well beyond what is considered usual and customary. These charges above usual and customary sometimes amount to thousands of dollars above what the Fund pays. The Fund cannot make exceptions in paying these charges.

I strongly advise our members to do two things when visiting a provider. The first item is to call the Health Fund office and determine if the provider is in the PHCS (private health care system) network. The second item is to determine if the doctor or provider is going to use a laboratory for analysis work. If M.R.I's, X-RAYS, E.K.G's or other tests are going to be conducted or if any specimens are going to be analyzed, it is extremely important to call the Health Fund office to determine if the provider is in-network.

I confess that I have been guilty many times of not checking to see if a provider is in- or out-of-network. I have paid the price. I have done this several times, and I have no one to blame but myself.

Going to the Web to get this information is not always reliable. Providers go in- and out-of-network at will. A case in point: Southwest Texas Radiology was in-network, out-of-network, and now it is back in-network. I happened to have visited this Lab at the time it was out-of-network. I had to pay the charges that were above usual and customary.

For out of town providers, there is a number on your health card that will get you information on who is or is not in-network. Please do not take the word of the doctor's nurse, secretary, home care provider or any other person that is not at the number listed on your card or a staff member at the Health Fund office.

Again, please call the Health Fund Office before visiting a provider unless you are very sure that the provider is in-network.

Additionally, we ask our members to be patient with the Health Fund staff. They are health benefits specialists and know what benefits are payable and which are not. They must follow the dictates of the Plan Document; however, they will do their utmost to get you the benefits you are due. Sometimes they have to ask you questions that you have answered before and this may cause some frustration. They must have all the information available to be able to help you receive your benefits.

There will be times that the member does not get the answers he or she expects. This is not the staff's fault. If you are not satisfied with the resolution of your case, you can always appeal to the Board of Trustees. Remember though, the Board must also follow the mandates of the Plan Document.

We want our members to receive all the health benefits that they are entitled to. The Board will listen and evaluate the claim, but strict adherence to the Plan Document must be followed. If the Board makes a decision for a member outside of the requirements of the Plan Document, other members will want the same benefits. The results of paying benefits not covered will seriously undermine paying down the unfunded liability of the Fund. This could lead to future increases in contributions or decreases in benefits for all members.