If you are a member of Health First Medicare Group's HMO known as POS (point of service), this may benefit you. Look at your card to see if it contains the following: HMO-POS. If so, then you may receive reimbursement for your health care provided by a non-participating provider, such as Dr. Richard Simmons.

1) "POS (Point of Service) benefit covers medically necessary services you get from providers outside of our network … Some POS services may require a prior authorization. These services are not automatically covered." Please see images below from the Health First Medicare manual.
2) On the date of service you will be expected to pay in full the 2022 Medicare Part "B" approved amount for the services rendered. Simmons' Podiatry, P.A. will then submit your claim to Health First for them to reimburse you. A copy of the claim will be mailed to you for your reference.
3) You may find it simpler and easier to request concierge services. Please click here to understand concierge services.

Section 2.4 How to get care from out-of-network providers

The POS (Point-of-Service) benefit covers medically necessary services you get from providers outside of our network. When you use the POS benefit, you may be responsible for a higher cost share. (See Chapter 4, Section 2.1 for covered POS services along with the cost-share.) If your provider does not participate with Original Medicare the provider is allowed to charge 115% of the Medicare allowable. The plan will send you an Explanation of Benefits that includes any statement of coinsurance for out-of-network services when you use the POS benefit.

Some POS services may require a prior authorization. These services are not automatically covered. If you receive a service that requires a prior authorization from an out-of-network provider, it is your responsibility to work with your provider to obtain prior authorization for these services. You are financially responsible for all services rendered by an out-of-network provider when plan rules are not followed.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you may be required to use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which *the Classic Plan (HMO-POS)* authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

The Point-of-Service (out-of-network) benefit that comes with your plan covers medically necessary services you get from non-participating providers. Regardless of where you receive covered services, some services require a prior authorization. If you receive a service that requires a prior authorization from an out-of-network provider, it is your responsibility to work with your provider to obtain prior authorization for these services. You are financially responsible for all services rendered by an out of network provider when plan rules are not followed. Please see the Medical Benefits Chart in Chapter 4 for details. Please visit our website at myHFHP.org for our current Prior Authorization List or contact Customer Service for details

SECTION 1 Introduction

Section 1.1 You are enrolled in *the Classic Plan (HMO-POS)*, which is a Medicare HMO Point-of-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, *the Classic Plan (HMO-POS)*.

There are different types of Medicare health plans. *the Classic Plan (HMO-POS)* is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.) **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Benefits	Classic Plan (HMO-POS)	Value Plan (HMO)	Rewards Plan (HMO)
Supervised Exercise Therapy (SET)	You pay $10 for each Medicare-covered supervised exercise therapy visit	You pay $20 for each Medicare-covered supervised exercise therapy visit	You pay $20 for each Medicare-covered supervised exercise therapy visit
Chiropractic Services	You pay $20 for each Medicare-covered visit	You pay $20 for each Medicare-covered visit	You pay $20 for each Medicare-covered visit
Point-of-Service**	You pay 20% of the cost for all Medicare-covered services	Not covered	Not covered

Dr. Simmons receives his Medicare through the Health First Class Plan (HMO-POS) and has provided a copy of the top of his card as an example.

**Point-of-Service means you may use providers outside of the plan's network for an additional cost. Please refer to the Evidence of Coverage for out-of-pocket and annual maximum coverage amounts. Facilities may charge different amounts, so your final cost may vary depending on which facility you choose.