Lighthouse HEALTH PLAN

Come shine with us!

Lighthouse Health Plan's Florida Medicaid Member Handbook 2020-2021

Effective 10/01/20

Introduction

Lighthouse Health Plan is your Medicaid plan. We are here for you and your family. We are doctors and nurses working to help you. We bring your health care, health plan, and community services together. This makes getting good health care easier for you. Here is what you get:

- Doctors in charge of your care and your plan
- There are no co-pays with Lighthouse Health Plan. We fully cover all of your medically
  necessary needs
- Added benefits such as chiropractic services, over-the-counter products, prenatal services
  like breast pumps
- Personalized support for conditions like asthma, diabetes, and high blood pressure
- Member Service representatives who are helpful, friendly and understand you
- Easy connections to services that are close to your home, work or school
- A team working closely with you and your doctor to help you get and stay healthy
- Extra support if you need to see a specialist or help with an appointment

This handbook helps you understand your coverage. It explains how to get the most out of your benefits. It also provides tools and resources to help you manage health care expenses for you
and your family.

Keep it handy as you use your benefits throughout the year. We look forward to serving you and your family!

“If you do not speak English, call us at 1-844-243-5176 (TTY: 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language."

Spanish: Si usted no habla inglés, llámenos al 1-844-243-5176 (TTY: 711). Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: **Si vous ne parlez pas anglais**, appelez-nous au 1-844-243-5176 (TTY: 711). Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole: **Si ou pa pale lang Anglè**, rele nou nan 1-844-243-5176 (TTY: 711). Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian: **"Se non parli inglese** chiamaci al 1-844-243-5176 (TTY: 711). Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua."

Russian: **«Если вы не разговариваете по-английски,** позвоните нам по номеру 1-844-243-5176 (TTY: 711). У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Important Contact Information

Member Services Helpline	1-844-243-5176	8am-8pm (ET) / 7am-7pm (CT), Mon - Fri
Member Services Help Line TTY	711	8am-8pm (ET) / 7am-7pm (CT), Mon - Fri
Website	www.lighthousehealthplan.com	
Address	700 E. Gregory Street, Suite 150 Pensacola, FL 32502 Hours: 9 am - 4 pm (CT)	

Transportation	OneCall Toll Free Phone: 1-877-611-3446 TTY: 711 Fax: 1-844-418-0531 Website: www.onecallhealth.com/members Email: RideRequest@onecallcm.com
Vision	Icare Health Solutions Toll Free Phone: 1-855-373-7627 Fax: 1-305-675-8195 Website: www.myicarehealth.com Email: info@myicarehealth.com
Behavioral Health	Access Behavioral Health Toll Free Phone: 1-800-342-3222 (24/7) Fax: 1-850-479-3661 www.abhfl.org
Over the Counter Supplies	CVS Health Toll Free Phone: 1-833-331-1571 TTY: 1-877-672-2688 Website: https://www.cvs.com/otchs/lighthouse
Nurse Advice Line	Health Dialog Toll Free Phone: 1-844-865-7922 TTY: 711 Fax: 1-800-499-7033 Website: www.healthdialog.com Email: referral@healthdialog.com

DME/Home Health/Infusion Pharmacy	Coastal Care Services, Inc. 1-855-481-0505 (24 hours/7 days/week) 1-855-481-0606 (Fax) Website: http://www.ccsi.care/patients/
Dental	Contact your case manager directly or our Member Services at 1-844-243-5176 (TTY: 711) for help with arranging these services.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-800-96-ABUSE (1-800-962-2873) TTY: 711 or 1-800-955-8771 http://www.myflfamilies.com/service-programs/abuse-hotline
For Medicaid Eligibility	1-866-762-2237 TTY: 711 or 1-800-955-8771 http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid
To report Medicaid Fraud and/or Abuse	1-888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	1-888-419-3450 http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml
To request a Medicaid Fair Hearing	1-877-254-1055 1-239-338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com
To file a complaint about Medicaid services	1-877-254-1055 TDD: 1-866-467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	1-800-96-ELDER (1-800-963-5337) http://elderaffairs.state.fl.us/doea/arc.php

To find out information about domestic violence	1-800-799-7233 TTY: 1-800-787-3224 http://www.thehotline.org/
To find information about health facilities in Florida	http://www.floridahealthfinder.gov/index.html
To find information about urgent care	Contact our Member Services: 1-844-243-5176 Website: www.lighthousehealthplan.com
For an emergency	**Call 9-1-1 or go to the nearest emergency room**

Table of Contents

Welcome to Lighthouse Health Plan's Statewide Medicaid Managed Care Plan

Thanks for being a member. We value you. We are dedicated to you and your family. We will work with you and your doctor to improve your health care experience.

This Member Handbook will describe your benefits. It also tells you about costs, if you have any. This document provides a lot of detail for you. Please keep this document so you can use it throughout the year.

We are available to walk you through the document to help you understand the information.

Lighthouse Health Plan has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the **Statewide Medicaid Managed Care (SMMC) Program**. You are enrolled in our SMMC plan. This means that we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services that you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

If your child is enrolled in the Florida KidCare **MediKids** program, most of the information in this handbook applies to you. We will let you know if something does not apply.

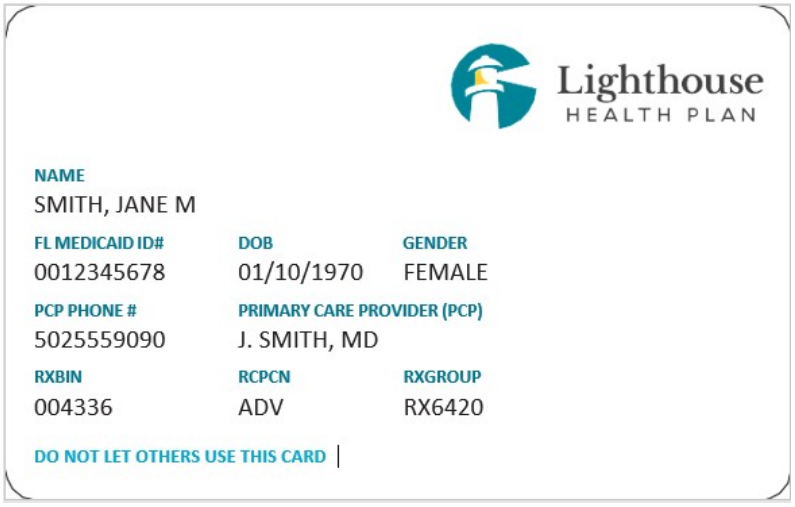
This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at 1-844-243-5176 (TTY: 711).

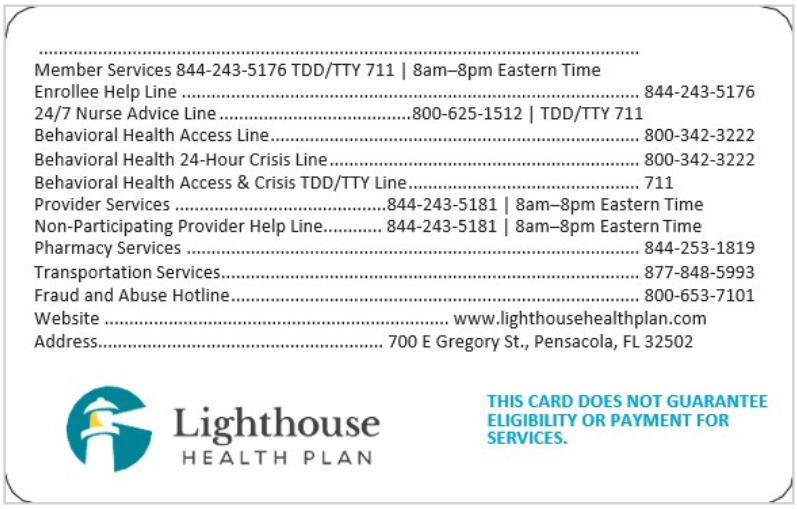
Section 1: Your Plan Identification Card (ID card)

You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

Carry your ID card at all times and show it each time you go to a health care appointment. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

Your ID card will look like this:





Section 2: Your Privacy

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, plan identification number, race, ethnicity, and other things that identify you. We will not share any health information about you that is not allowed by law. If you have any questions, call Member Services. Our privacy policies and protections are:

LIGHTHOUSE HEALTH PLAN NOTICE OF PRIVACY PRACTICES
THIS NOTICE TELLS YOU HOW YOUR HEALTH INFORMATION MAY BE USED AND SHARED BY YOUR HEALTH PLAN. IT ALSO DESCRIBES HOW YOU CAN ACCESS YOUR OWN HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHAT IS THIS DOCUMENT?

This document, called a Notice of Privacy Practices, tells you how Lighthouse Health Plan may use and share your health information. We must keep your oral, written and electronic health information private. We must keep it secure. We will let you know if a breach occurs that affects the privacy or security of your information. The notice also explains how you can get access to your own health information.

WHAT IS HEALTH INFORMATION?

The words “health information” mean any information that identifies you. Examples include your name, date of birth, details about health care you received, or amounts paid for your care.

WHY ARE YOU GIVING THIS TO ME?

We are required by law to give you this notice. We must follow the practices in this notice. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can share your information, you may change your mind at any time. Let us know in writing if you change your mind.

WHO FOLLOWS THIS NOTICE?

All employees, contractors, consultants, vendors, volunteers, and other health care professionals and organizations who work with Lighthouse Health Plan follow this notice.

HOW WE CAN USE AND SHARE YOUR HEALTH INFORMATION

To Manage Your Health Care Treatment. We will use and share your health information to help with your health care.

> ***For Example*:** A doctor sends us information about your diagnosis and treatment plan so we can arrange for additional services.

For Health Care Operations. We will use and share your health information to help us do our job. We may contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

For Example: We use your health information to develop better services for you or to make sure you are receiving good services.

***For Example*:** We submit data related to your health information to the state to show we are following our contract.

To Pay for your Health Services. We will use and share your health information as we pay for your health services.

***For Example*:** We share information about you with your prescription plan to coordinate payment for your prescriptions.

To Administer Your Plan. We may share your health information with other businesses for plan administration.

***For Example*:** We share your information with a transportation company to make sure you get to your important.

With Business Associates. We may share your health information with another company, called a business associate, which we hire to provide a service to us or on our behalf. We will only share your information if the business associate has agreed in writing to keep health information private and secure.

WAYS WE CAN USE OR SHARE YOUR HEALTH INFORMATION WITH YOUR PERMISSION

You can choose how we share your information in the situations described below. Tell us what you want us to do and we will follow your instructions. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest.

Research. We can use or share your information for health research.

With Individuals Involved in Payment for Your Care. We may share health information about you with your family members, friends or other people who are involved in your health care or who help pay for it. You have the right to ask that we not share your information with certain people, but you must let us know.

To Share Information About Health-Related Benefits, Services and Treatment Alternatives. We may tell you about health services, products, possible treatments or alternatives available to you. We may not sell your health Information without your written permission

Sensitive Information. Some types of medical information are very sensitive. The law may require that we obtain your written permission to share this information. Sensitive medical information may include genetic testing, HIV/AIDS testing, diagnosis or treatment, mental health, alcohol and substance abuse, sexual assault or in- vitro fertilization. Your permission is also required for the use and sharing of psychotherapy notes.

Use of Your Information for Our Marketing. We may not use or disclose your health information for marketing purposes unless we have your written permission.

Sale of Your Information. We may not sell your health information unless we have your written permission.

HOW WE MUST SHARE YOUR HEALTH INFORMATION

We also have to share your information in situations that help contribute to the public good or safety. We have to meet many conditions in the law before we can share your information for these purposes.

Research. We can use or share your information for health research.

Public Health and Safety. We may share your health information for public health and safety reasons. For example:

- to prevent or control disease
- to help report information about bad products
- to report adverse reactions to medications
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition or
- to your employer in certain limited instances.

Abuse and Neglect. We may have to share your information to report suspected abuse, neglect or domestic violence to state and federal agencies.

For Disaster Relief. We may share your health information in a disaster relief situation.

Prevent a Serious Threat to Safety. We may use and share your medical information to prevent or reduce a serious threat to your health and safety or the health and safety of others.

Comply with the Law. We must share health information about you when we are required to do so by federal or state laws.

As a Part of Legal Proceedings. We can share health information about you in response to a court order or a subpoena. We will only share the information stated in the order. If we receive any other legal requests, we may share your health information if we are told that you know about it and do not object to the release.

With Law Enforcement. We must share health information about you when we are required to do so by law or by the court process, including for the following:

- To identify or locate a suspect, fugitive, material witness or missing person
- To obtain information about an actual or suspected victim of a crime
- We may also share information with law enforcement if we believe a death was the result of a crime or to report crimes on our property or in an emergency.

During an Investigation. We will share your information with the Secretary of the Department of Health and Human Services if they ask for it as part of an investigation of a privacy violation.

Special Governmental Functions. We may share your health information with:

- Authorized federal officials
- Military
- For intelligence, counterintelligence and other national security activities
- To protect the president.

Coroners, Medical Examiners and Funeral Directors. We may share health information with a coroner or medical examiner to identify a dead person or find the cause of death. We also may share health information with funeral directors if they need it to do their job.

Health Oversight Activities. Certain health agencies are in charge of overseeing health care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Organ and Tissue Donation. If you are an organ donor, we may release health information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.
Workers Compensation. We may share your health information with agencies or individuals to follow workers compensation laws or other similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You Have a Right to Request Restrictions. You have the right to ask us to limit the ways we use and share your health information for treatment, payment, and health care operations. We do not have to agree if it would affect your care.

You must submit your request in writing, and it must be signed and dated. You should describe the information you want limited and tell us who should not receive this information. You must submit your written request to the Office of Corporate Compliance, 5775 Blue Lagoon Dr. Miami FL 33126. We will tell you if we agree with your request or not. If we do agree, we will follow your request unless the information is needed to treat you in an emergency.

You Have a Right Get a Copy of Health and Claims Records. You have the right to read or get a copy of your health and claims records and other health information we have about you.

To see and obtain copies of your information you must complete your request in writing. We will give you a copy or a summary of your health and claims record within 30 days of your request. If you request a copy of your health and claims record, we may charge a reasonable, cost-based fee for the costs of copying, mailing or other expenses associated with your request.

You Have a Right to Request Changes. You may ask us to change your health information or payment record if you think it is incorrect or incomplete. You must send us a written request and you must provide the reason why you want the change. We are not required to agree to make the change. If we do not agree to the requested change, we will tell you why in writing within 60 days. You may then send another request disagreeing with us. It will be attached to the information you wanted changed or corrected.

You Have a Right to Request Confidential Communication. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests.
We must agree if you tell us you would be in danger if we do not follow your request.

You Have a Right to an Accounting of Disclosures. You have the right to make a written request for a list of the times we've shared your health information in the past six years. The list will have who we shared it with, the date it was shared and why. We will include all the disclosures except for those about treatment, payment, and health care operations and any disclosure you asked us to make.

We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Your written request must designate a time period.

You Have a Right to a Paper Copy of This Notice. You have the right to ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.

You Have a Right to Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

CHANGES TO THIS NOTICE

We may change our privacy policies, procedures, and this Notice at any time, and the changes will apply to all information we have about you. If we change this Notice, the new Notice will be posted on our web site and we will mail a copy to you.

WHAT IF I NEED TO REPORT A PROBLEM?

If you are unhappy and report a problem, we will not use your complaint against you.
If you believe Lighthouse Health Plan has violated your privacy rights in this Notice, you may file a complaint with Lighthouse Health Plan or with the Office for Civil Rights, U.S. Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

You can also call 1-877-696-6775 or you may visit www.hhs.gov/ocr/privacy/hipaa/complaints/

You can contact the Lighthouse Health Plan Compliance and Privacy Officer to discuss any concern you have using the information below:

Office of Corporate Compliance
Lighthouse Health Plan
Lighthouse Health Plan
700 E. Gregory Street, Suite 150
Pensacola, FL 32502
Telephone: 1-850-505-4266

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your Primary Care Provider (PCP for short), find out if a service is covered, get referrals, find a provider, replace a lost ID card, report the birth of a new baby, and explain any changes that might affect you or your family's benefits.

Contacting Member Services

You may call us at 1-844-243-5176 or TTY: 711, Monday to Friday, 8 a.m. to 7 p.m., Eastern Time, but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our Nurse Advice Line at 1- 1-844-865-7922 or TTY: 711. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

If you do not speak English, we can help. We have people who help us talk to you in your language. We provide this help for free.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a provider's office is wheelchair accessible or has devices for communication. Also, we have services like:

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 1-844-243-5176. They will connect you to us
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (ACCESS) account at https://dcf-access.dcf.state.fl.us/access/index.do.

You may also contact the Social Security Administration (SSA) to report changes. Call SSA toll free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your Social Security account at https://secure.ssa.gov/RIL/SiView.do.

Section 6: Your Medicaid Eligibility

In order for you to go to your health care appointments and for Lighthouse Health Plan to pay for your services, you have to be covered by Medicaid and enrolled in our plan. This is called having **Medicaid eligibility**. DCF decides if someone qualifies for Medicaid.

Sometimes things in your life might change, and these changes can affect whether or not you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean that you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services and we can help you check on it.

If you Lose your Medicaid Eligibility
If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare
If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a baby
If you have a baby, he or she will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived, and we will help make sure your

baby is covered and has Medicaid right away.

It is helpful if you let us know that you are pregnant **before** your baby is born to make sure that your baby has Medicaid. Call DCF toll free at 1-866-762-2237 while you are pregnant. If you need help talking to DCF, call us. DCF will make sure your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Section 7: Enrollment in Our Plan

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in this region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open Enrollment

Open enrollment is a period that starts 60 days before the end of your year in our plan. The State's Enrollment Broker will send you a letter letting you know that you can change plans if you want. This is called your **Open Enrollment** period. You do not have to change plans. If you leave our plan and enroll in a new one, you will start with your new plan at the end of your year in our plan. Once you are enrolled in the new plan, you will have another 60 days to decide if you want to stay in that plan or change to a new one before you are locked-in for the year. You can call the Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Section 8: Leaving Our Plan (Disenrollment)

Leaving a plan is called **disenrolling.** If you want to leave our plan while you are locked-in, you have to call the State's Enrollment Broker. By law, people cannot leave or change plans while they are locked-in except for very special reasons. The Enrollment Broker will talk to you about why you want to leave the plan. The Enrollment Broker will also let you know if the reason you stated allows you to change plans.

You can leave our plan at any time for the following reasons (also known as **Good Cause Disenrollment** reasons[1]):

- You are getting care at this time from a provider that is not part of our plan but is

[1] For the full list of Good Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: https://www.flrules.org/gateway/RuleNo.asp?title=MANAGED CARE&ID=59G-8.600

a part of another Plan
- We do not cover a service for moral or religious reasons
- You are an American Indian or Alaskan Native
- You live in and get your Long-Term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[2]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason

If you have any questions about whether you can change plans, call Member Services or the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Removal from Our Plan (Involuntary Disenrollment)
The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called **involuntary disenrollment**. These reasons include:

- You lose your Medicaid
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions
- You or your caregivers behave in a way that makes it hard for us to provide you with care

If the Agency removes you from our plan because you broke the law or for your behavior, you cannot come back to the SMMC program.

[2] To learn how to ask for an appeal, please turn to Section 13, Member Satisfaction, on page 56.

Section 9: Managing Your Care

If you have a medical condition or illness that requires extra support and coordination, we may assign a case manager to work with you. Your case manager will help you get the services you need. The case manager will work with your other providers to manage your health care. If we provide you with a case manager and you do not want one, call Member Services to let us know.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing Case Managers

If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter to let you know.

Important Things to Tell Your Case Manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service
- You have concerns about a service provider
- Your services aren't right
- You get new health insurance
- You go to the hospital or emergency room
- Your caregiver can't help you anymore
- Your living situation changes
- Your name, telephone number, address, or county changes

Request to Put Your Services on Hold

If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a form to put your service(s) on hold.

Section 10: Accessing Services

Before you get a service or go to a health care appointment, we have to make sure that you need the service and that it is medically right for you. This is called **prior authorization.** To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in Our Plan

For the most part, you must use doctors, hospitals, and other health care providers that are in our **provider network**. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your **freedom of choice**. If you use a health care provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call 1-844-243-5176 (TTY: 711) to get a copy or visit our website at www.lighthousehealthplan.com.

Providers Not in Our Plan

There are some services that you can get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Lighthouse Health Plan. The table below will help you to decide which plan pays for a service.

Type of Dental Service(s):	Dental Plan Covers:	Medical Plan Covers:
Dental Services	Covered when you see your dentist or dental hygienist	Covered when you see your doctor or nurse
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist	Covered for doctors, nurses, hospitals, and surgery centers
Hospital visit for a dental problem	*Not covered*	Covered
Prescription drugs for a dental visit or problem	*Not covered*	Covered
Transportation to your dental service or appointment	*Not covered*	Covered

Contact Member Services at 1-844-243-5176 (TTY: 711) for help with arranging these services.

What Do I Have to Pay For?

You may have to pay for appointments or services that are not covered**.** A covered service is a service that we have to provide in the Medicaid program. All of the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean that you will need it. You may have to pay for services if we did not approve it first.

You do not need to send us claims for medical care you got. Your doctor will send us claims for care they have given you. If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[3]

We must provide all medically necessary services for our members who are ages 0 – 20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limits; or
- No time limits, like hourly or daily limits

Your provider may need to ask us for approval before giving your child the service. Call

[3] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements.

Member Services if you want to know how to ask for these services.

Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Lighthouse Health Plan

The Medicaid fee-for-service program is responsible for covering the following services, instead of Lighthouse Health Plan covering these services:

- Behavior Analysis (BA)
- County Health Department (CHD) Certified Match Program
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver
- Hemophilia Factor-related Drugs
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)
- Medicaid Certified School Match (MCSM) Program
- Model Home and Community-Based Services Waiver
- Newborn Hearing Services
- Prescribed Pediatric Extended Care
- Substance Abuse County Match Program

This Agency webpage provides details about each of the services listed above and how to access these services: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml.

Moral or Religious Objections

If we do not cover a service because of a religious or moral reason, we will tell you that the service is not covered. In these cases, you must call the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970). The Enrollment Broker will help you find a provider for these services.

Section 11: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

If you have Medicare, please contact the number on your Medicare ID card for information about your PCP. You do not have to change your Medicare PCP to get medical services. You can keep your same Medicare PCP.

If you have Medicaid or MediKids but you do not have Medicare, one of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will see your PCP for regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PCP by calling Member Services.

You can choose a different PCP for each family member or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family.

You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for Your Child

You can pick a PCP for your baby before your baby is born. We can help you with this by calling Member Services. If you do not pick a PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.[4]

You can take your child to a pediatrician, family practice provider, or other health care provider.

You do not need a referral for well child visits.

There is no charge for well child visits.

[4] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care – Periodicity Schedule" at www.aap.org.

Your child will get too old to see a pediatrician. When this happens, we can help your child get a new PCP. Call Member Services to get a new PCP for your child when they become older.

Specialist Care and Referrals

Sometimes, you may need to see a provider other than your PCP for medical problems like special conditions, injuries, or illnesses. Talk to your PCP first. Your PCP will refer you to a **specialist**. A specialist is a provider who works in one health care area.

If you have a case manager, make sure you tell your case manager about your **referrals**. The case manager will work with the specialist to get you care.

Second Opinions

You have the right to get a **second opinion** about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you to get a second opinion.

Your PCP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PCP, or it is after your PCP's office has closed.

If you need Urgent Care after office hours and you cannot reach your PCP, you can call our 24-hour Nurse Advice Line at 1-844-865-7922 or TTY: 711 or your urgent care center.

You may also find the closest participating urgent care center to you by calling Member Services at 1-844-243-5176 or going to https://lighthousehealthplan.com/en/members/find-provider/

If you would like to talk to your PCP's office, the phone number is on the front of your ID card. Your PCP will have a doctor who monitors and returns calls also known as being "on call." This doctor will call you back and tell you what to do. If you go to an Urgent Care center be sure to call your PCP the next day to ensure you get the follow up care you need.

Hospital Care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PCP will set it up. We must approve services in the hospital before you go, except for emergencies. We will not pay for hospital services unless we approve them ahead of time or it is an emergency.

If you have a case manager, they will work with you and your provider to put services in place when you go home from the hospital.

Emergency Care

You have a medical **emergency** when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Telemedicine

Teladoc helps you get care when you can’t get to your doctor. You can talk with a doctor at any time during the day or night. You can talk to a doctor by phone, computer or mobile app. You can use Teladoc for things like colds, cough, sore throat or earaches. You can call Teladoc at 1-800-835-2362 or Member Services for help.

Filling Prescriptions and Pharmacy Services

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Formulary**. You can find this list on our Web site at www.lighthousehealthplan.com or by calling Member Services.

We cover **brand name** and **generic** drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. Sometimes, we may need to approve using a brand name drug before your prescription is filled.

Sometimes the drug your doctor ordered is not on the Formulary. If this happens, your pharmacist will give you a different drug. Your pharmacist will talk with your doctor if this change is made.

Below are some words that can help you learn how to get your medicine:

- Prior authorization (PA) – this is a special request made by tour doctor to see if a drug can be approved
- Quantity Limit (QL) – this is a limit on how much of a drug you get for a specific number of days
- Step Therapy (ST) – this is using less expensive drugs that should treat you before "stepping up" to more expensive drugs
- Formulary Exception – this is when you may need a drug that is not listed on the Formulary

A Prior Authorization (PA) is needed when:

- Drugs are over the Quantity Limit
- Step-therapy drugs are prescribed
- A brand name drug is prescribed when you can get a generic drug on the Formulary
- A drug is not listed on the is prescribed

Prior Authorizations or Formulary Exceptions can be made by your doctor. Your doctor will give us what we need to get you the drug you need.

You do not have a co-payment for drugs we cover.

We have pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes. You can find changes and a drug list at https://lighthousehealthplan.com/en/pharmacy/. You can call Member Services to ask about a drug. We will notify you about changes to drugs you take.

Certain drugs can only be filled at Specialty Pharmacies. For a list of these drugs, you can visit www.lighthousehealthplan.com.These drugs may not be available at all retail pharmacies. We prefer specialty drugs to be filled at a CVS Specialty Pharmacy. A list of CVS Specialty Pharmacies near you can be found at www.lighthousehealthplan.com. Please call Member Services if you would like to get your specialty drugs from a different participating provider.

Behavioral Health Services

There are times when you may need to speak to a therapist or counselor, for example, if you are having any of the following feelings or problems:

- Always feeling sad
- Not wanting to do the things that you used to enjoy

- Feeling worthless
- Having trouble sleeping
- Not feeling like eating
- Alcohol or drug abuse
- Trouble in your marriage
- Parenting concerns

We cover many different types of behavioral health services that can help with issues you may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Calling 1-800-342-3222 or TTY 711
- Looking at our provider directory
- Going to our website: https://www.lighthousehealthplan.com

Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is out of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member Reward Programs

We offer programs to help keep you healthy and to help you live a healthier life (like losing weight or quitting smoking). We call these **healthy behavior programs**. You can earn rewards while participating in these programs. Our plan offers the following programs:

- Medically approved smoking cessation
- Medically directed weight loss program
- Alcohol or Substance Abuse recovery program

You may earn $25 per qualifying activity up to $50.00 a year given to you on a reloadable debit card. Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us at 1-844-243-5176 or TTY: 711.

Disease Management Programs

We have special programs available that will help you if you have one of these conditions:

- Cancer

- Diabetes
- Asthma
- High blood pressure (hypertension)
- Behavioral Health
- End of life issues including information on advance directives

Our special programs are here for you if you have a new diagnosis or need ongoing help. Our Care Team will ensure you get the right care at the right time. Our Care Team will help you understand your condition and how to best manage it. Our Care Team will also refer you to local community services based on your needs.

Care Management Programs

We have other special programs to help you take care of yourself. Some of these programs are:

- **Complex Care:** This is for people that have more than one illness like HIV, Hep C, Asthma, COPD, CHF, CAD, and Diabetes.

- **Catastrophic Care:** We will call you to talk about how you are feeling and when you need to see your doctor.

- **Transition Care:** If you have been in the hospital, we will call you to help you learn how to take care of yourself. We can teach you to watch your symptoms so you know when you may have to go back to the hospital for care.

Our special programs are here for you. We will help you get the right care at the right time. We will help you learn how to take care of yourself. We can refer you to local services if you need them. You can tell our Care Team if you do not want to join any of these programs.

Quality Enhancement Programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

- **Early Intervention Services:** If you have a child who needs special care, we are here for you. We will link you to agencies like Women, Infant and Children (WIC). We will also link you to programs like Early Steps. No matter what you need, we will work closely with you and your child's doctor. Together, we will help your child reach his or her best health.

- **Domestic Violence Screening and Support Services:** You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. We train our providers to recognize signs of violence. If you have been put in danger, we can help. We will work with local agencies to help you be safe.

- **Healthy Start Services:** We want moms and babies to be healthy. If you are pregnant or have a young child, we will work with you and your local Healthy Start. We will make sure you have access to quality care and the help you need. This includes getting:

    - Helpful information for you and your child
    - Referrals for services, like WIC
    - Support for healthy life choices, like food and smoking
    - Help with breastfeeding
    - Home visits

- **Help for Members who are Homeless:** Not having a steady home can be scary. If you need help with housing, we will link you to agencies who can help with housing, food, life skills, and resources.

- **Pregnancy Care Services:** Being pregnant can be exciting and scary. If you are pregnant, we will support you. Our support starts as soon as we know you are pregnant. We will help you through delivery and after your baby is born. If you need special services, we will link you to local community agencies who focus on moms and babies.

- **Nutrition Assessment and Counseling:** Diet and nutrition are important for health. This is especially true if you are pregnant or recently had a baby. Healthy eating is also important for kids. We know eating healthy is not always easy. We partner with providers and the community to make sure you have:

    - enough safe nutrition for infants
    - nutrition review
    - diet counseling and a nutrition care plan
    - referrals to the local WIC program

- **Pregnancy Prevention Support:** Family planning and pregnancy prevention are important for your health. This is why we offer all members pregnancy prevention activities. We work with our providers and local agencies to make sure you get age-specific screenings, education, and referrals.

- **Remote Health Monitoring:** Sometimes you need extra help to manage your health. If you have asthma or COPD, you may be eligible for our Remote Health Monitoring program. We will help you manage your asthma or COPD from your home. We will work with you and your doctor to see if this program is right for you.

You also have a right to tell us about changes you think we should make.

To get more information about our quality enhancement program or to give us your ideas, call Member Services.

Doctors, hospitals and healthcare companies are creating new technologies. This can be anything from a new test to new machines. Lighthouse Health Plan has processes to look for and test these new technologies. When we find out about new devices, we research them. We may also ask experts for their views. We match the information with known national standards. We make sure new tests or devices are safe and good for you. We base our decisions on making sure you have the right care.

Section 12: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary in order for us to pay for them[5]. Talk to your doctor. Your doctor will get the prior authorization for the care you need.

You will get care because you need it and have medical coverage. We do not reward for denials. Our doctors do not get money for denying care to you.

After we get a request for service, this is how much time it may take to get for us to review and make a decision:

- Pre-Service Review: Up to 7 calendar days for regular care
- Urgent Pre-Service Review: Up to 2 calendar days for urgent care
- Urgent Concurrent Review: Up to 2 calendar days for care you already get
- Post-Service Review: Up to 30 days for care you got but was not first approved by Lighthouse Health Plan first

There may be some services that we do not cover but might still be covered by Medicaid. To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call 1-844-243-5176 or TTY: 711 to schedule a ride.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

If you have questions about any of the covered medical services, please call Member Services.

[5] You can find the definition for Medical Necessity at http://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf

Service	Description	Coverage/Limitations	Prior Authorization
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us.	Prior authorization is required.
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots.	Prior authorization is required.
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary.	Prior authorization is required for Non- Emergent Ground Ambulance Medical Transport and all Air Medical Transport.
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	Certain outpatient surgeries require prior authorization. Call 1-844-243-5187 for more information.
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	All inpatient elective admissions require prior authorization.

Service	Description	Coverage/Limitations	Prior Authorization
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year.	No prior authorization is required.
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No prior authorization is required.
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program	We cover 365/366 days of services per year, including therapy, support services and aftercare planning.	Prior authorization is required.
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: • Cardiac testing • Cardiac surgical procedures • Cardiac devices	Certain Cardiovascular services may require prior authorization. Call 1-844-243-5187 for more information.

Service	Description	Coverage/Limitations	Prior Authorization
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services	Your child must be enrolled in the DOH Early Steps program.	No prior authorization is required.
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover: • One new patient visit • 24 established patient visits per year, per member • X-rays	No prior authorization is required.
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic		No prior authorization is required.
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor: • Hemodialysis treatments • Peritoneal dialysis treatments	No prior authorization is required.

Service	Description	Coverage/Limitations	Prior Authorization
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	Some service and age limits apply. Call 1- 844-243-5187 for more information.	Certain DME services may require prior authorization. Call 1-844-243-5187 for more information.
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover: • One initial evaluation per lifetime, completed by a team • Up to 3 screenings per year • Up to 3 follow-up evaluations per year • Up to 2 training or support sessions per week	No prior authorization is required.
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	All air ambulance services require prior authorization (emergent requests may be submitted post-service).

Service	Description	Coverage/Limitations	Prior Authorization
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: • One adult health screening (check-up) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facilities • Up to two office visits per month for adults to treat illnesses or conditions	No prior authorization is required.
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover up to 26 hours per year..	No prior authorization is required.
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	Covered as medically necessary.	Certain Gastrointestinal services may require prior authorization. Call 1-844-243-5187 for more information.

Service	Description	Coverage/Limitations	Prior Authorization
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	Covered as medically necessary..	No prior authorization is required.
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover up to 39 hours per year.	No prior authorization is required.
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor: • Cochlear implants • One new hearing aid per ear, once every 3 years • Repairs	Certain Hearing services require authorization. Call 1-844-243-5187 for more information.
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover: • Up to 4 visits per day for pregnant recipients and recipients ages 0-20 • Up to 3 visits per day for all other recipients	Prior authorization is required.

Service	Description	Coverage/Limitations	Prior Authorization
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	Covered as medically necessary.	Prior authorization is required.
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover up to 26 hours per year.	No prior authorization is required.
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation: • Up to 365/366 days for recipients ages 0-20 • Up to 45 days for all other recipients (extra days are covered for emergencies)	Inpatient admissions require prior authorization.

Service	Description	Coverage/Limitations	Prior Authorization
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	Covered as medically necessary.	Certain Integumentary services may require prior authorization. Call 1-844-243-5187 for more information.
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary.	Certain Laboratory services may require prior authorization. Call 1-844-243-5187 for more information.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families.	No prior authorization is required.
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	Covered as medically necessary	No prior authorization is required.
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary	No prior authorization is required.

Service	Description	Coverage/Limitations	Prior Authorization
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Prior authorization is required.
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary	Certain neurology services may require prior authorization. Call 1-844-243-5187 for more information.
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary	No prior authorization is required.
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	We cover 365/366 days of services in nursing facilities as medically necessary	Prior authorization is required.

Service	Description	Coverage/Limitations	Prior Authorization
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	The initial evaluation does not require prior authorization. Subsequent visits do require prior authorization.
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary	Certain Oral Surgery services may require prior authorization. Call 1-844-243-5187 for more information.
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	Certain Orthopedic services may require prior authorization. Call 1-844-243-5187 for more information.

Service	Description	Coverage/Limitations	Prior Authorization
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	• Emergency services are covered as medically necessary • Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Certain Outpatient Hospital services may require prior authorization. Call 1-844-243-5187 for more information.
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	Covered as medically necessary. Some service limits may apply	Certain pain management services require prior authorization. Call 1-844-243-5187 for more information.

Service	Description	Coverage/Limitations	Prior Authorization
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	The initial evaluation does not require prior authorization. Subsequent visits do require prior authorization.
Podiatry Services	Medical care and other treatments for the feet	We cover: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging for the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg	No prior authorization is required.
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover: • Up to a 34-day supply of drugs, per prescription • Refills, as prescribed	Certain Prescribed Drug services require prior authorization. Call 1-844-243-5187 for more information.

Service	Description	Coverage/Limitations	Prior Authorization
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover up to 24 hours per day.	Prior authorization is required.
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover 10 hours of psychological testing per year	Prior authorization is required.
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover up to 480 hours per year	Prior authorization is required.
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	Covered as medically necessary	Certain imaging services may require prior authorization. Call 1-844-243-5187 for more information.

Service	Description	Coverage/Limitations	Prior Authorization
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	Regional Perinatal Intensive Care Center Services may require prior authorization. Call 1-844-243-5187 for more information.
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No prior authorization is required.
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover: • Respiratory testing • Respiratory surgical procedures • Respiratory device management	Certain Respiratory services may require prior authorization. Call 1-844-243-5187 for more information

Service	Description	Coverage/Limitations	Prior Authorization
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover: • One initial evaluation per year • One therapy re-evaluation per 6 months • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	No prior authorization required.
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders	We cover the following: • Assessments • Foster care services • Group home services	No prior authorization is required.
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 0-20: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year We cover the following services for adults: • One communication evaluation per 5 years	The initial evaluation does not require prior authorization. Subsequent visits do require prior authorization.

Service	Description	Coverage/Limitations	Prior Authorization
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Prior authorization is required.
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover up to 9 hours per month.	Prior authorization is required.
Transplant Services	Services that include all surgery and pre- and post-surgical care	Covered as medically necessary	Prior authorization is required.
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0-20 • Contact lenses • Prosthetic eyes	No prior authorization is required.

Service	Description	Coverage/Limitations	Prior Authorization
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	Covered as medically necessary	Certain Visual Care services may require prior authorization. Call 1-844-243-5187 for more information.

Your Plan Benefits: Expanded Benefits

Expanded benefits are extra goods or services we provide to you, free of charge. For expanded benefits, please visit www.lighthousehealthplan.com

Call Member Services to ask about getting expanded benefits.

Service	Description (including limits)	Prior Authorization Required	Phone Number/ Web Site
General Expanded Benefits			
Cellular Phone Service	Get a free cell phone from Safelink/TracFone • 350 minutes for talk • 3 GB of data & unlimited texting • Free calls to the plan • Optional health text messages	No	Call SafeLink at 1-877-631-2550 www.safelink.com
CVS Discount Program	20% off approved products in select CVS stores	No	Call CVS at 1-800-746-7287 www.cvs.com/extracarehealth

Service	Description (including limits)	Prior Authorization Required	Phone Number/ Web Site
Doula Services	One visit per month during pregnancy for qualifying members age 12-19	Yes	Call Lighthouse at 1-844-824-8846
Circumcision (newborns only)	One per lifetime for infants up to 28 days old	No	Call Lighthouse Member services at 1-844-243-5176
Home Delivered Meals	Up to ten (10) meals following an enrollee's discharge from a hospital or nursing facility; benefit is limited to four hospital nursing facility admissions per year	Yes	Call Lighthouse at 1-844-824-8846
Meal Stipend (available for long distance medical appointment day- trips)	$80 per day (up to $1000 per year) for meal reimbursement for members traveling over 100 miles from home for an approved medical appointment.	Yes	Call One Call at 1-877-848-5993 www.onecallhealth.com
Over-the-Counter Benefit	$25/month to spend on an approved list of products	No	www.cvs.com/otchs/lighthouse
Swimming Lessons	Up to $100 reimbursement for swimming lessons for members age 0-18	No	Call Lighthouse Member Services at 1-844-243-5176

Service	Description (including limits)	Prior Authorization Required	Phone Number
Adult Expanded Benefits			
Chiropractic Services	4 established patient visits per year, in addition to the state benefit of 24	No prior authorization is required	
Computerized Cognitive Behavioral Therapy	Unlimited visits for health and behavior assessment and re- assessment; individual, group, and family (with or without the patient present) health and behavior intervention	No prior authorization is required	
Hearing Services	The following services are provided 1 per every 2 years: assessment for hearing aids, hearing aid fitting/checking, hearing aid monaural in ear, behind ear hearing aid, hearing aid dispensing fee, in ear binaural hearing aid, behind ear binaural hearing aid, dispensing fee, behind ear cros hearing aid, cros hearing aid dispensing fee, behind ear bicros hearing aid, dispensing fee bicros, and hearing evaluation	No prior authorization is required for hearing assessments. Hearing Aids require prior authorization	

Service	Description (including limits)	Prior Authorization Required	Phone Number
Occupational Therapy	One evaluation and one re-evaluation per year, and up to 7 therapy treatment units per week	No prior authorization is required for initial evaluation. Prior authorization is required for subsequent visits thereafter	
Physical Therapy	One evaluation and one re-evaluation per year, and up to 7 therapy treatment units per week	No prior authorization is required for initial evaluation. Prior authorization is required for subsequent visits thereafter	
Prenatal Services	• One breast pump rental per year with prior authorization • 14 prenatal visits for low-risk pregnancies; 18 prenatal visits for high-risk pregnancies • 3 postpartum visits within 90 days following delivery	Breast pump rental: Yes Prenatal & postpartum visits: No	Breast pump: Call Coastal Care at 1-855-481-0505 Prenatal & postpartum visits: Call Lighthouse Member Services at 1-844-243-5176

Service	Description (including limits)	Prior Authorization Required	Phone Number
Primary Care Services	Unlimited outpatient visits	No	Call Lighthouse Member Services at 1-844-243-5176
Psychosocial Rehabilitation	Unlimited	No	Call Access Behavioral Health at 1-800-342-3222
Psychotherapy (individual / family)	Available subject to medical necessity requirements	Yes	Call Access Behavioral Health at 1-800-342-3222
Respiratory Therapy	One initial evaluation and one re-evaluation per year; one respiratory therapy visit per day	No	Call Lighthouse Member Services at 1-844-243-5176
Speech Therapy	One initial evaluation / re-evaluation per year; one evaluation of oral an pharyngeal swallowing function per year; up to 7 therapy treatment units per week One AAC initial evaluation / re-evaluation per year; up to four 30-minute AAC fitting, adjustment, and training sessions per year	No	Call Lighthouse Member Services at 1-844-243-5176
Targeted Case Management	Unlimited	No	Call Access Behavioral Health at 1-800-342-3222
Therapeutic Behavioral On-Site Services	Available subject to medical necessity requirements	Yes	Call Access Behavioral Health at 1-800-342-3222

Service	Description (including limits)	Prior Authorization Required	Phone Number
Treatment Plan Development & Review	Unlimited	No	Call Access Behavioral Health at 1-800-342-3222
Vaccine – Influenza	One vaccination per enrollee age 21+ per year per CDC ACIP guidelines	No	Call Lighthouse Member Services at 1-844-243-5176
Vaccine – Pneumonia	As recommended by physician based on CDC ACIP guidelines for age 21+	No	Call Lighthouse Member Services at 1-844-243-5176
Vaccine - TDaP	Tetanus diphtheria toxoids acellular pertussis vaccine (TDaP) intramuscular. Once per pregnancy including all Florida Medicaid eligible household members over 21.	No	Call Lighthouse Member Services at 1-844-243-5176
Vaccine – Shingles	Maximum lifetime benefit of one series of 2 injections for qualifying members	Yes	Call Lighthouse at 1-844-824-8846
Vision Services	Limited to one eye exam and one pair of frames per year One six-month supply of contact lenses with prescription	No	Call iCare at 855-373-7627 www.myicarehealth.com

Service	Description (including limits)	Prior Authorization Required	Phone Number
Waived Copayments	No copays for: • Allergy Services • Behavioral Health Assessment Services • Cardiovascular Services • Chiropractic Services • Clinic Services • Evaluation and Management Services • Family Therapy Services • Gastrointestinal Services • Genitourinary Services • Group Therapy Services • Home Health Services • Hospice Services • Individual Therapy Services • Integumentary Services • Laboratory Services • Medication Assisted Treatment Services • Medication Management Services • Neurology Services • Non-Emergency Transportation Services • Nursing Facility Services • Oral Surgery Services • Orthopedic Services • Outpatient Hospital Services • Pain Management Services • Podiatry Services • Psychological Testing Services • Radiology and Nuclear Medicine Services • Respiratory Services • Therapeutic Behavioral On-Site Services • Visual Care Services No Prior Authorization Required		Call Lighthouse Member Services at 1-844-243-5176

Section 13: Member Satisfaction

Complaints, Grievances, and Plan Appeals

We want you to be happy with us and the care you receive from our providers. Let us know right away if at any time you are not happy with anything about us or our providers. This includes if you do not agree with a decision we have made.

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. 1-844-243-5176	We will: • Try to solve your issue within 1 business day.
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Write us or call us at any time. • Call us to ask for more time to solve your grievance if you think more time will help. Lighthouse Health Plan 700 E. Gregory Street Suite 150 Pensacola, FL 32502 1-844-243-5176	We will: • Review your grievance and send you a letter with our decision within 90 days. If we need more time to solve your grievance, we will: • Call you on the same day that we decide to extend the time; and • Send you a letter with our reason and tell you about your rights if you disagree.

	What You Can Do:	What We Will Do:
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Lighthouse Health Plan 700 E. Gregory Street Suite 150 Pensacola, FL 32502 1-844-243-5176	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. Lighthouse Health Plan 700 E. Gregory Street Suite 150 Pensacola, FL 32502 1-844-243-5176	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.

	What You Can Do:	What We Will Do:
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing**	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ***You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. Lighthouse Health Plan 700 E. Gregory Street Suite 150 Pensacola, FL 32502 1-844-243-5176	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.

	What You Can Do:	What We Will Do:
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing**	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ***You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal

If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid Members)

You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:
Agency for Health Care Administration Medicaid Fair Hearing Unit
P.O. Box 60127
Ft. Meyers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:
- Your name
- Your member number
- Your Medicaid ID number
- A phone number where you or your representative can be reached

You may also include the following information, if you have it:

- Why you think the decision should be changed
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request. A hearing officer who works for the State will review the decision we made.

If you are a Title XXI MediKids member, you are not allowed to have a Medicaid Fair Hearing.

Review by the State (for MediKids Members)

When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 30 days after you get the notice. **You must finish your appeal process first.**

You may ask for a review by the State by calling or writing to: Agency for Health Care Administration:

P.O. Box 60127
Ft. Myers, FL 33906
1-877 254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

After getting your request, the Agency will tell you in writing that they got your request.
Continuation of Benefits for Medicaid Members

If you are now getting a service that is going to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal or Medicaid fair hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued and our decision is not in your favor, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

- 10 days after you receive a Notice of Adverse Benefits Determination (NABD), or
- On or before the first day that your services will be reduced, suspended or terminated

Section 14: Your Member Rights

As a recipient of Medicaid and a member in a Plan, you also have certain rights. You have the right to:

- Be treated with courtesy and respect
- Have your dignity and privacy respected at all times
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services, who is responsible for your care and participate in making decisions about your health care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given easy to follow information about your diagnosis, the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you, regardless of cost or benefit coverage
- Make choices about your health care and say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can’t make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan’s decision about your services.
- To appeal a Plan’s decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- To receive information about your rights and responsibilities

- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly
- To recommend changes to the rights and responsibilities policy
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy of your medical records and ask that they be amended or corrected

Section 15: Your Member Responsibilities

As a recipient of Medicaid and a member in a Plan, you also have certain responsibilities. You have the responsibility to:

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions and plan you and your provider have agreed to, and ask questions
- Keep your appointments or notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary, for your safety
- Report fraud, abuse and overpayment

Section 16: Other Important Information

Indian Health Care Provider (IHCP) Protection

Indians are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services.

Emergency Disaster Plan

Disasters can happen at any time. To protect yourself and your family, it is important to be prepared. There are three steps to preparing for a disaster: 1) Be informed; 2) Make a Plan; and 3) Get a Kit. For help with your emergency disaster plan, call Member Services or your case manager. The Florida Division of Emergency Management can also help you with your plan. You can call them at 1-850-413-9969 or visit their website at www.floridadisaster.org.

Tips on How to Prevent Medicaid Fraud and Abuse:

- DO NOT share personal information, including your Medicaid number, with anyone other than your trusted providers.
- Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information.
- Be careful with door-to-door visits or calls you did not ask for.
- Be careful with links included in texts or emails you did not ask for, or on social media platforms.

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/mpi-complaintform/

You can also report fraud and abuse to us directly by contacting Alicia Skolrood, Lighthouse Health Plan's Compliance Officer.

ASkolrood@LighthouseHealthPlan.com
700 E. Gregory Street
Suite 150
Pensacola, FL 32502
1-850-505-4266 office

You can leave a message without leaving your name. If you do leave your number, we will call you back. We will call to make sure the information we have is complete and accurate. You can also report suspected fraud, waste and abuse on our website at 1-850-434-4841 fax.

Abuse/Neglect/Exploitation of People

You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.
If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873) or for TTY/TDD at 1- 800-955-8771.

You can also call the hotline if you know of someone else that is being mistreated.
Domestic Violence is also abuse. Here are some safety tips:

- If you are hurt, call your PCP
- If you need emergency care, call 911 or go to the nearest hospital. For more information, see the section called EMERGENCY CARE
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

If you have questions or need help, please call the National Domestic Violence Hotline toll free at 1-800-799-7233 (TTY 1-800-787-3224).

Advance Directives

An **advance directive** is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

1. A Living Will
2. Health Care Surrogate Designation
3. An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website:
http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx

Make sure that someone, like your PCP, lawyer, family member, or case manager knows that you have an advance directive and where it is located.

If there are any changes in the law about advance directives, we will let you know within 90 days. You don't have to have an advance directive if you do not want one.

If your provider is not following your advance directive, you can file complaint with Member Services at 1-844-243- 5187 or the Agency by calling 1-888-419-3456.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member records
- A description of how we operate
- Our Quality Improvement Program with goals and performance targets set up to make sure you get safe quality health care
- Clinical Practice Guidelines used by our doctors and nurses to help keep you healthy
- To see if you can join our special programs like Population Health or Case Management
- How to get community resources if you need help with getting a place to live, food or clothing
- Programs and services to help you get healthy and stay healthy. These programs can help you get vaccinations, cancer screenings, how to quit smoking or lose weight that help you get healthy and stay healthy
- Staff to help you take care of yourself when you have a chronic condition like asthma, depression, diabetes or cancer
- Our HEDIS and CAHPS results at https://lighthousehealthplan.com/en/about-us/
- For more information call Member Services or go to our website at www.lighthousehealthplan.com

Section 17: Additional Resources

Floridahealthfinder.gov

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website www.FloridaHealthFinder.gov where you can view information about Florida home health agencies, nursing facilities, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures
- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit http://www.floridahealthfinder.gov/HealthPlans/search.aspx. You may choose to view the information by each Plan or all Plans at once.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing facilities at http://elderaffairs.state.fl.us/doea/housing.php as well as links to additional Federal and State resources.

MediKids Information

For information on MediKids coverage please visit: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ISCP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit http://elderaffairs.state.fl.us/doea/smmcltc.php.

Section 18: Forms

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. For questions about advanced directive please visit http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx.

To download the individual forms, go to the following links:

- Living Will
  https://fhfstore.blob.core.windows.net/documents/reports-guides/documents/LivingWill.pdf
- Designation of Health Care Surrogate
  https://fhfstore.blob.core.windows.net/documents/reports-guides/documents/DesignationofHealthCareSurrogate.pdf
- Designation of Health Care Surrogate for a Minor
  https://fhfstore.blob.core.windows.net/documents/reports-guides/documents/DesignationofHealthCareSurrogateForMinor.pdf
- Donor Form
  https://fhfstore.blob.core.windows.net/documents/reports-guides/documents/UniformDonorForm.pdf
- Wallet Card about your Advance Directive
  https://fhfstore.blob.core.windows.net/documents/reports-guides/documents/WalletCard.pdf

Section 19: Interpretation Services

This information is available for free in other languages. If you need auxiliary aids and services, including the provision of the materials in alternative formats, including large print, please call us at 1-844-243-5176 or 711.

English	*This information is available for free in other languages. Please contact our customer service number at 1-844-243-5176 or TTY Number 711 during 8:00am to 8:00pm Eastern Time Monday through Friday.* *If you do not speak English, call us at 1-855-854-8691, Pin L221. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.*
Spanish	*Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con nuestro servicio al cliente a través del 1-844-243-5176 o por TTY NUMBER 711 durante el 8:00am to 8:00pm Eastern Time Monday through Friday.* *Si no habla inglés, llámenos al 1-855-854-8691, Pin L221. Contamos con servicios de intérpretes y podemos ayudar a responder sus preguntas en su idioma. También podemos ayudarlo a encontrar un proveedor de atención médica que pueda comunicarse con usted en su idioma.*
French	*Ces informations sont disponibles gratuitement dans d'autres langues. Veuillez contacter notre assistance à la clientèle au 1-844-243-5176 ou au TTY NUMBER 711 aux heures suivantes: 8:00am to 8:00pm Eastern Time Monday through Friday.* *Si vous ne parlez pas anglais, contactez-nous au 1-855-854-8691, Pin L221. Nous avons accès à des services d'interprétariat et pouvons répondre à vos questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé capable de communiquer avec vous dans votre langue.*
Haitian Creole	*Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri kontakte sèvis kliyantèl nou nan nimewo 1-844-243-5176 oswa TTY NUMBER 711 pandan 8:00am to 8:00pm Eastern Time Monday through Friday.* *Si ou pa pale anglè, rele nou nan 1-855-854-8691, Pin L221. Nou gen aksè ak sèvis entèprèt e nou ka ede reponn kesyon ou yo nan lang pa w. Nou ka ede w tou jwenn pwofesyonèl lasante ki kapab kominike avèk ou nan lang pa w.*

Italian	*Queste informazioni sono disponibili gratuitamente in altre lingue. Contattare il nostro servizio clienti al numero 1-844-243-5176 o TTY NUMBER 711 durante 8:00am to 8:00pm Eastern Time Monday through Friday.* *Se non parla inglese, si rivolga al numero 1-855-854-8691, Pin L221. Abbiamo a disposizione servizi di interpretariato; pertanto, se ha domande, possiamo fornirle risposte nella sua lingua. Possiamo inoltre aiutarla a trovare un assistente sanitario in grado di comunicare con lei nella sua lingua.*
Russian	*Эта информация доступна бесплатно на других языках. Пожалуйста, свяжитесь с нами по номеру обслуживания клиентов 1-844-243-5176 или TTY NUMBER 711 в течение 8:00am to 8:00pm Eastern Time Monday through Friday.* *Если вы не говариваете по-английски, позвоните нам по номеру 1-855-854-8691, Pin L221. Мы имеем доступ к услугам переводчика и можем ответить на ваши вопросы на вашем языке. Мы также можем помочь вам найти поставщика медицинских услуг, который сможет общаться с вами на вашем языке.*

Section 20: Non-Discrimination Notice

Lighthouse Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Lighthouse Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Lighthouse Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please contact our Yemisi Oloruntola-Coates at 1-239-424-3806.

If you believe that Lighthouse Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Alicia Skolrood, Lighthouse Health Plan Compliance Officer:

ASkolrood@LighthouseHealthPlan.com
700 E. Gregory Street, Suite 150
Pensacola, FL 32502
1-850-505-4266 office
1-850-434-4841 fax

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Lighthouse Health Plan Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Section 21: Translation Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-854-8691 Pin L323 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-854-8691 Pin L323 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-854-8691 Pin L323 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-854-8691 Pin L323 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-854-8691 Pin L323 (TTY: 711) 。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-854-8691 Pin L323 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-854-8691 Pin L323 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-854-8691 Pin L323 (телетайп:711).

- ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1 - 855 - 854 8691)711: رقم هاتف الصم والبكم .)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-854-8691 Pin L323 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-854-8691 Pin L323 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-855-854-8691 Pin L323 (TTY: 711).번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-854-8691 Pin L323 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-854-8691 (TTY: 711).