



Ambetter

from Sunshine Health

ambetter.

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YOUR HEALTH. OUR PRIORITY.

*With quality healthcare solutions, Sunshine Health helps residents of Florida live better. And now, it's easier to stay covered with our new Health Insurance Marketplace insurance plan: **Ambetter.***

At Sunshine Health, we believe that nothing is more important than your health. We also believe that you deserve to get the most out of your Marketplace health insurance plan.

That's why we make sure our Ambetter plans fit your health needs and your budget. But our focus doesn't stop there. In fact, our commitment to your well-being extends far

beyond the doctor's office and into your everyday life. Sunshine Health is active in your local community—and we're dedicated to helping you live well.

Our Ambetter plans also offer a wide variety of valuable programs, educational tools and support. With Ambetter from Sunshine Health it's easy to stay in charge of your health. And to lead a healthy, fulfilling life.



Comprehensive Medical Care

Complete medical care that covers all of your Essential Health Benefits.



My Health Pays Program

Earn reward dollars just by staying proactive about your health.



Integrated Care Management

Get well and stay well with preventive care and whole health services.



Extensive Prescription Coverage

Get coverage for your medical prescriptions.



24/7 Nurse Line

Call and talk to a registered nurse 24 hours a day, 7 days a week to ask questions or get advice.



Optional Adult Dental Coverage

Coverage for services such as teeth cleanings, screenings and exams.



Vision Coverage

Pediatric coverage for services such as eye exams and prescription eyewear. Optional adult vision coverage also available.

FROM



To learn more, visit sunshinehealth.com.

Silver Plan 2 Benefits + Vision & Adult Dental

| | |
|-------------------------------------|--|
| Medical Annual Deductible | Individual: \$250; Family: \$500 |
| Medical Coinsurance | 75/25% after annual deductible |
| Prescription Drug Annual Deductible | Individual: \$250; Family: \$500 |
| Prescription Drug Coinsurance | 70/30% after annual deductible |
| Maximum Annual Out-of-pocket | Individual: \$2,250; Family: \$4,500 |

| Emergency Services | You Pay | Subject to Deductible |
|--|---|-----------------------|
| Emergency Room Services | \$150 copay after annual deductible | X |
| Emergency Transportation/Ambulance (Air or Ground) | 25% coinsurance after annual deductible | X |
| Urgent Care | 25% coinsurance after annual deductible | |

Provider Services

| | | |
|---|---|---|
| Annual Well Visit/Screening/Immunization/Well Baby | \$0 | |
| Primary Care Visit to treat an injury or illness and Maternity | \$5 copay | |
| Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care) | \$10 copay | |
| Imaging (CT/PET Scans, MRIs) | 25% coinsurance after annual deductible | X |
| X-rays & Diagnostic Imaging | 25% coinsurance after annual deductible | X |

Inpatient & Outpatient Services

| | | |
|--|---|---|
| All Inpatient Hospital Services (Includes Mental Health & Substance Abuse and Maternity) | 25% coinsurance after annual deductible | X |
| Outpatient Facility Fee (e.g. Ambulatory Surgery Center) | 25% coinsurance after annual deductible | X |
| Outpatient Surgery Physician/Surgical Services | 25% coinsurance after annual deductible | X |
| Laboratory Outpatient & Professional Services | 25% coinsurance after annual deductible | X |

Other Medical Services

| | | |
|---|--|----|
| Mental/Behavioral Health & Substance Abuse Disorder Outpatient Services | 25% coinsurance after annual deductible | X |
| Rehabilitative Speech Therapy/Rehabilitative Occupational & Rehabilitative Physical Therapy | 25% coinsurance after annual deductible | X |
| Skilled Nursing Facility | 25% coinsurance after annual deductible | X |
| Out-of-network Benefits | Not covered except for out-of-area emergencies | NC |

Prescription Drugs (Prescription Drugs available by mail order with a 90 day supply.)

| | | |
|---------------------------|---|---|
| Generics | \$5 copay* | |
| Preferred Brand Drugs | \$30 copay after annual deductible | X |
| Non-preferred Brand Drugs | \$75 copay after annual deductible | X |
| Specialty Drugs | 30% coinsurance after annual deductible, \$350 maximum per prescription | X |

*If the cost of the generic drug is less than the copay, you pay the lesser amount.

Information shown represents a 87% Actuarial Value. This is only a summary of the major benefits provided by our plans.

This is not a contract. Benefits may vary by state. You must meet certain eligibility requirements to purchase this plan.

For help understanding the terms used above, see the *Words to Know* page on AmbetterHealth.com.



ADDITIONAL SERVICES

My Health Pays Program:

Ambetter offers a unique rewards program for our members when they receive annual preventive services. Members can earn reward dollars for these types of services:

- Getting your Annual Wellness Exam.
- Completing your Health Risk Screening.
- Getting an Annual Flu Shot.

Rewards are automatically put onto your Incentive card, so there's nothing extra to do! Then, you can use the reward dollars to help pay for your copays, deductibles and premiums.

Gym Reimbursement Program:

Ambetter promotes healthy lifestyle choices with our members. For those members who want to stay active and use their local health club or gym regularly, Ambetter will reimburse a portion of your monthly dues onto your Member Incentive card. This helps make staying healthy and active more affordable.

24/7 Nurse Line:

Call and talk to a registered nurse 24 hours a day, 7 days a week to ask questions or get advice.



Silver Plan 2 Benefits + Vision & Adult Dental

| Pediatric Vision (Up to 19 years of age) | In-network | Out-of-Network |
|--|-------------------------------|-----------------------|
| Exams and Eyewear: | | |
| Routine Eye Exam (1 visit per year) | 100% covered after \$20 copay | Not covered |
| Eyeglasses (frames) and contacts (1 item per year) | 100% covered after \$20 copay | Not covered |
| Lenses (per pair): | | |
| Single | 100% covered after \$20 copay | Not covered |
| Bifocal | 100% covered after \$20 copay | Not covered |
| Trifocal | 100% covered after \$20 copay | Not covered |
| Lenticular | 100% covered after \$20 copay | Not covered |
| Contact Lenses: | | |
| Contact lenses (in lieu of glasses) | 100% covered after \$20 copay | Not covered |
| Contact lens fitting | 100% covered after \$20 copay | Not covered |
| Specialty lens fitting | 100% covered after \$20 copay | Not covered |

| Adult Vision (Ages 19 years of age and older) | In-network | Out-of-Network |
|--|--------------------------------------|-----------------------|
| Exams and Eyewear: | | |
| Routine Eye Exam (1 visit per year) | 100% covered after \$20 copay | Not covered |
| Eyeglasses (frames) and contacts (1 item per year) | Covered up to \$130 after \$20 copay | Not covered |
| Lenses (per pair): | | |
| Single | 100% covered after \$20 copay | Not covered |
| Bifocal | 100% covered after \$20 copay | Not covered |
| Trifocal | 100% covered after \$20 copay | Not covered |
| Lenticular | 100% covered after \$20 copay | Not covered |
| Contact Lenses: | | |
| Contact lenses (in lieu of glasses) | Covered up to \$130 after \$20 copay | Not covered |
| Contact lens fitting | 100% covered after \$20 copay | Not covered |
| Specialty lens fitting | Covered up to \$50 after \$20 copay | Not covered |



Silver Plan 2 Benefits + Vision & Adult Dental

Adult Dental* (Ages 19 years of age and older, does not include Pediatric Dental Coverage)

Annual Maximum Dental Benefit** \$1,000 per covered person per calendar year

| Basic Dental (Class 1) | In-network | Out-of-Network |
|--|--------------------------------------|----------------|
| Routine Oral Exam (1 per 6 months) | No charge, subject to Annual Maximum | Not covered |
| Routine Cleaning (1 per 6 months) | No charge, subject to Annual Maximum | Not covered |
| Bite-wing X-ray (1 per 12 months) | No charge, subject to Annual Maximum | Not covered |
| Full Mouth X-ray (1 per 60 months) | No charge, subject to Annual Maximum | Not covered |
| Panoramic Film (1 per 60 months) | No charge, subject to Annual Maximum | Not covered |
| Topical Fluoride Application (2 per 12 months) | No charge, subject to Annual Maximum | Not covered |
| Palliative Treatment for relief of pain (minor procedures) | No charge, subject to Annual Maximum | Not covered |

| Comprehensive Dental (Class 2) | In-network | Out-of-Network |
|---|--|----------------|
| Basic Services: | | |
| Silver Fillings (1 per 2 years) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Tooth Colored Fillings (1 per 2 years, front teeth only) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Endodontics: | | |
| Therapeutic Pulpotomy on permanent teeth (1 per lifetime per tooth) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Periodontics: | | |
| Scaling & Root Planning (1 per 24 months) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Periodontal Maintenance (4 in 12 months) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Oral Surgery: | | |
| Simple Extractions | 50% coinsurance, subject to Annual Maximum | Not covered |
| Surgical Extractions | 50% coinsurance, subject to Annual Maximum | Not covered |
| Removal of Impacted Teeth | 50% coinsurance, subject to Annual Maximum | Not covered |
| Alveoloplasty | 50% coinsurance, subject to Annual Maximum | Not covered |
| Prosthodontics: | | |
| Relines (1 per 36 months) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Rebase (1 per 36 months) | 50% coinsurance, subject to Annual Maximum | Not covered |
| Adjustments | 50% coinsurance, subject to Annual Maximum | Not covered |
| Repairs | 50% coinsurance, subject to Annual Maximum | Not covered |

*If you require coverage for Pediatric Dental please shop on the Health Insurance Marketplace for a stand alone dental plan.

**Dental Annual Maximum Benefit does not apply toward any other maximums.