Is there an overall annual limit on what the No covered services, such as office visits. plan pays? Yes. See http://ambetter. sunshinehealth.com/findadoc Does this plan use a

No, you don't need a referral to

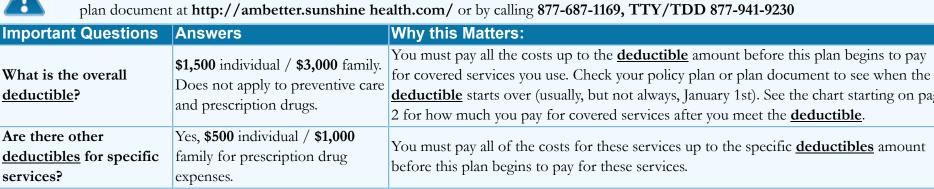
see a specialist.

Yes

\$5,200 individual/**\$10,400** family.

No, for out-of-network providers. care expenses.

Premiums, balance-billed charges, What is not included in and out-of-network services this Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. the out-of-pocket limit? plan doesn't cover. The chart starting on page 2 describes any limits on what the plan will pay for specific If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, network of providers? or call **1-877-687-1169** for a list of or participating for **providers** in their **network**. See the chart starting on page 2 for how participating providers. this plan pays different kinds of **providers**.



deductible starts over (usually, but not always, January 1st). See the chart starting on page deductible? 2 for how much you pay for covered services after you meet the **deductible**. Are there other You must pay all of the costs for these services up to the specific deductibles amount deductibles for specific services? The out-of-pocket limit is the most you could pay during a coverage period (usually one Yes, for in-network providers Is there an out-of-

Important Questions

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

from Sunshine Health Ambetter Silver 1 + Vision

Coverage Period:

year) for your share of the cost of covered services. This limit helps you plan for health

You can see the **specialist** you choose without permission from this plan.

plan document for additional information about excluded services.

Some of the services this plan doesn't cover are listed on page 6. See your policy or

Coverage for: Individual/Family | Plan Type:HMO



pocket-limit on my

Do I need a referral to

Are there services this

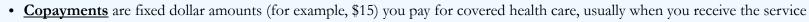
plan doesn't cover?

see a specialist?

expenses?

ambetter."

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In- network Provider	Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	\$20 Copay/visit	Not covered	None
If you visit a health	Specialist visit	\$50 Copay/visit	Not covered	None
care <u>provider's</u> office	Other practitioner office visit	\$20 Copay/visit	Not covered	None
or clinic	Preventive care/screening/immunization	No charge	Not covered	Preventive colonoscopy (age 50+) 1 every 10 years. High risk colonoscopy 1 every 2 years.
If you have a test	Diagnostic test (x-ray, blood work)	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
If you have a test	Imaging (CT/PET scans, MRIs)	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.

Questions: Call 877-687-1169, TTY/TDD 877-941-9230 or visit us at http://ambetter.sunshine health.com/. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 877-687-1169, TTY/TDD 877-941-9230 to request a copy. 86382FL0020005-04

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Common Medical Event	Services You May Need		Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
	Generic drugs	Retail: \$20 Copay/30 day supply. Mail Order: \$60 Copay/90 day supply	Not covered	None
If you need drugs to treat your illness or condition	Preferred brand drugs	Retail: \$50 Copay after deductible/30 day supply. Mail Order: \$150 Copay after deductible/90 day supply	Not covered	
More information about <u>prescription</u> <u>drug coverage</u> is available at http:// ambetter.sunshine health.com/.	Non-preferred brand drugs	Retail: \$75 Copay after deductible/30 day supply. Mail Order: \$225 Copay after deductible/90 day supply	Not covered	\$500 individual / \$1,000 family Rx deductible for preferred brand drugs, non-preferred brand drugs and specialty drugs
	Specialty drugs	Retail: 30% Coinsurance after deductible/30 day supply. Mail Order: 30% Coinsurance after deductible/90 day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
	Physician/surgeon fees	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Common Medical Event	Services You May Need		Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$150 Copay after deductible /visit	\$150 Copay after deductible /visit	None
	Emergency medical transportation	25% Coinsurance after deductible	25% Coinsurance after deductible	None
	Urgent care	\$75 Copay/visit	Not covered	None
If you have a hospital	Facility fee (e.g., hospital room)	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
stay	Physician/surgeon fee	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
	Mental/Behavioral health outpatient services	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
health, or substance abuse needs	Substance use disorder outpatient services	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
	Substance use disorder inpatient services	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
If you are pregnant	Prenatal and postnatal care	\$20 Copay/visit	Not covered	None
	Delivery and all inpatient services	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period:

Coverage for: Individual/Family | Plan Type:HMO

Common Medical Event	Services You May Need		Your Cost If You Use an Out-of- network Provider	Limitations & Exceptions
	Home health care	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied. 20 Visit(s) per Year
	Rehabilitation services	25% Coinsurance after deductible	Not covered	Prior approval required after limits have been met. 35 Visit(s) per Year
If you need help recovering or have other special health needs	Habilitation services	25% Coinsurance after deductible	Not covered	Prior approval required after limits have been met. Your benefits/ services may be denied.
	Skilled nursing care	25% Coinsurance after deductible	Not covered	60 Days per Year
	Durable medical equipment	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
	Hospice service	25% Coinsurance after deductible	Not covered	Prior approval required. Your benefits/services may be denied.
TC 1'11 1	Eye exam	\$20 Copay/visit	Not covered	1 Visit(s) per Year
If your child needs dental or eye care	Glasses	\$20 Copay/pair	Not covered	1 Item(s) per Year
dental of cyc care	Dental check-up	Not covered	Not covered	None

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Excluded Services & Other Covered Services

Services Your Plan Does Not Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)					
Acupuncture	Bariatric surgery	Cosmetic surgery			
• Dental care (Adult)	• Dental care (child)	Hearing aids			
• Infertility treatment	• Long-term care	Private-duty nursing			
Weight loss programs					
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)					
Chiropractic care	Non-emergency care when travel	• Routine eye care (Adult)			

Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

• You commit fraud

• Routine foot care

- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-687-1169, TTY/TDD 877-941-9230. You may also contact your state insurance department at 200 East Gaines Street, Tallahassee, FL 32399 (850) 413-3140.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 200 East Gaines Street, Tallahassee, FL 32399 (850) 413-3140.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy <u>does</u> <u>provide</u> minimum essential coverage.

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the U.S.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-687-1169, TTY/TDD 877-941-9230

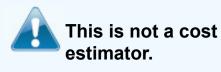
- To see examples of how this plan might cover costs for a sample medical situation, see the next page. -

Coverage Examples

Coverage Period: Coverage for: Individual/Family | Plan Type:HMO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,580
- Patient pays \$2,960

Sample care costs:

Upprited abarross (mother)	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
TT 1 1	¢40
Vaccines, other preventive	\$4 0
Vaccines, other preventive Total	\$40 \$7,540
· •	
Total	
Total Patient pays:	\$7,540
Total Patient pays: Deductibles	\$7,540 \$1,520
Total Patient pays: Deductibles Copays	\$7,540 \$1,520 \$20

Managing type 2 diabetes (routine maintenance of a

well-controlled condition)

Amount owed to providers: \$5,400

- **Plan pays** \$2,400
- Patient pays \$3,000

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$900
Laboratory tests	\$500
Vaccines, other preventive	\$40
Total	\$5,400

Patient pays:

Deductibles	\$2,000
Copays	\$770
Coinsurance	\$150
Limits or exclusions	\$80
Total	\$3,000

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Examples helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in outof-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.