



# 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](https://www.sunshinehealth.com).

# Gold Plan 3 Benefits + Vision & Adult Dental

Medical Annual Deductible	<b>Individual:</b> \$0; <b>Family:</b> \$0
Medical Coinsurance	0% after annual deductible
Prescription Drug Annual Deductible	<b>Individual:</b> \$0; <b>Family:</b> \$0
Prescription Drug Coinsurance	0% after annual deductible
Maximum Annual Out-of-pocket	<b>Individual:</b> \$0; <b>Family:</b> \$0

Emergency Services	You Pay	Subject to Deductible
Emergency Room Services	\$0 copay	
Emergency Transportation/Ambulance (Air or Ground)	0% coinsurance	
Urgent Care	0% coinsurance	

Provider Services	You Pay	Subject to Deductible
Annual Well Visit/Screening/Immunization/Well Baby	\$0	
Primary Care Visit to treat an injury or illness and Maternity	\$0 copay	
Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care)	\$0 copay	
Imaging (CT/PET Scans, MRIs)	0% coinsurance	
X-rays & Diagnostic Imaging	0% coinsurance	

Inpatient & Outpatient Services	You Pay	Subject to Deductible
All Inpatient Hospital Services (Includes Mental Health & Substance Abuse and Maternity)	0% coinsurance	
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	0% coinsurance	
Outpatient Surgery Physician/Surgical Services	0% coinsurance	
Laboratory Outpatient & Professional Services	0% coinsurance	

Other Medical Services	You Pay	Subject to Deductible
Mental/Behavioral Health & Substance Abuse Disorder Outpatient Services	0% coinsurance	
Rehabilitative Speech Therapy/Rehabilitative Occupational & Rehabilitative Physical Therapy	0% coinsurance	
Skilled Nursing Facility	0% coinsurance	
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.)

Prescription Drugs	You Pay	Subject to Deductible
Generics	\$0 copay	
Preferred Brand Drugs	\$0 copay	
Non-preferred Brand Drugs	\$0 copay	
Specialty Drugs	0% coinsurance	

Information shown represents a Zero Cost Sharing Plan. 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.



# Gold Plan 3 Benefits + Vision & Adult Dental

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

<b>Adult Vision</b> (Ages 19 years of age and older)	<b>In-network</b>	<b>Out-of-Network</b>
<b>Exams and Eyewear:</b>		
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
<b>Lenses (per pair):</b>		
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
<b>Contact Lenses:</b>		
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



# Gold Plan 3 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
<b>Basic Services:</b>		
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
<b>Endodontics:</b>		
Therapeutic Pulpotomy on permanent teeth (1 per lifetime per tooth)	50% coinsurance, subject to Annual Maximum	Not covered
<b>Periodontics:</b>		
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
<b>Oral Surgery:</b>		
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
<b>Prostodontics:</b>		
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.