ambetter.™

Essential Care Standard Plans

FROM sunshine health

YOUR HEALTH. OUR PRIORITY.

Sunshine Health delivers quality healthcare solutions that help Florida residents live better. And with Ambetter, our Health Insurance Marketplace insurance plan, we offer a variety of affordable options that make it easier to stay healthy—and to stay covered.

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.

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.

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

Integrated Care Management
Get well and stay well with preventive care and whole health services.

Gym Reimbursement Program
Ambetter's gym membership benefits program makes it easier to stay in shape and stay healthy.

Prescription Coverage
Get coverage for your medical prescriptions.

Health Insurance Marketplace

Ambetter from Sunshine Health is a Qualified Health Plan issuer in the Florida Health Insurance Marketplace and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Enroll TODAY!

Call us today at 1-877-687-1169 (Relay FL: 1-800-955-8770) or visit us at Ambetter.SunshineHealth.com.

Essential Care Standard Plans (bronze level)

	Essential Care 1	Essential Care 2	Essential Care 3 with 3 Free PCP Visits	Essential Care 4 with 3 Free PCP Visits
Medical & Prescription Drug Annual Deductible	**Individual:** $6,500; **Family:** $13,000	**Individual:** $5,000; **Family:** $10,000	**Individual:** $6,000; **Family:** $12,000	**Individual:** $4,000; **Family:** $8,000
Medical Coinsurance	100/0% coinsurance after annual deductible	60/40% coinsurance after annual deductible	60/40% coinsurance after annual deductible	60/40% coinsurance after annual deductible
Prescription Drug Coinsurance	100/0% coinsurance after annual deductible	60/40% coinsurance after annual deductible	70/30% coinsurance after annual deductible	70/30% coinsurance after annual deductible
Maximum Annual Out-of-Pocket	**Individual:** $6,500; **Family:** $13,000	**Individual:** $6,500; **Family:** $13,000	**Individual:** $6,350; **Family:** $12,700	**Individual:** $6,350; **Family:** $12,700
Emergency Services	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**	**Your Cost (In-Network Providers only)**
Emergency Room Services	0% coinsurance after annual deductible*	40% coinsurance after annual deductible*	40% coinsurance after annual deductible*	40% coinsurance after annual deductible*
Emergency Transportation/Ambulance (Air or Ground)	0% coinsurance after annual deductible*	40% coinsurance after annual deductible*	40% coinsurance after annual deductible*	40% coinsurance after annual deductible*
Urgent Care	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Provider Services				
Annual Well Visit/Screening/Immunization/Well Baby	No Charge	No Charge	No Charge	No Charge
Primary Care Visit to treat an injury or illness and Maternity	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible (3 free visits per person, 4th visit and after are subject to annual deductible and coinsurance)	40% coinsurance after annual deductible (3 free visits per person, 4th visit and after are subject to annual deductible and coinsurance)
Specialist Visit (e.g. Cardiology, Podiatry, Chiropractic Care)	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Imaging (CT/PET Scans, MRIs)	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
X-rays & Diagnostic Imaging	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Inpatient & Outpatient Services				
All Inpatient Hospital Services (Includes Mental Health & Substance Abuse and Maternity)	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Outpatient Surgery Physician/Surgical Services	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Laboratory Outpatient & Professional Services	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Other Medical Services				
Mental/Behavioral Health & Substance Abuse Disorder Outpatient Services	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Rehabilitative Speech Therapy/Rehabilitative Occupational & Rehabilitative Physical Therapy	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Skilled Nursing Facility	0% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible	40% coinsurance after annual deductible
Pediatric Vision				
Routine Eye Exam (1 visit per year)	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay
Eyeglasses (frames, 1 item per year)	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay
Lenses (per pair)	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay	100% covered after $20 copay
Prescription Drugs				
Generics	$20 copay**	$25 copay**	$25 copay**	$25 copay**
Preferred Brand Drugs	0% coinsurance after annual deductible	$50 copay after annual deductible	$50 copay after annual deductible	$100 copay after annual deductible
Non-preferred Brand Drugs	0% coinsurance after annual deductible	$100 copay after annual deductible	$100 copay after annual deductible	$150 copay after annual deductible
Specialty Drugs	0% coinsurance after annual deductible	40% coinsurance after annual deductible	30% coinsurance after annual deductible, $350 maximum per prescription	30% coinsurance after annual deductible, $350 maximum per prescription
Optional Services				
Optional Adult Vision or Adult Vision/Dental coverage also available. See details on back.			Optional Adult Vision or Adult Vision/Dental coverage also available. See details on back.	

*Eligible Out-of-network expenses are covered at the In-network level.
**If the cost of the generic drug is less than the copay, you pay the lesser amount.
Information shown represents a 60% 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.
For help understanding the terms used above, see the *Words to Know* page on Ambetter.SunshineHealth.com.

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ADDITIONAL SERVICES

My Health Pays™ - Earn up to $125:
Ambetter from Sunshine Health rewards your healthy choices through our My Health Pays incentive program. Earn up to $125 on your My Health Pays card for:

- Completing your online Welcome Survey ($50)
- Getting your Annual Wellness Exam ($50)
- Getting your Annual Flu Vaccine ($25)

Use your card to pay for out-of-pocket costs such as doctor copays, deductibles or monthly premium payments.

Gym Membership Benefits:
Ambetter's gym membership benefits program makes it easier to stay in shape and stay healthy. With Ambetter, you can:

- Earn $20 on your My Health Pays card every month you visit the gym of your choice at least eight times.
- Get discounts on gym membership fees at approved locations. We've partnered with gyms and health clubs across the country. Just visit Ambetter.SunshineHealth.com to find an eligible gym in your area.

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Adult Vision Benefits *(Optional)*

(Ages 19 years of age and older)

	Your Cost (In-network Providers only)	Out-of-network
Routine Eye Exam (1 visit per year)	100% covered after $20 copay	Not Covered
Eyeglass Frames or Contacts (in lieu of glasses)	Covered up to $130 after $20 copay	Not Covered
Lenses for Eyeglasses (per pair)	100% covered after $20 copay	Not Covered

Adult Dental Benefits* *(Optional)*

(Ages 19 years of age and older, does not include Pediatric Dental coverage)

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

Basic Dental (Class 1)	Your Cost (In-network Providers only)	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
X-rays (1 per 12 months)	No Charge, subject to Annual Maximum	Not Covered

Comprehensive Dental (Class 2)***		
Basic Services: Fillings (1 per 2 years)	50% coinsurance, subject to Annual Maximum	Not Covered
Periodontics: Scaling & Root Planning (1 per 24 months)	50% coinsurance, subject to Annual Maximum	Not Covered
Oral Surgery: Simple Extractions	50% coinsurance, subject to Annual Maximum	Not Covered
Prosthodontics	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.
***Please Note: Comprehensive Dental Benefits (Class 2) are subject to a six month waiting period until services can be rendered.

IMPORTANT NOTE: The information shown in this brochure and in any accompanying literature is not intended to provide full details of Ambetter plans and may change at the discretion of Sunshine State Health Plan. Complete terms of coverage are outlined in the Schedule of Benefits and set forth in the applicable Member Contract. In applying for coverage, the primary insured agrees to be bound by the Member Contract. The benefits described in this brochure and any accompanying literature are the standard benefits offered by Ambetter from Sunshine Health. Policy provisions vary in some states. This is a solicitation for insurance.

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