PY 2026 QHP SBC Guidelines

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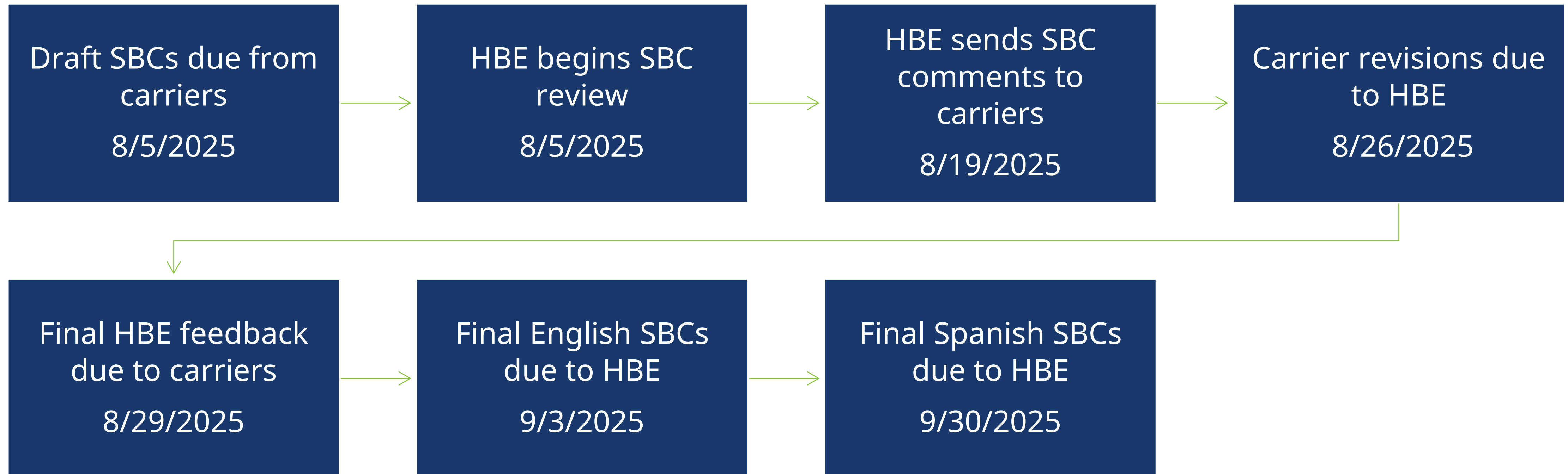
SBC Review Timeline



General: Font, page maximum, & template accuracy

- Font size in the document 12-point
- Font style Arial Narrow, Arial, Garamond
- Complies with the 8-page maximum guidelines
- All template rows and columns are present within the document
    - 3 columns on page 1
    - 4 columns on remaining pages
    - 5 columns for Cost sharing reduction (CSR) Tier 3

Front Page: Plan name & coverage period

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Coverage Period: 01/01/2025 – 12/31/2025
Ambetter from Coordinated Care Corporation
Coverage for: Individual/Family | Plan Type: HMO
Ambetter Cascade Silver: Standard Silver On Exchange Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://ambetter.coordinatedcarehealth.com/2025-brochures.html, or call 1-877-687-1197 (TTY 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-877-687-1197 (TTY 711) to request a copy.

- Beginning and end dates for applicable coverage period
- Indicate who coverage is for, e.g., individual, family
- Indicate coverage type
- Plan name and insurance company in bold

Front Page: Disclaimer Language

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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- Defined terms underlined
- Healthcare.gov glossary must be linked
  - Optional for carrier to link terms throughout SBC
- Issuer specific information including website or phone numbers are up to date
- Disclaimer at top of page includes required information and replicated exactly

Benefit summary: If you are pregnant

If you are pregnant	Office visits	No Charge	Not Covered	Cost-sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	Included in facility fee	Not Covered	
	Childbirth/delivery facility services	$800 copay /day up to 5 days /admission	Not Covered	

- Benefit section breaks out cost sharing for office visits and delivery separately, or
- Explains in “Limitations, exceptions, and other important information" why cost sharing is not broken out

Benefit summary: Home health, rehabilitation, habilitation & hospice

If you need help recovering or have other special health needs	Home health care	$30 Copay per day Deductible does not apply.	Not covered	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $40 Copay/visit Deductible does not apply. Inpatient: $800 Copay per day	Not covered	One copayment per day up to a maximum of 5 copayments per admission for inpatient services. Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: no coverage.
	Habilitation services	Outpatient: $40 Copay/visit Deductible does not apply. Inpatient: $800 Copay per day	Not covered	One copayment per day up to a maximum of 5 copayments per admission for inpatient services. Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: no coverage.
	Hospice services	Outpatient: $30 Copay/day Deductible does not apply. Inpatient: $800 Copay per day	Not covered	One copayment per day up to a maximum of 5 copayments per admission for inpatient services. Respite care limited to 14 days lifetime.

Benefit summary: Visits at $1

If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First two visits: $1 Copay / visit; deductible does not apply. Additional visits: $30 Copay / visit; deductible does not apply.
	Specialist visit	$65 Copay / visit; deductible does not apply
	Preventive care/screening/ immunization	No charge; deductible does not apply

If you need mental health, behavioral health, or substance abuse services	Outpatient services	First two office visits: $1 Copay / visit; deductible does not apply. Additional office visits: $30 Copay / visit; deductible does not apply. Other outpatient services: $30 Copay / visit; deductible does not apply

*For standard Bronze & Silver plans only

- First 2 primary care visits are $1
- First 2 behavioral health visits are $1

Excluded and Other Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Infertility Treatment (except for Artificial Insemination)	•	•

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Acupuncture	• Chiropractic care
• Hearing Aids	• Routine Foot Care	

- Reminder to update "Excluded Services" to reflect new state Essential Health Benchmark (EHB) Plan
- Include state EHBs in "Other Covered Services" Section
  - Add visit limits listed for chiropractic care

Rights, grievance, & appeals

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Washington State Office of the Insurance Commissioner 1-800-562-6900. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Washington State Office of the Insurance Commissioner 1-800-562-6900.

- Your right to continue coverage section complete
  - Inclusive of the number for OIC: 1-800-562-6900?
- Grievance and appeals rights section complete
  - Inclusive of the number for OIC: 1-800-562-6900?

Minimum essential coverage & value standards

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

- Minimum essential coverage complete statement present & complete
  - Statement should always read 'Yes.'
- Minimum value standards statements present & complete
  - Statement should always read as 'Not Applicable'

Indian Health Care Provider

What You Will Pay		
Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)
No charge	First two visits: $1 Copay / visit; deductible does not apply. Additional visits: $30 Copay / visit; deductible does not apply.	Not covered

- Where SBC notes zero-dollar deductible and cost sharing for IHCP benefit, IHCP facility dependency should be noted for Tier 3 SBCs
- AI/AN coverage for Tier 3 scenarios include IHCP disclaimer language

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language access taglines

- SBC contains language access taglines
  - Not included in the 8-page limit

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-857-9944 (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 1-855-857-9944 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-857-9944 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-857-9944 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-857-9944 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-857-9944 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-857-9944 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-857-9944 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-855-857-9944 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-855-857-9944 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-857-9944 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-857-9944 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-857-9944 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-855-857-9944 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-855-857-9944 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-857-9944 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-857-9944 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-857-9944 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-855-857-9944 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-857-9944 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-857-9944 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-855-857-9944 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-855-857-9944 تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-857-9944 (رقم هاتف الصم والبكم TTY: 711)

Questions & Next Steps

- The Exchange will provide a template for standard plan SBCs
  - Function as a baseline
  - Carriers can add more information
- Questions?

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