2022 SEBB Spousal Plan Calculator

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Clear form

Complete this calculator if you answered **Yes** to all the questions on the *2022 SEBB Premium Surcharge Attestation Help Sheet*. If you need help:

- Employees: Contact your payroll or benefits office.
- SEBB Continuation Coverage subscribers: Contact the SEBB Program.

Use the *2022 Summary of Benefits and Coverage* from your spouse's or state-registered domestic partner's employer-based group medical plans to answer the questions below. Do not return the *Summary of Benefits and Coverage* with this calculator.

The medical plans must:

- Serve your spouse's or state-registered domestic partner's county of residence.
- Cost less than **$114.01** for the employee's share of the monthly medical premium.

Complete a *2022 SEBB Spousal Plan Calculator* for each medical plan that meets the criteria above. If you are completing a form for more than one plan, and at least one results in "You will have to pay the Surcharge," then you will be charged the surcharge in addition to your monthly medical premium.

1 Subscriber information

Social Security number

Last name

First name

Middle initial

Suffix

2 Plan information

⚠ For question 1A, look at the top-right corner of the *Summary of Benefits and Coverage*, next to "Plan Type."

1. Is this a high-deductible health plan (HDHP) or consumer directed health plan (CDHP)?
If the Plan Type is HMO, PPO, or POS, check **No**.

A. ☐ Yes ☐ No

B. If **Yes**, how much does the employer contribute each year for an individual's health savings account (HSA) or health reimbursement account (HRA)?

$

⚠ For questions 2 and 3, look at the Summary of Benefits and Coverage under "Important Questions." Only look at amounts for a single person (or individual) using a preferred (or in-network) provider.

2. How much are the plan's deductibles? Answer either A or B (1 and 2), but not both.

A. $ Overall deductible (if you see one deductible for the plan) or

B1. $ Medical deductible, and

B2. $ Prescription drug deductible

3. How much are the plan's out-of-pocket limits? Answer either A or B (1 and 2), but not both.

A. $ Out-of-pocket limit (if you only see one out-of-pocket limit for the plan), or

B1. $ Medical out-of-pocket limit, and

B2. $ Prescription drug out-of-pocket limit

For questions 4 through 7, look at the *Summary of Benefits and Coverage* under "Common Medical Events" and "Services You May Need." Only look for amounts for a single person (or individual) using a preferred (or in-network) provider.

4. What is the plan's most common coinsurance among these three services?

1. Primary care visit to treat an injury or illness
2. Diagnostic test
3. Durable medical equipment

- If you see the same coinsurance (%) for at least two of these services, write that amount ____ %
- If you see different coinsurance amounts, or copays ($) with coinsurance, write the highest coinsurance amount you see.
  $ ____
- If you only see copays ($) for all three services, skip this question.

5. How much is the plan's copay for a primary care visit to treat an injury or illness? $ ____
Skip this question if you see:
- Only coinsurance (%), **or**
- Copay ($) and coinsurance (%)

6. How much is the plan's copay for emergency room services? $ ____
Skip this question if you see:
- Only coinsurance (%), **or**
- Copay ($) and coinsurance (%)

7. How much is the plan's coinsurance or copay for preferred brand drugs (or formulary drugs)? Answer either A or B, but not both.

A. ____ **%** Coinsurance, **or**

B. **$** ____ Copay

3 Signature

By submitting this form, I declare the information I have provided is true, complete, and correct. If it isn't, or if I do not provide timely, updated information, I will owe the $50 spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly medical premium.

Signature

Date

Last four digits of Social Security number

Last name

4 Form return

Return form and documentation to the appropriate location for your member type:

For employees: your payroll or benefits office.
For SEBB Continuation Coverage subscribers:
SEBB Program
Washington State Health Care Authority
PO Box 42720
Olympia, WA 98504-2720
Or fax to: 1-360-725-0771

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact the following:
Employees: Your payroll or benefits office.
SEBB Continuation Coverage subscribers: The SEBB Program at 1-800-200-1004 (TRS: 711).

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, go to HCA's website at **hca.wa.gov/erb**.