Clear form

2021 **PEBB Spousal Plan Calculator**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Complete this calculator if you answered **Yes** to all the questions on the *2021 PEBB Premium Surcharge Attestation Help Sheet*. If you need help, contact your payroll or benefits office (for employees) or the PEBB Program (for retirees and PEBB Continuation Coverage subscribers).

Use the *2021 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 form.

The medical plans must:

- Serve your spouse's or state-registered domestic partner's county of residence, and
- Cost less than $109.26 for the employee's share of the monthly medical premium.

Complete a *2021 PEBB Spousal Plan Calculator* for **each** medical plan that meets the criteria above. If more than one plan meets the criteria, submit one copy of this form for **each medical** plan. If at least one plan results in "You will have to pay the surcharge," then you will be charged the premium 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 is/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 is/are the plan's out-of-pocket limits?

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 that 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.

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

Signature

Date

Last four digits of Social Security number

Last name

Employing agency (Employees only)

4 Form return

Sign, date and return form and documentation to the appropriate location: **For employees:** your payroll or benefits office. **For retirees and PEBB Continuation Coverage subscribers:** PEBB Program, Washington State Health Care Authority, PO Box 42684, Olympia, WA 98504-2684. **Fax to:** 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. **Retirees and PEBB Continuation Coverage members:** The PEBB Program at 1-800-200-1004 (TRS: 711).