Clear form

2023 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 *2023 PEBB Premium Surcharge Attestation Help Sheet*. If you need help:

- **Employees:** Contact your payroll or benefits office.
- **Retirees and PEBB Continuation Coverage subscribers:** Contact the PEBB Program.

To answer the questions below, use the *2023 Summary of Benefits and Coverage* (SBC) for each of your spouse's or state-registered domestic partner's employer-based group medical plans to answer the questions below. Do not return the SBC with this calculator.

The SBC must represent the medical plans that:

- Serve your spouse's or state-registered domestic partner's county of residence, **and**
- Cost less than **$137.76** for the employee's share of the monthly medical premium.

Complete a separate *PEBB Spousal Plan Calculator* for **each** medical plan that meets the criteria above. If more than one plan meets the criteria, you will need to complete more than one calculator. 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 SBC, 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 SBC 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 SBC under "Common Medical Events" and "Services You May Need." Only look at 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 only see copays ($) for all three services, skip this question.
- If you see the same coinsurance (%) for at least two of these services, write that amount. _____ %
- If you see different coinsurance amounts, or copays ($) with coinsurance, write the highest coinsurance amount you see.

$ _____

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. Don't answer both.

A. _____ **%** Coinsurance, **or**

B. $ _____ Copay

3 Signature

By signing 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 be charged 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 _____

Employing agency (employees only) _____

4 Form return

Sign, date, and return this calculator with your enrollment form or the *2023 PEBB Premium Surcharge Attestation Change Form* to the appropriate location:

For employees: Your payroll or benefits office.
For retirees and PEBB Continuation Coverage subscribers, mail to:
PEBB Program
Washington State Health Care Authority
PO Box 42684
Olympia, WA 98504-2684
Or 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 subscribers: The PEBB 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.wa.gov/erb**.