2020 SEBB Spousal Plan Calculator

Complete this calculator if you answered YES to all the questions on the *2020 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.

Please type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example:

Use the *2020 Summary of Benefits and Coverage* from your spouse's or state-registered domestic partner's employer-based group medical plan(s) to answer the questions below. Do not return the *Summary of Benefits and Coverage* with this calculator. The plan(s) must:

- Serve your spouse's or state-registered domestic partner's county of residence.
- Cost less than $108.31 for the employee's share of the monthly medical premium.

Complete a *2020 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

Date of birth (mm/dd/yyyy)

Last name

First name

Middle initial

Suffix

Birth sex (M/F)

2 Plan information

1 Is this a high-deductible health plan (HDHP) or a 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)?

$

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

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

$

B1. Medical deductible

$

B2. Prescription drug deductible

$

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

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.

3 **How much is/are the plan's out-of-pocket limit(s)?**
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)

$

B1. Medical out-of-pocket limit

$

B2. Prescription drug out-of-pocket limit

$

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, and
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, but not both.

A. Coinsurance %

B. Copay $

For questions **4** through **7**, look at the *Summary of Benefits and Coverage* 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.

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 to the SEBB Program in addition to my monthly medical premium.

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**.

Date (mm/dd/yyyy) ___ / ___ / ______

Last four digits of Social Security number ____

Last name ____________________

4 Form return

Sign, date, and return completed form and documentation to the appropriate location:

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: 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 members: The Health Care Authority at 1-800-200-1004 (TRS: 711).