Washington State Health Care Authority

It's easier online
Use the *2016 Spousal Plan Calculator* at **www.hca.wa.gov/pebb**.

2016 Spousal Plan Calculator

Clear All Form Entries

Subscriber's last name	First name	Middle initial	Social Security number

If you answered "YES" to all the questions in the *2016 Premium Surcharge Help Sheet*, complete this calculator and send it to your employer (for employees) or the PEBB Program (for COBRA, LWOP, and non-Medicare retirees) with your 2016 enrollment form or *2016 Premium Surcharge Change Form*.

Use the *2016 Summary of Benefits and Coverage* from your spouse's or registered domestic partner's employer-based group medical insurance plan(s) to answer the questions below. Do not return the *Summary of Benefits and Coverage* with this form.

The plan(s) must:

- Serve your spouse's or registered domestic partner's county of residence, **and**
- Cost less than $89.31 for the employee's share of the monthly premium.

Complete a *2016 Spousal Plan Calculator* for **each** medical plan that meets the criteria above. If there is more than one plan that meets the criteria above, copy this form as needed and submit a form for **each** plan. If you are entering more than one plan, and at least one results in "You will have to pay the surcharge," then you will have to pay the surcharge.

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 a consumer-driven 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 deductible(s)?
Answer either A or B. Don't answer both.

A. $ _____ Overall deductible (if you only 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 limit(s)?
Answer either A or B. Don't answer 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 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, and 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. Don't answer both.

A. _____ % coinsurance, **OR**

B. $ _____ copay

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 owe spousal coverage premium surcharges to the PEBB Program.

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

Name (print)_____ Last four digits of Social Security number _____

Signature _____ Date _____

Agency name (employees only) _____

Please sign and date this form.

If you're:	**Return it to:**
An employee	Your personnel, payroll, or benefits office.
Any other subscriber	PEBB Program Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684 or fax to: 360-725-0771