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

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

ABC Insurance: Example Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014-12/31/2014

Coverage for: XXXX | Plan Type: 1A

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.example.com or by calling 1-800-XXX.XXXX.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**2A or 2B1** /person, **$XXX**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **2B2** for prescription drug coverage.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **3A or 3B1** /person, **$XXX**/family. Prescription drugs: **3B2**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, prescription drugs, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.example.com or call 1-800-XXX-XXXX for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-XXX-XXXX or visit us at www.example.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.example.com or call 1-800-XXX-XXXX to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Primary care visit to treat an injury or illness**	**4** **5**	X% co-insurance	——————none——————
	Specialist visit	$X co-pay	X% co-insurance	——————none——————
	Other practitioner office visit	$X co-pay	X% co-insurance	——————none——————
	Preventive care/screening/immunization	No charge	X% co-insurance	——————none——————
If you have a test	**Diagnostic test** (x-ray, blood work)	**4**	X% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$ X% co-insurance	X% co-insurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.example.com.	Generic drugs	$X co-pay	X% co-insurance	——————none——————
	Preferred brand drugs	**7A or 7B**	X% co-insurance	——————none——————
	Non-preferred brand drugs	$X co-pay	X% co-insurance	——————none——————
	Specialty drugs	$X co-pay	X% co-insurance	——————none——————
If you have	Facility fee (e.g., ambulatory surgery center)	X% co-insurance	X% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
outpatient surgery	Physician/surgeon fees	X% co-insurance	X% co-insurance	——————none——————
If you need immediate medical attention	Emergency room services	6	X% co-insurance	——————none——————
	Emergency medical transportation	X% co-insurance	X% co-insurance	——————none——————
	Urgent care	X% co-insurance	X% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	X% co-insurance	X% co-insurance	——————none——————
	Physician/surgeon fee	X% co-insurance	X% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$X co-pay	X% co-insurance	——————none——————
	Mental/Behavioral health inpatient services	$X co-pay	X% co-insurance	——————none——————
	Substance use disorder outpatient services	$X co-pay	X% co-insurance	——————none——————
	Substance use disorder inpatient services	$X co-pay	X% co-insurance	——————none——————
If you are pregnant	Prenatal and postnatal care	X% co-insurance	X% co-insurance	——————none——————
	Delivery and all inpatient services	X% co-insurance	X% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	X% co-insurance	X% co-insurance	——————none——————
	Rehabilitation services	X% co-insurance	X% co-insurance	——————none——————
	Habilitation services	X% co-insurance	X% co-insurance	——————none——————
	Skilled nursing care	X% co-insurance	X% co-insurance	——————none——————
	Durable medical equipment	4	X% co-insurance	——————none——————
	Hospice service	X% co-insurance	X% co-insurance	——————none——————
If your child needs dental or eye care	Eye exam	$X co-pay	Not covered	——————none——————
	Glasses	X% co-insurance	Not covered	——————none——————

You will find all the answers you need to complete the *Spousal Plan Calculator* in this first portion of the *Summary of Benefits and Coverage*.