Clear form

2024 SEBB Spousal Plan Calculator

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Complete this calculator if you answered **Yes** to all the questions on your enrollment or surcharge change form. If you need help:

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

Toanswer the questions below, use the 2024 Summary of Benefits and Coverage (SBC) for each of your spouse's or state-registered domestic partner's (SRDP) employer-based group medical plans that:

- Serve your spouse's or SRDP's county of residence, **and**
- Cost less than **$117.81** for the employee's share of the monthly medical premium.

Complete a seperate *SEBB 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 one copy of this calculator for each medical plan. Do not return the SBC with this 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 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)?
$

⚠ 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. **$** verall 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

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

⚠ 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.

- 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 name 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 *2024 SEBB Premium Surcharge Attestation Change Form* to the appropriate location:

For employees: Your payroll or benefits office.

For SEBB Continuation Coverage subscribers:
Mail to:
SEBB Program
Washington State Health Care Authority
PO Box 42720
Olympia, WA 98504-2720
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. SEBB Continuation Coverage subscribers: The SEBB Program at 1-800-200-1004 (TRS: 711).

HCA 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.