

# Benefit Cost Worksheet

For Plan Year 2009-2010



THE UNIVERSITY of TEXAS SYSTEM  
*Nine Universities. Six Health Institutions. Unlimited Possibilities.*

This is NOT an enrollment form. You must enroll online using **MY UT BENEFITS** (formerly UT TOUCH) during Annual Enrollment or for new employees through your institution's Benefits Office.

Please remember that this form only provides you (the subscriber) with an estimate of your total out-of-pocket cost per month based on state-appropriated funds and contracted premium rates. Be sure to review available benefits information for more information on the plans listed.

For each section, figure the correct cost and enter it in the TOTAL boxes to the right of each section.

MEDICAL PLAN OUT-OF-POCKET COST PER MONTH:		FULL-TIME EMPLOYEES & RETIREES ONLY			
Plan Available – Worldwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	MEDICAL (FULL-TIME) TOTAL
UT SELECT	\$0	\$169.23	\$177.00	\$333.28	
<i>(Administered by Blue Cross &amp; Blue Shield of Texas)</i>					
<b>Medical Plan Rates include:</b> Employee - \$10,000 Life & \$10,000 AD&D Retiree - \$3,000 Life		<b>Full-time =</b> Appointed for at least 40 Hours/Week			

OR

MEDICAL PLAN OUT-OF-POCKET COST PER MONTH:		PART-TIME EMPLOYEES ONLY			
Plan Available – Worldwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	MEDICAL (PART-TIME) TOTAL
UT SELECT	\$196.54	\$468.80	\$439.45	\$699.37	
<i>(Administered by Blue Cross &amp; Blue Shield of Texas)</i>					
<b>Medical Plan Rates include:</b> Employee - \$10,000 Life & \$10,000 AD&D Retiree - \$3,000 Life		<b>Part-time =</b> Appointed for at least 20 hours but less than 40 hours per week			

*If you are electing health coverage for previously eligible dependents or if you currently waived your coverage, Evidence of Insurability (EOI) will be required unless proof of other group coverage can be provided at the time of enrollment.*

DENTAL PLAN OUT-OF-POCKET COST PER MONTH:					DENTAL TOTAL
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	
<b>Worldwide:</b>					<div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div>
UT SELECT Dental <i>(Administered by Delta Dental)</i>	\$29.96	\$56.87	\$62.69	\$89.14	
<b>Austin, Dallas, El Paso, Galveston, Houston &amp; San Antonio:</b>					
Assurant Dental HMO	\$10.05	\$19.10	\$21.11	\$30.15	

VISION OUT-OF-POCKET COST PER MONTH:					VISION TOTAL
Plan Available – Nationwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	
Superior Vision	\$6.80	\$10.76	\$10.96	\$17.40	<div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div>

LIFE OUT-OF-POCKET COST PER MONTH:		Fort Dearborn Life
For <b>RETIRED EMPLOYEE</b> coverage, skip to <b>C</b> . For <b>EMPLOYEES</b> : Enter your basic annual earnings (or contract salary) rounded up to the next \$1,000 increment (e.g. \$21,454 = \$22,000).		<b>A</b>
Select from 1-6 times basic annual earnings and enter how many times your earnings you desire for coverage amount. Enter a number from 1 to 6 (see <sup>1</sup> below).		<b>B</b>
Enter Elected Coverage Amount: <b>Employees</b> <ul style="list-style-type: none"> <li>Multiply <b>A x B</b> and enter amount here. If <b>C</b> is greater than \$1.5 million, enter \$1.5 million.</li> </ul> <b>Retirees</b> <ul style="list-style-type: none"> <li>Select from the following options and enter here (see <sup>1</sup> below).                             <ul style="list-style-type: none"> <li>\$7,000</li> <li>\$10,000</li> <li>\$25,000</li> <li>\$50,000</li> </ul> </li> </ul> <i>Note: For those retired employees of the System who retired through the 1993 one-time retirement option, enter the amount of coverage currently in place.</i>		<b>C</b>
Divide total in <b>C</b> by 1,000 to determine units of \$1,000 for premium calculation. Enter here.		<b>D</b>
Refer to <b>Employee and Retiree Rate Chart</b> below. Enter the rate that corresponds with your age on September 1, 2009		<b>E</b>
To determine the premium cost per month, multiply <b>D x E</b> .		<b>F</b>
<i>The remainder of the Life Out-of-Pocket calculation section relates to eligible dependents of <b>Employees only</b>. Dependents of retirees are not eligible for dependent life coverage.</i>		
If you are electing the \$10,000 Family Coverage option, enter \$2.87 (see <sup>2</sup> below). Otherwise, enter zero.		<b>G</b>
<ul style="list-style-type: none"> <li>If you are eligible and choose to elect Spouse Coverage of \$25,000, enter \$15,000 (see <sup>1</sup> below); <b>OR</b></li> <li>If you are eligible and choose to elect Spouse Coverage of \$50,000, enter \$40,000 (see <sup>1</sup> below); <b>OR</b></li> <li>Enter zero.</li> </ul>		<b>H</b>
Divide total in <b>H</b> by 1,000 to determine units of \$1,000 for premium calculation. Otherwise, enter zero.		<b>I</b>
Refer to <b>Spouse Rate Chart</b> below. Enter the rate that corresponds to your spouse's age on September 1, 2009. Otherwise, enter zero.		<b>J</b>
To determine the total Spouse Coverage premium cost per month, multiply <b>I x J</b> . Otherwise, enter zero.		<b>K</b>
To determine total Dependent (Family Coverage Option + Spouse Coverage Option) Coverage premium cost per month, add <b>G + K</b> . Otherwise, enter zero.		<b>L</b>
		<p><b>LIFE TOTAL</b> Employees (F + L) Retirees (F only)</p>

EMPLOYEE AND RETIREE RATE CHART	
Age of Subscriber on 9/01/09	Rate per \$1,000 Coverage
< 35	\$0.041
35 - 39	\$0.053
40 - 44	\$0.074
45 - 49	\$0.114
50 - 54	\$0.177
55 - 59	\$0.278
60 - 64	\$0.422
65 - 69	\$0.760
70 and over	\$0.792

SPOUSE RATE CHART	
Age of Spouse on 9/01/09	Rate per \$1,000 Coverage
15 - 24	\$0.055
25 - 29	\$0.056
30 - 34	\$0.059
35 - 39	\$0.074
40 - 44	\$0.104
45 - 49	\$0.159
50 - 54	\$0.248
55 - 59	\$0.388
60 - 64	\$0.592
65 - 69	\$0.884
70 and over	\$1.167

<sup>1</sup> If you are increasing your life coverage amount or are electing spouse coverage amounts above \$10,000, Evidence of Insurability (EOI) is required.  
<sup>2</sup> Provides coverage of \$10,000 for each covered dependent.

<b>ACCIDENTAL DEATH AND DISMEMBERMENT OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY)</b>		<b>Fort Dearborn Life</b>
Enter desired coverage amount in \$10,000 increments. <i>Coverage is available up to 10 times your basic annual earnings or contract salary. Basic annual earnings should be rounded up to the next \$1,000 increment (e.g. \$21,323 would be rounded to \$22,000, maximum coverage amount of \$220,000). Total employee coverage cannot exceed \$1,000,000.</i>		<b>A</b>
Enter desired spouse coverage amount in increments of \$10,000. The maximum spouse coverage is 50% of the amount in item <b>A</b> (rounded down to nearest \$10,000). Employee must have \$20,000 Voluntary AD&D coverage to elect spouse AD&D coverage.		<b>B</b>
If you desire dependent child(ren) coverage, enter \$10,000 in item <b>C</b> . <i>Employee must have \$20,000 Voluntary AD&amp;D coverage to elect dependent AD&amp;D coverage. All of your eligible children are covered for one monthly premium cost.</i> If not electing dependent coverage, enter zero.		<b>C</b>
Enter the sum of <b>A</b> plus the greater of <b>B</b> or <b>C</b>		<b>D</b>
Multiply amount in <b>D</b> x \$.000016 for Total AD&D		<b>AD&amp;D TOTAL</b>

<b>SHORT TERM DISABILITY (STD) OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY)</b>	<b>Fort Dearborn Life</b>
Basic <b>MONTHLY</b> earnings (includes salary, longevity pay & hazard pay <i>BUT</i> cannot exceed \$5,000) times \$0.00267 or... If you are on a 9 or 12-month contract, divide your contract salary by the number of months of the contract. Multiply this amount by \$0.00267.	<b>STD TOTAL</b>

*Evidence of Insurability (EOI) is required for enrollment after your initial period of eligibility except during 2009 Annual Enrollment and following a qualified status change event.*

<b>LONG TERM DISABILITY (LTD) OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY)</b>	<b>Fort Dearborn Life</b>
Basic <b>MONTHLY</b> earnings (includes salary, longevity pay & hazard pay <i>BUT</i> cannot exceed \$20,042) times \$0.00397 or... If you are on a 9 or 12-month contract, divide your contract salary by the number of months of the contract. Multiply this amount by \$0.00397.	<b>LTD TOTAL</b>

*Evidence of Insurability (EOI) is required for enrollment after your initial period of eligibility except during 2009 Annual Enrollment and following a qualified status change event.*

<b>UT FLEX SALARY REDUCTIONS PER MONTH (EMPLOYEES ONLY)</b>			<b>PayFlex</b>
Type of Account	Minimum	Maximum	Monthly Contribution
Medical Expense *	\$15 per month	\$5,000 Annual Election	
Dependent Day Care	\$15 per month	<ul style="list-style-type: none"> <li>• \$5,000 Annual Election ** <i>If single or married filing jointly on your Federal Income Tax Return</i></li> <li>• \$2,500 Annual Election ** <i>If married filing separately on your Federal Income Tax Return</i></li> </ul>	
			<b>FLEX TOTAL A + B</b>

\* The PayFlex Debit Card is available for the Medical Expense Reimbursement Account only. The annual fee for the Debit Card is \$9 if selected during Annual Enrollment. If you enroll during the plan year and select the Debit Card, the fee is prorated. The annual fee is deducted from your first account contribution in the new plan year.

\*\* For a new employee hired during the plan year, the Dependent Day Care maximum annual election cannot exceed approximately \$416 per month for a 12-month employee (or \$555 per month for a 9-month employee) multiplied by the number of remaining months in the plan year. **IMPORTANT:** In any given calendar year (Jan. 1-Dec. 31), the Dependent Day Care deductions cannot exceed \$5,000 for federal income tax filing purposes.

LONG TERM CARE (LTC) OUT-OF-POCKET COST PER MONTH									CNA
Age	PLAN A				PLAN B				
	Basic Benefit with Guaranteed Benefit Increase Option				Basic Benefit with Lifetime Automatic Benefit Increase Option (Inflation Protection)				
	\$100 BENEFIT	\$125 BENEFIT	\$150 BENEFIT	\$200 BENEFIT	\$100 BENEFIT	\$125 BENEFIT	\$150 BENEFIT	\$200 BENEFIT	
<25	5.64	7.05	8.46	11.28	16.96	21.20	25.44	33.92	
25-29	6.68	8.35	10.02	13.36	19.88	24.85	29.82	39.76	
30-34	8.00	10.00	12.00	16.00	23.09	28.86	34.64	46.18	
35-39	9.76	12.20	14.63	19.51	29.99	37.49	44.99	59.98	
40	11.84	14.81	17.77	23.69	34.52	43.15	51.78	69.04	
41	12.60	15.75	18.90	25.20	35.76	44.70	53.64	71.52	
42	13.39	16.74	20.09	26.78	37.43	46.79	56.14	74.86	
43	13.99	17.49	20.98	27.98	39.10	48.88	58.65	78.21	
44	14.64	18.31	21.97	29.29	40.85	51.06	61.27	81.70	
45	15.42	19.27	23.12	30.83	43.09	53.87	64.64	86.18	
46	16.17	20.21	24.25	32.34	45.18	56.48	67.77	90.36	
47	17.04	21.29	25.55	34.07	47.54	59.42	71.31	95.08	
48	18.12	22.65	27.18	36.24	50.05	62.56	75.07	100.09	
49	19.28	24.10	28.92	38.56	52.63	65.79	78.95	105.26	
50	20.78	25.97	31.16	41.55	56.01	70.02	84.02	112.02	
51	22.27	27.84	33.40	44.54	59.36	74.20	89.04	118.71	
52	24.14	30.18	36.21	48.28	63.39	79.23	95.08	126.77	
53	26.28	32.85	39.43	52.57	67.94	84.93	101.91	135.89	
54	28.73	35.91	43.10	57.46	72.88	91.10	109.32	145.76	
55	32.43	40.54	48.65	64.86	78.93	98.66	118.39	157.85	
56	36.28	45.35	54.42	72.55	84.78	105.98	127.17	169.56	
57	40.21	50.27	60.32	80.42	91.24	114.05	136.86	182.48	
58	44.14	55.17	66.20	88.27	98.69	123.36	148.03	197.37	
59	48.49	60.62	72.74	96.98	106.93	133.66	160.40	213.86	
60	54.16	67.70	81.24	108.32	116.55	145.68	174.82	233.09	
61	59.65	74.57	89.48	119.30	125.17	156.47	187.76	250.34	
62	65.29	81.61	97.93	130.57	133.34	166.68	200.02	266.69	
63	70.61	88.27	105.92	141.23	139.99	174.99	209.99	279.99	
64	76.53	95.67	114.80	153.06	146.88	183.60	220.32	293.76	
65	83.69	104.62	125.54	167.39	155.31	194.14	232.97	310.63	
66	91.32	114.15	136.98	182.64	164.13	205.16	246.20	328.26	
67	98.84	123.55	148.26	197.68	176.10	220.13	264.15	352.20	
68	107.48	134.35	161.22	214.96	190.68	238.35	286.02	381.36	
69	116.92	146.15	175.38	233.84	204.96	256.20	307.44	409.92	
70	127.68	159.60	191.52	255.36	221.56	276.95	332.34	443.12	
71	140.44	175.55	210.66	280.88	241.32	301.65	361.98	482.64	
72	155.80	194.75	233.70	311.60	264.84	331.05	397.26	529.68	
73	173.92	217.40	260.88	347.84	292.16	365.20	438.24	584.32	
74	194.36	242.95	291.54	388.72	322.68	403.35	484.02	645.36	
75	216.96	271.20	325.44	433.92	355.80	444.75	533.70	711.60	
76	241.32	301.65	361.98	482.64	390.96	488.70	586.44	781.92	
77	267.24	334.05	400.86	534.48	427.56	534.45	641.34	855.12	
78	294.48	368.10	441.72	588.96	465.28	581.60	697.92	930.56	
79	320.56	400.70	480.84	641.12	500.04	625.05	750.06	1,000.08	
80	350.88	438.60	526.32	701.76	540.36	675.45	810.54	1,080.72	
81	380.00	475.00	570.00	760.00	577.60	722.00	866.40	1,155.20	
82	414.40	518.00	621.60	828.80	621.56	776.95	932.34	1,243.12	
83	452.04	565.05	678.06	904.08	669.00	836.25	1,003.50	1,338.00	
84	492.80	616.00	739.20	985.60	719.48	899.35	1,079.22	1,438.96	
85	530.56	663.20	795.84	1,061.12	764.00	955.00	1,146.00	1,528.00	
86	572.68	715.85	859.02	1,145.36	813.24	1,016.55	1,219.86	1,626.48	
87	613.48	766.85	920.22	1,226.96	858.88	1,073.60	1,288.32	1,717.76	
88	647.08	808.85	970.62	1,294.16	893.00	1,116.25	1,339.50	1,786.00	
89	679.52	849.40	1,019.28	1,359.04	924.12	1,155.15	1,386.18	1,848.24	
90	717.32	896.65	1,075.98	1,434.64	961.20	1,201.50	1,441.80	1,922.40	

**LTC  
TOTAL**

(EOI is not required for new employees who enroll during their initial period of eligibility. EOI is required for all other new enrollees.)

**Estimated Total Monthly Out-of-Pocket Cost**  
(Add ALL boxes and enter total)