



The University of Texas System Benefit Cost Worksheet PLAN YEAR 2006-2007

This is NOT an enrollment form. You must enroll using the UT TOUCH system.

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 and provider directories 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.

HEALTH PLAN OUT-OF-POCKET COST PER MONTH:		FULL-TIME EMPLOYEES & RETIREES ONLY		
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
All Areas:				
UT SELECT	\$0	\$149.87	\$156.75	\$295.15
Austin Area:				
HMO Blue	\$25.45	\$222.33	\$225.92	\$408.84
Dallas/Ft Worth Area:				
HMO Blue	\$12.15	\$192.97	\$198.66	\$366.15
El Paso Area:				
HMO Blue	\$0	\$152.01	\$158.99	\$299.38
Houston Area:				
HMO Blue	\$40.99	\$249.25	\$250.04	\$444.14
San Antonio Area:				
HMO Blue	\$26.87	\$198.59	\$200.71	\$360.44
Corpus Christi Area:				
HMO Blue	\$0	\$163.38	\$170.88	\$321.75

*Health Plan Rates include:
Employee - \$10,000 Life & \$10,000 AD&D
Retiree - \$3,000 Life*

HEALTH FULL-TIME TOTAL

Full-time =
Appointed for at
least 40
Hours/Week

HEALTH PLAN OUT-OF-POCKET COST PER MONTH:		PART-TIME EMPLOYEES ONLY		
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
All Areas:				
UT SELECT	\$174.17	\$415.28	\$389.29	\$619.47
Austin Area:				
HMO Blue	\$225.70	\$527.56	\$493.34	\$781.87
Dallas/Ft Worth Area:				
HMO Blue	\$208.58	\$492.36	\$460.96	\$732.03
El Paso Area:				
HMO Blue	\$176.66	\$421.21	\$394.86	\$628.34
Houston Area:				
HMO Blue	\$237.17	\$548.26	\$512.01	\$809.56
San Antonio Area:				
HMO Blue	\$196.47	\$457.02	\$427.14	\$676.23
Corpus Christi Area:				
HMO Blue	\$189.78	\$452.62	\$424.29	\$675.21

OR

HEALTH PART-TIME TOTAL

Part-time =
Appointed for at
least 20 hours but
less than 40 hours
per week

DENTAL PLAN OUT-OF-POCKET COST PER MONTH:				
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
All Areas:				
UT DENTAL SELECT (Delta Dental)	\$26.41	\$50.14	\$55.27	\$78.59
Austin, Dallas, El Paso, Galveston, Houston & San Antonio:				
Assurant Dental HMO	\$10.05	\$19.10	\$21.11	\$30.15

DENTAL TOTAL

VISION OUT-OF-POCKET COST PER MONTH:				
Plans Available – All Areas	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family
Superior Vision	\$7.22	\$11.20	\$11.46	\$18.48

**VISION
TOTAL**

SHORT TERM DISABILITY (STD) OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY) Plans Available – All Areas		The Hartford
Basic MONTHLY earnings (includes salary, longevity pay & hazard pay BUT cannot exceed \$5,000) times \$0.0051 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 \$0.0051.		

**STD
TOTAL**

LONG TERM DISABILITY (LTD) OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY) Plans Available – All Areas		The Hartford
Basic MONTHLY earnings (includes salary, longevity pay & hazard pay BUT cannot exceed \$20,042) times \$0.0041 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 \$0.0041.		

**LTD
TOTAL**

ACCIDENTAL DEATH AND DISMEMBERMENT OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY) Plans Available – All Areas		Fort Dearborn Life
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>		A
Enter desired spouse coverage amount in increments of \$10,000. The maximum spouse coverage is 50% of the amount in item A (rounded down to nearest \$10,000). Employee must have \$20,000 Voluntary AD&D coverage to elect spouse AD&D coverage.		B
If you desire dependent child(ren) coverage, enter \$10,000 in item C . <i>All of your eligible children are covered for one monthly premium cost. Employee must have \$20,000 Voluntary AD&D coverage to elect dependent AD&D coverage. If not electing dependent coverage, enter zero.</i>		C
Enter the sum of A plus the greater of B or C		D
Multiply amount in D x \$.000016 for Total AD&D		

**AD&D
TOTAL**

LIFE OUT-OF-POCKET COST PER MONTH: Plans Available – All Areas		Fort Dearborn Life
For RETIREE coverage, skip to C .		
For EMPLOYEES: Enter your basic annual earnings (or contract salary) rounded up to the next \$1,000 increment (e.g. \$21,454 = \$22,000).		A
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 ¹ below).		B
Enter Elected Coverage Amount: Employees <ul style="list-style-type: none"> Multiply A x B and enter amount here. If C is greater than \$1.5 million, enter \$1.5 million. Retirees <ul style="list-style-type: none"> Select from the following options and enter here (see ¹ below). <ul style="list-style-type: none"> \$7,000 \$10,000 \$25,000 \$50,000 <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>		C
Divide total in C by 1,000 to determine units of \$1,000 for premium calculation. Enter here.		D
Refer to Employee and Retiree Rate Chart below. Enter the rate that corresponds with your age on September 1, 2006.		E
To determine the premium cost per month, multiply D x E .		F
<i>The remainder of the Life Out-of-Pocket calculation section relates to eligible dependents of Employees only. 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 ² below). Otherwise, enter zero.		G

LIFE OUT-OF-POCKET COST PER MONTH (continued on page 3)

LIFE OUT-OF-POCKET COST PER MONTH (continued from page 2)

<ul style="list-style-type: none"> If you are eligible and choose to elect Spouse Coverage of \$25,000, enter \$15,000 (see ¹ below); OR If you are eligible and choose to elect Spouse Coverage of \$50,000, enter \$40,000 (see ¹ below); OR Enter zero. 	H	
Divide total in H by 1,000 to determine units of \$1,000 for premium calculation. Otherwise, enter zero.	I	
Refer to Spouse Rate Chart below. Enter the rate that corresponds to your spouse's age on September 1, 2006. Otherwise, enter zero.	J	
To determine the total Spouse Coverage premium cost per month, multiply I x J . Otherwise, enter zero.	K	
To determine total Dependent (Family Coverage Option + Spouse Coverage Option) Coverage premium cost per month, add G + K . Otherwise, enter zero.	L	<p>LIFE TOTAL Employees (F + L) Retirees (F only)</p>

EMPLOYEE AND RETIREE RATE CHART	
Age of Subscriber on 9/01/06	Rate per \$1,000 Coverage
< 35	\$0.046
35 - 39	\$0.060
40 - 44	\$0.084
45 - 49	\$0.129
50 - 54	\$0.200
55 - 59	\$0.314
60 - 64	\$0.476
65 - 69	\$0.858
70 and over	\$0.894

SPOUSE RATE CHART	
Age of Spouse on 9/01/06	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

¹ If you are increasing your life coverage amount or are electing spouse coverage amounts above \$10,000, Evidence of Insurability (EOI) will be required.

² Provides coverage of \$10,000 for each covered dependent.

LONG TERM CARE (LTC) OUT-OF-POCKET COST PER MONTH						
Plans Available – All Areas						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	\$100 BENEFIT	\$125 BENEFIT	\$150 BENEFIT
<25	5.64	7.05	8.46	16.96	21.20	25.44
25-29	6.68	8.35	10.02	20.08	25.10	30.12
30-34	8.00	10.00	12.00	23.56	29.45	35.34
35-39	10.84	13.55	16.26	30.92	38.65	46.38
40	13.16	16.45	19.74	35.96	44.95	53.94
41	14.00	17.50	21.00	37.64	47.05	56.46
42	14.88	18.60	22.32	39.40	49.25	59.10
43	15.72	19.65	23.58	41.16	51.45	61.74
44	16.64	20.80	24.96	43.00	53.75	64.50
45	17.72	22.15	26.58	45.36	56.70	68.04
46	18.80	23.50	28.20	47.56	59.45	71.34
47	20.04	25.05	30.06	50.04	62.55	75.06
48	21.32	26.65	31.98	52.68	65.85	79.02
49	22.68	28.35	34.02	55.40	69.25	83.10
50	24.44	30.55	36.66	58.96	73.70	88.44
51	26.20	32.75	39.30	62.48	78.10	93.72
52	28.40	35.50	42.60	66.72	83.40	100.08
53	30.92	38.65	46.38	71.52	89.40	107.28
54	33.80	42.25	50.70	76.72	95.90	115.08
55	37.28	46.60	55.92	83.08	103.85	124.62
56	40.76	50.95	61.14	89.24	111.55	133.86
57	44.68	55.85	67.02	96.04	120.05	144.06
58	49.04	61.30	73.56	103.88	129.85	155.82
59	53.88	67.35	80.82	112.56	140.70	168.84
60	59.52	74.40	89.28	122.68	153.35	184.02

LONG TERM CARE OUT-OF-POCKET COST PER MONTH (continued on page 4)

LONG TERM CARE OUT-OF-POCKET COST PER MONTH (continued from page 3)

61	64.84	81.05	97.26	131.76	164.70	197.64
62	70.20	87.75	105.30	140.36	175.45	210.54
63	75.12	93.90	112.68	147.36	184.20	221.04
64	79.72	99.65	119.58	153.00	191.25	229.50
65	85.40	106.75	128.10	160.12	200.15	240.18
66	91.32	114.15	136.98	167.48	209.35	251.22
67	98.84	123.55	148.26	177.88	222.35	266.82
68	107.48	134.35	161.22	190.68	238.35	286.02
69	116.92	146.15	175.38	204.96	256.20	307.44
70	127.68	159.60	191.52	221.56	276.95	332.34
71	140.44	175.55	210.66	241.32	301.65	361.98
72	155.80	194.75	233.70	264.84	331.05	397.26
73	173.92	217.40	260.88	292.16	365.20	438.24
74	194.36	242.95	291.54	322.68	403.35	484.02
75	216.96	271.20	325.44	355.80	444.75	533.70
76	241.32	301.65	361.98	390.96	488.70	586.44
77	267.24	334.05	400.86	427.56	534.45	641.34
78	294.48	368.10	441.72	465.28	581.60	697.92
79	320.56	400.70	480.84	500.04	625.05	750.06
80	350.88	438.60	526.32	540.36	675.45	810.54
81	380.00	475.00	570.00	577.60	722.00	866.40
82	414.40	518.00	621.60	621.56	776.95	932.34
83	452.04	565.05	678.06	669.00	836.25	1,003.50
84	492.80	616.00	739.20	719.48	899.35	1,079.22
85	530.56	663.20	795.84	764.00	955.00	1,146.00
86	572.68	715.85	859.02	813.24	1,016.55	1,219.86
87	613.48	766.85	920.22	858.88	1,073.60	1,288.32
88	647.08	808.85	970.62	893.00	1,116.25	1,339.50
89	679.52	849.40	1,019.28	924.12	1,155.15	1,386.18
90	717.32	896.65	1,075.98	961.20	1,201.50	1,441.80

**LTC
TOTAL**

UT FLEX SALARY REDUCTIONS PER MONTH (EMPLOYEES ONLY)			PayFlex
Type of Account	Minimum	Maximum	
Medical Expense	<ul style="list-style-type: none"> \$15 (12 month contract) \$20 (9 month contract) 	<ul style="list-style-type: none"> \$416 if single or married filing jointly for employees with a 12-month contract \$555 if single or married filing jointly for employees with a 9-month contract 	A
Medical Expense Debit Card	\$9.00/year	<ul style="list-style-type: none"> For employees with a 9-month contract, divide \$9 by 9 and enter here. For employees with a 12-month contract, divide \$9 by 12 and enter here. 	B
Day Care	<ul style="list-style-type: none"> \$15 (12 month contract) \$20 (9 month contract) 	<ul style="list-style-type: none"> \$416 if single or married filing jointly for employees with a 12-month contract \$555 if single or married filing jointly for employees with a 9-month contract \$208 if married and filing separately for employees with a 12-month contract \$277 if married and filing separately for employees with a 9-month contract 	C

**FLEX
TOTAL
A + B + C**

Add all boxes and enter total below.

Estimated Total Monthly Out-of-Pocket Cost