



The University of Texas System Benefit Cost Worksheet PLAN YEAR 2007-2008

This is NOT an enrollment form. You must enroll using the UT TOUCH system during Annual Enrollment or for new employees through your campus 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.

HEALTH PLAN OUT-OF-POCKET COST PER MONTH:		FULL-TIME EMPLOYEES & RETIREES ONLY			
Plan Available – Worldwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	HEALTH (FULL-TIME) TOTAL
UT SELECT	\$0	\$158.86	\$166.15	\$312.85	
<i>(Administered by Blue Cross & Blue Shield of Texas)</i>					
Health Plan Rates include: Employee - \$10,000 Life & \$10,000 AD&D Retiree - \$3,000 Life		<i>Full-time = Appointed for at least 40 Hours/Week</i>			<div style="border: 1px solid black; width: 100px; height: 30px;"></div>

OR

HEALTH PLAN OUT-OF-POCKET COST PER MONTH:		PART-TIME EMPLOYEES ONLY			
Plan Available – Worldwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	HEALTH (PART-TIME) TOTAL
UT SELECT	\$184.56	\$440.13	\$412.58	\$656.57	
<i>(Administered by Blue Cross & Blue Shield of Texas)</i>					
Health Plan Rates include: Employee - \$10,000 Life & \$10,000 AD&D Retiree - \$3,000 Life		<i>Part-time = Appointed for at least 20 hours but less than 40 hours per week</i>			<div style="border: 1px solid black; width: 100px; height: 30px;"></div>

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:					
Plans Available	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	DENTAL TOTAL
Worldwide:					
UT DENTAL SELECT <i>(Administered by Delta Dental)</i>	\$28.26	\$53.65	\$59.14	\$84.09	
Austin, Dallas, El Paso, Galveston, Houston & San Antonio:					
Assurant Dental HMO	\$10.05	\$19.10	\$21.11	\$30.15	<div style="border: 1px solid black; width: 100px; height: 30px;"></div>

VISION OUT-OF-POCKET COST PER MONTH:					
Plan Available – Nationwide	Subscriber Only	Subscriber & Spouse	Subscriber & Child(ren)	Subscriber & Family	VISION TOTAL
Superior Vision	\$7.36	\$11.48	\$11.74	\$18.90	

LIFE OUT-OF-POCKET COST PER MONTH:	Fort Dearborn Life
For RETIRED EMPLOYEE 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 <p style="font-size: small; margin-top: 5px;"><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></p>	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
<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

LIFE TOTAL
 Employees (F + L)
 Retirees (F only)

EMPLOYEE AND RETIREE RATE CHART	
Age of Subscriber on 9/01/07	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 9/01/07	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) is required.

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

SHORT TERM DISABILITY (STD) OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY)	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**

Evidence of Insurability (EOI) is required for enrollment after your initial period of eligibility. For 2007 Annual Enrollment, EOI is not required.

LONG TERM DISABILITY (LTD) OUT-OF-POCKET COST PER MONTH (EMPLOYEES ONLY)	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**

Evidence of Insurability (EOI) is required for enrollment after your initial period of eligibility.

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

**AD&D
TOTAL**

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	

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)

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**

Evidence of Insurability (EOI) is not required for employees during FY2007 annual enrollment only or for new employees who enroll during their initial period of eligibility. EOI is required for all other new enrollees.

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