UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

Benefits Cost Worksheet for Employees

PLAN YEAR 2022-2023

This is NOT an enrollment form. You must enroll online using *My UT Benefits* or 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 materials 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 OUT-OF-POCKET COST PER MONTH *Full-Time Employees:*				*BLUE CROSS BLUE SHIELD OF TEXAS*	
Plan Available – Worldwide	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
UT SELECT (OUT-OF-POCKET)	$0	$290.70	$304.04	$572.46	**MEDICAL**
UT CONNECT (OUT-OF-POCKET) ***DALLAS-FORT WORTH AREA ONLY***	$0	$261.64	$273.64	$515.22	***(FULL-TIME)*** **TOTAL**
PREMIUM SHARING *(PAID BY STATE OF TEXAS AND YOUR UT INSTITUTION)*	*$675.16*	*$1,029.06*	*$901.60*	*$1,257.62*	
Medical Plan Rates include: **Prescription benefit coverage + $50,000 Life + $50,000 AD&D**					**$**

OR

MEDICAL OUT-OF-POCKET COST PER MONTH *Part-Time Employees:*				*BLUE CROSS BLUE SHIELD OF TEXAS*	
Plan Available – Worldwide	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
UT SELECT (OUT-OF-POCKET)	$337.58	$805.22	$754.84	$1,201.26	**MEDICAL**
UT CONNECT (OUT-OF-POCKET) ***DALLAS-FORT WORTH AREA ONLY***	$337.58	$805.22	$754.84	$1,201.26	***(PART-TIME)*** **TOTAL**
PREMIUM SHARING *(PAID BY STATE OF TEXAS AND YOUR UT INSTITUTION)*	*$337.58*	*$514.54*	*$450.80*	*$628.82*	
Medical Plan Rates include: **Prescription benefit coverage + $50,000 Life + $50,000 AD&D**					**$**

TOBACCO PREMIUM PROGRAM (TPP)					
Tobacco User(s)	**Non-user**	**Subscriber**	**Spouse**	**Child(ren)**	**TPP TOTAL[2]**
Tobacco User(s) Cost	$0	$30.00	$30.00	$30.00[1]	**$**

1 Maximum cost of $30 per month regardless of how many covered dependent children use tobacco.
2 Maximum cost per family is $90 per month.

DENTAL OUT-OF-POCKET COST PER MONTH				*DELTA DENTAL*	
Plans Available	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
NATIONWIDE					
UT SELECT Dental	$28.52	$54.14	$59.66	$84.84	
UT SELECT Dental Plus	$61.40	$116.60	$128.66	$183.30	**DENTAL TOTAL**
CERTAIN AREAS IN TEXAS					
DeltaCare Dental HMO	$8.80	$16.74	$18.50	$26.40	**$**

VISION OUT-OF-POCKET COST PER MONTH					*SUPERIOR VISION*
Plans Available	**Subscriber Only**	**Subscriber & Spouse**	**Subscriber & Child(ren)**	**Subscriber & Family**	
Superior Vision	$5.02	$7.90	$8.10	$12.84	**VISION TOTAL**
Superior Vision Plus	$7.64	$11.98	$12.82	$18.10	**$**

LIFE OUT-OF-POCKET COST PER MONTH		*BCBSTX LIFE*
Enter your basic annual earnings (or contract salary) rounded up to the next $1,000 increment (e.g. $51,454 = $52,000).	**A**	
Select from 1-10 times basic annual earnings and enter how many times your earnings you desire for coverage amount. Enter a number from 1 to 10 (see [1] below for details about Evidence of Insurability requirements).	**B**	
Enter Elected Coverage Amount: Multiply **A x B** and enter amount here. If **C** is greater than $2 million, enter $2 million.	**C**	
Divide total in **C** by 1,000 to determine units of $1,000 for premium calculation. Enter here.	**D**	
Refer to Employee Rate Chart below. Enter the rate that corresponds with your age on September 1, 2021.	**E**	
To determine the estimated premium cost per month, multiply **D x E**.	**F**	

The remainder of the Life Out-of-Pocket calculation section relates to eligible dependents of Employees.

If you are electing the $10,000 Family Coverage option, enter $2.87 (see [2] below). Otherwise, enter zero.	**G**	
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 if you do not choose to elect Spouse Coverage.	**H**	
Divide total in **H** by 1,000 to determine units of $1,000 for premium calculation. Otherwise, enter zero.	**I**	
Refer to Spouse Rate Chart below. Enter the rate that corresponds to your Spouse's age on September 1, 2021. Otherwise, enter zero.	**J**	
To determine the total Spouse Coverage premium cost per month, multiply **I x J**. Otherwise, enter zero.	**K**	
To determine total Dependent Coverage premium cost per month, add **G + K**. Otherwise, enter zero.	**L**	
Add F + L	**LIFE TOTAL**	**$**

EMPLOYEE RATE CHART	
AGE OF SUBSCRIBER ON 9/1/2021	**RATE PER $1,000 COVERAGE**
15 - 34	$0.035
35 - 39	$0.045
40 - 44	$0.059
45 - 49	$0.092
50 - 54	$0.142
55 - 59	$0.221
60 - 64	$0.345
65 - 69	$0.616
70 - 74	$0.713
75 - 79	$0.884
80 and over	$1.549

SPOUSE RATE CHART	
AGE OF SPOUSE ON 9/1/2021	**RATE PER $1,000 COVERAGE**
15 - 24	$0.053
25 - 29	$0.054
30 - 34	$0.057
35 - 39	$0.072
40 - 44	$0.101
45 - 49	$0.154
50 - 54	$0.241
55 - 59	$0.376
60 - 64	$0.574
65 - 69	$0.857
70 - 74	$1.167
75 - 79	$1.446
80 and over	$2.536

1 If you are adding or increasing your Life coverage amount to a level of 4X-10X annual salary or if are electing Spouse coverage, Evidence of Insurability (EOI) is always required. For initial enrollment, elections made following qualifying change of status events, and during the July 2022 Annual Enrollment period ONLY, no EOI is required to add or increase your Life coverage amount up to 1X, 2X, or 3X salary.

2 The Family Coverage option provides coverage of $10,000 for each covered Dependent.

ACCIDENTAL DEATH & DISMEMBERMENT OUT-OF-POCKET COST PER MONTH		*BCBSTX AD&D*
Enter desired coverage amount in $10,000 increments. *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. $51,454 would be rounded to $52,000, maximum coverage amount of $520,000). Total employee coverage cannot exceed $2,000,000.*	**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**. *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.* If not electing Dependent coverage, enter zero.	**C**	
Enter the sum of **A** plus the greater of **B** or **C**	**D**	
Multiply amount in **D** x $.000012 for Total AD&D	**AD&D TOTAL**	**$**

SHORT TERM DISABILITY (STD) OUT-OF-POCKET COST PER MONTH	*BCBSTX DISABILITY*
Multiply Basic **MONTHLY** earnings (cannot exceed $6,139) x $0.0030.	**STD TOTAL**
*To calculate basic **MONTHLY** earnings, divide annual contract salary (including longevity and hazardous duty pay) by 12 months.* **Evidence of Insurability (EOI) is generally required for enrollment in this coverage during Annual Enrollment, but EOI is NOT required during July 2021.**	**$**

LONG TERM DISABILITY (LTD) OUT-OF-POCKET COST PER MONTH	*BCBSTX DISABILITY*
Multiply Basic **MONTHLY** earnings (cannot exceed $25,000) x $0.0034.	**LTD TOTAL**
*To calculate basic **MONTHLY** earnings, divide annual contract salary (including longevity and hazardous duty pay) by 12 months.* **Evidence of Insurability (EOI) is generally required for enrollment in this coverage during Annual Enrollment, but EOI is NOT required during July 2021.**	**$**

UT FLEX SALARY REDUCTIONS PER MONTH					*PAYFLEX*
Type of Account	**Minimum**	**Maximum**	**Monthly Contribution**		
Health Care Reimbursement Account [1]	**$15** per month	$2,850 Annual Election		**A**	
Dependent Day Care Reimbursement Account [2]	**$15** per month	$5,000 Annual Election If single or married filing jointly on your Federal Income Tax Return $2,500 Annual Election If married filing separately on your Federal Income Tax Return		**B**	**FLEX TOTAL A + B** **$**

1 **Health Care Reimbursement Account (HCRA):**

Maximum Election – HCRA deductions cannot exceed $2,850 per employee per plan year for federal income tax filing purposes.

2 **Dependent Day Care Reimbursement Account (DCRA):**

Maximum Election - In any given calendar year (Jan.1-Dec.31), the DCRA deductions cannot exceed $5,000 for federal income tax filing purposes.

ESTIMATED TOTAL MONTHLY OUT-OF-POCKET *(Add **ALL** boxes and enter total)*	**$**