



## 2019 Cost of Benefit Coverage

Medical Coverage – Pretax			
Plan Type	\$ 800 Deductible Plan	\$1,250 Deductible Plan	\$3,000 Deductible Plan
Coverage Level	Full & Part Time Biweekly Cost	Full & Part Time Biweekly Cost	Full & Part Time Biweekly Cost
Employee Only	\$75.07	\$41.49	\$21.47
Double	\$150.15	\$82.98	\$42.93
Family	\$225.23	\$124.48	\$64.40

Dental Coverage – Pretax				
Coverage Level	Full Time Biweekly Cost		Part Time Biweekly Cost	
	Basic Dental Plan Biweekly Cost	Enhanced Dental Plan Biweekly Cost	Basic Dental Plan Biweekly Cost	Enhanced Dental Plan Biweekly Cost
Employee Only	\$7.66	\$8.49	\$13.54	\$15.00
Double	\$15.02	\$17.65	\$26.53	\$31.19
Family	\$22.31	\$32.59	\$39.42	\$57.58

Vision Coverage – Pretax		
Plan Type	Basic Vision Plan	Enhanced Vision Plan
Coverage Level	Full & Part Time Biweekly Cost	Full & Part Time Biweekly Cost
Employee Only	\$3.96	\$5.91
Double	\$7.53	\$11.24
Family	\$11.05	\$16.50

Tobacco Surcharge	
Coverage Level	Biweekly Cost
One Tobacco User	\$55.00
Two Tobacco Users	\$110.00

Working Spouse Surcharge	
Coverage Level	Biweekly Cost
Double or Family	\$150.00

## Flexible Spending Accounts - Pretax

Plan Type	2019 IRS Annual Contribution Limit
Health Care FSA	\$2,650
Dependent Care FSA	\$5,000*

### \*Dependent Care IRS FSA Limits

If you are married and file your tax return jointly with your spouse, then you and your spouse are allowed to contribute up to the lesser of \$5,000 or the earned income of the lower-paid spouse.

If you are married and file separately, you and your spouse are each allowed to contribute up to the lesser of \$2,500 of your respective earned incomes.

**A Dependent Care FSA cannot be used for medical, dental or prescription expense reimbursements for a child.**

## MetLife – Accident Insurance

	Low Plan Option	High Plan Option
Coverage Level	Full & Part Time Biweekly Cost	Full & Part Time Biweekly Cost
Employee Only	\$3.20	\$5.96
Employee + Spouse	\$4.97	\$9.24
Employee + Child(ren)	\$5.79	\$10.77
Family	\$7.58	\$14.35

## MetLaw – Legal Insurance

Coverage Level	Full & Part Time Biweekly Cost
Employee Only	\$7.62
Double	\$7.62
Family	\$7.62

## Employee Optional Term Life Insurance Rates \*

YOUR AGE AT MONTH OF COVERAGE	BIWEEKLY RATE PER \$1,000 OF COVERAGE
Under 30	\$0.012
30 - 34	\$0.015
35 - 39	\$0.021
40 - 44	\$0.024
45 - 49	\$0.036
50 - 54	\$0.064
55 - 59	\$0.107
60 - 64	\$0.149
65 +	\$0.295

\*Actual calculated premium deduction may differ slightly due to rounding.

- ✓ **New Hire employees electing coverage of 4 or 5 times annual base pay, or \$500,000 or more in coverage are required to complete a Statement of Health (SOH) questionnaire which will be subject to approval by underwriting.**
- ✓ **Employees requesting a mid-year change in status event or an Annual Enrollment election or increase in coverage are required to complete a Statement of Health (SOH) questionnaire which will be subject to approval by underwriting.**

**Note: Any request for additional coverage is contingent upon underwriting review and approval.**

### Calculating the Cost of Optional Term Life Insurance

*Employee may elect 1,2,3,4 or 5 times annual base pay with a maximum amount of \$1,500,000.*

#### Step 1: Calculate the Total Coverage Elected

\$	x	1, 2, 3, 4, or 5 times	=	\$	*
Annual Base Salary (skip this box if Part Time)		Multiply Annual Base Salary		Coverage Amount*	
				If part time, enter 5,000; 10,000; 15,000; 20,000; 25,000 or 50,000	

\*Round Total Coverage Elected UP to the next \$1,000 (example: \$20,123 becomes \$21,000)

#### Step 2: Calculate your Biweekly Cost

\$	/ 1,000 =	\$	x	\$	=	\$
Coverage Amount				Biweekly Rate by Age (refer to table above)		Biweekly Premium Cost

## Spouse Term Life Insurance Rates\*

SPOUSE AGE AT MONTH OF COVERAGE	BIWEEKLY <u>RATE PER \$1,000</u> OF COVERAGE
Under 30	\$0.025
30 - 34	\$0.033
35 - 39	\$0.037
40 - 44	\$0.042
45 - 49	\$0.063
50 - 54	\$0.096
55 - 59	\$0.179
60 - 64	\$0.275
65 - 69	\$0.529
70 & Over	\$0.858

\*Actual calculated premium deduction may differ slightly due to rounding.

- ✓ **New Hire employees may purchase Spouse Term Life Insurance for \$10,000, \$20,000, \$30,000\*, \$40,000\*, or \$50,000\***

\*Elections of \$30,000, \$40,000, or \$50,000 require completion of a Statement of Health (SOH) questionnaire by the Spouse, which will be subject to approval by underwriting.

- ✓ **A mid-year change in status event or Annual Enrollment election in any coverage amount, or any other increase in coverage requires completion of a Statement of Health (SOH) questionnaire by the Spouse, which will be subject to approval by underwriting.**
- ✓ **Employees are not required to purchase Optional Life Insurance for themselves in order to purchase Optional Spouse Life Insurance**
- ✓ **Any request for additional coverage is contingent upon underwriting review and approval.**

### Calculating the Cost of Spouse Optional Term Life Insurance

*Employee may elect \$10,000; \$20,000, \$30,000, \$40,000, or \$50,000.*

#### Calculate your Biweekly Cost

$$\begin{array}{ccccccc}
 \boxed{\$ \phantom{00000}} & / 1,000 = & \boxed{\$ \phantom{00000}} & \times & \boxed{\$ \phantom{00000}} & = & \boxed{\$ \phantom{00000}} \\
 \text{Coverage Amount} & & & & \text{Rate by Age} & & \text{Biweekly Premium} \\
 & & & & \text{of Spouse} & & \text{Cost} \\
 & & & & \text{(refer to table above)} & & 
 \end{array}$$

<b>Dependent Child(ren) Term Life Insurance Rates*</b> <small>BIWEEKLY RATE COVERS ALL ELIGIBLE DEPENDENT CHILDREN</small>	
LEVEL OF COVERAGE ELECTED	BIWEEKLY RATE
\$5,000	\$0.300
\$10,000	\$0.600
\$15,000	\$0.900

\*Actual calculated premium deduction may differ slightly due to rounding.

- ✓ The biweekly rates shown are for the full level of coverage amount elected  
e.g., \$5,000 in coverage will cost \$0.300 per biweekly pay period.
- ✓ Statement of Health (SOH) is NOT required for child life insurance

<b>Accidental Death &amp; Dismemberment Insurance (AD&amp;D) Rates*</b>		
	BIWEEKLY RATES	
AMOUNT OF COVERAGE	EMPLOYEE ONLY	FAMILY COVERAGE (INCLUDES EMPLOYEE)
\$50,000	\$0.39	\$0.63
\$100,000	\$0.78	\$1.25
\$150,000	\$1.17	\$1.88
\$200,000	\$1.56	\$2.50
\$250,000	\$1.95	\$3.13
\$300,000	\$2.34	\$3.75
\$350,000	\$2.73	\$4.38
\$400,000	\$3.12	\$5.00
\$450,000	\$3.51	\$5.63
\$500,000	\$3.90	\$6.25

\*Actual calculated premium deduction may differ slightly due to rounding.

- ✓ Statement of Health (SOH) is NOT required for AD&D Insurance Coverage

### **Working Spouse Surcharge**

Applies to employees who choose to cover a spouse under the UC Health medical plan when the spouse has medical insurance coverage available through his/her employer but chooses not to enroll in that coverage.

### **Tobacco Surcharge**

Applies to employees and their spouse who use tobacco products and are covered under the UC Health medical plan.

The tobacco surcharge is \$55.00 per person per bi-weekly pay

### **Dependent Verification Documentation**

UC Health requires that employees provide documents to validate all dependents enrolling in UC Health benefits (also applies if the employee removes a dependent from the plan and then re-enrolls the dependent at a future date).

This requirement is part of an important initiative to ensure legal compliance and good governance, and is intended to aid in our continuing efforts to control healthcare costs.

### **Questions?**

**Contact: [Benefits@UCHealth.com](mailto:Benefits@UCHealth.com)  
(513) 585 – MYHR (6947)**

**Benefit Consultants are available M – F, 8am – 5pm**

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