**Premium Worksheet**

1. **Health:** Enter premium amount. The employer contribution has already been deducted. Add $30 if you or your spouse use tobacco products.
   
   Add $30 each if your A&M System Medical coverage began prior to September 1, 2016 and if you or your spouse have not had a preventive wellness exam processed through BlueCross BlueShield.

   - $_____________

2. **Dental:** Enter premium amount.
   - $_____________

3. **Vision:** Enter premium amount.
   - $_____________

4. **Optional Life:** Take your annualized salary, multiply by your coverage amount ($\frac{1}{2}, 1, 2, 3, 4, 5 \text{ or } 6$), and round down to the nearest thousand (maximum is $1,000,000$). Divide by 1,000: _________ × your age-based premium of _________ =
   - $_____________

5. **Alternate Basic Life:** Divide your coverage amount by 1,000: _________ × .878 =
   - $_____________*

6. **Dependent Life:**
   - **Plan A Premium:** Your spouse's age-based premium of _________ × (spouse coverage amount/1000) + (child coverage amount/1000 × .06) =
   - $_____________
   - **Plan B Premium:** $1.37/month (flat rate)
   - $_____________*
   - **Plan C Premium:** Your Alternate Basic Life premium (see #5) _________ × .5 (.1 if covering children only) =
   - $_____________

7. **Accidental Death and Dismemberment:** Choose your coverage amount and divide by 10,000: _________ × your premium of _________ =
   - (Maximum coverage is the greater of $250,000$ or 10 times your annual salary, not to exceed coverage of $800,000.)
   - $_____________

8. **Long-Term Disability:** Divide your annual salary by 12. Divide the lesser of that number or $12,307 by 100: _________ × your premium of _________ =
   - $_____________*

9. **Spending Accounts:** Enter Health Care Account monthly contribution $_____________ + Dependent Day Care Account monthly contribution $_____________ =
   - $_____________

10. **YOUR TOTAL MONTHLY COST** (Add 1 through 9) =
    - $_____________

    * The premiums may increase based on your salary.
    ** Include only premiums you choose to pay using the employer contribution.

Complete items 11 and 12 if you do not have A&M System health coverage but certify that you have other health coverage:

11. **Employer Contribution:** Enter the total of your premiums shown above for Dental (line 2), Vision (line 3), Alternate Basic Life (line 5), AD&D (line 7) and Long-Term Disability (line 8)** or $300.18 ($150.09 if part-time), whichever is less.
    - $_____________

12. **YOUR TOTAL MONTHLY OUT-OF-POCKET COST** (Subtract line 11 from line 10) =
    - $_____________