



MONTHLY RATES FOR THE 2023-24 PLAN YEAR

Faculty, Officers, University Staff and Classified Staff

Medical Plans	CU Health Plan — Exclusive			CU Health Plan — Extended		
	TOTAL RATE	CU COST	YOUR COST	TOTAL RATE	CU COST	YOUR COST
Employee only	\$780.00	\$699.50	\$80.50	\$838.50	\$699.50	\$139.00
Employee + Spouse	\$1,615.50	\$1,381.00	\$234.50	\$1,761.00	\$1,381.00	\$380.00
Employee + Child(ren)	\$1,486.00	\$1,337.50	\$148.50	\$1,595.00	\$1,337.50	\$257.50
Family	\$2,374.50	\$2,085.50	\$289.00	\$2,563.50	\$2,085.50	\$478.00
	CU Health Plan — High Deductible			CU Health Plan — Kaiser		
	TOTAL RATE	CU COST	YOUR COST	TOTAL RATE	CU COST	YOUR COST
Employee only	\$699.50	\$699.50	\$0.00	\$850.50	\$699.50	\$151.00
Employee + Spouse	\$1,408.00	\$1,381.00	\$27.00	\$1,763.50	\$1,381.00	\$382.50
Employee + Child(ren)	\$1,361.50	\$1,337.50	\$24.00	\$1,602.00	\$1,337.50	\$264.50
Family	\$2,124.50	\$2,085.50	\$39.00	\$2,578.50	\$2,085.50	\$493.00

Dental Plans	CU Health Plan — Essential Dental			CU Health Plan — Choice Dental		
	TOTAL RATE	CU COST	YOUR COST	TOTAL RATE	CU COST	YOUR COST
Employee Only	\$29.50	\$29.50	\$0.00	\$52.00	\$35.00	\$17.00
Employee + Spouse	\$59.00	\$42.00	\$17.00	\$104.00	\$52.50	\$51.50
Employee + Child(ren)	\$63.50	\$41.50	\$22.00	\$112.50	\$52.00	\$60.50
Family	\$92.50	\$43.00	\$49.50	\$164.00	\$58.00	\$106.00

Vision Plan	CU Health Plan — Vision		
	TOTAL RATE	CU COST	YOUR COST
Employee Only	\$6.25	\$0.00	\$6.25
Employee + Spouse	\$11.00	\$0.00	\$11.00
Employee + Child(ren)	\$11.75	\$0.00	\$11.75
Family	\$18.00	\$0.00	\$18.00



University of Colorado

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EMPLOYEE SERVICES

Address: 1800 Grant St.,
Suite 400, Denver, CO 80203

Email: benefits@cu.edu

Phone: 1-855-216-7740 (option 3)

On the Web
www.cu.edu/benefits



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Short-term Disability

Faculty and University Staff

Employees who qualify for this benefit will receive 60 percent of their weekly, pre-disability earnings, to a maximum of \$1,500.

To calculate your monthly coverage cost:

Steps	Example
Multiply your monthly salary by 0.60. This is the percentage of your monthly salary you'll receive while on short-term disability.	$\$5,000 \times .60 = \$3,000$
Divide that number by 100.	$\$3,000 / 100 = \30
Multiply this final amount by the option rate 0.1846. This is the amount of money that will be deducted from your pay each month for this coverage.	$\$30 \times .1846 = \5.54

Optional Term Life

This coverage includes Accidental Death and Dismemberment coverage for employee or spouse.

Age	Standard rate per \$1,000 of coverage	Discount rate per \$1,000 of coverage*
Under age 20	\$0.076	\$0.057
20-24	\$0.078	\$0.060
25-29	\$0.083	\$0.063
30-34	\$0.100	\$0.064
35-39	\$0.110	\$0.071
40-44	\$0.137	\$0.096
45-49	\$0.201	\$0.141
50-54	\$0.305	\$0.210
55-59	\$0.484	\$0.341
60-64	\$0.893	\$0.625
65-69	\$1.44	\$1.04
70-74	\$2.51	\$1.86
75+	\$4.50	\$2.08

*No tobacco use in the last 12 months.

Long-term Disability

Classified Staff

Multiply your monthly salary by the rate shown for your age to get your monthly premium amount.

Age	Vested*	Non-vested
Under age 30	\$0.0010	\$0.0028
30-34	\$0.0011	\$0.0034
35-39	\$0.0014	\$0.0042
40-44	\$0.0019	\$0.0058
45-49	\$0.0030	\$0.0089
50-54	\$0.0044	\$0.0132
55-59	\$0.0061	\$0.0194
60-64	\$0.0066	\$0.0199
65+	\$0.0081	\$0.0242

*You need five years of PERA service to be vested.

Optional Term Life

This coverage includes Accidental Death and Dismemberment coverage for children, with one enrollment covering all eligible children in your family.

	Coverage amount	Monthly cost
Option A	\$5,000 group term + \$5,000 AD&D	\$1.10
Option B	\$10,000 group term + \$10,000 AD&D	\$2.20

Voluntary AD&D

	Coverage amount	Monthly cost
Employee or Spouse	\$10,000 to \$250,000	\$0.28 for every \$10,000 in coverage
Child(ren)	\$5,000	\$0.14



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