HEALTH CARE REIMBURSEMENT PLAN
COMPENSATION REDUCTION WORKSHEET

This worksheet will help you estimate your annual medical costs for you and your dependents, which will not be reimbursed by insurance. This list is not all-inclusive, but it contains some of the more common medical expenses.

Remember to ***estimate the expenses you incur for yourself, your spouse, and dependents*** even if they are covered under another employer's insurance plan.

DEDUCTIBLES and CO-PAYS	**ESTIMATED ANNUAL EXPENSE**
Medical Plan Deductibles	$_____
Dental Plan Deductibles	$_____
Vision Plan Deductibles	$_____
Co-Pays (office visits – medical, dental, vision)	$_____
Prescription Drug Co-Pays	$_____
Over the Counter Drugs and Medicines	$_____
Dental / Vision Co-Pays	$_____

EXPENSES NOT FULLY COVERED BY MEDICAL, DENTAL and / or VISION PLANS

Physician's Services / Office Visits	$_____
Surgery	$_____
Ambulance Service	$_____
Well Baby Care	$_____
Prescription Drugs	$_____
Psychiatrists, Psychologists	$_____
Physical or Speech Therapy	$_____
Hearing Care (hearing aides, batteries, etc.)	$_____
Chiropractors	$_____
Acupuncture	$_____
Nursing Home Costs	$_____
Dental – Basic and Major (fillings, root canals, crowns, dentures, etc.)	$_____
Orthodontia	$_____
Eyeglasses, Contact lenses (Including solutions)	$_____
Laser Eye surgery	$_____
Other expenses	$_____
A. TOTAL ESTIMATED ANNUAL EXPENSES	$_____
B. NUMBER OF PAY PERIODS	$_____
C. AMOUNT OF REDUCTION PER PAY PERIOD	**$**_____