

UNREIMBURSED MEDICAL PLAN EMPLOYEE WORKSHEET

This worksheet will help you estimate your annual medical care costs, which may not be reimbursed by insurance. This list is not intended to be comprehensive, but it contains some of the more common medical expenses.

List all costs that are not reimbursed by other coverage incurred by you, your spouse and/or qualified dependents:

Qualifying Medical Care Expenses	Estimated Annual Expense
Co-pays & Deductibles	_____
Annual Physical Examinations	_____
Dental Examinations	_____
Orthodontia	_____
Eyeglasses and Prescription Sunglasses	_____
Contact Lenses & Saline Solution	_____
Prescription Drugs	_____
X-rays	_____
Lab Fees	_____
Immunizations including Flu Shots	_____
Chiropractors	_____
Hearing Aids	_____
Over-the-Counter Drugs— NEW!	_____
Ambulance Service	_____
Medical Monitoring/Testing Devices (blood pressure monitor, glucose kit, etc.)	_____
False Teeth	_____
Insulin	_____
Lasik Eye Surgery	_____
_____	_____
_____	_____
_____	_____
TOTAL ESTIMATED ANNUAL EXPENSES	(A) \$ _____
NUMBER OF PAY PERIODS IN A YEAR (i.e. 24, 26 ...)	(B) _____
AMOUNT OF REDUCTION PER PAY PERIOD (A/B)	\$ _____