

**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.

<u>DEDUCTIBLES and CO-PAYS</u>	<u>ESTIMATED ANNUAL EXPENSE</u>
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	\$ _____
 <u>EXPENSES NOT FULLY COVERED BY MEDICAL, DENTAL and / or VISION PLANS</u>	
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	\$ _____