

# Healthcare Reimbursement Account Worksheet

Type of Service (what plan pays for)	Cost	Frequency	Total Cost
<b>Prescription Drugs:</b> (Mail order: 90 day supply for 2 Co-Pays)	\$10, \$25, or \$40 (per script)	(per year)	
_____	_____	X_____	_____
_____	_____	X_____	_____
_____	_____	X_____	_____
_____	_____	X_____	_____
<b>Doctor's Office Visits</b> (HMO: \$20 PCP / \$25 Specialist Co-Pay) (PPO: \$20 Co-Pay PCP and Specialist)	\$20 / \$25 Co-pay		
_____	_____	X_____	_____
_____	_____	X_____	_____
_____	_____	X_____	_____
<b>Lab or X-ray</b> (HMO: 100%; MRI/CT Scan/PET Scan \$50 Co-Pay) (PPO 80% after \$500 Deductible)	Co-insurance and/ or PPO deductible		
_____	_____	X_____	_____
_____	_____	X_____	_____
_____	_____	X_____	_____
<b>Hospital Services (facility and professional)</b> (HMO: \$500 Deductible then 80% to \$1,500 total out-of-pocket) (PPO: \$500 Deductible then 80% to \$1,500 total out-of-pocket)	Co-insurance and/ or PPO deductible		
_____	_____	X_____	_____
_____	_____	X_____	_____
_____	_____	X_____	_____
<b>Chiropractic Care</b> (HMO: \$25 Specialist Co-pay; limited to 36 visits per year) (PPO: 80% after \$500 Deductible; limited to 40 visits per year)	Co-pay or Co-insurance and/ or PPO deductible		
_____	_____	X_____	_____

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<b>Outpatient Mental Health Services – Biologically based</b> (HMO: \$25 Specialist Co-pay) (PPO: \$20 Co-pay)	Co-pay	X	
_____	_____	X	_____
<b>Hearing Aids (under age 18; no coverage over age 18)</b> (80% after deductible up to maximum of \$1,400 per hearing impaired ear every three years)	Enter total cost	X	
_____	_____	X	_____
_____	_____	X	_____
<b>Vision Expenses</b> <b>Exams(1 exam every 2 years)</b> (HMO: \$25 copay) (PPO: \$20 Co-Pay)	Co-pay	X	
_____	_____	X	_____
_____	_____	X	_____
<b>Contacts/Glasses (Not covered under PPO or HMO)</b>	Enter total cost	X	
_____	_____	X	_____
_____	_____	X	_____
<b>Dental Expenses (under dental plan)</b> (Preventive care covered at 100% - Basic services at 80% after \$50 deductible)	Basic services deductible and co- pay	X	
_____	_____	X	_____
_____	_____	X	_____
<b>Major Services, such as crowns and dentures (Not covered under Dental Plan)</b>	Enter total cost	X	
_____	_____	X	_____
_____	_____	X	_____
<b>Orthodontia (Braces) (Not covered under Dental Plan)</b>	Enter total cost	X	
_____	_____	X	_____