Benefits Needs Estimator

YOUR HEALTH PLAN OUT-OF-POCKET COSTS		BENEFIT	PREMIUM
Hospital Confinement Daily Co-Pay _________ x ___ days =	_____________	_____________	_____________
Ambulance Service Co-Pay	_____________	_____________	_____________
Radiation/Chemotherapy Max. Out-of-pocket	_____________	_____________	_____________
Skilled Nursing Facility Daily Co-Pay_________ x ___ days =	_____________	_____________	_____________
Outpatient Surgical Co-Pay	_____________	_____________	_____________
Outpatient Therapy Co-Pay	_____________	_____________	_____________
Dental/Vision Average Monthly Costs	_____________	_____________	_____________

Potential Out-of-Pocket Costs $ _____________ Premium _____________

You shouldn’t have to worry about covering out-of-pocket medical expenses...