# Employee Worksheet

This worksheet will help you estimate the expenses for you, your spouse, and eligible dependents. Transfer the Deduction Per Pay Period for Health and Dependent Care to the Enrollment Form.

## Group Insurance Premiums

If you participate in your employer’s insurance plan(s), your premiums are deducted from your pay pre-tax unless you notify your employer otherwise.

## My BESTflex Plan Accounts

If you establish a Health Savings Account (HSA), you may only enroll in the Limited Health Care FSA, which can only reimburse you for eligible dental, vision and preventative expenses and the Dependent Care FSA.

## My Plan Dates (Refer to “My Company Plan” Eligibility section)

<table>
<thead>
<tr>
<th>My Effective Start Date (mm-dd-yyyy)</th>
<th>My Plan Year Start (mm-yyyy)</th>
<th>My Plan Year End (mm-yyyy)</th>
<th># Payroll Deductions</th>
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<tbody>
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## Examples of Eligible Health Care FSA Expenses:

### DENTAL SERVICES
- $______ Crowns/Bridges
- $______ Dental X-Rays
- $______ Dentures
- $______ Exams/Teeth Cleanings
- $______ Extractions
- $______ Fillings
- $______ Gum Treatments
- $______ Oral Surgery
- $______ Orthodontia/Braces

### INSURANCE-RELATED ITEMS
- $______ Copays
- $______ Coinsurance
- $______ Deductibles

### LAB EXAMS / TESTS
- $______ Blood Tests
- $______ Cardiograms
- $______ Diagnostic Fees
- $______ Laboratory Fees
- $______ Spinal Fluid Tests
- $______ Urine/Stool Analyses
- $______ X-Rays

### MEDICATION
- $______ Insulin
- $______ Prescribed Birth Control
- $______ Prescribed Vitamins*
- $______ Prescription Drugs (including co-pays)*

### OVER-THE-COUNTER MEDICINE

Important: Starting January 1, 2010, the following over-the-counter medicines can only be reimbursed by the BESTflex Plan with a doctor’s prescription:

- $______ Allergy Medicines
- $______ Antibiotics
- $______ Analgesics
- $______ Antacids
- $______ Anti-Diarrhea Medications
- $______ Anti-Itch Medications
- $______ Anti-Nausea Medications
- $______ Aspirin
- $______ Athletes Foot Creams and Powders
- $______ Cold Sore Remedies
- $______ Cough Drops
- $______ Cough Syrups
- $______ Decongestants
- $______ Eye Drops
- $______ Fever Reducers
- $______ First Aid Cream (Band-Aid, special ointments, calamine lotion, bug bite medication, wart remover treatments)
- $______ Digestive Tract Relief Medications
- $______ Flu and Cold Medications
- $______ Hemorrhoidal Medications
- $______ Laxatives
- $______ Lice and Scabies Treatments
- $______ Menstrual Cycle Products (for pain and cramp relief)
- $______ Motion Sickness Pills
- $______ Muscle / Joint Pain Relievers
- $______ Nasal Sinus Sprays
- $______ Nicotine Gum / Patches
- $______ Pain Relievers
- $______ Pedialyte
- $______ Retin A (non-cosmetic)
- $______ Rubbing Alcohol
- $______ Sinus Medications
- $______ Sleeping Aids
- $______ Smoking Cessation Products
- $______ Sore Throat Sprays
- $______ Special Ointments / Cream for Sunburns
- $______ Throat Lozenges
- $______ Vapor Rubs
- $______ Weight Loss Drugs (only to treat a specific disease)
- $______ Yeast Infection Treatments

### OTHER MEDICAL TREATMENTS / PROCEDURES
- $______ Acupuncture
- $______ Alcoholism (inpatient treatment)
- $______ Breast Pumps and Lactation Supplies
- $______ Chiropractor Services
- $______ Drug Addiction (inpatient treatment)
- $______ Hearing Exams
- $______ Hospital Services
- $______ Infertility
- $______ In-vitro Fertilization
- $______ Nonplant Insertion or Removal
- $______ Orthopedic Shoes
- $______ Pain Management
- $______ Physical Examination (not employment related)
- $______ Physical Therapy

### OTHER MEDICAL SUPPLIES/SERVICES
- $______ Abdominal/Back Supports
- $______ Ambulance Services
- $______ Arch Supports/Othotics
- $______ Counseling (except for Marriage and Family)
- $______ Crutches
- $______ Guide Dog (and other animal aides)
- $______ Hearing Aids & Batteries
- $______ Hospital Bed
- $______ Insulin Supplies
- $______ Learning Disability
- $______ Lead Paint Removal (if not capital expense and incurred for a disabled child)
- $______ Medic Alert Bracelet or Necklace
- $______ Medical Miles, Tolls, and Parking
- $______ Orthopedic Shoes**
- $______ OTC Equipment
- $______ Pregnancy Tests
- $______ Pre-Natal Vitamins
- $______ Prosthesis
- $______ Reading Glasses
- $______ Splints/Casts
- $______ Support Hose (if medically necessary)
- $______ Syringes
- $______ Transportation Expenses
- $______ Vitamins

### VISION EXPENSES
- $______ Contact Lenses
- $______ Contact Lens Solution
- $______ Eye Examinations
- $______ Eyeglasses
- $______ Laser Eye Surgery
- $______ Prescription Sunglasses
- $______ Radial Keratotomy/LASIK

### Subtotal

This list is not meant to be all inclusive. Other expenses not listed may also qualify. Please refer to Section 213 of the Internal Revenue Code or call our toll free customer service line 800 346 2126.

Some medically necessary items may be covered by the Health Care FSA if prescribed by a physician for a specific medical condition. The prescription should contain the specific medical condition and timeframe for treatment.

**Custom made shoes to treat or alleviate a specific medical condition. Included with the receipt should be a Letter of Medical Necessity from a physician. The excess cost above the normal cost of shoes is the eligible medical expense.

**Excludes drugs imported from Canada and other countries

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### OVER-THE-COUNTER (OTC) MEDICINE

Important note about OTC medicine reimbursement: The Health Care FSA only reimburses your OTC medicine expenses if you have a doctor’s prescription for them. Doctor’s prescriptions must include the patient name, medication name, dosage, time frame for treatment and any other state law requirements. Only OTC drugs and medicines with a prescription and filled by the pharmacy will be eligible for reimbursement. Make sure you plan your annual Health Care FSA election accordingly.

### Subtotal

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