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)

- My Effective Start Date (mm-dd-yyyy)  
- My Plan Year Start (mm-yyyy)  
- My Plan Year End (mm-yyyy)  
- # Payroll Deductions

**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:  
$_______ Eye Drops  
$_______ Fever Reducers  
$_______ First Aid Cream (Bactine, special diaper rash 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  
$_______ Patterning Exercises  
$_______ Physical Examination (not employment related)  
$_______ Physical Therapy

**OTHER MEDICAL SUPPLIES/SERVICES**  
$_______ Abdominal/Back Supports  
$_______ Ambulance Services  
$_______ Arches (requires doctor’s prescription)  
$_______ Artificial Contraceptives  
$_______ Counseling (except for Marriage and Family)  
$_______ Crutches  
$_______ Guide Dog (and other animal aides)  
$_______ Hearing Aids & Batteries  
$_______ Hospital Bed  
$_______ Insulin Supplies  
$_______ Learning Disability (special school/teacher)  
$_______ Lead Paint Removal (if not capital expense and incurred for a poisoned child)  
$_______ Medic Alert Bracelet or Necklace  
$_______ Medical Miles, Tolls, and Parking  
$_______ Orthopedic Shoes (cost above regular shoes)  
$_______ Oxygen Equipment  
$_______ Pregnancy Tests  
$_______ Pre-Natal Vitamins  
$_______ Prosthesis  
$_______ Reading Glasses  
$_______ Splints/Casts  
$_______ Support Hose (if medically necessary)  
$_______ Syringes  
$_______ Transportation Expenses (essential to medical care)  
$_______ Wheelchair  
$_______ Wigs (hair loss due to disease)

**VISION EXPENSES**  
$_______ Contact Lenses  
$_______ Contact Lens Solution  
$_______ Eye Examinations  
$_______ Eye glasses  
$_______ Laser Eye Surgeries  
$_______ Prescription Sunglasses  
$_______ Radial Keratotomy/LASIK

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.

**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.

*Excludes drugs imported from Canada and other countries

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