DIVERSIFIED BENEFIT SERVICES, INC.

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Flexible Benefit Plan Expense Worksheet

Use this worksheet to estimate your expenses. Plan Year: _____/_____/_____ to _____/_____/_____

Dependent Care FSA

Consider what expenses you will have in the next plan year for dependent care such as day care, adult care, etc. to allow you or your spouse to work or attend school full time. This is for dependents under the age of 13, adult dependents or other legal dependents.

Total Annual Amount $_____

Health Care FSA

Consider what expenses you and/or your spouse and legal dependents will have during the upcoming plan year that will not be paid for by insurance. Also look at what expenses you had during the past year or two and give a conservative estimate for what they might be for the upcoming plan year.
(Expenses must be incurred, this means having a date of service—not paid for—during the plan year.)

Health insurance deductible (not including premiums) $_____

Co-pays for medical expenses $_____

Dental insurance deductible $_____

Dental expenses such as exams, cleanings, fillings, caps, crowns, braces, bridges, x-rays, etc. $_____

Vision expenses such as exams, glasses, frames, contact lenses, supplies or LASIK surgery $_____

Hearing aids (including batteries) $_____

Prescription drugs $_____

Over-the-counter (OTC) drugs such as allergy and anti-inflammatory drugs, cold and flu medications, muscle relaxants, pain relievers, cough suppressants and acid reflux medications (OTC drugs require a prescription number) $_____

Other expenses (see additional expenses below) $_____

Total Annual Amount $_____

Additional Eligible Expenses for the Health Care FSA

- Acupuncture
- Alcoholism treatment
- Ambulance service fee
- AODA assessment
- Artificial teeth—medically necessary
- Artificial limbs
- Bandages
- Birth Control by prescription (and/or over-the-counter contraceptives)
- Braces
- Braille—books and magazines
- Breast pump and supplies
- Car controls for the disabled
- Care for mentally handicapped child
- Chiropractic expense
- Co-insurance amounts you pay
- Contact lenses
- Contact lens solutions and enzyme cleaners
- Cost and repair of special telephone equipment for the hearing-impaired
- Cost of medically necessary operations and related treatments
- Crutches
- Dental fees such as X-rays, cleanings, exams or crowns
- Dentures
- Diabetic supplies
- Diagnostic fees
- Disposable contact lenses
- Eye examinations
- Eyeglasses
- Fee for in-home practical nurse
- Hearing aid devices and batteries
- Hospital services
- In-patient treatment expense for drug and alcohol addiction
- Insulin
- Kera Vision Intacs surgery
- Laboratory fees as prescribed by a physician
- LASIK surgery
- Mammograms
- Medical deductibles
- Medical services
- Medical supplies (medically necessary)
- Mentally handicapped person's cost for special home nursing services for in-home care (including nurses' meals and Social Security tax)
- Mileage for medical care
- Obstetrical expenses
- Organ donor transplant medical expense payments for surgical, hospital, laboratory and transportation expenses
- Orthopedic inserts
- Osteopath fees
- Oxygen and medically necessary oxygen equipment
- Physician fees
- Physician-prescribed swimming pool or spa equipment costs and maintenance due to medically necessary reasons
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Radial keratotomy
- Routine physicals
- Seeing eye dog and its upkeep
- Smoking cessation programs (by prescription only)
- Special education for the blind
- Special plumbing for the handicapped
- Special school for mentally impaired or physically disabled person
- Sterilization fees
- Surgical fees
- Television audio display equipment for the hearing-impaired
- Therapy treatments for medically necessary reasons
- Transportation expenses primarily for and essential to rendering special medical services as prescribed by a physician
- Vitamins and nutritional supplements (with pre-approved letter of medical necessity from physician)
- Weight loss program fees (with pre-approved letter of medical necessity from physician)
- Wheelchair
- X-rays

Expenses NOT Eligible for Reimbursement

Surgery for cosmetic reasons

Medical supplies that are not medically necessary

Teeth bleaching/bonding/whitening

Health club membership dues

Over-the-counter vitamins and other dietary supplements for general health purposes

Cosmetic drugs

Marriage counseling

Group insurance premiums deducted from your paycheck

Your Estimated Plan Year Savings

Total plan year elections for the above categories: $_____

Multiply by approximately 30% (estimated tax savings): x 30%

This is your estimated tax savings for the plan year:
(Your savings may be different due to your effective income tax rate)

$_____

Note: If further verification is needed regarding whether an expense qualifies, please call our office at (800) 234-1229. Consult your tax advisor for maximum benefit. It is understood that Diversified Benefit Services, Inc. is not engaged in the practice of law or giving tax advice.