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.

### 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
- $______ Antihistamines
- $______ 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

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.

**OTHER MEDICAL SERVICES/SERVICES**
- $______ Abdominal/Back Supports
- $______ Ambulance Services
- $______ Arches (requires doctor’s prescription)
- $______ 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 other animal aides)
- $______ Laser Eye Surgeries
- $______ Medical Miles, Tolls, and Parking
- $______ Medical Supplies
- $______ Medical Сlocks
- $______ Medical Supplies
- $______ Medical Treatments/Procedures
- $______ Physical Therapy
- $______ Speech Therapy
- $______ Sterilization
- $______ Vaccinations and Immunizations
- $______ Vasectomy and Vasectomy Reversals
- $______ Well Baby Care

**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
- $______ Norplant Insertion or Removal
- $______ Orthopedic Shoes
- $______ Orthodontia/Braces
- $______ Physical Examination (not employment related)
- $______ Physical Therapy

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

Total Health or Limited Health FSA Election
- $______ Divided by #Payrolls = Deduction per Pay Period

Total Dependent Care FSA Election
- $______ Divided by #Payrolls = Deduction per Pay Period