

S125 FLEXIBLE BENEFITS PLAN EXPENSE ESTIMATE WORKSHEET

MEDICAL EXPENSES

	<u>Total Annual Expenses for the Current Plan Year</u>			<u>Estimated Annual Expenses for the New Plan Year</u>
	<u>Employee</u>	<u>Spouse</u>	<u>Dependents</u>	
Deductibles	\$ _____	\$ _____	\$ _____	\$ _____
Coinsurance and/or co-payments	\$ _____	\$ _____	\$ _____	\$ _____
Medical expenses partially covered or not covered by insurance plan:				
Prescription drugs	\$ _____	\$ _____	\$ _____	\$ _____
Physician & hospital costs	\$ _____	\$ _____	\$ _____	\$ _____
Emergency service	\$ _____	\$ _____	\$ _____	\$ _____
Vision & hearing				
Eyeglasses and exam	\$ _____	\$ _____	\$ _____	\$ _____
Contact lens (& solution)	\$ _____	\$ _____	\$ _____	\$ _____
Over-the-Counter medicines	\$ _____	\$ _____	\$ _____	\$ _____
Chiropractic/Acupuncture Expenses	\$ _____	\$ _____	\$ _____	\$ _____
Other qualified expenses _____	\$ _____	\$ _____	\$ _____	\$ _____
Total Medical Expenses	\$ _____	+ \$ _____	+ \$ _____	= \$ _____

DENTAL EXPENSES

Dental expenses partially covered or not covered by an insurance plan:				
Restorative services (i.e. fillings)	\$ _____	\$ _____	\$ _____	\$ _____
Oral surgery (i.e. root canal)	\$ _____	\$ _____	\$ _____	\$ _____
Orthodontics (braces)	\$ _____	\$ _____	\$ _____	\$ _____
Prosthodontics (i.e. dentures)	\$ _____	\$ _____	\$ _____	\$ _____
Deductibles, coinsurance or copayments (if you use a dental plan)	\$ _____	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____	\$ _____
Total Dental Expenses	\$ _____	+ \$ _____	+ \$ _____	= \$ _____

TOTAL HEALTHCARE EXPENSES

\$ _____ **\$ _____**