

Flex Save Expense Worksheet

Instructions: Estimate the expenses you expect to incur during the plan year (January – December) for you and your dependents for the following items. (Note: These items are the expense that is NOT covered by our medical, dental, and or vision insurance)

REMEMBER: Be conservative when you estimate eligible expenses because any money put into a Flex Save Account and not used will be forfeited at the end of the plan year.

<u>Unreimbursed Healthcare Expense</u>	<u>Current Year's Out of Pocket Expenses</u>	<u>Projected Next Year's Out of Pocket Expenses</u>
Routine Annual Exams	_____	_____
Immunizations	_____	_____
Prescription Drugs	_____	_____
Deductibles	_____	_____
Co-Pays	_____	_____
Co-Insurance	_____	_____
Allergy Testing	_____	_____
Dental Exams/Fillings	_____	_____
Bridges/Crowns	_____	_____
Orthodontia	_____	_____
Over the Counter items (with prescripion from your Doctor	_____	_____
Vision Expenses – Eyeglasses, Contact Lenses	_____	_____
Hearing Exam/Hearing Aid	_____	_____
Other	_____	_____
Other	_____	_____

TOTAL of Next Year's Projected Out-of-Pocket Healthcare Expenses _____
 Divide total on previous line by the number of pay periods in plan year: _____
 What you want to consider for your Flex Save Amount for Next Year _____

FLEX SAVE ACCOUNT PLAN YEAR Maximum \$2400.00