



SINCE 1953

BENEFIT ADMINISTRATION CORPORATION

FLEXIBLE BENEFITS PLAN ANNUAL EXPENSE WORKSHEET

ANNUAL EXPENSE

PART I Group Medical Insurance Premium Expenses \$
Enter on the FLEXIBLE BENEFITS Enrollment Form under Medical Premium

PART 2 Medical Reimbursement Expenses

Listed below are medical expenses you and your family may have that are not completely covered by insurance. Estimate your annual medical related expenses** not paid by group insurance for the upcoming plan year:

- Allergy medicines (Prescription Required)
Antacids (Prescription Required)
Child Birth (portion not covered by insurance)
Chiropractor
Cold medicines (Prescription Required)
Contraceptives
Contact Lens Solution
Co-Payments
Dental Care Expenses (routine checkups, filings)
Deductibles
Fees to doctors, hospitals (not covered by insurance)
First aid Kits
Hearing Aids
Immunization & inoculations
Incontinence supplies (Prescription Required)
In Vitro fertilization
Orthodontic Expense
Oxygen Equipment
Pain relievers (Prescription Required)
Psychiatric Therapy, Psychological Treatments
Routine Physicals
Special education for Deaf and Blind
Substance Abuse Rehabilitation
Support for corrective devices (i.e. Orthopedic shoes)
Transportation to receive health care (\$.165 per mile)
Tuition for special school for handicapped
Vision Care (contact lenses, eyeglasses, etc.)
Other

TOTAL*

*Determine the portion you want withheld. Divide that amount by your number of pay periods and enter on the FLEXIBLE BENEFIT Enrollment Form under Health Care Flexible Spending Account.

**Insurance premiums are not eligible medical related expenses.

Effective January 1, 2011, over-the-counter (OTC) medications must be accompanied by a doctor's prescription. This new legislation affects OTC medications only. Most other supplies are still eligible for reimbursement. If you have questions or concerns please feel free to contact our office. You may also visit http://www.irs.gov/pub/irs-drop/n-10-59.pdf for a complete listing of updates.