

# S125 FLEXIBLE BENEFITS PLAN EXPENSE ESTIMATE WORKSHEET

## MEDICAL EXPENSES

	<u>Total Annual Expenses for New Plan Year (per individual)</u>			<u>Total Expenses For New 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	\$ _____	\$ _____	\$ _____	\$ _____
Contact lens (& solution)	\$ _____	\$ _____	\$ _____	\$ _____
Other expenses	\$ _____	\$ _____	\$ _____	\$ _____
Over the Counter Products:	\$ _____	\$ _____	\$ _____	\$ _____
Other _____:	\$ _____	\$ _____	\$ _____	\$ _____
<b>Total Medical Expenses</b>	<b>\$ _____ + \$ _____ + \$ _____ = \$ _____</b>			<b>\$ _____</b>

## DENTAL EXPENSES

Deductibles	\$ _____	\$ _____	\$ _____	\$ _____
Coinsurance and/or co-payments	\$ _____	\$ _____	\$ _____	\$ _____
Dental expenses partially covered or not covered by insurance plan:				
Restorative services (i.e. fillings)	\$ _____	\$ _____	\$ _____	\$ _____
Oral surgery (i.e. root canal)	\$ _____	\$ _____	\$ _____	\$ _____
Orthodontics (braces)	\$ _____	\$ _____	\$ _____	\$ _____
Prosthodontics (i.e. dentures)	\$ _____	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>Total Dental Expenses</b>	<b>\$ _____ + \$ _____ + \$ _____ = \$ _____</b>			<b>\$ _____</b>

<b>TOTAL EXPENSES</b>	<b>\$ _____ + \$ _____ + \$ _____ = \$ _____</b>			<b>\$ _____</b>
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