

Flex Benefit Plan WORKSHEET

Visit www.advantageadmin.com for a list of covered items

Now that you know about the many ways you can use pre-tax earnings to keep more of what you earn, take a moment to fill out this worksheet to determine how much money you'll save annually by participating in your employer's flex benefit plan.

Simply check off the items you wish to save for and budget how much you'll spend in the upcoming year on those products and services. Fill in the estimate in the space next to each item. Then add up each category and place those totals in the corresponding section below the checklist.



HEALTHCARE EXPENSES (estimated) FOR EXPENSES NOT COVERED BY INSURANCE

- | | | | |
|--|----------|---|----------|
| <input type="checkbox"/> Co-pays to doctors & pharmacies | \$ _____ | <input type="checkbox"/> Sealants, crowns, bridges & dentures | \$ _____ |
| <input type="checkbox"/> Oxygen, insulin, syringes & supplies | \$ _____ | <input type="checkbox"/> Walkers, canes & wheelchairs | \$ _____ |
| <input type="checkbox"/> Dual Purpose Items (Letter of Medical Necessity is needed in order for these items to be flex eligible) | \$ _____ | <input type="checkbox"/> Braces, spacers & retainers | \$ _____ |
| <input type="checkbox"/> Special schooling for disabled child | \$ _____ | <input type="checkbox"/> Arches & orthopedic shoes | \$ _____ |
| <input type="checkbox"/> Prescription drugs | \$ _____ | <input type="checkbox"/> Wisdom teeth, implants & oral surgery | \$ _____ |
| <input type="checkbox"/> Wigs for hair loss caused by disease | \$ _____ | <input type="checkbox"/> Artificial limbs & braces | \$ _____ |
| <input type="checkbox"/> Office visits & checkups | \$ _____ | <input type="checkbox"/> Psychologist & psychiatrist fees | \$ _____ |
| <input type="checkbox"/> Reconstructive surgery (birth defect, disease) | \$ _____ | <input type="checkbox"/> Physical & speech therapy | \$ _____ |
| <input type="checkbox"/> Prescribed sunglasses & eyeglasses | \$ _____ | <input type="checkbox"/> Obstetrics & fertility | \$ _____ |
| <input type="checkbox"/> Medical alert bracelet & fees | \$ _____ | <input type="checkbox"/> Hearing aids, batteries & exams | \$ _____ |
| <input type="checkbox"/> Contact lenses, solutions & supplies | \$ _____ | <input type="checkbox"/> Lab tests & body scans | \$ _____ |
| <input type="checkbox"/> Alcoholism & drug treatment | \$ _____ | <input type="checkbox"/> Chiropractic & podiatrist fees | \$ _____ |
| <input type="checkbox"/> Eye exams, surgery & LASIK | \$ _____ | <input type="checkbox"/> Travel & mileage to doctor or hospital, etc. | \$ _____ |
| <input type="checkbox"/> Quit-smoking program & medications | \$ _____ | <input type="checkbox"/> Misc/Other | \$ _____ |
| <input type="checkbox"/> Dental cleanings, fillings & x-rays | \$ _____ | | |
| <input type="checkbox"/> Weight-loss program (prescribed by doctor) | \$ _____ | | |

TOTAL OPTION 1 \$ _____

DEPENDENT CARE EXPENSES (estimated) SO YOU CAN WORK

- | | | | |
|--|----------|--|----------|
| <input type="checkbox"/> Nanny & babysitter | \$ _____ | <input type="checkbox"/> Before & after-school care | \$ _____ |
| <input type="checkbox"/> Day camp | \$ _____ | <input type="checkbox"/> Elder daycare for parent or dependent | \$ _____ |
| <input type="checkbox"/> Pre-K or nursery school | \$ _____ | | |
| <input type="checkbox"/> Daycare for a disabled adult or child | \$ _____ | | |

TOTAL OPTION 2 \$ _____

ESTIMATED ANNUAL EXPENSES AND TAX SAVINGS

TOTAL 1 _____ + **TOTAL 2** _____ + Other _____ = \$ _____

Save between 25% and 40% on FICA, federal & state income tax (in applicable states).

x 36%

Based on national averages, you'll save 25% if your annual household earnings are less than

\$30,000, 36% if you earn \$30,000 to \$60,000, or 40% if you earn more than \$60,000.

Federal and/or plan limits apply to all options. See your summary plan description for plan limits.

YOU SAVE \$ _____