SMART·ER·START HEALTHCARE SAVINGS TOOLS

(*if you are enrolling*)

- ► Healthcare Expense Estimator
- ► Dependent Care Expense Estimator
- ► Tax Savings Estimator

Healthcare Expense Worksheet

(*For Your Records Only. Do Not Turn In.*)

Instructions:
Using this form, you can identify an estimate of the amount of annual medical, dental, vision, and childcare expenses you pay out-of-pocket. You may find it helpful to review your expenses last year and adjust that amount by any new information you may have.

Eligible Expenses	Copayments	Deductible	Coinsurance	Other	Total
Baby/Child					
Lactation Consultant*					
Lead Paint Removal					
Special Formula*					
Special School Tuition (Disability or Learning Disability)					
Well Baby/Well Childcare					
Dental					
X-Rays					
Dentures/Bridges					
Exams/Teeth Cleaning					
Extractions/Fillings					
Oral Surgery					
Orthodontia					
Periodontal Services					
Vision					
Eye Exams					
Eyeglasses and Contacts					
Laser Eye Surgeries					
Prescription Sunglasses					
Radial Keratotomy					
Hearing					
Hearing Aids / Batteries					
Hearing Exams					
Diagnostic Lab/X-Ray					
Blood Tests					
Metabolism Tests					
Body Scans					
Cardiograms					
Laboratory Fees					
X-Rays					
Medical Equip / Supplies					
Air Purification Equip.*					
Arches/Orthotic Inserts					

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Eligible Expenses	Copayments	Deductible	Coinsurance	Other	Total
Medical Equip / Supplies					
Contraceptive Devices					
Crutches and Walkers					
Wheelchairs					
Exercise Equipment*					
Hospital Beds*					
Mattresses*					
Medic Alert Bracelet, Etc.					
Nebulizers					
Orthopedic Shoes*					
Oxygen*					
Post-Mastectomy Clothing					
Prosthetics					
Syringes					
Wigs*					
Medical Services					
Acupuncture					
Inpatient/Outpatient Alcohol/Drug Treatment					
Ambulance					
Fertility Treatment					
Hair Loss Treatment*					
Hospital Services					
Immunizations					
In Vitro Fertilization					
Physical Examination					
Reconstructive Surgery (congenital defect or accident or medical treatment)					
Service Animals					
Sterilization / Reversal					
Transplants (including donor)					
Transportation*					
Medications					
Insulin					
Prescription Drugs					
Obstetrics					
Doulas*					
Lamaze Class					
OB/GYN Exams					
Pre- and Postnatal Svcs.					

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Eligible Expenses	Copayments	Deductibles	Coinsurance	Other	Total
Practitioners					
Allergist					
Chiropractor					
Christian Science Practitioner					
Dermatologist					
Homeopath					
Naturopath*					
Optometrist					
Physician					
Psychiatrist/Psychologist					
Outpatient Therapies					
Alcohol & Drug Addiction					
Counseling (not marital or career)					
Exercise Programs*					
Hypnosis					
Massage*					
Occupational					
Physical					
Smoking Cessation Programs					
Speech					
Weight Loss Programs*					
Over-The-Counter Items *(prescription not required)*					
Antiseptics, Wound Cleaners					
Baby Electrolytes					
Denture Adhesives, Repair, Cleansers					
Diabetes Testing and Aids					
Diagnostic Products *(thermometers, blood pressure monitors, cholesterol testing)*					
Elastic Bandages, Athletic Treatments *(ACE, braces, hot/cold therapy, orthopedic supports)*					
Contact Lens Care					

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Eligible Expenses	Copayments	Deductibles	Coinsurance	Other	Total
Over-The-Counter Items *(prescription not required)*					
Family Planning *(pregnancy and ovulation kits)*					
First Aid Dressing and Supplies					
Hearing Aid/Batteries					
Incontinence Products					
Reading Glasses and Maintenance Accessories					
All Other Over-The-Counter Items ***(****prescription* ***REQUIRED)***					
Effective 1/1/2011, all Over-the-Counter medications require a prescription unless otherwise noted above.					
Total Healthcare Expenses **(enter on line #1-next page)**	**$**	**$**	**$**	**$**	**$**

*=Potentially eligible expenses requiring proof of medical necessity to qualify for reimbursement.

Dependent Care Expense Worksheet

(*For Your Records Only. Do Not Turn In.*)

Eligible Expenses	Amount
Day Care Expenses	
Before and After School Care	
Preschool	
Day Camp	
Day Care Center	
Au Pair (Nanny)	
Transportation (*if provided by Day Care Center*)	
Sick Child Facility	
FICA/FUTA Taxes of Provider	
Elder Day Care (*parent claimed as dependent on tax return*)	
Total Dependent Care Expenses ***(enter on line #2 – next page)***	**$**

My Tax Savings (*Optional Calculation*)

Line #	My Data	My Results
1	My Total Healthcare Expense Estimate (page 13)	
2	My Total Dependent Care Expense Estimate (above)	**+**
3	Total Annual Estimated Expenses:	**=**
4	My Federal Tax Bracket	%
5	My State Tax Bracket	+ 6.00%
6	My FICA Tax Bracket	+ 7.65%
7	Total Tax Percentage:	= %
8	Multiply Line 7 x Line 3	=
9	Less: Estimated Child Care Credit from Federal Income Tax Form (if itemized)	-
10	**My Tax Dollars Saved by Using the Cafeteria Plan**	**=**

** This is a quick estimation tool. Please consult your financial advisor for specific questions or amounts as they relate to your personal situation.**