EBS-RMSCO, Inc.

FSA Estimated Annual Expense Worksheet

Use this worksheet to help estimate your out-of pocket health and/or dependent care expenses for the Plan year. You may include expenses for anyone who will be included on your Federal Tax Return (i.e. spouse, children, etc).

Remember: You can not change your election during the Plan year unless you experience a qualifying change in status.

Health Care Account	**Annual Expense**
Deductibles	$
Co-payments	$
Routine Well Visits	$
Dental Expenses not covered by insurance	$
Orthodontia	$
Vision Expenses *(Exams, Glasses, Contact Lenses)*	$
Hearing Expenses *(Exams, Hearing Aids)*	$
Prescription Drugs	$
Over the Counter Drugs	$
Diabetic Supplies	$
Therapy/Treatments *(Physical Therapy, Speech, Chiropractic)*	$
Mileage for medical care related transportation	$
Other Medically Necessary Un-reimbursed Expenses	$
Total Estimated Health Care Expenses (A)	$

Dependent Care Account	**Annual Expense**
Payment to a Dependent Care Facility	$
Payment to a Dependent Care Individual	$
Payment to Adult Care Provider	$
Total Estimated Dependent Care Expenses (B)	$

Health Care + Dependent Care Total	**Total Expense**
Total Estimated Annual Expenses (A)+(B) = (C)	**$**

Summary				
$__________ Total Annual Expenses (C)	÷ Divided by	__________ Number of Pay Periods *	= Equals	$__________ Total Per Pay Period Deduction

**If enrolling mid year, account for the number of pay periods remaining in current Plan year.*