

Healthcare Flexible Spending Account (FSA) Worksheet/Election Calculator



Examples of Eligible Expenses

Medical: deductibles, co pays, co-insurance, diagnostic tests, durable medical equipment, lab work, chiropractic care, acupuncture, and massage therapy.

Dental: exams, x-rays, cleanings, fillings, sealants, root canals, dentures, crowns and orthodontia.

Vision: exams, contacts, glasses, laser eye surgery, prescription sunglasses, and contact lens solution.

Prescriptions: all prescriptions are covered. This includes over the counter medications with a RX.

Over the Counter: first aid supplies, hearing aids, orthopedic inserts, thermometers, and sunscreen.

*Treatments for cosmetic reasons are not covered.

*Some services/purchases need to have a note of medical necessity or prescription to be eligible.

*You can access an updated list of eligible expenses at: <http://hcet.ebia.com/hrcllc>. Please contact HRC for access code first. Please note this list of eligible expenses is subject to change according to the IRS.

Examples of Ineligible: cosmetic surgery, teeth whitening, toothpaste, family counseling, shampoo, laser hair removal and deodorant.

Examples of Expenses requiring documentation: vitamins, pain relief, digestive aids, allergy medication, acid controllers, cold & flu medications and eye drops.

(These items must be used to treat the condition and cannot be for preventative purposes. A doctor's prescription or note of medical necessity is required.)



How Do You Determine Your Expenses?

You can use this worksheet to estimate how much you will need to put into your FSA. Please be conservative and don't forget that this account covers you, your spouse, and eligible children.

<u>Health Care Expenses</u>	<u>You</u>	<u>Your Spouse</u>	<u>Your Children</u>
Deductibles:			
Medical	\$ _____	\$ _____	\$ _____
Dental	\$ _____	\$ _____	\$ _____
Vision	\$ _____	\$ _____	\$ _____
Co-pays:			
Medical	\$ _____	\$ _____	\$ _____
Dental	\$ _____	\$ _____	\$ _____
Dental Care	\$ _____	\$ _____	\$ _____
Prescriptions	\$ _____	\$ _____	\$ _____
Vision Care:			
Eye Exams	\$ _____	\$ _____	\$ _____
Glasses	\$ _____	\$ _____	\$ _____
Contacts	\$ _____	\$ _____	\$ _____
Chiropractic	\$ _____	\$ _____	\$ _____
Other	\$ _____	\$ _____	\$ _____
Total Estimated Expenses	(A.) \$ _____	(B.) \$ _____	(C.) \$ _____
(Total Annual Election)	(D.) \$ _____	(Add total of lines A, B and C above)	

<p>Number of Pay Periods In Plan Year (E.) _____</p>	<p>Divide Line D. Above By Line E. (This is your deduction per payroll) \$ _____</p>
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Dependent Care Account (DCA) Worksheet/Election Calculator



Things To Remember

Understand that your election is based on the eligible expenses allowed by the IRS. These expenses must meet the following requirements:

1. Daycare expenses must be incurred during the plan year for the care of a dependent age 12 or younger.
2. Daycare expenses may be incurred for a spouse or other tax dependent that is mentally or physically incapable of caring for him or herself.
3. The expense needs to be incurred during the time that you and your spouse (if applicable) are gainfully employed and at work.
4. The daycare provider must be either a babysitter that cares for the dependent in or outside of your home or a daycare center that meets state and local requirements, such as, a pre-school, summer day camp, and after school programs. Any form of day care provider you use needs to provide you with a tax ID or social security number.
5. Expense cannot exceed your taxable compensation, or your spouse's actual earned income.

You can use this worksheet to estimate how much you will need to put into your DCA. Please remember to be conservative, but don't forget that all the money you put into this account goes in on a pre-tax basis and comes out tax-free!



How Do You Determine Your Expenses?

Weekly Dependent Care Expenses

Preschool	(A.)\$ _____
Daycare	(B.)\$ _____
Baby Sitting	(C.)\$ _____
After School Programs	(D.)\$ _____
Adult Daycare	(E.)\$ _____

Total Estimated Weekly Daycare Expenses (F.)\$ _____ (Add Lines A - E)

Total Estimated Annual Dependent Care Expenses This Plan Year (G.)\$ _____

(Multiply Line F. above by the total number of weeks this plan year. Please remember that this amount cannot exceed \$5,000 Or \$2,500 if married and filing separately. If it does, please adjust the amount accordingly)

<p>Number of Pay Periods In Plan Year (H.) _____</p>	<p>Divide Line G. Above By Line H. (This is your deduction per payroll) \$ _____</p>
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QUESTIONS?... Please don't hesitate to contact HR Concepts!



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