

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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