



# ELECTION WORKSHEET

## HOW MUCH SHOULD I CONTRIBUTE?

Use this worksheet to help estimate your annual FSA or HSA election:\*\*

MEDICAL EXPENSES NOT COVERED BY INSURANCE	Current Year's OOP* Expenses (\$)	Next Year's Estimated OOP* Expenses (\$)
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Annual Physical/Routine Exam:

Copays/Coinsurance:

Deductibles:

Diabetic Supplies:

Immunizations (flu shots, etc.):

Laboratory Fees:

Maternity Expenses:

Over-the-Counter Drugs:

Prescription Drugs:

Psychiatric/Psychologist Fees:

Other:

### Dental Expenses Not Covered by Insurance

Check Ups/Cleanings:

Copays/Coinsurance:

Crowns/Bridges/Dentures:

Deductibles:

Fillings:

Oral Surgery:

Orthodontia (braces):

Root Canals:

Other:

### Vision Expenses Not Covered by Insurance

Contact Lenses:

Contact Cleaners/Solutions:

Copays/Coinsurance:

Corrective Eye Surgery:

Deductibles:

Eye Exams:

Eyeglasses:

Other:

Total Out-of Pocket Expenses:	\$0	\$0
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When deciding how much to set aside for next year's medical expenses, think about the following:

- + Does anyone in your family have any medical, dental or vision expenses that will not be covered by insurance?
- + Does anyone in your family need prescription eyeglasses, contact lenses and contact solutions or cleaners?
- + Is anyone in your family currently in orthodontics (braces) or do you expect anyone to begin treatment in the next year?
- + Does anyone in your family have an ongoing illness that requires frequent doctor visits and/or medication?

*\*Out-Of-Pocket*

*\*\*Election amount may not exceed your plan's cap or the maximum contribution amount allowed by the IRS, whichever is less.*