



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 (\$)

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

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.*