Health Care Expenses Worksheet

Use this worksheet to estimate the health care expenses you (and your eligible dependents) expect to incur during the plan year that will not be reimbursed from another source (that is, insurance). The total you get here is the total amount you may want to deposit in your Health Flexible Spending Account. Remember to be conservative in your estimates because any unused balances in your Health FSA are forfeited.

ESTIMATE YOUR UN-REIMBURSED COSTS FOR:

Medical:

Medical deductibles	$_____
Out-of-Pocket payments	$_____
Routine exams (OB-GYN, physicals, etc.)	$_____
Medical Office Co-payments ($10 per visit, for example)	$_____
Prescription Drugs (including birth control, allergy shots, insulin)	$_____
Hearing aids and exams	$_____
Vision Care (eye exams, contact lenses, prescription eyeglasses)	$_____
Medically required equipment (wheelchair, prosthetic devices)	$_____
Chiropractor	$_____
Emergency Room charges	$_____
Over-the-counter medications	$_____
Other medical expenses not covered by insurance	$_____

Dental:

Dental deductibles	$_____
Co-insurance payments	$_____
Orthodontia (braces, retainers)	$_____
Other Dental expenses not covered by insurance:	$_____
_____	$_____
_____	$_____

TOTAL HEALTH CARE EXPENSES $_____
(indicate this amount on your Enrollment Form)

Note: To determine the impact on each paycheck, divide your Total Health Care Expenses by the number of pay periods remaining in the plan year.

$_____ / _____ =_____/paycheck