Limited Purpose FSA Eligible Expense List

IMPORTANT: An LP FSA covers eligible dental, orthodontia and vision expenses only and is intended for employees enrolled in a Health Savings Account (HSA).

Eligible Dental & Orthodontia Expenses

Dental care for non-cosmetic purposes, such as:

- Cleanings and exams
- Crowns and bridges
- Dental reconstruction, implants
- Dentures and denture care
- Diagnostic services
- Fillings
- Root canals
- X-rays

Dental plan copays

Dental plan co-insurance

Dental plan deductibles

Dental surgery

Diagnostic services

Orthodontia work and appliances

Over-the-counter dental products that do not contain a drug or medicine

Over-the-counter dental products that contain a drug or medicine

Teeth grinding prevention devices, such as occlusal guards

Eligible Vision Expenses

Contact lenses

Contact lens solution

Diagnostic services

Eye exams

Eye related equipment/materials

Eyeglasses (over-the-counter and prescription)

Eyeglass repair kit

Eye surgery

Guide dog (dog, training and care)

Optometrist/ophthalmologist fees

Orthokeratology

Over-the-counter vision products that do not contain a drug or medicine

Over-the-counter vision products that contain a drug or medicine

Sunglasses (prescription only)

Vision plan co-insurance

Vision plan copays

Vision plan deductibles

Vision correction, such as corneal keratotomy and Lasik eye surgery

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If you have questions on what constitutes an LP FSA eligible expense, please contact our Customer Relations Team through online chat, 1-888-401-FLEX(3539) or email info@benstrat.com.

Ineligible Expenses Examples

Teeth Bleaching/Whitening
Cosmetic Dental Surgery
Dental Hygiene Products (Ex: Toothpaste)
Medical Treatment & Care

Election Worksheet

The Limited Purpose FSA and Dependent Care Election Worksheets can help you determine how much to set aside in your FSA. You can also use the Tax Savings Calculator at **benstrat.com.**

Important: Make a conservative election, only considering expenses that are expected to be incurred by you and your FSA eligible dependents while you are enrolled during the FSA plan year.

Limited Purpose FSA Election Worksheet

Dental and Vision Expenses Per Plan Year	For You	For Your Spouse	For Your Children
Dental copays, co-insurance, deductibles	**$**	**$**	**$**
Dental Exams and Dental Work and Orthodontia	**$**	**$**	**$**
Orthodontia	**$**	**$**	**$**
Eye Exams, LASIK Surgery	**$**	**$**	**$**
Prescription Eyeglasses, Reading Glasses, Contact Lenses etc.	**$**	**$**	**$**
Other Eligible Dental and Vision Expenses	**$**	**$**	**$**
Total each family member column	**(A)$**	**(B)$**	**(C)$**
Total cost of dental and vision expenses for the plan year (A)+(B)+(C)	**(D)$**		
Maximum LP FSA election amount (refer to your LP FSA enrollment form for plan maximum)	**(E)$**		
Election Amount. Enter (D) or (E), whichever is less	**(F)$**		
Number of pay periods in a plan year	**(G)**		
Payroll deduction amount per pay period (F) ÷ (G)	**$**		

Dependent Care FSA Election Worksheet

Eligible weekly dependent care cost	**(A)$**
Weeks of dependent care you will have in the plan year	**(B)**
Total cost of dependent care for the plan year (A) x (B)	**(C)$**
If you are single or married filing jointly enter $5,000 If you are married filing single, enter $2,500	**(D)$**
Election amount. Enter (C) or (D), whichever is less	**(E)$**
Number of pay periods in a plan year	**(F)**
Payroll deduction amount per pay period (E) ÷ (F)	**(G)**