ELECTION WORKSHEET
HOW MUCH SHOULD I CONTRIBUTE?

Use this worksheet to help estimate your annual FSA:**

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.*

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