FSA Worksheet

Use this worksheet to help calculate your eligible FSA expenses. This is not an all-inclusive list of eligible expenses, but it contains some of the most common ones. Identify the amounts you spent last year, adjust the expenses based on your future health care needs and enter the amounts in the spaces below. Remember, to be eligible for reimbursement, incurred expenses cannot be reimbursed from another source, e.g., the UAS Medical Plan. It is your responsibility to be sure that expenses qualify for reimbursement. Call TASC at 800-422-4661 to ensure that your anticipated expenses qualify for reimbursement. After an election is made, it cannot be revised or revoked unless you experience a qualified family status change. Remember, eligible expenses must be incurred by December 31 of the current plan year and reimbursement claims must be made by March 31 of the following year.

ANTICIPATED MEDICAL EXPENSES – not reimbursed by your medical insurance	**Cost Estimate**
1. Co-pays *(office visit/prescription co-pay amounts x number of anticipated visits/prescriptions)*	$
2. Deductibles *(for you and eligible dependents)*	$
3. Coinsurance amount *(e.g., 20% of the services after deductible)*	$
4. Routine exam *(annual physical, yearly exams, well-baby)*	$
5. Hearing care expenses *(hearing aids, exams, etc.)*	$
6. Prescription drugs *(not covered by insurance)*	$
7. Eligible over-the-counter medications (may require prescription)	$
8. Alternative care *(chiropractor, acupuncture office visits)*	$
9. Weight loss program *(must submit a letter from doctor regarding medical condition)*	$
10. Massage Therapy *(must submit a letter from doctor regarding medical condition)*	$
11. Other anticipated qualified expenses not listed	$
Sub Total	$

ANTICIPATED DENTAL EXPENSES – not reimbursed by your dental insurance	**Cost Estimate**
1. Deductibles *(for you and eligible dependents)*	$
2. Coinsurance amount *(e.g., 20%, 50% of services after deductible)*	$
3. Examinations, cleanings, fluoride treatments, x-rays, space maintainers, sealants	$
4. Fillings, extractions, root canals, denture repairs	$
5. Crowns, inlays, onlays, bridges, dentures	$
6. Orthodontia treatment	$
7. Other anticipated qualified dental expenses not listed	$
Sub Total	$

ANTICIPATED VISION EXPENSES – not reimbursed by your vision insurance	**Cost Estimate**
1. Deductibles *(for you and eligible dependents)*	$
2. Co-pays *(exam and material co-pays x number of visits)*	$
3. Vision examinations	$
4. Frames, lenses, contact lenses	$
5. Laser vision correction procedures	$
6. Other anticipated qualified vision expenses not listed	$
Sub Total	$

Total Anticipated Annual Medical, Dental & Vision Expenses (enter amount on FSA Election Form) $

ANTICIPATED DEPENDENT CARE EXPENSES	**Cost Estimate**
1. Dependent care center fees (qualifying child or adult day care)	$
2. Licensed nursery school fees	$
3. Other anticipated eligible dependent care expenses	$

Total Anticipated Annual Dependent Care Expenses (enter amount on FSA Election Form) $