# FSA Worksheets

How much you save depends on how much you spend on health and dependent care, and on your tax situation. To estimate your expenses and see for yourself how your savings can add up, use the savings calculators at: **client.benefitadminsolutions.com/fsaestimator/** for the Health FSA, and at **benefitadminsolutions.com/dcapestimator/calculatedcap.aspx** for the Dependent Care FSA.

If you prefer, use the worksheets below to determine how much to contribute to your account(s). Calculate the amount you expect to pay during the plan year for eligible out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits.

**Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you.**

## Health FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year. IRS contribution limits for the health FSA are based on the plan year (July 1 - June 30), not the calendar year.

**UNINSURED MEDICAL EXPENSES**

| | |
|---|---|
| Health insurance deductibles | $ _____ |
| Coinsurance or co-payments | $ _____ |
| Vision care | $ _____ |
| Dental care | $ _____ |
| Prescription drugs | $ _____ |
| Travel costs for medical care | $ _____ |
| Other eligible expenses | $ _____ |
| **TOTAL** (IRS contribution limit: Up to $2,600) | $ _____ |
| **DIVIDE** by the number of paychecks you will receive during your coverage period | ÷ _____ |
| **This is your pay period contribution** (whole dollar amounts only) | $ _____ |

## Dependent Care Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

**CHILD CARE EXPENSES**

| | |
|---|---|
| Day care services | $ _____ |
| In-home care/au pair services | $ _____ |
| Nursery and preschool | $ _____ |
| After-school care | $ _____ |
| Summer day camps | $ _____ |

**ELDER CARE SERVICES**

| | |
|---|---|
| Day care center | $ _____ |
| In-home care | $ _____ |
| **TOTAL** (IRS contribution limit: Up to $5,000, depending on how your taxes are filed) | $ _____ |
| **DIVIDE** by the number of paychecks you will receive during your coverage period | ÷ _____ |
| **This is your pay period contribution** (whole dollar amounts only) | $ _____ |