

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)