

# FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

**Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.**

## HEALTHCARE FSA WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

### UNINSURED MEDICAL EXPENSES

Health insurance deductibles	\$ _____
Coinurance or co-payments	\$ _____
Vision care	\$ _____
Dental care	\$ _____
Prescription drugs	\$ _____
Travel costs for medical care	\$ _____
Other eligible expenses	\$ _____

### TOTAL

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed \$4,949.04. \$ \_\_\_\_\_

**DIVIDE** by the number of paychecks you will receive during the plan year (26).\* \$ \_\_\_\_\_

**This is your pay period contribution.** \$ \_\_\_\_\_

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary (\$190.34 maximum per pay period).

\* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

## DEPENDENT CARE FSA 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

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed \$4,949.04. \$ \_\_\_\_\_

**DIVIDE** by the number of paychecks you will receive during the plan year (26).\* \$ \_\_\_\_\_

**This is your pay period contribution.** \$ \_\_\_\_\_

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary (\$190.34 maximum per pay period).

\* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Your annual FSA administrative fee is \$50.96, regardless of which type of account you select. However, even if you select both accounts, your total fee will not exceed \$50.96.

**At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.**