

# Flexible Spending Account Health and Dependent Care Worksheet

Use this worksheet to help you determine your health care and dependent care annual contribution for the upcoming plan year. You may want to review your health and dependent care expenses in your check book and/or credit card statements from last year to help you decide how much to set aside in your Flexible Spending Account (FSA).

## Health Care FSA

To determine your expenses, review health care expenses from last year to consider any anticipated new health care expenses for you, your spouse and your dependents.

### Annual Health Care Expenses

**Deductibles** \$ \_\_\_\_\_  
Medical, Dental, Vision

**Co-payments/Co-insurance** \$ \_\_\_\_\_  
The amount not paid by your health plan coverage

**Amounts paid over plan limits** \$ \_\_\_\_\_  
Over reasonable and customary allowance \$ \_\_\_\_\_  
Over psychiatric limits \$ \_\_\_\_\_

**Vision Care/Hearing Care** \$ \_\_\_\_\_  
(glasses, contacts, solutions, exams, Screenings, hearing aids, etc.)

**Dental Care** \$ \_\_\_\_\_  
(cleanings, orthodontics, crowns, etc.) \$ \_\_\_\_\_  
Treatment/Therapies \$ \_\_\_\_\_  
Medical Equipment \$ \_\_\_\_\_

**Other expenses not covered by Insurance**  
Over the counter drugs and medicines \$ \_\_\_\_\_

*( IMPORTANT NOTE: Effective January 1, 2011, a doctor's prescription is required for reimbursement of over-the-counter drugs and medicines).*

**Other anticipated health care expenses**  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

### **Total Estimated Annual Health Care Contribution**

**Total** \$ \_\_\_\_\_

*(Divide the total by the number of paychecks you will receive during the year for your per pay period contribution)*

**Per Pay Period Contribution** \$ \_\_\_\_\_

## Dependent Care FSA

To determine your expenses, enter in the estimated annual amounts you will pay for child and/or elder care. Provided care must be to enable you to work, not for personal reasons.

### Annual Child Care Expenses

Day care center \$ \_\_\_\_\_

In-home care \$ \_\_\_\_\_

Nursery and pre-school \$ \_\_\_\_\_

After-school care \$ \_\_\_\_\_

Au pair services \$ \_\_\_\_\_

Summer day camp \$ \_\_\_\_\_

### Annual Elder Care Services

Day care center \$ \_\_\_\_\_

In-home care \$ \_\_\_\_\_

**Other anticipated dependent care expenses to enable you to work.** (Do not include any medical expenses in this section)

\_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_

### **Total Estimated Annual Dependent Care Contribution**

**Total** \$ \_\_\_\_\_

*(Divide by the number of paychecks you will receive during the year for your per pay period contribution)*

**Per Pay Period Contribution** \$ \_\_\_\_\_