TEXFLEX℠ PAYFLEX®

TexFlex℠ FSA Contribution Worksheet

Plan carefully and know the rules when deciding how much to contribute

If you're thinking about enrolling in a TexFlex flexible spending account (FSA) or changing your annual contribution, this worksheet can help you estimate how much to contribute to your account(s). It's important to calculate your annual TexFlex contribution carefully to avoid losing your TexFlex funds at the end of the plan year. Review your current and prior years' expenses to help estimate expenses for the coming year. Make sure to be conservative while planning your contribution.

- **For health care or limited-purpose FSA participants:** Unused funds of up to $550 remaining in your account will carry over for use in the next plan year. However, you will forfeit any funds over $550 that you don't spend by the end of the plan year (August 31).
- **For dependent care FSA participants:** You are not allowed to carry over unused funds into the next plan year. However, you do have a 2½-month grace period (after the end of the plan year) to continue spending your account funds on eligible items. This means, you can incur costs for 14½ months total — from September 1 through November 15 of the following year.

NOTE: The federal government waived carryover limits and suspended the dependent care FSA grace period for Plan Year 2021, due to the COVID-19 pandemic. They are back in place for Plan Year 2022.

TexFlex health care FSA	TexFlex dependent care FSA	TexFlex limited-purpose FSA
Health care FSA contributions are limited to **$2,750** for Plan Year 2022.	Dependent care FSA contributions are limited to **$5,000** for Plan Year 2022.	Limited-purpose FSA contributions are limited to **$2,750** for Plan Year 2022.
Enter your annual out-of-pocket eligible expenses for each of the following: Medical care: $_____ Over-the-counter items: $_____ Dental Care: $_____ Vision Care: $_____ Prescriptions: $_____ Medical supplies: $_____ **Total lines above*: $**_____	Enter your out-of-pocket eligible expenses for each of the following: Your <u>weekly</u> child/elder cost: $_____ Other eligible <u>weekly</u> expenses: $_____ Total lines above: $_____ Number of weeks you'll incur expenses: _____ **Multiply total by # of weeks*: $**_____	Enter your annual out-of-pocket eligible expenses for each of the following— do not include expenses you plan to pay for with your Consumer Directed HealthSelect℠ health savings account (HSA) funds: Dental Care: $_____ Vision Care: $_____ **Total lines above*: $**_____
*This is your estimated annual spending of eligible expenses, related to that TexFlex account.		

For more information or to view a full list of eligible expense items, visit www.TexFlexERS.com.

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