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 $570 remaining in your account will carry over for use in the next plan year. However, you will forfeit any funds over $570 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 eligible expenses from September 1 through November 15 of the following year.

TexFlex health care FSA	TexFlex dependent care FSA	TexFlex limited-purpose FSA
Health care FSA contributions are limited to **$2,850** for Plan Year 2023.	Dependent care FSA contributions are limited to **$5,000** for Plan Year 2023.	Limited-purpose FSA contributions are limited to **$2,850** for Plan Year 2023.
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 weekly child/elder cost: $_____ Other eligible weekly 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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