FLEXSAVE Of America, Inc.
Consumer Driven Healthcare Solutions

What is a Flexible Spending Account?

The FSA is an account that allows you to set aside up to $3,300 of pre-tax funds from your paycheck to be used on IRS approved expenses you and your family incur throughout the year. The full annual election you choose during enrollment is available to you on the 1st day of the plan year. Eligible dependents include your spouse and any children you claim on your taxes up through the end of the tax year of their 26th birthday.

What is a Limited Flexible Spending Account?

The LFSA is similar to the FSA. Both plans are pre-funded and tax-free with a maximum contribution of $3,300, but the Limited FSA is for dental and vision expenses only. This plan is only available to those who enrolled in the High Deductible Health Plan and are enrolled in a Health Savings Account (HSA). Use this account to pay for larger expense items like braces, contacts, and glasses.

What is the Dependent Care Account?

The DCA allows you to set aside up to $5,000 of pre-tax funds to pay for eligible child care expenses throughout the year. Eligible dependents includes children you claim on your federal tax return up to the age of 12.

How Do I Access My Money?

Before the year begins, we'll send you a FlexSave MasterCard in the mail for you and your spouse (if applicable). When you incur an expense, just present your FlexSave MasterCard for payment. If you need a reimbursement, claims can be submitted through our mobile app or website.

What Happens If I Have Money Left-Over at the End of the Year?

You get a total of 14.5 months to spend down your account balances, but it must be spent by 3/15/2026.

WHAT'S ELIGIBLE?

Flexible Spending Account (Medical)

- Prescriptions
- Over-the-counter drugs
- Copayments
- Deductibles
- Co-Insurance
- Glasses
- Contacts
- Exams
- Refractions
- Contact Lens Solutions
- Dental Xrays
- Exams
- Fillings
- Cleanings
- Crowns
- Root Canals
- Braces
- Mileage to and from appointments
- Chiropractic Care
- Immunizations

Limited Flexible Spending Account

- Dental expenses (exams, fillings, xrays, cleanings, dentures, root canals, crowns, braces)
- Vision expenses (glasses, contact lenses, fittings, refractions, exams, contact lens solutions)

Dependent Care Account (Child Care)

- Before and after school programs
- Summer Camps (day camps only)
- Pre-school
- Nursery school
- Pre-K
- Daycare facilities
- Children 12 and under (only)

Macomb Community College
FSA Enrollment Form

Social Security Number: _____/_____/_____

Last Name:_____ First Name:_____ M.I.: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone #: _____ Email Address: _____

Date of Birth: _____/_____/_____

Please list all dependents and spouse (if applicable) who will be covered under your plan(s). Dependent children up to the age of 26 are eligible for benefits through the end of the tax year of their 26th birthday. Please do not request new FlexCards if you do not need them. If cards are set to expire, you will receive new cards automatically.

Relationship	Last Name	First Name	M.I.	SSN Only include soc #'s for new dependents	DOB Only include DOB for new dependents	Issue Card Y/N*
Spouse						
Child						
Child						
Child						
Child						

Benefit Account	Annual Election
FSA	$
DCA	$
Limited-FSA	$

FSA (medical) $3300 MAX

DCA (child care) $5000 MAX

Limited FSA (dental/vision only) $3300 MAX (available only to those enrolled in the High Deductible Health Plan through the College)

I hereby apply for the options listed above. I authorize my employer to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in effect throughout the plan year, unless I have a change in family status. I also understand that any unspent money remaining in my account(s) at the end of the plan year will be forfeited. I agree that if my employer pays out of FlexSave Spending Accounts, whether by inadvertence or design, more than I was entitled to receive, my employer may withhold amounts from my wages until the improperly paid portion has been recovered. My submission of this form authorizes my employer to reduce my compensation to recover amounts improperly paid from my Health Care Account.

Date: / / Signature: _____

_____

Bargaining Group

Please return this form to Human Resources