EMPLOYEE BENEFITS GUIDE

For Employee Benefits

Effective July 1 through December 31, 2026

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

Students Rise. We All Rise.

Notice of Non-Discrimination

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HEALTH BENEFITS GLOSSARY OF TERMS SOURCE: SHRM

- BENEFIT ELECTIONS: The benefit choices you make as a new hire or during open enrollment. You may only change your benefits during open enrollment unless you experience a qualified change in status during the year.

- BENEFIT CLAIM: The amount of money payable by an insurance company when you or a covered dependent receive covered health care services. A request by an individual (or a health care provider) for the insurance company to pay for services received by a person covered under the insurance policy.

- COINSURANCE: A percentage of healthcare cost, such as 20%, that the covered employee or a covered dependent pays after meeting the deductible.

- COPAY: The fixed dollar amount, such as $20 for each doctor's visit, that the covered employee or a covered dependent pays for medical services.

- DEDUCTIBLE: A fixed dollar amount that the covered employee or a covered dependent must pay out-of-pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits per person and per family. Each covered family member only needs to satisfy his or her individual deductible prior to receiving plan benefits. Benefits are payable for the entire family once the family deductible has been reached.

- EMPLOYEE CONTRIBUTIONS: Employee contributions are the dollars deducted from your paycheck each pay period for your share of medical, dental, or vision insurance premiums. If you enroll in our health plans, you share the cost of premiums with the district. Your contributions will vary based on the plans in which you enroll and the number of dependents you enroll for benefits.

- FLEXIBLE SPENDING ACCOUNT (FSA): A Flexible Spending Account (FSA) allows you to set aside a portion of your pay pre-tax to use for eligible expenses that are not covered by insurance or only partially covered. You can save up to 30% on your dollar (depending on your tax bracket) by estimating how much you usually spend on these types of expenses in a year and setting aside that dollar amount into your FSA.

- FORMULARY: A list of prescription drugs covered by the health plan, structured in tiers indicating applicable copays for low-cost generics and more expensive brand name or specialty drugs.

- HEALTH MAINTENANCE ORGANIZATION (HMO): If you are enrolling in an HMO plan, you must receive your health care from a "network" provider. HMOs require that you select a primary care physician (PCP) at enrollment who is responsible for managing and coordinating all of your health care and must provide a referral to a specialist or to see a chiropractor.

- IN-NETWORK: Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network healthcare providers than for providers who are out-of-network.

- OUT-OF-NETWORK: A provider that does not participate in the insurance company's network of providers. Employees will pay more out-of-pocket for covered out-of-network services. Not all out-of-network services are covered. Some plans do not cover out-of-network services.
- OUT-OF-POCKET MAXIMUM: The most an employee could pay during a coverage period (usually one year) for his or her share of the costs for covered services, including deductibles, coinsurance and copays.
- PREFERRED PROVIDER ORGANIZATION (PPO): A Preferred Provider Organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. With a PPO plan, you have the flexibility of visiting "in" or "out" of network providers but save significant dollars by obtaining services from in-network providers. You do not need to select a primary care physician (PCP) and you do not need referrals to see other providers in the network.
- PREMIUM: The cost of the healthcare coverage that you have elected. This cost may be shared by the covered employee and their employer.
- PREVENTIVE CARE: Medical, dental, or vision checkups, tests, immunization, or counseling services designed to detect or prevent chronic illnesses from occurring.
- PRIMARY CARE PHYSICIAN (PCP): A health care professional who is responsible for monitoring your overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.
- PROVIDER: Doctors, hospitals, pharmacies, dentists, and other types of health care professionals that provide health care services to members covered under health insurance plans.
- PROVIDER NETWORK: Most health insurance companies (medical, pharmacy, dental, and vision) contract with groups of health care providers to provide health care services to their members (covered employees and dependents) for a mutually agreed upon fee schedule.
    - Health Maintenance Organizations (HMOs) require you to use providers within their network for services to be covered.
    - Preferred Provider Organizations (PPOs) pay a higher benefit when you use providers within their network and a lower benefit when you use providers outside of their network.
- QUALIFIED CHANGE IN STATUS: IRS rules govern when you can change your benefit elections during a plan year and what changes you can make. You may be allowed to change your benefit elections if you experience one of the following changes in status and you request a corresponding change in your benefit elections within 30 days of the status change event (within 60 days for Medicaid or CHIP eligibility).
    - Change in marital status
    - Change in the number of dependents
    - Change in employment status
    - A dependent satisfying or ceasing to satisfy dependent eligibility requirements

- Change in residence
- Commencement or termination of adoption proceedings

- REFERRAL: HMO plans require you to see your primary care physician, or PCP, as your first point of contact for care. If your PCP cannot provide the care you need, she or he will provide you the name of a doctor who can. That is called getting a referral.

- SECTION 125 CAFETERIA PLAN: In a section 125 plan or cafeteria plan, employees can pay qualified medical, dental or vision and Dependent-care expenses on a pretax basis, which has the effect of reducing their taxable income as well as their employer's Social Security (FICA) liability, federal income and unemployment taxes, and state unemployment taxes where applicable. Qualified cafeteria plans are excluded from gross income. To qualify, a cafeteria plan must allow employees to choose from two or more benefits consisting of cash or qualified benefit plans. The Internal Revenue Code explicitly excludes deferred compensation plans from qualifying as a cafeteria plan subject to a gross income exemption.

- SPECIALIST: Specialists provide routine or complex services to treat specific types of conditions. Examples of specialists include cardiologists, oncologists, psychologists, radiologists, allergists, podiatrists, and orthopedists.

- SUMMARY OF BENEFITS AND COVERAGE: An outline of a health insurance plan that allows you to evaluate costs and benefits and compare against other health plans.

2026 BENEFITS OVERVIEW

Detroit Public Schools Community District (DPSCD) offers an array of health care benefits for you to choose from to best meet your needs. Below is a list of plans available to you.

MEDICAL

Blue Care Network (BCN) Healthy Blue Living HMO

- BCN HBL HMO Economy-Full HMO Network
- BCN HBL HMO Core-Full HMO Network
- BCN HBL HMO Core Plus-Full HMO Network

Blue Cross Blue Shield of Michigan (BCBSM) PPO

- BCBSM Simply Blue PPO-Statewide and National Network

Health Alliance Plan (HAP) HMO

- Health Alliance Plan—Full HMO Network

DENTAL

Delta Dental

- Dental PPO Standard Core
- Dental PPO Point of Service Core Plus
- Dental EPO

VISION

Heritage Vision Plans

- Vision Core-Select Network
- Vision Core Plus-Select Network
- Vision Premium-National Network

LIFE

Securian Group Life Plan

- Employer Paid Life
- Employee Paid Supplemental Life

FLEXIBLE SPENDING ACCOUNTS (FSA)

Kapnick Insurance

- Health FSA
- Dependent Care FSA

ELIGIBILITY REQUIREMENTS & COVERAGE EFFECTIVE DATES

Unless otherwise stated, you are eligible for healthcare and life insurance benefits if you are a full-time active employee.

Full-time active employees must be regularly scheduled to work 30 hours or more per week or 130 hours per month to be eligible for medical, dental, vision insurance, life insurance, health Flexible Spending Account (FSA) and dependent care Flexible Spending Account (FSA).

As a participant of the Detroit Public Schools Community District Employee Benefits Plan, you may choose coverage for:

- Yourself only
- Yourself and one dependent
- Yourself and two or more dependents

Eligible dependents are defined as your:

- Legal spouse
- Natural child(ren)
- Legally adopted child(ren)
- Child(ren) placed in your home for legal adoption
- Stepchild(ren)
- Child(ren) over whom you have legal guardianship

Dependent children include children of the employee or spouse by birth, legal adoption, legal guardianship, or children from a former marriage of whom the employee has custody. Dependent children do not have to be full-time students to remain on your medical, dental and vision coverage.

You will be required to provide a copy of your marriage certificate when enrolling your spouse for the first time, and a copy of a birth certificate or other legal documentation when enrolling your child(ren) for the first time. Dependent documentation must be received within 30 days for both a new hire and rehire. Coverage will not be effective until documentation is provided.

Social security numbers are required for all enrollees, and coverage will not be effective until they are received.

Please Note: Married couples who are both employed by DPSCD must enroll in one medical/dental/vision plan together as employee + spouse or family. Dependent children who work for DPSCD cannot be enrolled on the DPSCD parent coverage and have individual employee coverage.

Employees enrolling their spouses in the medical plan not employed by DPSCD will have an additional payroll deduction of $50 per month.

WHEN COVERAGE BEGINS

Coverage for all elected plans (Medical, Prescription, Dental, Vision, Life Insurance, Health FSA and Dependent Care FSA) for you and your eligible dependents will begin the first day of the calendar month following your date of hire.

If you are electing coverage during open enrollment, coverage begins on January 1, the first day of the next plan year.

MAKING CHANGES OUTSIDE OF OPEN ENROLLMENT

The choices you make during open enrollment or when you first become eligible remain in effect for the remainder of the plan year. Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add/remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS. Changes to your coverage must be made within 30 days of the life event.

Examples include, but are not limited to, the following:

- Marriage or divorce
- Birth or adoption of a child
- Loss of other health coverage
- New eligibility for other health coverage
- Change in your dependent's eligibility status

Any change you make to your coverage must be consistent with the change in status. Changes to coverage made within 30 days of the life event will become effective on the date of the event. Failure to remove an ex-spouse from your coverage within 30 days of the date of the divorce may result in your ex-spouse no longer being eligible for Cobra benefits.

WHEN COVERAGE ENDS

Coverage for you and your dependents will end on the last day of the month in which your employment terminates for all benefits except the Flexible Spending Accounts (FSA) and life insurance. FSA and life insurance benefits end on the date on which your employment terminates. For example, if your last day of employment is April 15, your FSA and life insurance ends April 15 and any other health coverage ends April 30.

As long as your coverage is active, dependent children may be covered under the medical, dental and vision benefit plans until the end of the month in which they reach age 26.

PPO PLAN VS. HMO PLAN

PPO PLAN

A Preferred Provider Organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. With a PPO plan, you have the flexibility of visiting "in" or "out" of network providers but save significant dollars by obtaining services from in-network providers. You do not need to select a primary care physician (PCP) and you do not need referrals to see other providers in the network.

HMO PLAN

If you are enrolling in a Health Maintenance Organization (HMO) you will need to receive your health care from a "network" provider. HMOs require that you select a primary care physician (PCP) at enrollment who is responsible for managing and coordinating all of your health care and must provide a referral to a specialist or to see a chiropractor.

BENEFITS	PPO	HMO
Primary Care Physician (PCP) Required	No	Yes
Referral Required to see a Specialist	No	BCN-Yes HAP-No
"In-Network" Benefits	Yes	Yes
"Out-of-Network" Benefits	Yes	No*
Flexibility	Highest	Lowest
Premium Cost	$$$	$

*Out-of-Network benefits covered only in emergency situations.

MEDICARE ELIGIBLE

You can become eligible for Medicare based on age, declaration of total disability, or diagnosis of End Stage Renal Disease (ESRD). We are required to inform the health insurance carriers of your Medicare status. Federal law determines whether Medicare or the DPSCD health plan pays primary. Please contact the Benefit Solution Center if you or your covered dependent enroll in Medicare.

The Benefit Solution Center is available Monday through Friday, 8:30 a.m. to 5:00 p.m. via phone by calling 888.447.9038. Questions can also be emailed to servicecenter@kapnick.com.

- Benefit Solution Center website: https://detroitk12.bswift.com

2026 MEDICAL CONTRIBUTIONS EFFECTIVE 7/1/26

EMPLOYEE COST PER PAY – 22 PAYS

COVERAGE STATUS	BCN HMO ECONOMY	BCN HMO CORE	BCN HMO CORE PLUS	BCBSM PPO	HAP HMO
Employee Only	$40.92	$96.05	$208.54	$201.49	$27.42
Employee + Child or DPSCD Spouse	$85.54	$200.75	$435.86	$602.02	$78.74
Employee + Non-DPSCD Spouse	$112.81	$228.02	$463.13	$629.29	$106.01
Employee + Family w/DPSCD Spouse -or- Employee w/2 or More Children	$106.82	$250.70	$544.30	$753.47	$98.54
Employee + Family w/Non-DPSCD Spouse	$134.09	$277.97	$571.57	$780.75	$125.81

EMPLOYEE COST PER PAY – 26 PAYS

COVERAGE STATUS	BCN HMO ECONOMY	BCN HMO CORE	BCN HMO CORE PLUS	BCBSM PPO	HAP HMO
Employee Only	$34.62	$81.27	$176.46	$170.49	$23.20
Employee + Child or DPSCD Spouse	$72.38	$169.86	$368.81	$509.40	$66.63
Employee + Non-DPSCD Spouse	$95.46	$192.94	$391.88	$532.48	$89.70
Employee + Family w/DPSCD Spouse -or- Employee w/2 or More Children	$90.38	$212.13	$460.56	$637.56	$83.38
Employee + Family w/Non-DPSCD Spouse	$113.46	$235.20	$483.64	$660.63	$106.46

Employees enrolling their spouses in the medical plan who are not employed by DPSCD are charged a $50 per month spousal surcharge fee which is included in the "Non-DPSCD Spouse" per pay tier contributions listed in the 2026 Medical Contributions chart.

2026 DENTAL CONTRIBUTIONS

DELTA DENTAL EMPLOYEE COST PER PAY – 22 PAYS

COVERAGE STATUS	PPO CORE	PPO CORE PLUS	EPO
Employee cost per pay	22 Pays	22 Pays	22 Pays
Single	$3.63	$7.25	$1.69
Two Person	$7.17	$13.91	$3.39
Family	$10.50	$20.53	$5.25

DELTA DENTAL EMPLOYEE COST PER PAY – 26 PAYS

COVERAGE STATUS	PPO CORE	PPO CORE PLUS	EPO
Employee cost per pay	26 Pays	26 Pays	26 Pays
Single	$3.07	$6.13	$1.43
Two Person	$6.06	$11.77	$2.87
Family	$8.88	$17.37	$4.44

2026 VISION CONTRIBUTIONS

HERITAGE VISION EMPLOYEE COST PER PAY – 22 PAYS

COVERAGE STATUS	CORE	CORE PLUS	PREMIUM
Employee cost per pay	22 Pays	22 Pays	22 Pays
Single	$0.00	$0.08	$1.35
Two Person	$0.00	$2.35	$4.62
Family	$0.00	$4.61	$7.89

HERITAGE VISION EMPLOYEE COST PER PAY – 26 PAYS

COVERAGE STATUS	CORE	CORE PLUS	PREMIUM
Employee cost per pay	26 Pays	26 Pays	26 Pays
Single	$0.00	$0.07	$1.14
Two Person	$0.00	$1.98	$3.91
Family	$0.00	$3.90	$6.68

BSWIFT LOGIN INSTRUCTIONS

HOW TO LOG IN:

Log in now!

https://detroitk12.bswift.com

Follow these steps to complete the registration process:

1. In a web browser, from your computer, tablet or smart phone, go to: https://detroitk12.bswift.com .

2. Enter the information below. Your name should appear as it does in your work email address including number if applicable.

   - Username: Your name as it appears in your work email address - ex: John.Doe or John.Doe02. Do not include the @detroitk12.org.
   - Password: For your initial sign-in and open enrollment only, enter the last four digits of your social security number.
   - Change Password: 8 characters minimum with at least 1 number, 1 capital letter, and 1 special character (!,@,$,etc.). After you have changed your password, for your subsequent logins please use the password you created.
   - Security Question/Answer: Click on the drop down and select a security question. Enter your answer and click Save. (This security question will be used if you forget your password or after 3 failed attempts to sign into the DPSCD Online Benefit Center.)

3. After you have completed these steps, sign in with the password you created, and begin using the DPSCD Online Benefit Center.

   - Once at the home page, you can enroll in benefits, report life event changes, designate a beneficiary, and make benefit changes (e.g., marriage, birth, divorce, death, and adoption).
   - You can also view your plan options and benefit elections, as well as access the insurance carrier web sites and documents.

Please Note: If you have forgotten your password or you are not able to enter the site after three failed attempts:

1. Click> Forgot Password
2. Enter your username or work email address
3. Enter your birth date
4. Select the method you would like to use to receive your password reset information.

QUESTIONS ABOUT YOUR BENEFITS?

Please contact the DPSCD Benefits Solution Center
Phone: 888.447.9038
Email: servicecenter@kapnick.com

LOCKED OUT

If you are locked out of the Online Benefit Center, contact DPSCD Benefits Solution Center for support at 888.447.9038.

BROWSER REQUIREMENTS

If you are experiencing browser issues, you can easily access the correct browser by clicking on the Browser Requirements located at the bottom of every screen in bSwift.

YOU MUST HAVE THE FOLLOWING ENABLED:

Cookies: OK

JavaScript: OK

Style Sheets: OK

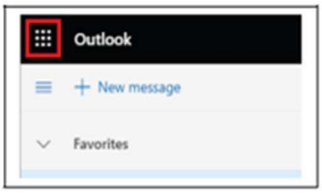
*BROWSER REQUIREMENTS (THIS SITE SUPPORTS THE FOLLOWING):

Microsoft® Edge	Safari
Mozilla Firefox	Google Chrome

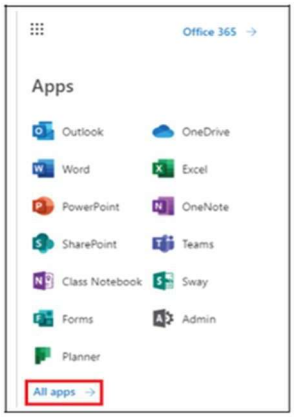
*You are encouraged to keep your browser updated with the latest version.

EMPLOYEE BENEFITS SINGLE SIGN ON – ONLINE ENROLLMENT

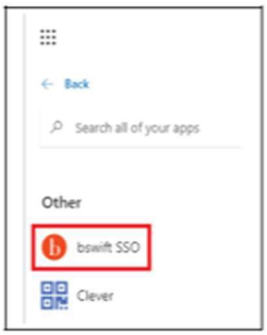
1. From the Hub or any online office 365 app, click the App Launcher in the upper left corner:



2. MS Office app icons, click the ALL APPS link:

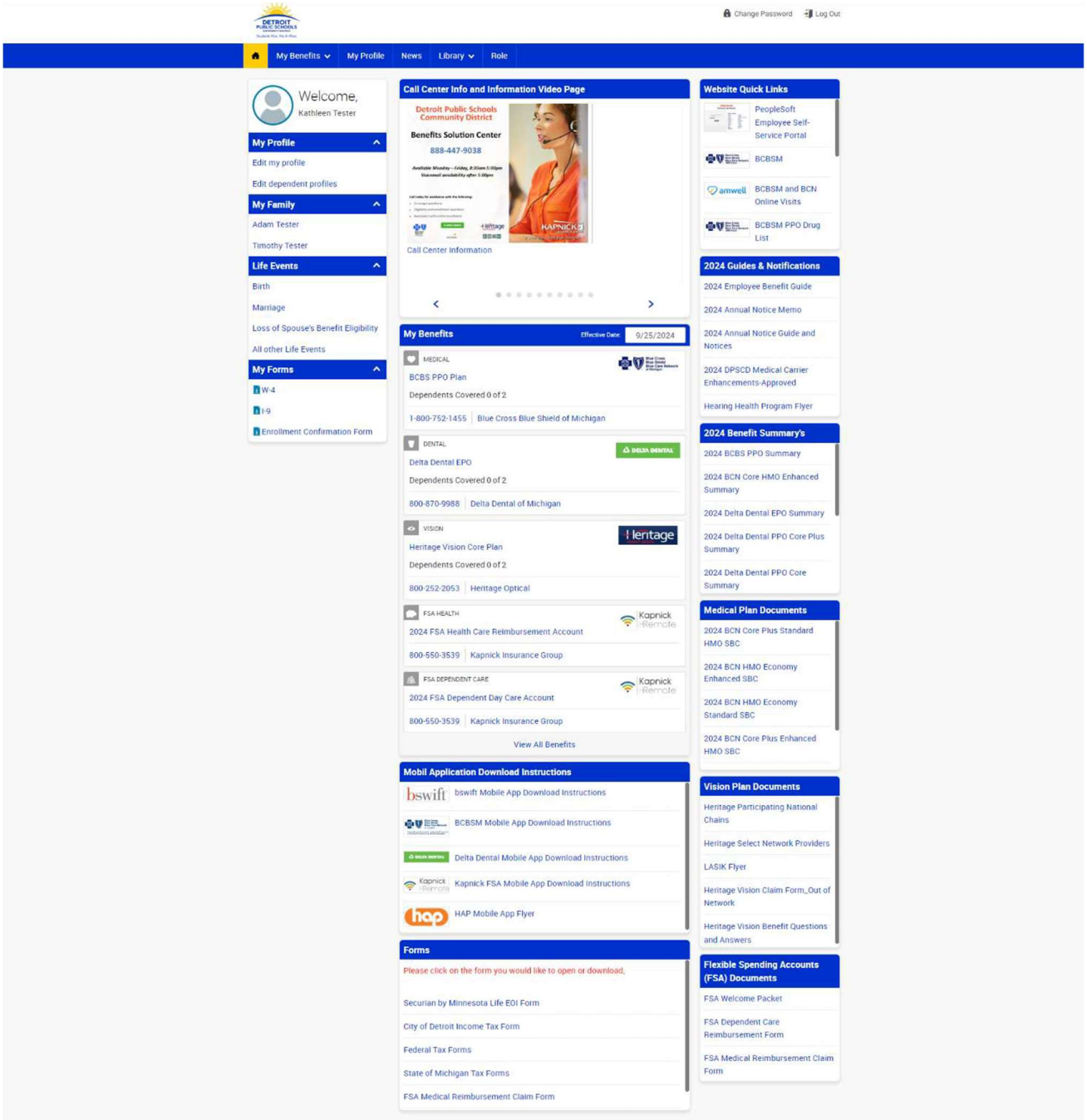


3. Within the menu, scroll down to the OTHER heading, then click the bswift SSO link:



PROCESSING A LIFE EVENT

Once at the home page, you can enroll in benefits, report life event changes and make benefit changes (marriage, birth, divorce, death, adoption, etc.)



If you need to update your name or address, please contact DPSCD Human Resources for assistance.

2026 BCN HEALTHY BLUE LIVING REQUIREMENTS - APPLIES TO ALL BCN HMO PLANS

PARTICIPATION REQUIREMENTS

There are two easy steps to complete in order to maintain enhanced benefits. ONLY the employee must qualify for the enhanced benefits for themselves and their dependents each year by completing these steps within 90 days of being covered on the plan, and within 90 days of the beginning of each plan year (March 30th).

Please note additional action will be required if you do not meet the tobacco use and weight management requirements.

Step 1: See your Primary Care Physician (PCP) for a BCN Qualification Form visit. After your exam, your doctor needs to electronically submit your qualification form to BCN.

Step 2: Log into your BCN account at www.bcbsm.com, and complete your health assessment or call 855.326.5098 to request a paper copy.

COPAYS FOR HEALTHY BLUE LIVING (HBL) QUALIFICATION FORM VISITS

A visit to complete your HBL Qualification Form is considered preventive, and you will not be charged a copay. However, if you receive non-preventive care during the visit or additional lab work that is not required for completing the Qualification Form, there will be a charge for those services. For example, if you decide to have vitamin D testing during your visit, you will be billed for that test. Any fees that are not considered preventive may be applied toward meeting your deductible. In addition, if your doctor recommends a follow-up visit based on your Qualification Form visit, you may be charged a copay for that visit.

TOBACCO USE AND WEIGHT MANAGEMENT

To be in the enhanced level, all employees must meet the requirements as it relates to tobacco use and weight management. Participating in the below programs, if required, will ensure you remain in the Enhanced benefit level. BCN will provide program requirements to all participants.

Step 3: If your Body Mass Index (BMI) is 30 or more, you are required to enroll in a BCN-sponsored weight-management program within the first 120 days of the plan year (at no additional cost to you). You will receive communications from BCN should your BMI be at or above 30. Members must participate in the weight management program until their BMI is under 30 as evidenced by their PCP's submission of an updated Qualification Form.

Members with a BMI of 30 or above must enroll and participate in the 20-day Triple Tracker program or Lifestyle Coaching program powered by Personify Health™ within 120 days of the enrollment/renewal date to maintain enhanced benefits. Members must start the 20-day Triple Tracker program or Lifestyle Coaching program within two (2) weeks of their enrollment. Members must actively participate in the selected weight management program until BCN receives an updated qualification form showing the participant has a BMI that is less than 30. Members may not switch weight management programs mid-plan year.

20-DAY TRIPLE TRACKER

20-day Triple Tracker is a program that requires you to complete 20 days of physical activity each month. You can choose any combination of these activities: 7,000 steps, 15-minute workout, or 15 active minutes. Members enroll using your online member account.

LIFESTYLE COACHING

Lifestyle Coaching is a program that requires you to complete one session per month – either by phone or messaging. You will have unlimited messaging with a health coach, and it requires no self-reporting attendance or re-enrollment. Members enroll using your online member account.

Step 4: Tobacco will be tested through a blood or urine cotinine test during your initial Blue Care Network qualification form visit. If your Qualification Form shows that you use tobacco, you must enroll in the Tobacco Coaching program within 120 days of the plan start date and participate in the program through the end of the plan year to earn or maintain Enhanced benefits. You must start your program within two (2) weeks of your enrollment.

TOBACCO COACHING

Tobacco coaching is a program that requires you to attend one session a month – either by phone or messaging. Members enroll using your online member account.

NEW HIRES FOLLOW THESE STEPS FOR YOUR HEALTHY BLUE LIVING REQUIREMENTS:

EMPLOYEES HIRED IN FIRST, SECOND, OR THIRD QUARTER

You will have Enhanced benefits for 90-days

You must complete the plan requirements within the first 90 days of your coverage effective date in order for you and your enrolled dependents to earn or maintain Enhanced benefits.

EMPLOYEES HIRED IN FOURTH QUARTER

You will have Enhanced benefits for the remainder of the plan year

You must complete the plan requirements within the first 90 days of the plan year in order for you and your enrolled dependents to earn or maintain Enhanced benefits.

HOW TO CHOOSE A MEDICAL PLAN

Finding the right coverage may seem complicated. Here are some important things to consider when evaluating your plan options.

- Blue Care Network (BCN) Health Maintenance Organization (HMO) – Three Plans with wellness requirements
- Health Alliance Plan (HAP) HMO – One Plan with no wellness requirements
- Blue Cross / Blue Shield (BCBSM) Preferred Provider Organization (PPO) – One Plan with no wellness requirements

ACCESS TO HEALTH CARE PROVIDERS

It is important to understand your plan's requirements when it comes to doctors, hospitals, and other health care professionals.

- HMO plans cover health care services rendered by a health care provider in the HMO's network and referrals may be required for visits to specialists, hospital stays, and other services. Costs for non-emergency care received from a non-network provider (or without a referral if/when required) are your responsibility.
- PPO plans allow you to seek care from providers in or outside the PPO network, but you will share more of the costs in the form of higher deductibles, coinsurance, and copays when you use providers outside the network. Referrals are not required, but some services require prior authorization.
- During open enrollment, determine whether your doctors and other providers are in the plan's network. Unless you are willing to change doctors, this is a good first step in choosing a plan. You can search for providers on the insurance carrier's website and call your doctor to verify that they are a member of the network.
- See the Key Features for more details on the provider networks for each plan.

BENEFIT USE

When you consider your health plan options, it is important to balance your cost to participate in the plan (employee contributions) with the level of out-of-pocket expenses you are likely to pay when you need health care services.

- If you know you will be using your benefits often, you may choose a plan with a higher premium in exchange for lower copays, deductibles, and coinsurance. This means you will pay more in employee contributions from your paycheck throughout the year, but the amount you pay out-of-pocket when using your benefits will be less.

- If much of the care you receive is routine or preventive, you may want to consider a plan that offers a lower employee contribution from your paycheck throughout the year, but your copays, deductibles, and coinsurance may be higher when you need services.

WELLNESS INCENTIVES

- All three of the BCN HMO plans include steps you must take to earn Enhanced Benefits. Enhanced Benefits are the highest level of benefits under the plans. If you do not take these steps, you will receive Standard Benefits which means that your out-of-pocket costs will be higher when you seek health care services.
- The HAP HMO plan has one level of benefits and does not require you to have an annual physical, complete a health risk assessment or participate in weight-management or smoking cessation programs.
- The BCBSM PPO plan does not require you to have an annual physical, complete a health risk assessment or participate in weight-management or smoking cessation programs. The plan has two levels of benefits depending on whether you use PPO providers or providers outside of the PPO network. You receive the highest level of benefits when you use PPO providers. You may see providers outside of the PPO network, but your out-of-pocket costs may be higher when you seek health care services from a provider outside of the PPO network.

KEY FEATURES

Key Features	Blue Care Network HMO	HAP HMO	Blue Cross Blue Shield Simply Blue PPO
Provider Network Access	Michigan Statewide network	Limited to 50 counties in Michigan	Michigan statewide network plus access to Blue Cross/Blue Shield PPO providers in other states with Blue Card program
Primary Care Physician (PCP) Required?	Yes	Yes	No – but some services require prior authorization
Referral required for specialist visits?	Yes	Not required for most services, but certain specialists may require a referral before they will see you	No
"In-network" benefits?	Yes	Yes	Yes
"Out-of-Network" benefits?	Limited to emergency care	Limited to emergency care	Yes, higher deductible and coinsurance than in-network
Premium Cost	$	$	$$$

2026 BCN MEDICAL PLAN COVERAGE

HBL = Healthy Blue Living	BCN HMO ECONOMY OPTION 1		BCN HMO CORE OPTION 2		BCN HMO CORE PLUS OPTION 3	
Benefits	HBL ECONOMY ENHANCED Member's Responsibility	HBL ECONOMY STANDARD Member's Responsibility	HBL CORE ENHANCED Member's Responsibility	HBL CORE STANDARD Member's Responsibility	HBL CORE PLUS ENHANCED Member's Responsibility	HBL CORE PLUS STANDARD Member's Responsibility
Deductibles Individual/Family	$1,500/$3,000	$4,000/$8,000	$500/$1,000	$2,000/$4,000	None	$500/$1,000
*Coinsurance	20% (50% for select services)	30% (50% for select services)	10%	20%	N/A	N/A
*Coinsurance Maximum Individual/Family	$1,500/$3,000	$2,500/$5,000	$1,500/$3,000	$2,000/$4,000	N/A	N/A
**Out-of-Pocket Maximum Individual/Family	$6,600/$13,200	$6,600/$13,200	$6,600/$13,200	$6,600/$13,200	$6,600/$13,200	$6,600/$13,200
Office Visit	$20 copay	$35 copay	$20 copay	$30 copay	$20 copay	$20 copay
Specialist Visit	$30 copay when referred except for preventive services	$45 copay after deductible when referred except for preventive services	$40 copay	$45 copay	$20 copay	$20 copay
Online Visit	$20 copay	$35 copay	$20 copay	$30 copay	$20 copay	$20 copay
Chiropractic Services *When referred* (up to 30 visits per year)	$30 copay	$45 copay	$40 copay	$45 copay	$20 copay	$20 copay
Preventive Care Services	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Emergency Room *Waived if admitted*	$250 copay after deductible	$250 copay after deductible	$100 copay	$150 copay	$100 copay	$100 copay
Urgent Care	$35 copay	$50 copay	$40 copay	$45 copay	$50 copay	$50 copay
Ambulance Services	20% after deductible	30% after deductible	10% after deductible	20% after deductible	Covered 100%	Covered 100% after deductible
Hospitalization	20% after deductible	30% after deductible	10% after deductible	20% after deductible	Covered 100%	Covered 100% after deductible
Prescription Drug Copay Generic Preferred Brand Non Preferred Brand ***Preferred Specialty ***Non Preferred Specialty Mail Order (90 day)	$4/$15 $40 $80 20% (max $200) 20% (max $300) 3x minus $10	$6/$25 $50 $80 20% (max $200) 20% (max $300) 3x minus $10	$7 $25 $50 2x	$15 $30 $60 2x	$5 $25 $40 2x	$5 $25 $40 2x

*Coinsurance (your share of cost after you have met your deductible)

**Calendar Year Out-of-Pocket Maximum (*applies to deductibles, copays and coinsurance amounts for all covered services, including prescription drug cost-sharing amounts, if applicable).*

***Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs.

Please Note: Durable medical equipment including prosthetic and orthotics, and medical supplies which includes diabetic supplies must be obtained from Northwood Inc. or they will not be covered.

2026 BCBSM AND HAP MEDICAL PLAN COVERAGE

	BCBSM PPO OPTION 4		HAP HMO OPTION 5
Benefits	IN-NETWORK Member's Responsibility	OUT-OF-NETWORK Member's Responsibility	IN-NETWORK Member's Responsibility
Deductibles Individual/Family	$500/$1,000	$1,000/$2,000	$1,200/$2,400
*Coinsurance	20% (70% for select services)	40% (70% for select services)	20%
*Coinsurance Maximum Individual/Family	$1,500/$3,000	$3,000/$6,000	$2,000/$4,000
**Out-of-Pocket Maximum Individual/Family	$6,600/$13,200	$13,200/$26,400	$6,600/$13,200
Office Visit	$20 copay	40% after deductible	$20 copay
Specialist Visit	$20 copay	40% after deductible	$40 copay
Online Visit	$20 copay	40% after deductible	$10 copay
Chiropractic Services	$40 copay	40% after deductible	$40 copay up to 20 visits per year
	up to 12 visits per year		
Preventive Care Services	Covered 100%	Not covered	Covered 100%
Emergency Room *Waived if admitted*	$150 copay	$150 copay	$250 copay
Urgent Care	$40 copay	40% after deductible	$75 copay
Ambulance Services	20% after deductible	20% after in-network deductible	20% after deductible
Hospitalization	20% after deductible	40% after deductible	20% after deductible
Prescription Drug Copay Generic Preferred Brand Non Preferred Brand ***Preferred Specialty ***Non Preferred Specialty Mail Order (90 day)	$15 $30 $60 2x	You pay your in-network copay plus an additional 25% of the approved amount and any excess over the approved amount.	$7/$20 $30 $60 ***20% (max $200) ***50% (max $200) 2x copay (3x specialty)

*Coinsurance (your share of cost after you have met your deductible)

**Calendar Year Out-of-Pocket Maximum (*applies to deductibles, copays and coinsurance amounts for all covered services, including prescription drug cost-sharing amounts, if applicable).*

***Specialty drugs are covered only when purchased through the BCBSM Exclusive Pharmacy Network for Specialty Drugs for the BCBSM PPO plan and through the HAP Specialty Pharmacy only for the HAP HMO plan.

BCBSM Plan—Please Note: Durable medical equipment including prosthetic and orthotics, and medical supplies which includes diabetic supplies must be obtained from Northwood Inc. or they will not be covered.

2026 BCN PHARMACY

EXCLUSIVE SPECIALTY PHARMACY

- BCN covers specialty medications ONLY when filled at a Walgreens retail or the AllianceRX Walgreens mail order pharmacy. Specialty medications filled elsewhere are not covered. This does not apply to specialty medications administered under the medical benefit.

MAIL ORDER PHARMACY

- The BCN mail order pharmacy is Optum.

2026 BCBSM PHARMACY

EXCLUSIVE SPECIALTY PHARMACY

- BCBSM covers specialty medications ONLY when filled at a Walgreens retail or the AllianceRX Walgreens mail order pharmacy. Specialty medications filled elsewhere are not covered. This does not apply to specialty medications administered under the medical benefit.

MAIL ORDER PHARMACY

- The BCBSM mail order pharmacy is Optum.

2026 HAP PHARMACY

EXCLUSIVE SPECIALTY AND MAIL ORDER PHARMACY

The HAP mail order pharmacy is Pharmacy Advantage. Pharmacy Advantage helps you get the prescriptions you need at home. There is no cost to have your regular medication, specialty drugs and other prescriptions dropped off. Just pay your prescription copay. HAP covers specialty medications ONLY when filled by the Pharmacy Advantage mail order pharmacy. Specialty medications filled elsewhere are not covered. This does not apply to specialty medications administered under the medical benefit.

- Step 1: Sign up for home delivery

  Call 800.456.2112 Monday through Friday from 8am to 6pm. Or visit hap.org/delivery. Have your HAP ID card and a list of prescriptions you would like to have transfer ready.

- Step 2: You'll get a call from Pharmacy Advantage

  They will make sure your medication is covered, get prescriptions from your doctor, and call your

pharmacy to transfer it all. If you use Pharmacy Advantage to fill your prescriptions, the pharmacists can answer medication-related questions. If needed, they can also help you find assistance programs.

- Step 3: Set up automatic refills

  Before you run out of a prescription, Pharmacy Advantage will ship a refill to your home. Or they will call you when it is time to refill.

- Step 4: Have prescriptions delivered right to your door

  Just allow 4 to 5 business days for them to be dropped off. Prescriptions can be delivered to most states and whenever is most convenient.

FLEXIBLE SPENDING ACCOUNTS PLAN YEAR JANUARY 1 – DECEMBER 31

A Flexible Spending Account (FSA) allows you to set aside a portion of your pay pre-tax to use for eligible expenses that are not covered by insurance or only partially covered. You can save up to 30% on your dollar (depending on your tax bracket) by estimating how much you usually spend on these types of expenses in a year and setting aside that dollar amount into your FSA.

Health FSAs are tax-advantaged accounts that can be used for medical, dental, and vision expenses only.

An Health FSA account can help you spend less on health care, but only if used correctly - by spending all the money no later than December 31. In other words, FSA funds are use it or lose it, and any unused money left over at the end of the year is no longer yours.

HEALTH FSA

Covers the cost of medical, dental, and vision expenses incurred by you, your spouse and your eligible child(ren). Some eligible expenses include deductibles, copays, eyeglasses, dental work, and over the counter medical supplies.

- Maximum annual election amount: $3,400*
- Minimum annual election amount: $260

*Indexed based on IRS Contribution Limit.

DEPENDENT CARE FSA

Covers the amount you pay to daycare centers, babysitters, after school programs, day camp programs for a tax-dependent child under age 13 who lives with you, or an eldercare facilities a tax-dependent parent, spouse or child who lives with you and is physically or mentally incapable of caring for himself or herself.

- Maximum annual election amount: $7,500
- Minimum annual election amount: $260

RUN-OUT PERIOD (PROOF OF LOSS)

Active participants have until March 16, 2027, to submit expenses incurred during the 2026 plan year. If you terminate employment with DPSCD during the plan year, you have 60 days from your separation date to submit eligible expenses (for services prior to your termination date) for reimbursement.

HOW TO ACCESS YOUR FUNDS

- Paper Claim: Fax (517) 264-6172 or email flex@kapnick.com

- Debit Card: When you enroll in the FSA, Kapnick will provide you with two medical FSA Benny Cards, a MasterCard with the value of your account contribution stored on it (there is a $10 replacement fee for lost or stolen cards).

KAPNICK FSA MOBILE APP

The Kapnick FSA Mobile App allows you to easily and securely access your healthcare accounts to:

- View account balance and detail
- Submit healthcare account claims
- Capture and upload pictures of your receipts anytime
- The Kapnick FSA Mobile App can be located by searching Kapnick FSA in the app store or browser on your mobile device.

The example below is based on an annual salary of $50,000 and an annual Health FSA election of $1,200. Payroll taxes calculated to assume federal and state taxes, Social Security and Medicare.

WITHOUT THE FSA		WITH THE FSA	
Annual gross earnings	$50,000	Annual gross earnings	$50,000
Taxable income	$50,000	Medical expenses	-$1,200
Payroll taxes	-$15,503	Taxable income	$48,800
Net Income	$34,497	Payroll taxes	-$15,131
Medical expenses	-$1,200	Net Income	$33,669
Total take home pay	$33,297	Total take home pay	$33,669
		ESTIMATED ANNUAL SAVINGS: $372	

2026 DENTAL IN-NETWORK COVERAGE OPTIONS

Please refer to your benefit summaries for out-of-network coverage and additional plan details.

BENEFITS	DELTA DENTAL PPO STANDARD CORE PPO DENTIST MEMBER'S RESPONSIBILITY IN-NETWORK	DELTA DENTAL PPO POINT OF SERVICE CORE PLUS PPO DENTIST MEMBER'S RESPONSIBILITY IN-NETWORK	DELTA DENTAL EPO MEMBER'S RESPONSIBILITY IN-NETWORK
Deductible (Individual/Family)	None	$50/$150	None
Diagnostic & Preventive	Covered 100% (except x-rays–covered at 85%)	Covered 100% (except x-rays–covered at 85%)	Covered 100%
Basic Services	15%	15% (includes crowns)	See EPO Schedule for cost details
Major Services	50% (includes crowns)	50%	See EPO Schedule for cost details
Maximum Payment	$1,500 calendar year benefit maximum (per person) for all services except orthodontia	$1,250 calendar year benefit maximum (per person) for all services except orthodontia	$125 calendar year benefit maximum (per person) for emergency dental treatment by a Non-EPO dentist
Orthodontics	50% copay; benefits are limited to $1,000 lifetime (per child)	50% copay; benefits are limited to $1,000 lifetime (per child)	See EPO Schedule for cost details

For the Core PPO and the PPO Core+ - the percentages are the same In/Out Network, but they are based on different approved amounts.

The PPO Non-participating dentist fee schedule may be less than what the dentist charges or Delta approves, and you are responsible for that difference.

For more benefit details click here: https://detroitk12.bswift.com

DELTA DENTAL PRE-TREATMENT ESTIMATES HELP YOU AVOID SURPRISES

Unexpected bills are not fun for anyone. It is much easier to budget for the expenses you are expecting. That is why Delta Dental makes it easy for you to find out whether a proposed dental treatment is covered, what amount the plan will pay and the difference you will be responsible for.

Here is how: When you are having extensive work done and want to know what your share of the cost will be, ask your dentist to submit the proposed treatment plan to Delta Dental for a pre-treatment estimate. A pre-treatment estimate gives Delta Dental a chance to review the proposed treatment in accordance with your dental coverage. Delta Dental can then determine what portion of treatment will be covered under the plan chosen by your employer if you will exceed your maximum and what portion will be your financial responsibility.

Delta Dental will send a pre-treatment estimate notice to you and your dentist. Delta Dental encourages you to review this notice together and discuss treatment options before deciding on treatment.

With a pre-treatment estimate you will know ahead of time how much of the bill you will be responsible for. A pre-treatment estimate gives you the opportunity to learn about your options - and it makes it easier for you to budget for your dental care.

NOTE: A pre-treatment estimate is NOT a guarantee of future dental benefits or payment. When the services are complete. Delta Dental will calculate its payment based on your current eligibility, remaining maximum and any deductible requirements.

2026 VISION IN-NETWORK COVERAGE OPTIONS

Please refer to your benefit summaries for out-of-network coverage and additional plan details.

BENEFITS	HERITAGE VISION SELECT NETWORK CORE MEMBER'S RESPONSIBILITY IN-NETWORK	HERITAGE VISION SELECT NETWORK CORE PLUS MEMBER'S RESPONSIBILITY IN-NETWORK	HERITAGE VISION NATIONAL NETWORK PREMIUM MEMBER'S RESPONSIBILITY IN-NETWORK
Eye Exam (once-12 months)	100% Covered, No Copay	100% Covered, No Copay	100% Covered, $10 Copay
Standard Lenses	One Pair - 24 months 100% Covered, No Copay	One Pair - 12 months 100% Covered, No Copay	One Pair - 12 months 100% Covered, $15 Copay
Standard Frames	One Pair - 24 months $50 allowance (20% discount over $50)	One Pair - 12 months $50 allowance (20% discount over $50)	One Pair - 12 months $130 allowance (20% discount over $130)
Medically Necessary Contact Lenses	One Pair - 24 months $45 allowance (10% discount over $45)	One Pair - 12 months $45 allowance (10% discount over $45)	One Pair - 12 months 100% Covered up to U&C $15 Copay
Elective Contact Lenses	One Pair - 24 months $45 allowance (10% discount over $45)	One Pair - 12 months $45 allowance (10% discount over $45)	One Pair - 12 months $130 allowance (10% discount over $130)

You are eligible for glasses OR contacts, not both, in each benefit period. Includes one year manufacturer's warranty for in-program frames. Preferred pricing discounts may not be available for certain frame brands, or lens options, as determined by the manufacturer or where prohibited by law. You are responsible for fitting fees. Discount may not apply to disposable contact lenses.

For the Core and Core Plus Plans, services must be obtained from a Select Network Provider. Out of network reimbursement is only available for these plans when no Select Network Provider is within 25 miles of residence. Prior approval is required. Claims for out of network reimbursement must be filed within six months of the service date.

For the Premium Plan, out of network reimbursement is available for services obtained outside of the National Network.

Benefits cannot be combined with any discount or promotional offering. Fees charged for non-covered services and materials must be paid in full to the provider.

For more benefit details click here: https://detroitk12.bswift.com

HERITAGE VISION NATIONAL LASIK NETWORK

Heritage members have access to the National Lasik Network, offering the following:

ACCESS TO PROVIDERS

The National Lasik Network is one of the largest networks in the U.S. with over 600 locations nationwide.

QUALITY

All providers are credentialed every 3 years and must meet National Lasik Network quality standards to participate.

VALUE

All in-network providers are contracted to extend 15% off standard prices or 5% off promotional prices.

$800 SAVINGS ON LASIK

PLUS

- Free LASIK exam (over $100 value)
- Custom All-Laser LASIK Procedures
- FREE enhancements for life on most treatments
- Guaranteed Financing

Call 1-855-373-2020 or visit www.heritagevisionplanslasik.com

HERITAGE HEARING DISCOUNT PROGRAM

WHAT CAUSES HEARING LOSS?

Hearing loss is caused by temporary obstructions in the outer or middle ear or permanent damage to the tiny hairs in the inner ear. Common causes of damage include exposure to noise, aging, other health conditions, and certain medications.

DID YOU KNOW?
1 IN 9 Americans have hearing loss AND by 2030, that number is expected to double.
Source: https://www.asha.org/articles/untreated-hearing-loss-in-adults/

WHEN SHOULD I GET MY HEARING CHECKED?

Hearing loss can come on gradually. You may not even notice it is happening. If your hearing test reports your hearing is OK, stick to once every three to five years. You should test your hearing more often if you are 55 or older or are experiencing any of the following:

- Consistent Exposure to loud noises

- Difficulty understanding in noisy environments or in groups

- Hearing mumbling or feeling as though people are not speaking clearly

- Ringing in your ears

WHO TO CONTACT

If you think you may have hearing loss, rest easy. Heritage Vision Plans has teamed up with Amplifon to offer you quality hearing health care.

To learn more, call or visit:
www.amplifonusa.com/heritagevisionplans
1.833.934.0222

*Risk-free trial – 100% money back guarantee if not completely satisfied, no return or restocking fees. Follow up care – for one year following purchase. Batteries – two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty – Exclusions and limitations may apply. Contact Client Services (1-844-267-5436) for details.

Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Heritage Vision Plans and Amplifon are independent, unaffiliated companies. The Amplifon Hearing Health Care discount program is not approved for use with any third party payor program, including government and private third party payor programs. Hearing services are administered by Amplifon Hearing Health Care, Corp.

2026 EMPLOYEE LIFE COVERAGE OPTIONS

SECURIAN FINANCIAL: EMPLOYER PAID LIFE INSURANCE

Basic Life Insurance is provided to all eligible DPSCD employees. DPSCD provides this coverage to help protect your family's financial security in the event of your death. The online enrollment system lists your benefit amount as determined by your employment contract or collective bargaining agreement.

All coverage is guaranteed, and you are automatically enrolled on the first day of the calendar month following your date of hire.

SECURIAN FINANCIAL: EMPLOYEE PAID SUPPLEMENTAL LIFE

In some situations, the Basic life insurance coverage provided to you by DPSCD may not meet your family's needs. Group supplemental term life insurance is a simple, cost-effective way to provide an extra level of financial protection for your family during your working years. Beneficiaries receive funds to help with their everyday living expenses – such as mortgage payments or medical bills, education expenses, your funeral costs and more – so they can continue to live the lifestyle they do today.

If you elect supplemental life initial enrollment within 31 days of the date you are first eligible for this coverage, you may elect 1x to 5x your annual salary of supplemental life insurance, up to $750,000. During this initial enrollment period, you may elect 1x or 2x your annual salary up to a maximum benefit of $300,000 without answering any health questions. Elections for higher amounts of coverage require you to demonstrate good health by completing a health statement, also known as evidence of insurability (EOI).

During each annual enrollment, you may purchase 1x to 5x your annual salary of supplemental life insurance, up to a maximum of $750,000. If you have previously declined supplemental life insurance or wish to increase your life insurance during annual enrollment, you may purchase 1x to 5x your annual salary up to a maximum of $750,000. You will be required to answer health questions to demonstrate your good health, also known as evidence of insurability (EOI) for any amount of life insurance that you elect. Your coverage will not be effective until your EOI is approved by the insurance company.

AMOUNT OF ADDITIONAL LIFE INSURANCE:

- 1x your annual earnings up to $750,000
- 2x your annual earnings up to $750,000
- 3x your annual earnings up to $750,000
- 4x your annual earnings up to $750,000
- 5x your annual earnings up to $750,000

2026 SUPPLEMENTAL EMPLOYEE LIFE 1X to 5X SALARY		
Low Age	High Age	Monthly EE Cost Per $1,000 Unit
18	24	$0.050
25	34	$0.051
35	39	$0.065
40	44	$0.086
45	49	$0.129
50	54	$0.200
55	59	$0.323
60	64	$0.423
65	69	$0.810
70	74	$1.310
75	99	$2.060

This benefit is portable. You can continue these life insurance benefits by making payments to Securian Financial. You must contact Securian and complete the portability process within 31 days of your separation date from DPSCD.

2026 RETIREMENT PLANNING

THE OMNI GROUP 403(B) AND 457

All DPSCD employees have the opportunity to save for retirement on a pre-tax basis by participating in the Detroit Public Schools Community District 403(b) or 457 plans. DPSCD has partnered with The OMNI Group to administer these plans and help ensure compliance with IRS regulations. We recommend that all our employees go to https://www.omni403b.com/Employees to learn more about the 403(b) and 457 plans offered to DPSCD employees.

If you choose to participate, you will first need to set up an investment account with the 403(b) service provider of your choice. Participating providers are listed at https://www.omni403b.com/PlanDetail.aspx?clientID=PAE4A6DVhyo=

Next, you will need to complete the Salary Reduction Agreement (SRA) in order to begin your contributions. A copy of the SRA can be completed electronically at: https://www.omni403b.com/Forms.aspx

No login information is required to complete this form.

Please contact The OMNI Group at 877.544.6664 with any questions regarding this plan or your enrollment.

MPSERS PENSION / HEALTH CARE BENEFITS

The Michigan Public Schools Employees Retirement System (MPSERS) was developed for Michigan Public School Employees to provide a monthly pension and health care benefits for you and your family after you retire.

The MPSERS plans are administered by the State of Michigan Office of Retirement Services (ORS) and is controlled by the Michigan Public School Employees Retirement Act (Public Act 300 of 1980 as amended).

When you retire, you, your spouse and your eligible dependent children can enroll in the plan's group insurance offerings. Your share of the insurance premium is deducted from your monthly pension payments. These rates apply to all public-school retirees who retired after January 1, 2013, or to previous retirees who were not yet eligible for Medicare coverage as of January 1, 2013.

If you have questions or for more information regarding this plan, you should contact ORS directly at 800.381.5111 or visit the website www.michigan.gov.orsschools/your-insurance-benefits. For written correspondence, the address is:

Office of Retirement Services (ORS) P.O. Box 30171 Lansing, MI 48909-7671.

YOUR RETIREMENT PLAN

- If you began working for a Michigan public school before July 1, 2010 or later, you are a member of either the Pension Plus, Pension Plus 2 or Defined Contribution (DC) plan.

- If you began working for a Michigan public school on or after January 1, 1990 but before July 1, 2010 you are in the Member Investment Plan (MIP) - MIP Fixed, MIP Graded, MIP Plus, MIP 7%, or MIP DC Converted.

- If you began working for a Michigan public school before January 1, 1990 and did not elect MIP, then you are in the Basic Plan - Basic, Basic 4% or Basic DC Converted.

CHOOSING A RETIREMENT PLAN

Employees who have never worked in a Michigan Public School system are provided retirement options through the State of Michigan Office of Retirement Services (ORS). Contributions will begin on the first day of work. The plan you choose will be your retirement plan throughout your entire career as a Michigan Public School employee. Your retirement journey begins with an important first step; electing your retirement plan. Employees must elect one of the two retirement plan options described here within 75 calendar days from your first payroll end date to decide which retirement plan best meets your needs.

- Pension Plus 2 plan or

- Defined Contribution plan

Visit www.pickmiplan.org to learn more about the plans. Then go to miAccount at ORS - Office of Retirement Services (michigan.gov) and make your election. If a retirement plan is not selected by the deadline, employees are automatically enrolled in the Pension Plus 2 plan. Once an election is submitted or the deadline passes, the selected or defaulted retirement plan cannot be changed.

PENSION PLUS 2 PLAN - (PENSION/SAVINGS PLAN)

- This is a plan that pairs a pension with a savings plan.

- The savings plan enrolls you in the State of Michigan 401(k) and the 457 plans.

- A pension guarantees you a monthly benefit for life after you meet age and service requirements.

- Pension payments are not affected by market fluctuations.

- The retirement system manages your pension; you manage your 401(k) and 457 plans.

DEFINED CONTRIBUTION PLAN - (SAVINGS PLAN)

- This is a savings plan only.
- The Defined Contribution option enrolls you in the State of Michigan 401(k) and the 457 plans.
- Retirement income will depend on contributions to your 401(k) and the 457 plans and investment performance.
- Investment returns are not guaranteed. Retirement income ends when your accounts are depleted.
- You manage your 401(k) and 457 plans.

PERSONAL HEALTHCARE FUND

In either plan you are placed in a Personal Health Care Fund (PHF). Contributions from you and your employer are deposited into your State of Michigan 401(k) and 457 plans. This can be used to pay for health insurance or other expenses when you retire.

For questions, please contact the State of Michigan Office of Retirement Services at 800.381.5111 or visit www.pickmiplan.org

REMEMBER YOU HAVE: Up to 75 days after your first payroll retirement deduction to elect your plan.

ULLIANCE EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Ulliance Life Advisor Employee Assistance Program is designed to help each employee and their covered family members deal with the many personal and family issues that we all encounter at some point in our lives. For example, you might need assistance coping with stress or depression, learning new parenting skills, or finding a nursing home for a loved one. Ulliance provides many services to meet your needs, including counseling, coaching, crisis intervention, and community resources.

The Life Advisor Employee Assistance Program provides completely confidential, free assistance in many areas, including:

- Relationship and family concerns
- Death of a loved one
- Stress, anxiety and depression
- Substance Abuse
- Eldercare or childcare referrals
- Financial or legal referrals

There is no cost to you or your dependents for the Ulliance services which are available 24 hours a day, 7 days a week.

You can contact Ulliance to get answers to your questions. The Ulliance toll free number 800.448.8326 is all you need to reach free, confidential assistance. We hope you and your dependents take advantage of the many valuable services the Life Advisor EAP has to offer.

Visit: LifeAdvisorWellness.com

Once at the site, log in with DPSCD as your employer and Detroit as the City of Employment.

WHO SHOULD I CALL FOR ASSISTANCE

THE DPSCD BENEFIT SOLUTION CENTER

The DPSCD Benefit Solution Center is staffed by highly trained employee advocates who are experienced in helping you understand your benefits and the enrollment process. Kapnick's high level of customer service allows you to not only understand your benefits but to use them to their fullest extent. We are available Monday-Friday, 8:30 am - 5:00 pm (Eastern) to answer questions concerning:

- Explanation of Benefits
- ID Card Reorders
- Carrier Information
- Participating Provider Assistance
- Claim Assistance
- FSA Account Balances/Inquiries
- COBRA Assistance
- Life Status Events

Contact us at 888.447.9038

* Translation Services Available In 100+ Languages

CARRIER CONTACT INFORMATION

COVERAGE	PHONE	WEBSITE / EMAIL
Enrollment: DPSCD Online Benefit Center Support: DPSCD Benefits Solution Center	Online Only 888.447.9038	https://detroitk12.bswift.com servicecenter@kapnick.com
Medical and Rx Plans		
BCN	800.662.6667	www.bcbsm.com
BCBSM	800.752.1455	www.bcbsm.com
HAP	800.422.4641	www.hap.org
Dental Plans		
Delta Dental	800.524.0149	www.deltadentalmi.com
Vision Plans		
Heritage Vision Plans	800.252.2053	www.heritagevisionplans.com
Heritage Hearing Value Add	833.934.0222	www.amplifonusa.com/heritagevisionplans
Heritage Lasik Value Add	855.373.2020	www.heritagevisionplanslasik.com
Employee Assistance Program		
Ulliance	800.448.8326	www.lifeadvisorwellness.com

Tax-Deferred Annuity Plan - 403(b)/457		
Omni Group - TDA Administrator	877.544.6664	www.omni403b.com
Life Insurance		
Securian	866.293.6047	www.lifebenefits.com
Flexible Spending Accounts		
Kapnick Flex	800.550.3539	flex@kapnick.com
Retirement and Group ORS		
Michigan Office of Retirement Services	800.381.5111	www.michigan.gov/orsschools