Mansfield ISD

Welcome New Hire!

First things first. Look through the interactive benefit guide and review all the great benefits available to you! Whether on your device or desktop, gain 24/7 access to all your benefit needs on the benefits website listed below.

30 DAYS

All new hires are required to log in to the benefits portal and either elect or decline benefits within 30 days of employment.

July RENEWAL

All employees will re-enroll each July for the next plan year.

Enrollment Assistance

Have Questions or need help?
Cara Hanes, our FBS Benefit Specialist is available to assist you in completing your enrollment and answering questions on supplemental benefits. Contact her at: carah@fbsbenefits.com or 469-636-8836.

For Detailed Questions on the TRS Medical Plans contact TRS directly at:
1 800-222-9205.

How to Enroll

www.mybenefitshub.com/mansfieldisd

CLICK LOGIN

ENTER USERNAME & PASSWORD

All login credentials have been RESET to the default described below:

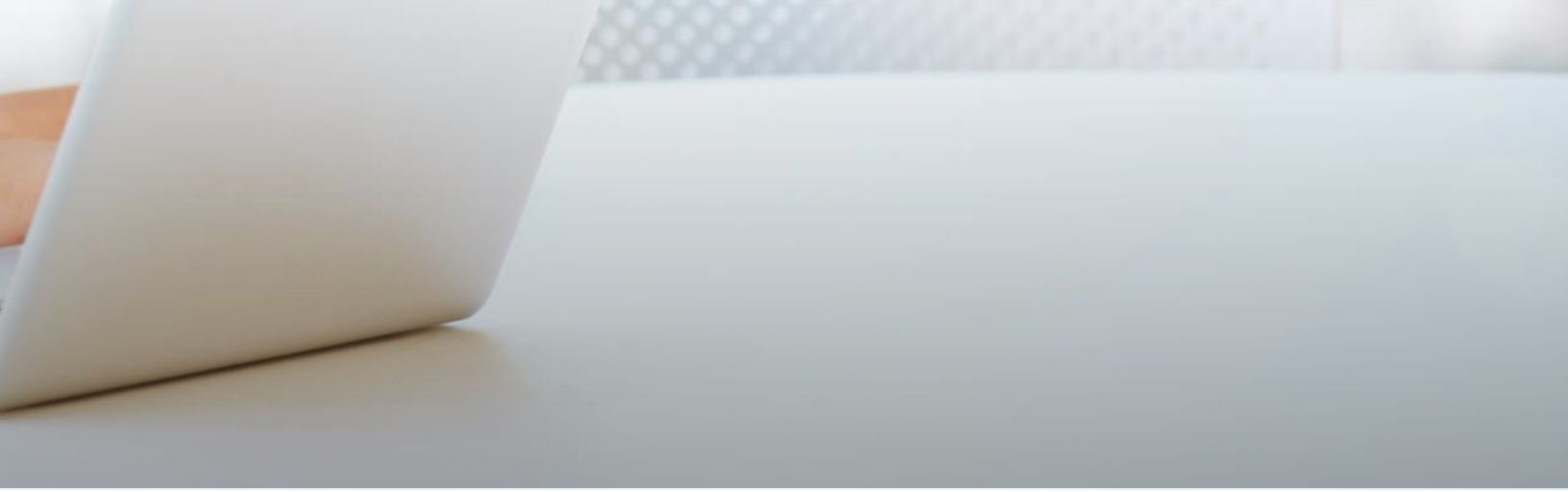
Username:

The first six (6) characters of your last name, followed by the first letter of your first name, followed by the last four (4) digits of your Social Security Number.

If you have less than six (6) characters in your last name, use your full last name, followed by the first letter of your first name, followed by the last four (4) digits of your Social Security Number.

Default Password:

Last Name* (lowercase, excluding punctuation) followed by the last four (4) digits of your Social Security Number.



Benefit Contact Information

BENEFIT ADMINISTRATORS

Financial Benefit Services
(800) 583-6908
www.mybenefitshub.com/mansfieldisd

DENTAL

Group # 3339927
Cigna
(800) 244-6224
www.mycigna.com

CANCER

Group # 18361
American Public Life
(800) 256-8606
www.ampublic.com

MEDICAL

Aetna
(800) 222-9205
www.trsactivecareaetna.com

VISION

Group # 7511
Davis Vision
(877) 923-2847
www.davisvision.com

ACCIDENT

Group # 695149
Voya
(800) 955-7736
www.voya.com

HEALTH SAVINGS ACCOUNT

HSA Bank
(800) 357-6246
www.hsabank.com

DISABILITY

Policy # G00614903
AUL a OneAmerica Company
(800) 553-5318
Claims: (855) 517-6365
www.oneamerica.com

CRITICAL ILLNESS

Group # 695149
Voya
(800) 955-7736
www.voya.com

MEDICAL SUPPLEMENT

Group# G4200 OP2 25180
Custom Link
Special Insurance Services, Inc.
(800) 767-6811
www.specialinc.com

FAMILY PROTECTION PLAN

5Star Life Insurance Company
(866) 863-9753
http://5starlifeinsurance.com

FLEXIBLE SPENDING ACCOUNT

National Benefit Services
(800) 274-0503
www.nbsbenefits.com

TELEHEALTH

MDLIVE
(888) 365-1663
www.consultmdlive.com

LIFE AND AD&D

Policy # G00614903
AUL a OneAmerica Company
Customer Service: (800) 553-5318
Life/Life Waiver Claims: (800) 553-3522
Employee Assistance Program: (855) 387-9727
Travel Assistance Program: (866) 294-2469
www.oneamerica.com

2018-19 TRS-ActiveCare Plan Highlights

Effective Sept. 1, 2018 through Aug. 31, 2019 | In-Network Level of Benefits[1]

Medical Coverage	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2 **NOTE:** If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Deductible (per plan year)			
In-Network	$2,750 employee only/$5,500 family	$1,200 individual/$3,600 family	$1,000 individual/$3,000 family
Out-of-Network	$5,500 employee only/$11,000 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$2,000 individual/$6,000 family
Out-of-Pocket Maximum (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum)	The individual out-of-pocket maximum only includes covered expenses incurred by that individual.		
In-Network	$6,650 individual/$13,300 family	$7,350 individual/$14,700 family	$7,350 individual/$14,700 family
Out-of-Network	$13,300 individual/$26,600 family	Not applicable. This plan does not cover out-of-network services except for emergencies.	$14,700 individual/$29,400 family
Coinsurance			
In-Network Participant pays (after deductible)	20%	20%	20%
Out-of-Network Participant pays (after deductible)	40% of allowed amount	Not applicable. This plan does not cover out-of-network services except for emergencies.	40% of allowed amount
Office Visit Copay Participant pays	20% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist
Diagnostic Lab Participant pays	20% after deductible	20% after deductible	20% after deductible
Preventive Care See below for examples	Plan pays 100%	Plan pays 100%	Plan pays 100%
Teladoc® Physician Services	$40 consultation fee (counts toward deductible and out-of-pocket maximum)	Plan pays 100%	Plan pays 100%
High-Tech Radiology (CT scan, MRI, nuclear medicine) Participant pays	20% after deductible	$100 copay plus 20% after deductible	$100 copay plus 20% after deductible
Inpatient Hospital (preauthorization required) (facility charges) Participant pays	20% after deductible	$150 copay per day plus 20% after deductible ($750 maximum copay per admission)	$150 copay per day plus 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Freestanding Emergency Room Participant pays	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible	$500 copay per visit plus 20% after deductible
Emergency Room (true emergency use) Participant pays	20% after deductible	$250 copay plus 20% after deductible (copay waived if admitted)	$250 copay plus 20% after deductible (copay waived if admitted)
Outpatient Surgery Participant pays	20% after deductible	$150 copay per visit plus 20% after deductible	$150 copay per visit plus 20% after deductible
Bariatric Surgery Physician charges (only covered if performed at an IOQ facility) Participant pays	$5,000 copay (does apply to out-of-pocket maximum) plus 20% after deductible	Not covered	$5,000 copay (does not apply to out-of-pocket maximum) plus 20% after deductible
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist using calibrated instruments) Participant pays	20% after deductible	$70 copay for specialist	$70 copay for specialist
Annual Hearing Examination Participant pays	20% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist

Preventive Care

Some examples of preventive care frequency and services:

- **Routine physicals** – annually age 12 and over
- **Mammograms** – one every year age 35 and over
- **Smoking cessation counseling** – eight visits per 12 months
- **Well-child care** – unlimited up to age 12
- **Colonoscopy** – one every 10 years age 50 and over
- **Healthy diet/obesity counseling** – unlimited to age 22; age 22 and over – 26 visits per 12 months
- **Well woman exam & pap smear** – annually age 18 and over
- **Prostate cancer screening** – one per year age 50 and over
- **Breastfeeding support** – six lactation counseling visits per 12 months

Note: Covered services under this benefit must be billed by the provider as "preventive care." Non-network preventive care is not paid at 100%. If you receive preventive services from a non-network provider, you will be responsible for any applicable deductible and coinsurance under the ActiveCare 1-HD and ActiveCare 2. There is no coverage for non-network services under the ActiveCare Select plan or ActiveCare Select Whole Health.

For a listing of preventive care services, please view the Benefits Booklet at **www.trsactivecareaetna.com** for the latest list of covered services.

TRS-ActiveCare is administered by Aetna Life Insurance Company. Aetna provides claims payment services only and does not assume any financial risk or obligation with respect to claims. Prescription drug benefits are administered by Caremark.

2018-19 TRS-ActiveCare Plan Highlights

Prescription Coverage	ActiveCare 1-HD	ActiveCare Select or ActiveCare Select Whole Health (Baptist Health System and HealthTexas Medical Group; Baylor Scott and White Quality Alliance; Kelsey Select; Memorial Hermann Accountable Care Network; Seton Health Alliance)	ActiveCare 2 **NOTE:** If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan. However, as of Sept. 1, 2018, TRS-ActiveCare 2 is closed to new enrollees.
Drug Deductible (per person, per plan year)	Must meet plan-year deductible before plan pays.[2]	$0 generic; $200 brand	$0 generic; $200 brand
Short-Term Supply at a Retail Location (up to a 31-day supply)			
Tier 1 – Generic	20% coinsurance after deductible, except for certain generic preventive drugs that are covered at 100%.[2]	$20 for a 1- to 31-day supply	$20 for a 1- to 31-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$40 for a 1- to 31-day supply[3]	$40 for a 1- to 31-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 1- to 31-day supply[3]	50% coinsurance for a 1- to 31-day supply (Min. $65[4]; Max. $130)[3]
Extended-Day Supply at Mail Order or Retail-Plus Pharmacy Location (60- to 90-day supply)[5]			
Tier 1 – Generic	20% coinsurance after deductible	$45 for a 60- to 90-day supply	$45 for a 60- to 90-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$105 for a 60- to 90-day supply[3]	$105 for a 60- to 90-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 60- to 90-day supply[3]	50% coinsurance for a 60- to 90-day supply (Min. $180[4]; Max. $360)[3]
Specialty Medications (up to a 31-day supply)	20% coinsurance after deductible	20% coinsurance	20% coinsurance (Min. $200[4]; Max. $900)
Short-Term Supply of a Maintenance Medication at Retail Location (up to a 31-day supply) The second time a participant fills a short-term supply of a maintenance medication at a retail pharmacy, they will pay a convenience fee. They will be charged the coinsurance and copays in the row below the second time they fill a short-term supply of a maintenance medication. Participants can avoid paying the convenience fee by filling a larger day supply of a maintenance medication through mail order or at a Retail-*Plus* location.			
Tier 1 – Generic	20% coinsurance after deductible	$35 for a 1- to 31-day supply	$35 for a 1- to 31-day supply
Tier 2 – Preferred Brand	20% coinsurance after deductible	$60 for a 1- to 31-day supply[3]	$60 for a 1- to 31-day supply[3]
Tier 3 – Non-Preferred Brand	50% coinsurance after deductible	50% coinsurance for a 1- to 31-day supply[3]	50% coinsurance for a 1- to 31-day supply (Min. $90[4]; Max. $180)[3]

What is a maintenance medication?

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

When does the convenience fee apply?

For example, if you are covered under TRS-ActiveCare Select, the first time you fill a 31-day supply of a generic maintenance drug at a retail pharmacy you will pay $20, then you will pay $35 each month that you fill a 31-day supply of that generic maintenance drug at a retail pharmacy. A 90-day supply of that same generic maintenance medication would cost $45, and you would save $225 over the year by filling a 90-day supply.

A specialist is any physician other than family practitioner, internist, OB/GYN or pediatrician.

[1] Illustrates benefits when in-network providers are used. For some plans non-network benefits are also available; there is no coverage for non-network benefits under the ActiveCare Select or ActiveCare Select Whole Health Plan; see Enrollment Guide for more information. Non-contracting providers may bill for amounts exceeding the allowable amount for covered services. Participants will be responsible for this balance bill amount, which maybe considerable.

[2] For ActiveCare 1-HD, certain generic preventive drugs are covered at 100%. Participants do not have to meet the deductible ($2,750 – individual, $5,500 – family) and they pay nothing out of pocket for these drugs. Find the list of drugs at **info.caremark.com/trsactivecare**.

[3] If a participant obtains a brand-name drug when a generic equivalent is available, they are responsible for the generic copay plus the cost difference between the brand-name drug and the generic drug.

[4] If the cost of the drug is less than the minimum, you will pay the cost of the drug.

[5] Participants can fill 32-day to 90-day supply through mail order.

Monthly Premiums

TRS-ActiveCare Monthly Premium	TRS-ActiveCare 1-HD			TRS-ActiveCare Select/ ActiveCare Select Whole Health			TRS-ActiveCare 2		
	Full monthly premium*	Amount Paid by MISD	Your monthly premium***	Full monthly premium*	Amount Paid by MISD	Your monthly premium***	Full monthly premium*	Amount Paid by MISD	Your monthly premium***
Individual	$367	$250	$ 117	$540	$250	$ 290	$782	$250	$ 532
+Spouse	$1,035	$250	$ 785	$1,327	$250	$ 1,077	$1,855	$250	$ 1,605
+Children	$701	$250	$ 451	$876	$250	$ 626	$1,163	$250	$ 913
+Family	$1,374	$250	$ 1,124	$1,668	$250	$ 1,418	$2,194	$250	$ 1,944

* If you are not eligible for the state/district subsidy, you will pay the full monthly premium. Please contact your Benefits Administrator for your monthly premium.

** **The premium after state, $75 and district, $150 contribution is the maximum you may pay per month. Ask your Benefits Administrator for your monthly cost.** (This is the amount you will owe each month after all available subsidies are applied to your premium.)

*** Completed by your benefits administrator. The state/district contribution may be greater than $225.

Mansfield Independent School District

Family Medical Leave Act
Q&A

What is the Family Medical Leave Act (FMLA)?

The Family Medical Leave Act entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any "qualifying exigency" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows an eligible employee who is a spouse, son, daughter, parent, or next of kin of a covered service member with a serious injury or illness up to a total of 26 workweeks of unpaid leave during a single 12-month period to care for the service member.

Who is eligible for FMLA?

Employees are eligible for leave if they have worked for their employer at least 12 months, and at least 1,250 hours over the past 12 months

What are qualifying events for taking FMLA?

- for the birth and care of a newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for a spouse, son, daughter, or parent with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition;
- **or** for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

What is intermittent leave?

Under some circumstances, employees may take FMLA leave intermittently – taking leave in separate blocks of time for a single qualifying reason – or on a reduced leave schedule – reducing the employee's usual weekly or daily work schedule. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

How and where do I obtain the necessary FMLA paperwork?

As soon as you know you need to take leave, you must notify Lisa LaFleur in the Benefits Office about the need for FMLA. A Family Medical Leave Request form should be submitted 30 days before the leave is scheduled to begin. In the event of a medical emergency or circumstance where it is not possible to anticipate the need for leave, the employee must notify the Benefits office as soon as possible. All FMLA paperwork and doctor's notes must go to the Benefits Office. It is the responsibility of the employee to meet all deadlines for turning in any requested paperwork to insure qualification of FMLA and to secure a release from the doctor before any employee can return to work. Once a release has been received by the Benefits office said employee will be provided a green release sheet to return to their campus/department. Employee will not be able to return to work without this green release sheet.

What level of involvement or communication may employees on FMLA keep with their campus/department during leave?

Employees requesting to be off work for a qualifying event under FMLA must provide medical documentation of why leave is needed and certification that they are unable to perform the essential functions of the job to which they are assigned. Therefore, once leave has been granted, employees should not be on campus until a physician's release has been obtained. If an extenuating circumstance exists which the employee believes necessitates a visit to his/her workplace, the employee must obtain principal approval prior to the visit.

For more questions, please contact the Benefits office via email at benefits@misdmail.org. The Benefits Office is located in building 200 at 605 E. Broad St. at the Administration Complex.

I'VE BEEN INJURED AT WORK, WHAT DO I DO?[i]

- Report the injury ***immediately*** to your supervisor and/or campus nurse; and complete an Incident Report.

- If you need to seek medical attention, please let your supervisor know and then you will need to go to an In-Network doctor (list provided when you complete the Incident Report).

- After your visit, the doctor will give you a DWC73-Texas Workers' Compensation Work Status Report. Immediately following your appointment, you will need to give a copy to your supervisor, as well as fax a copy to the Benefits Office at 817-473-5330.

- If you have ANY restrictions that your supervisor ***will be*** able to accommodate, a bona fide job offer letter will be put into place. Your supervisor will meet with you to discuss this.

- If your restrictions are ***not able*** to be accommodated, then you will be off of work until your restrictions are able to be accommodated by your supervisor, or your doctor releases you to full duty.

- If you need to go to the Emergency Room (***only for true emergencies***), you will need to follow-up with an In-Network doctor. The DWC73-Texas Workers' Compensation Work Status Report will need to be sent to your supervisor, as well as to the Benefits Dept. Please fax it to 817-473-5330.

- As long as you are under a doctor's care for your illness/injury, you are required to keep your follow-up appointments with the treating doctor until you are released. If your supervisor is able to accommodate your restrictions and you are working during this time, please keep in mind that all doctor appointments must be made *outside of work hours*. If you attend an appointment during work hours, the time you miss from work will be your own personal time.

[i] INFORMATION FOR THE EMPLOYEE---**PLEASE GIVE THEM THIS COPY**