Group Benefits Proposal
Prepared For
City of Glen Rose
Effective Date October 1, 2026

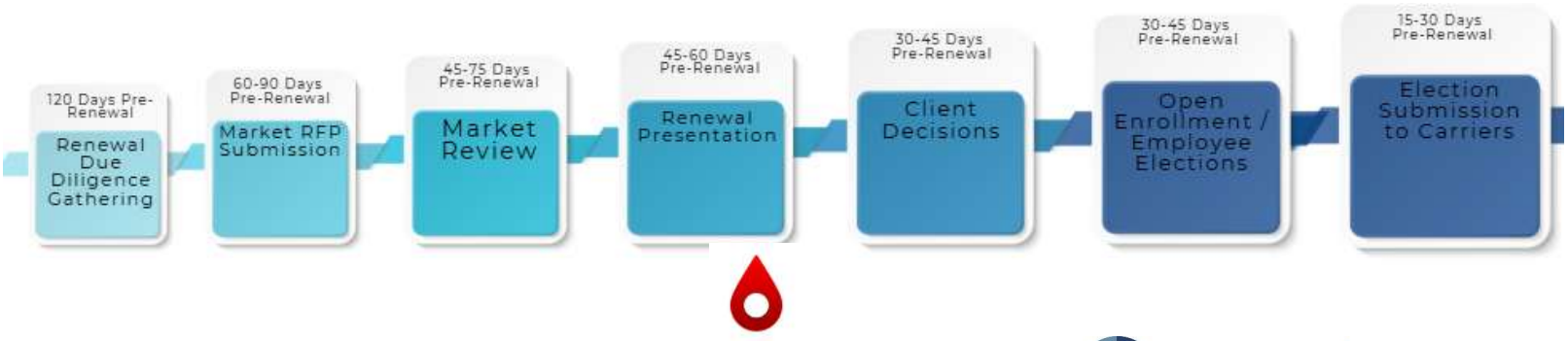
CA CLARK | ADAMSON
INSURANCE

MARKET SUMMARY

Medical Carriers	
Carrier Name	Status of RFP
Aetna	Currently In Place
BlueCross BlueShield	**Received**
United Healthcare Fully Insured	**Received**
EMI Health	**Received**
Angle	**Received**
TXHB	DTQ

Ancillary Carriers	
Carrier Name	Status of RFP
Mutual of Omaha	Currently In Place
Equitable	**Received**
Renaissance	**Received**
Principal	**Received**
Guardian	**Received**
UNUM	**Received**

STANDARD TIMELINE OF EVENTS



CA CLARK | ADAMSON INSURANCE

Claims versus Premiums
Prepared For
City of Glen Rose
Reporting Dates October 2023 - May 2026

2023 - 2024 (BCBSTX FI)

Month	Membership	Premiums	Claims	Loss Ratio
Oct-23	17	$10,896	$4,138	38%
Nov-23	17	$10,896	$5,579	51%
Dec-23	16	$10,442	$5,507	53%
Jan-24	16	$10,442	$3,951	38%
Feb-24	15	$9,534	$526	6%
Mar-24	15	$9,534	$619	6%
Apr-24	18	$10,896	$6,661	61%
May-24	18	$10,896	$55,521	510%
Jun-24	18	$10,896	$13,099	120%
Jul-24	19	$11,350	$1,228	11%
Aug-24	18	$10,896	$2,592	24%
Sep-24	19	$11,350	$2,481	22%
		$128,031	$101,903	80%

2024 - 2025 (BCBSTX FI)

Month	Membership	Premiums	Claims	Loss Ratio
Oct-24	16	$9,917	$364	4%
Nov-24	16	$9,917	$1,421	14%
Dec-24	20	$12,005	$1,186	10%
Jan-25	20	$12,527	$441	4%
Feb-25	19	$11,483	-$6,171	-54%
Mar-25	20	$12,005	$730	6%
Apr-25	20	$12,005	$12,847	107%
May-25	21	$12,527	$852	7%
Jun-25	18	$10,439	$1,155	11%
Jul-25	20	$11,483	$1,218	11%
Aug-25	19	$10,961	$701	6%
Sep-25	18	$10,439	$640	6%
		$135,712	$15,385	11%

2025 - 2026 (Aetna LF)

Month	Membership	Fixed Costs	Claims Fund	Monthly Total	Claims Payments	Loss Ratio
Oct-25	17	$9,220	$2,500	$11,719	$2,454	98%
Nov-25	17	$2,420	$2,500	$4,919	$1,132	45%
Dec-25	17	$9,220	$2,500	$11,719	$911	36%
Jan-26	18	$9,685	$2,590	$12,275	$2,088	81%
Feb-26	19	$10,151	$2,680	$12,831	$2,304	86%
Mar-26	19	$10,151	$2,680	$12,831	$7,985	298%
Apr-26	19	$10,151	$2,680	$12,831	$4,372	163%
May-26	19	$10,151	$2,680	$12,831	$5,410	202%
Jun-26						
Jul-26						
Aug-26						
Sep-26						
		$71,149	$20,808	$91,957	$26,654	128%

Plan Year	Billed Premium / Claims Fund	Claims Paid	Loss Ratio
2023 - 2024 (BCBSTX FI)	$128,031	$101,903	80%
2024 - 2025 (BCBSTX FI)	$135,712	$15,385	11%
2025 - 2026 (Aetna LF)	$20,808	$26,654	128%
Total	$284,551	$143,942	51%

CA CLARK | ADAMSON INSURANCE

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INSURANCE COMPANY			aetna						aetna					
			Current		Current		Current		Proposed		Proposed		Proposed	
In-Network Benefits														
Type of Plan - Plan Name			AFA OAAS 7500 HSA 100% CY V26 - EPO		AFA OAAS 3500 80% CY V26 - EPO		AFA CPOSII 1500 80/50 CY V26 - PPO		AFA OAAS 7500 HSA 100% CY V26 - EPO		AFA OAAS 3500 80% CY V26 - EPO		AFA CPOSII 1500 80/50 CY V26 - PPO	
Network			Open Access		Open Access		Open Access		Open Access		Open Access		Open Access	
Deductible			In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual			$7,500	N / A	$3,500	N / A	$1,500	$3,000	$7,500	N / A	$3,500	N / A	$1,500	$3,000
Family			$15,000	N / A	$7,000	N / A	$3,000	$9,000	$15,000	N / A	$7,000	N / A	$3,000	$9,000
Coinsurance Percentage			100%	N / A	80%	N / A	80%	50%	100%	N / A	80%	N / A	80%	50%
Maximum Out of Pocket (Deductible Included)														
Individual			$7,500	N / A	$7,000	N / A	$5,500	$13,000	$7,500	N / A	$7,000	N / A	$5,500	$13,000
Family			$15,000	N / A	$14,000	N / A	$11,000	$39,000	$15,000	N / A	$14,000	N / A	$11,000	$39,000
Office Visits														
Preventive Care			Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician			Ded.		$35 Copay		$25 Copay		Ded.		$35 Copay		$25 Copay	
Specialist			Ded.		$75 Copay		$75 Copay		Ded.		$75 Copay		$75 Copay	
Virtual Visits			Ded.		PCP: $35 Copay Specialist: $75 Copay		PCP: $25 Copay Specialist: $75 Copay		Ded.		PCP: $35 Copay Specialist: $75 Copay		PCP: $25 Copay Specialist: $75 Copay	
Urgent Care Facility Copay			Ded.		$75 Copay		$75 Copay		Ded.		$75 Copay		$75 Copay	
Lab & Xray			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Imaging - CT/PET scans, MRI			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Mental Health Outpatient			Ded.		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 20%		Ded.		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 20%	
Hospital & Emergency Room														
Inpatient Hospital Expenses			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Outpatient Surgery Facility			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Emergency Room Facility			Ded.		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 20%		Ded.		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 20%	
Prescription Drugs														
Prescription Deductible			Included with Medical		Not Applicable		Not Applicable		Included with Medical		Not Applicable		Not Applicable	
Tier 1			Ded.		$3		$3		Ded.		$3		$3	
Tier 2			Ded.		$10		$10		Ded.		$10		$10	
Tier 3			Ded.		$50		$45		Ded.		$50		$45	
Tier 4			Ded.		$80		$75		Ded.		$80		$75	
Specialty Drugs			Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500	
Mail Order (90 Day Supply)			Ded.		$6 / $20 / $100 / $160		$6 / $20 / $90 / $150		Ded.		$6 / $20 / $100 / $160		$6 / $20 / $90 / $150	
Monthly Premiums			Current	Renewal	Current	Renewal	Current	Renewal	Proposed		Proposed		Proposed	
Employee Only	13	12	$558.17	$607.90	$689.52	$751.76	$829.16	$856.96	$588.76		$734.20		$827.92	
Employee & Spouse	1	0	$1,401.21	$1,533.90	$1,751.60	$1,926.33	$2,130.32	$2,224.04	$1,477.99		$1,865.10		$2,127.12	
Employee & Child(ren)	1	1	$1,117.61	$1,222.38	$1,394.31	$1,531.19	$1,692.60	$1,764.13	$1,177.96		$1,484.66		$1,761.48	
Employee & Family	0	0	$1,925.15	$2,109.38	$2,411.66	$2,656.31	$2,938.98	$3,073.66	$2,030.65		$2,567.94		$2,934.57	
	15	0												
Total Monthly Premium			$7,815.65	$8,517.18	$1,751.60	$1,926.33	$829.16	$856.96	$8,243.08		$1,865.10		$827.92	
Total Annual Premium			$93,787.80	$102,206.16	$21,019.20	$23,115.96	$9,949.92	$10,283.52	$98,916.96		$22,381.20		$9,935.04	
Rate Adjustment			8.98%		9.98%		3.35%		5.47%		6.48%		-0.15%	
Combined Annual Premiums			Current	$124,756.92	Renewal	$135,605.64			Proposed	$131,233.20				
Total Rate Adjustment			8.70%						5.19%					
Total Annual Premium Adjustment			$10,848.72						$6,476.28					

State law prohibits EPO plans in the following states: Alabama, Arizona, Arkansas, Hawaii, Mississippi, Montana, New Mexico, North Carolina, North Dakota, and Oklahoma

Estimated Rates with 3.5% Rate Relief

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INSURANCE COMPANY	aetna						BlueCross BlueShield of Texas					
	Current		Current		Current		Proposed		Proposed		Proposed	
In-Network Benefits												
Type of Plan - Plan Name	AFA OAAS 7500 HSA 100% CY V26 - EPO		AFA OAAS 3500 80% CY V26 - EPO		AFA CPOSII 1500 80/50 CY V26 - PPO		B661CHC - PPO 2026 HDHP HSA QUALIFIED		S661CHC - PPO 2026		G652CHC - PPO 2026	
Network	Open Access		Open Access		Open Access		Blue Choice		Blue Choice		Blue Choice	
Deductible	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual	$7,500	N / A	$3,500	N / A	$1,500	$3,000	$7,500	$15,000	$3,650	$7,300	$1,600	$3,200
Family	$15,000	N / A	$7,000	N / A	$3,000	$9,000	$15,000	$30,000	$10,950	$21,900	$4,800	$9,600
Coinsurance Percentage	100%	N / A	80%	N / A	80%	50%	100%	100%	70%	50%	80%	60%
Maximum Out of Pocket (Deductible Included)												
Individual	$7,500	N / A	$7,000	N / A	$5,500	$13,000	$7,500	$15,000	$9,200	Unlimited	$5,350	Unlimited
Family	$15,000	N / A	$14,000	N / A	$11,000	$39,000	$15,000	$30,000	$18,400	Unlimited	$10,705	Unlimited
Office Visits												
Preventive Care	Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician	Ded.		$35 Copay		$25 Copay		Ded.		$55 Copay		$50 Copay	
Specialist	Ded.		$75 Copay		$75 Copay		Ded.		$100 Copay		$100 Copay	
Virtual Visits	Ded.		PCP: $35 Copay Specialist: $75 Copay		PCP: $25 Copay Specialist: $75 Copay		Ded.		$55 Copay		$50 Copay	
Urgent Care Facility Copay	Ded.		$75 Copay		$75 Copay		Ded.		$100 Copay		$100 Copay	
Lab & Xray	Ded.		Ded. + 20%		Ded. + 20%		Ded.		Lab: Ded. + 30% X-Ray: $150 Copay + Ded. + 30%		Ded. + 20%	
Imaging - CT/PET scans, MRI	Ded.		Ded. + 20%		Ded. + 20%		Ded.		$250 Copay + Ded. + 30%		$300 Copay	
Mental Health Outpatient	Ded.		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 20%		Ded.		OV: $55 Copay Outpatient: Ded. + 30%		OV: $50 Copay Outpatient: Ded. + 20%	
Hospital & Emergency Room												
Inpatient Hospital Expenses	Ded.		Ded. + 20%		Ded. + 20%		Ded.		$350 Copay + Ded. + 30%		Ded. + 20%	
Outpatient Surgery Facility	Ded.		Ded. + 20%		Ded. + 20%		Ded.		$300 Copay + Ded. + 30%		Ded. + 20%	
Emergency Room Facility	Ded.		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 20%		$750 Copay + Ded.		$750 Copay + Ded. + 30%		$500 Copay + Ded. + 20%	
Prescription Drugs									Preferred / Participating		Preferred / Participating	
Prescription Deductible	Included with Medical		Not Applicable		Not Applicable		Included with Medical		Not Applicable		Not Applicable	
Tier 1	Ded.		$3		$3		Ded.		$5 / $10		$5 / $15	
Tier 2	Ded.		$10		$10		Ded.		$10 / $20		$15 / $25	
Tier 3	Ded.		$50		$45		Ded.		$50 / $70		$50 / $70	
Tier 4	Ded.		$80		$75		Ded.		$100 / $120		$100 / $120	
Specialty Drugs	Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Ded.		Tier 5: $150 / Tier 6: $250		Tier 5: $150 / Tier 6: $250	
Mail Order (90 Day Supply)	Ded.		$6 / $20 / $100 / $160		$6 / $20 / $90 / $150		Ded.		$15 / $30 / $150 / $300		$15 / $45 / $150 / $300	
Monthly Premiums	Current	Renewal	Current	Renewal	Current	Renewal	Proposed		Proposed		Proposed	
Employee Only (13 / 12)	$558.17	$607.90	$689.52	$751.76	$829.16	$856.96	$1,014.58		$1,144.40		$1,377.12	
Employee & Spouse (1 / 0)	$1,401.21	$1,533.90	$1,751.60	$1,926.33	$2,130.32	$2,224.04	$2,029.16		$2,288.80		$2,754.24	
Employee & Child(ren) (1 / 1)	$1,117.61	$1,222.38	$1,394.31	$1,531.19	$1,692.60	$1,764.13	$2,029.16		$2,288.80		$2,754.24	
Employee & Family (0 / 0)	$1,925.15	$2,109.38	$2,411.66	$2,656.31	$2,938.98	$3,073.66	$3,043.74		$3,433.20		$4,131.36	
(15 / 0)			(1)		(1)							
Total Monthly Premium	$7,815.65	$8,517.18	$1,751.60	$1,926.33	$829.16	$856.96	$14,204.12		$2,288.80		$1,377.12	
Total Annual Premium	$93,787.80	$102,206.16	$21,019.20	$23,115.96	$9,949.92	$10,283.52	$170,449.44		$27,465.60		$16,525.44	
Rate Adjustment	8.98%		9.98%		3.35%		81.74%		30.67%		66.09%	
Combined Annual Premiums	Current $124,756.92		Renewal $135,605.64				Proposed $214,440.48					
Total Rate Adjustment	8.70%						71.89%					
Total Annual Premium Adjustment	$10,848.72						$89,683.56					

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Group Medical Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY			aetna						UnitedHealthcare					
			Current		Current		Current		Proposed		Proposed		Proposed	
In-Network Benefits														
Type of Plan - Plan Name			AFA OAAS 7500 HSA 100% CY V26 - EPO		AFA OAAS 3500 80% CY V26 - EPO		AFA CPOSII 1500 80/50 CY V26 - PPO		EO9N - Rx K35S - EPO HDHP HSA QUALIFIED 2026		EPAC - Rx K35S - EPO 2026		EPA3 - Rx K35S - PPO 2026	
Network			Open Access		Open Access		Open Access		Choice		Choice		Choice Plus	
Deductible			In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual			$7,500	N / A	$3,500	N / A	$1,500	$3,000	$7,500	N / A	$3,000	N / A	$1,500	$10,000
Family			$15,000	N / A	$7,000	N / A	$3,000	$9,000	$15,000	N / A	$9,000	N / A	$4,500	$20,000
Coinsurance Percentage			100%	N / A	80%	N / A	80%	50%	100%	N / A	80%	N / A	80%	50%
Maximum Out of Pocket (Deductible Included)														
Individual			$7,500	N / A	$7,000	N / A	$5,500	$13,000	$8,000	N / A	$6,500	N / A	$6,500	Unlimited
Family			$15,000	N / A	$14,000	N / A	$11,000	$39,000	$16,000	N / A	$13,000	N / A	$13,000	Unlimited
Office Visits														
Preventive Care			Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician			Ded.		$35 Copay		$25 Copay		Ded.		Under age 19: No Copay Age 19 or above: $30 Copay		Under age 19: No Copay Age 19 or above: $30 Copay	
Specialist			Ded.		$75 Copay		$75 Copay		Ded.		Designated: $60 Copay Network: $100 Copay		Designated: $60 Copay Network: $100 Copay	
Virtual Visits			Ded.		PCP: $35 Copay Specialist: $75 Copay		PCP: $25 Copay Specialist: $75 Copay		Ded.		No Copay		No Copay	
Urgent Care Facility Copay			Ded.		$75 Copay		$75 Copay		Ded.		$50 Copay		$50 Copay	
Lab & Xray			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Imaging - CT/PET scans, MRI			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Mental Health Outpatient			Ded.		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 20%		Ded.		OV: $30 Copay Outpatient: Ded. + 20%		OV: $30 Copay Outpatient: Ded. + 20%	
Hospital & Emergency Room														
Inpatient Hospital Expenses			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Outpatient Surgery Facility			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Emergency Room Facility			Ded.		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 20%		Ded.		$500 Copay + Ded. + 20%		$500 Copay + Ded. + 20%	
Prescription Drugs														
Prescription Deductible			Included with Medical		Not Applicable		Not Applicable		Included with Medical		Not Applicable		Not Applicable	
Tier 1			Ded.		$3		$3		$10 after Ded.		$10		$10	
Tier 2			Ded.		$10		$10		$40 after Ded.		$40		$40	
Tier 3			Ded.		$50		$45		$125 after Ded.		$125		$125	
Tier 4			Ded.		$80		$75		$300 after Ded.		$300		$300	
Specialty Drugs			Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500		($10 / $40 / $125 / $500) after Ded.		$10 / $40 / $125 / $500		$10 / $40 / $125 / $500	
Mail Order (90 Day Supply)			Ded.		$6 / $20 / $100 / $160		$6 / $20 / $90 / $150		($25 / $100 / $312.50 / $750) after Ded.		$25 / $100 / $312.50 / $750		$25 / $100 / $312.50 / $750	
Monthly Premiums			Current	Renewal	Current	Renewal	Current	Renewal	Proposed		Proposed		Proposed	
Employee Only	13	12	$558.17	$607.90	$689.52	$751.76	$829.16	$856.96	$1,050.92		$1,263.04		$1,299.92	
Employee & Spouse	1	0	$1,401.21	$1,533.90	$1,751.60	$1,926.33	$2,130.32	$2,224.04	$2,101.84		$2,526.08		$2,599.84	
Employee & Child(ren)	1	1	$1,117.61	$1,222.38	$1,394.31	$1,531.19	$1,692.60	$1,764.13	$2,101.84		$2,526.08		$2,599.84	
Employee & Family	0	0	$1,925.15	$2,109.38	$2,411.66	$2,656.31	$2,938.98	$3,073.66	$3,152.76		$3,789.12		$3,899.76	
	15	0												
Total Monthly Premium			$7,815.65	$8,517.18	$1,751.60	$1,926.33	$829.16	$856.96	$14,712.88		$2,526.08		$1,299.92	
Total Annual Premium			$93,787.80	$102,206.16	$21,019.20	$23,115.96	$9,949.92	$10,283.52	$176,554.56		$30,312.96		$15,599.04	
Rate Adjustment			8.98%		9.98%		3.35%		88.25%		44.22%		56.78%	
Combined Annual Premiums			Current $124,756.92		Renewal $135,605.64				Proposed $222,466.56					
Total Rate Adjustment			8.70%						78.32%					
Total Annual Premium Adjustment			$10,848.72						$97,709.64					

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INSURANCE COMPANY			aetna						EMI HEALTH					
			Current		Current		Current		Proposed		Proposed		Proposed	
In-Network Benefits														
Type of Plan - Plan Name			AFA OAAS 7500 HSA 100% CY V26 - EPO		AFA OAAS 3500 80% CY V26 - EPO		AFA CPOSII 1500 80/50 CY V26 - PPO		T 7000 7000 QHDHP 100%		T 3000 7000 80%		T 1000 5000 80%	
Network			Open Access		Open Access		Open Access		Aetna National PPO		Aetna National PPO		Aetna National PPO	
Deductible			In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual			$7,500	N / A	$3,500	N / A	$1,500	$3,000	$7,000	$14,000	$3,000	$6,000	$1,000	$2,000
Family			$15,000	N / A	$7,000	N / A	$3,000	$9,000	$14,000	$28,000	$6,000	$12,000	$2,000	$4,000
Coinsurance Percentage			100%	N / A	80%	N / A	80%	50%	100%	60%	80%	50%	80%	50%
Maximum Out of Pocket (Deductible Included)														
Individual			$7,500	N / A	$7,000	N / A	$5,500	$13,000	$7,000	$15,000	$7,000	$14,000	$5,000	$10,000
Family			$15,000	N / A	$14,000	N / A	$11,000	$39,000	$14,000	$30,000	$14,000	$28,000	$10,000	$20,000
Office Visits														
Preventive Care			Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician			Ded.		$35 Copay		$25 Copay		Ded.		Tier 1: $10 Copay Tier 2: $30 Copay		Tier 1: $10 Copay Tier 2: $30 Copay	
Specialist			Ded.		$75 Copay		$75 Copay		Ded.		Tier 1: $20 Copay Tier 2: $60 Copay		Tier 1: $20 Copay Tier 2: $60 Copay	
Virtual Visits			Ded.		PCP: $35 Copay Specialist: $75 Copay		PCP: $25 Copay Specialist: $75 Copay		Recuro Health: No Copay		Recuro Health: No Copay		Recuro Health: No Copay	
Urgent Care Facility Copay			Ded.		$75 Copay		$75 Copay		Ded.		$75 Copay		$75 Copay	
Lab & Xray			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Outpatient: Included in OV Inpatient: Ded. + 20%		Outpatient: Included in OV Inpatient: Ded. + 20%	
Imaging - CT/PET scans, MRI			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Mental Health Outpatient			Ded.		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 20%		Ded.		Tier 1 OV: $10 / Tier 2 OV: $30 Outpatient: Ded. + 20%		Tier 1 OV: $10 / Tier 2 OV: $30 Outpatient: Ded. + 20%	
Hospital & Emergency Room														
Inpatient Hospital Expenses			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Outpatient Surgery Facility			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Emergency Room Facility			Ded.		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 20%		Ded.		$250 Copay		$250 Copay	
Prescription Drugs														
Prescription Deductible			Included with Medical		Not Applicable		Not Applicable		Included with Medical		Not Applicable		Not Applicable	
Tier 1			Ded.		$3		$3		Ded.		$10		$10	
Tier 2			Ded.		$10		$10		Ded.		$35		$35	
Tier 3			Ded.		$50		$45		Ded.		$150		$150	
Tier 4			Ded.		$80		$75		Not Applicable		Not Applicable		Not Applicable	
Specialty Drugs			Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Ded.		Generic: 25% up to $150 Preferred: 25% up to $250 Non-Preferred: 30% up to $500		Generic: 25% up to $150 Preferred: 25% up to $250 Non-Preferred: 30% up to $500	
Mail Order (90 Day Supply)			Ded.		$6 / $20 / $100 / $160		$6 / $20 / $90 / $150		Ded.		$20 / $70 / $300		$20 / $70 / $300	
Monthly Premiums			Current	Renewal	Current	Renewal	Current	Renewal	Proposed		Proposed		Proposed	
Employee Only	13	12	$558.17	$607.90	$689.52	$751.76	$829.16	$856.96	$556.83		$746.77		$836.02	
Employee & Spouse	1	0	$1,401.21	$1,533.90	$1,751.60	$1,926.33	$2,130.32	$2,224.04	$1,169.31		$1,568.18		$1,755.61	
Employee & Child(ren)	1	1	$1,117.61	$1,222.38	$1,394.31	$1,531.19	$1,692.60	$1,764.13	$1,057.93		$1,418.82		$1,588.47	
Employee & Family	0	0	$1,925.15	$2,109.38	$2,411.66	$2,656.31	$2,938.98	$3,073.66	$1,781.80		$2,389.66		$2,675.27	
	15	0												
Total Monthly Premium			$7,815.65	$8,517.18	$1,751.60	$1,926.33	$829.16	$856.96	$7,739.89		$1,568.18		$836.02	
Total Annual Premium			$93,787.80	$102,206.16	$21,019.20	$23,115.96	$9,949.92	$10,283.52	$92,878.68		$18,818.16		$10,032.24	
Rate Adjustment			8.98%		9.98%		3.35%		-0.97%		-10.47%		0.83%	
Combined Annual Premiums			Current $124,756.92		Renewal $135,605.64				Proposed $121,729.08					
Total Rate Adjustment			8.70%						-2.43%					
Total Annual Premium Adjustment			$10,848.72						-$3,027.84					

State law prohibits EPO plans in the following states: Alabama, Arizona, Arkansas, Hawaii, Mississippi, Montana, New Mexico, North Carolina, North Dakota, and Oklahoma

Group Medical Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY			aetna						Angle					
			Current		Current		Current		Proposed		Proposed		Proposed	
In-Network Benefits														
Type of Plan - Plan Name			AFA OAAS 7500 HSA 100% CY V26 - EPO		AFA OAAS 3500 80% CY V26 - EPO		AFA CPOSII 1500 80/50 CY V26 - PPO		ANG HDHP 7000 7000		ANG TRAD 3000 5000		ANG TRAD 1000 2000	
Network			Open Access		Open Access		Open Access		Cigna		Cigna		Cigna	
Deductible			In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual			$7,500	N / A	$3,500	N / A	$1,500	$3,000	$7,000	$14,000	$3,000	$6,000	$1,000	$5,000
Family			$15,000	N / A	$7,000	N / A	$3,000	$9,000	$14,000	$28,000	$6,000	$12,000	$2,000	$10,000
Coinsurance Percentage			100%	N / A	80%	N / A	80%	50%	100%	50%	80%	50%	80%	50%
Maximum Out of Pocket (Deductible Included)														
Individual			$7,500	N / A	$7,000	N / A	$5,500	$13,000	$7,000	$15,400	$5,000	$10,000	$2,000	$10,000
Family			$15,000	N / A	$14,000	N / A	$11,000	$39,000	$14,000	$30,800	$10,000	$20,000	$4,000	$20,000
Office Visits														
Preventive Care			Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician			Ded.		$35 Copay		$25 Copay		Ded.		$20 Copay		$10 Copay	
Specialist			Ded.		$75 Copay		$75 Copay		Ded.		$50 Copay		$30 Copay	
Virtual Visits			Ded.		PCP: $35 Copay Specialist: $75 Copay		PCP: $25 Copay Specialist: $75 Copay		Ded.		PCP: $20 Copay Specialist: $50 Copay		PCP: $10 Copay Specialist: $30 Copay	
Urgent Care Facility Copay			Ded.		$75 Copay		$75 Copay		Ded.		$75 Copay		$50 Copay	
Lab & Xray			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Lab: $20 Copay X-Ray: Ded. + 20%		Lab: $10 Copay X-ray: Ded. + 20%	
Imaging - CT/PET scans, MRI			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Mental Health Outpatient			Ded.		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 20%		Ded.		$20 Copay		$10 Copay	
Hospital & Emergency Room														
Inpatient Hospital Expenses			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Outpatient Surgery Facility			Ded.		Ded. + 20%		Ded. + 20%		Ded.		Ded. + 20%		Ded. + 20%	
Emergency Room Facility			Ded.		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 20%		Ded.		$250 Copay + Ded. + 20%		$200 Copay + Ded. + 20%	
Prescription Drugs														
Prescription Deductible			Included with Medical		Not Applicable		Not Applicable		Included with Medical		Not Applicable		Not Applicable	
Tier 1			Ded.		$3		$3		Ded.		$20		$10	
Tier 2			Ded.		$10		$10		Ded.		$60		$30	
Tier 3			Ded.		$50		$45		Ded.		$85		$60	
Tier 4			Ded.		$80		$75		Not Applicable		Not Applicable		Not Applicable	
Specialty Drugs			Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Ded.		Ded. + 20%		Ded. + 20%	
Mail Order (90 Day Supply)			Ded.		$6 / $20 / $100 / $160		$6 / $20 / $90 / $150		Ded.		$50 / $150 / $212.50		$25 / $75 / $150	
Monthly Premiums			Current	Renewal	Current	Renewal	Current	Renewal	Proposed		Proposed		Proposed	
Employee Only	13	12	$558.17	$607.90	$689.52	$751.76	$829.16	$856.96	$670.95		$815.13		$936.87	
Employee & Spouse	1	0	$1,401.21	$1,533.90	$1,751.60	$1,926.33	$2,130.32	$2,224.04	$1,684.33		$2,046.28		$2,351.88	
Employee & Child(ren)	1	1	$1,117.61	$1,222.38	$1,394.31	$1,531.19	$1,692.60	$1,764.13	$1,343.43		$1,632.12		$1,875.86	
Employee & Family	0	0	$1,925.15	$2,109.38	$2,411.66	$2,656.31	$2,938.98	$3,073.66	$2,314.14		$2,811.43		$3,231.29	
	15	0												
Total Monthly Premium			$7,815.65	$8,517.18	$1,751.60	$1,926.33	$829.16	$856.96	$9,394.83		$2,046.28		$936.87	
Total Annual Premium			$93,787.80	$102,206.16	$21,019.20	$23,115.96	$9,949.92	$10,283.52	$112,737.96		$24,555.36		$11,242.44	
Rate Adjustment			8.98%		9.98%		3.35%		20.21%		16.82%		12.99%	
Combined Annual Premiums			Current	$124,756.92	Renewal	$135,605.64			Proposed	$148,535.76				
Total Rate Adjustment			8.70%						19.06%					
Total Annual Premium Adjustment			$10,848.72						$23,778.84					

State law prohibits EPO plans in the following states: Alabama, Arizona, Arkansas, Hawaii, Mississippi, Montana, New Mexico, North Carolina, North Dakota, and Oklahoma

Group Dental Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY		Mutual of Omaha		EQUITABLE		Renaissance DENTAL · VISION · LIFE · DISABILITY	
Type of Plan - Plan Name		PPO		PPO		MP0001129396	
Benefits		**Current**		**Proposed**		**Proposed**	
In Network / Out of Network		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Maximum Benefit		$1,000		$1,000		$1,000	
Individual Annual Deductible		$50		$50		$50	
Family Annual Deductible		$150		$150		$150	
Preventive		100%		100%		100%	
Basic		80%		80%		80%	
Major		50%		50%		50%	
Endodontics		Major		Major		Major	
Periodontics		Periodontal Maintenance: Basic All Other Periodontics: Major		Periodontal Maintenance: Basic All Other Periodontics: Major		Periodontal Maintenance: Basic All Other Periodontics: Major	
Implants		Not Covered		Not Covered		Not Covered	
Orthodontia		Child only prior to turning age 26: 50%		Child only up to age 19: 50%		Child only up to age 19: 50%	
Orthodontia Lifetime Maximum		$1,000		$1,000		$1,000	
Rollover Benefit		Included		Included		Included	
Reimbursement Method		Negotiated Rate	90% R&C	Negotiated Rate	90% R&C	Negotiated Rate	90% R&C
Waiting Period		None		None		None	
Network		Mutual of Omaha		Equitable		Renaissance	
Website		www.mutualofomaha.com/dental		www.equitable.com/finddentist		www.myrenproviders.com	
Participation		Current		Greater of 10 lives or 53%		Greater of 9 lives or 50%	
Rate Guarantee		12 Months		12 Months		12 Months	
Monthly Premium		**Current**	**Renewal**	**Proposed**		**Proposed**	
Employee Only	4	$28.64	$30.64	$29.66		$29.66	
Employee & Spouse	0	$64.38	$68.89	$66.66		$66.66	
Employee & Child(ren)	2	$80.09	$85.70	$82.93		$82.94	
Employee & Family	2	$112.46	$120.33	$116.45		$116.45	
	8						
Total Monthly Premium		$499.66	$534.62	$517.40		$517.42	
Total Annual Premium		$5,995.92	$6,415.44	$6,208.80		$6,209.04	
Rate Adjustment		7.00%		3.55%		3.55%	
Annual Premium Adjustment		$419.52		$212.88		$213.12	

Original: 9.00%

Package Pricing

Group Dental Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY		Mutual of Omaha		Principal		Guardian		unum	
Type of Plan - Plan Name		PPO		PPO		PPO		PPO	
Benefits		**Current**		**Proposed**		**Proposed**		**Proposed**	
In Network / Out of Network		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Maximum Benefit		$1,000		$1,000		$1,000		$1,000	
Individual Annual Deductible		$50		$50		$50		$50	
Family Annual Deductible		$150		$150		$150		$150	
Preventive		100%		100%		100%		100%	
Basic		80%		80%		80%		80%	
Major		50%		50%		50%		50%	
Endodontics		Major		Major		Major		Major	
Periodontics		Periodontal Maintenance: Basic All Other Periodontics: Major		Periodontal Maintenance: Basic All Other Periodontics: Major		Non-Surgical Periodontics: Basic All Other Periodontics: Major		Major	
Implants		Not Covered		Not Covered		Major		Major	
Orthodontia		Child only prior to turning age 26: 50%		Child only up to age 19: 50%		Child only up to age 19: 50%		Child only up to age 19: 50%	
Orthodontia Lifetime Maximum		$1,000		$1,000		$1,000		$1,000	
Rollover Benefit		Included		Included		Included		Excluded	
Reimbursement Method		Negotiated Rate	90% R&C	Negotiated Rate	90% R&C	Negotiated Rate	90% R&C	Negotiated Rate	90% R&C
Waiting Period		None		None		None		None	
Network		Mutual of Omaha		Principal		DentalGurd Preferred		Unum	
Website		www.mutualofomaha.com/dental		www.principal.com/dentist		www.guardianlife.com		www.unumdentalcare.com	
Participation		Current		Greater of 5 lives or 20% Ortho: 5 lives		53%		59%	
Rate Guarantee		12 Months		12 Months		12 Months		12 Months	
Monthly Premium		**Current**	**Renewal**	**Proposed**		**Proposed**		**Proposed**	
Employee Only	4	$28.64	$30.64	$32.78		$30.43		$30.32	
Employee & Spouse	0	$64.38	$68.89	$73.68		$61.77		$59.71	
Employee & Child(ren)	2	$80.09	$85.70	$91.67		$95.02		$94.45	
Employee & Family	2	$112.46	$120.33	$128.71		$136.29		$137.34	
	8								
Total Monthly Premium		$499.66	$534.62	$571.88		$584.34		$584.86	
Total Annual Premium		$5,995.92	$6,415.44	$6,862.56		$7,012.08		$7,018.32	
Rate Adjustment		7.00%		14.45%		16.95%		17.05%	
Annual Premium Adjustment		$419.52		$866.64		$1,016.16		$1,022.40	

Original: 9.00%

Group Vision Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY		Mutual of Omaha		EQUITABLE		Renaissance DENTAL · VISION · LIFE · DISABILITY	
Type of Plan - Plan Name		12/12/24/12		12/12/24/12		MP0001129394	
Benefits		Current		Current		Proposed	
In Network / Out of Network		In Network	Out of Network Reimbursement	In Network	Out of Network Reimbursement	In Network	Out of Network Reimbursement
Wellness Eye Exam		$10 Copay	Up to $37	$10 Copay	Up to $45	$10 Copay	Up to $45
		One Every 12 Months		One Every 12 Months		One Every 12 Months	
Materials Benefit - Lenses		$25 Copay	Up to $64	$25 Copay	Up to $100	$25 Copay	Up to $100
		One Every 12 Months		One Every 12 Months		One Every 12 Months	
Materials Benefit - Frames		$0 Copay $130 Allowance + 20% off over allowance	Up to $58	$25 Copay $130 Allowance + 20% off over allowance	Up to $70	$25 Copay $130 Allowance + 20% off over allowance	Up to $70
		One Every 24 Months		One Every 24 Months		One Every 24 Months	
Contact Lenses (instead of lenses & frames)		Elective: $40 (Fit & Eval) $130 Allowance Necessary: $0 Copay Covered in full	Elective: Up to $89 Necessary: Up to $210	Elective: $60 (Fit & Eval) $130 Allowance Necessary: $25 Copay Covered in full	Elective: Up to $105 Necessary: Up to $210	Elective: $60 (Fit & Eval) $130 Allowance Necessary: $25 Copay Covered in full	Elective: Up to $105 Necessary: Up to $210
		One Every 12 Months		One Every 12 Months		One Every 12 Months	
Extras		Savings on laser vision correction, additional complete pair eyeglasses, conventional contact lenses once funded benefit used, other add-ons		Savings on laser vision correction, additional pairs of eyeglasses, additional elective contact fit & eval fees, other add-ons and services		Savings on laser vision correction, additional pairs of glasses/sunglasses, lens enhancements, low vision aids	
Provider Network		EyeMed Insight		VSP		VSP	
Website		www.mutualofomaha.com/vision		www.equitable.com/findvision		www.myrenproviders.com	
Participation		Current		Greater of 4 lives or 59%		2 lives	
Rate Guarantee		24 Months		24 Months		24 Months	
Monthly Premium		Current	Renewal	Proposed		Proposed	
Employee Only	4	$5.49	$5.49	$5.22		$4.94	
Employee & Spouse	0	$12.61	$12.61	$11.98		$11.35	
Employee & Child(ren)	1	$13.98	$13.98	$13.28		$12.58	
Employee & Family	4	$21.34	$21.34	$20.27		$19.21	
	9						
Total Monthly Premium		$121.30	$121.30	$115.24		$109.18	
Total Annual Premium		$1,455.60	$1,455.60	$1,382.88		$1,310.16	
Rate Adjustment		0.00%		-5.00%		-9.99%	
Annual Premium Adjustment		$0.00		-$72.72		-$145.44	

Package Pricing

Group Vision Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

Vision sold with Dental

INSURANCE COMPANY		Mutual of Omaha		Principal		Guardian	
Type of Plan - Plan Name		12/12/24/12		12/12/24/12		12/12/24/12	
Benefits		Current		Proposed		Proposed	
In Network / Out of Network		In Network	Out of Network Reimbursement	In Network	Out of Network Reimbursement	In Network	Out of Network Reimbursement
Wellness Eye Exam		$10 Copay	Up to $37	$10 Copay	Up to $45	$10 Copay	Up to $39
		One Every 12 Months		One Every 12 Months		One Every 12 Months	
Materials Benefit - Lenses		$25 Copay	Up to $64	$25 Copay	Up to $100	$25 Copay	Up to $64
		One Every 12 Months		One Every 12 Months		One Every 12 Months	
Materials Benefit - Frames		$0 Copay $130 Allowance + 20% off over allowance	Up to $58	$25 Copay $130 Allowance + 20% off over allowance	Up to $70	$130 Allowance + 20% off over allowance	Up to $46
		One Every 24 Months		One Every 24 Months		One Every 24 Months	
Contact Lenses (instead of lenses & frames)		Elective: $40 (Fit & Eval) $130 Allowance Necessary: $0 Copay Covered in full	Elective: Up to $89 Necessary: Up to $210	Elective: $60 (Fit & Eval) $130 Allowance Necessary: $25 Copay Covered in full	Elective: Up to $105 Necessary: Up to $210	Elective: $60 (Fit & Eval) $130 Allowance Necessary: $25 Copay Covered in full	Elective: Up to $100 Necessary: Up to $210
		One Every 12 Months		One Every 12 Months		One Every 12 Months	
Extras		Savings on laser vision correction, additional complete pair eyeglasses, conventional contact lenses once funded benefit used, other add-ons		Savings on laser vision correction and additional pairs of prescription glasses and non-prescription sunglasses		Savings on laser vision correction and additional pairs of glasses, lens options	
Provider Network		EyeMed Insight		VSP Choice		VSP	
Website		www.mutualofomaha.com/vision		www.vsp.com		www.guardianlife.com	
Participation		Current		Greater of 5 lives or 20%		59%	
Rate Guarantee		24 Months		24 Months		24 Months	
Monthly Premium		Current	Renewal	Proposed		Proposed	
Employee Only	4	$5.49	$5.49	$6.29		$7.61	
Employee & Spouse	0	$12.61	$12.61	$12.61		$14.40	
Employee & Child(ren)	1	$13.98	$13.98	$14.13		$14.67	
Employee & Family	4	$21.34	$21.34	$22.02		$23.22	
	9						
Total Monthly Premium		$121.30	$121.30	$127.37		$137.99	
Total Annual Premium		$1,455.60	$1,455.60	$1,528.44		$1,655.88	
Rate Adjustment		0.00%		5.00%		13.76%	
Annual Premium Adjustment		$0.00		$72.84		$200.28	

Group Vision Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY		Mutual of Omaha		UNUM	
Type of Plan - Plan Name		12/12/24/12		12/12/24/12	
Benefits		Current		Proposed	
In Network / Out of Network		In Network	Out of Network Reimbursement	In Network	Out of Network Reimbursement
Wellness Eye Exam		$10 Copay	Up to $37	$10 Copay	Up to $40
		One Every 12 Months		One Every 12 Months	
Materials Benefit - Lenses		$25 Copay	Up to $64	$25 Copay	Up to $70
		One Every 12 Months		One Every 12 Months	
Materials Benefit - Frames		$0 Copay $130 Allowance + 20% off over allowance	Up to $58	$130 Allowance + 20% off over allowance	Up to $91
		One Every 24 Months		One Every 24 Months	
Contact Lenses (instead of lenses & frames)		Elective: $40 (Fit & Eval) $130 Allowance Necessary: $0 Copay Covered in full	Elective: Up to $89 Necessary: Up to $210	Elective: $40 (Fit & Eval) $130 Allowance Necessary: Covered in full	Elective: Up to $130 Necessary: Up to $210
		One Every 12 Months		One Every 12 Months	
Extras		Savings on laser vision correction, additional complete pair eyeglasses, conventional contact lenses once funded benefit used, other add-ons		Savings on laser vision correction, complete second pair glasses, non-prescription sunglasses	
Provider Network		EyeMed Insight		EyeMed	
Website		www.mutualofomaha.com/vision		www.eyemedvisioncare.com/unum	
Participation		Current		59%	
Rate Guarantee		24 Months		48 Months	
Monthly Premium		Current	Renewal	Proposed	
Employee Only	4	$5.49	$5.49	$5.40	
Employee & Spouse	0	$12.61	$12.61	$10.80	
Employee & Child(ren)	1	$13.98	$13.98	$12.04	
Employee & Family	4	$21.34	$21.34	$18.92	
	9				
Total Monthly Premium		$121.30	$121.30	$109.32	
Total Annual Premium		$1,455.60	$1,455.60	$1,311.84	
Rate Adjustment		0.00%		-9.88%	
Annual Premium Adjustment		$0.00		-$143.76	

Group Basic Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Mutual of Omaha		EQUITABLE	Renaissance DENTAL · VISION · LIFE · DISABILITY
Benefits	**Current**		**Proposed**	**Proposed**
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week		All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week
Benefit Amount	$40,000		$40,000	$40,000
Guarantee Issue Amount	$40,000		$40,000	$40,000
Age Reduction Schedule	Reduces to 65% at age 65; Reduces to 50% at age 70		Reduces to 65% at age 65; Reduces to 50% at age 70	Reduces to 65% at age 65; Reduces to 50% at age 70
Features				
Accelerated Death Benefit	Included		Included	Included
Waiver of Premium	Included		Included	Included
Travel Assist	Included		Included	Included
EAP	Included		Excluded	Included
Portability	Excluded		Excluded	Included
Conversion	Included		Included	Included
Participation Requirement	100%		100%	100%
Rate Guarantee	24 Months		24 Months	24 Months
Monthly Premium	**Current**	**Renewal**	**Proposed**	**Proposed**
Life Rate per $1,000	$0.138	$0.169	$0.115	$0.156
AD&D Rate per $1,000	$0.034	$0.034	$0.020	$0.020
Monthly Volume	$680,000	$680,000	$680,000	$560,000
Total Monthly Premium	$116.96	$138.04	$91.80	$98.56
Total Annual Premium	$1,403.52	$1,656.48	$1,101.60	$1,182.72
Rate Adjustment	18.02%		-21.51%	-15.73%
Annual Premium Adjustment	$252.96		-$301.92	-$220.80

Rates based on 17 covered employees

Original: 33.72%

Package Pricing

Group Basic Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Mutual of Omaha		Principal	Guardian
Benefits	**Current**		**Proposed**	**Proposed**
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week		All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week
Benefit Amount	$40,000		$40,000	$40,000
Guarantee Issue Amount	$40,000		$40,000	$40,000
Age Reduction Schedule	Reduces to 65% at age 65; Reduces to 50% at age 70		Reduces to 65% at age 65; Reduces to 50% at age 70	Reduces to 65% at age 65; Reduces to 50% at age 70
Features				
Accelerated Death Benefit	Included		Included	Included
Waiver of Premium	Included		Included	Included
Travel Assist	Included		Included	Excluded
EAP	Included		Excluded	*Included
Portability	Excluded		Excluded	Included
Conversion	Included		Included	Included
Participation Requirement	100%		100%	100%
Rate Guarantee	24 Months		24 Months, unless volume changes >25%	24 Months
Monthly Premium	**Current**	**Renewal**	**Proposed**	**Proposed**
Life Rate per $1,000	$0.138	$0.169	$0.199	$0.234
AD&D Rate per $1,000	$0.034	$0.034	$0.027	$0.023
Monthly Volume	$680,000	$680,000	$680,000	$680,000
Total Monthly Premium	$116.96	$138.04	$153.68	$174.76
Total Annual Premium	$1,403.52	$1,656.48	$1,844.16	$2,097.12
Rate Adjustment	18.02%		31.40%	49.42%
Annual Premium Adjustment	$252.96		$440.64	$693.60

Rates based on 17 covered employees

Original: 33.72%

*Included with purchase of 3 or more lines

Group Basic Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Mutual of Omaha		UNUM
Benefits	**Current**		**Proposed**
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week		All active full-time employees living in the United States working 30 or more hours per week
Benefit Amount	$40,000		$40,000
Guarantee Issue Amount	$40,000		$40,000
Age Reduction Schedule	Reduces to 65% at age 65; Reduces to 50% at age 70		Reduces to 65% at age 65; Reduces to 50% at age 70
Features			
Accelerated Death Benefit	Included		Included
Waiver of Premium	Included		Included
Travel Assist	Included		Excluded
EAP	Included		Excluded
Portability	Excluded		Included
Conversion	Included		Included
Participation Requirement	100%		100%
Rate Guarantee	24 Months		24 Months
Monthly Premium	**Current**	**Renewal**	**Proposed**
Life Rate per $1,000	$0.138	$0.169	$0.170
AD&D Rate per $1,000	$0.034	$0.034	$0.030
Monthly Volume	$680,000	$680,000	$680,000
Total Monthly Premium	$116.96	$138.04	$136.00
Total Annual Premium	$1,403.52	$1,656.48	$1,632.00
Rate Adjustment	18.02%		16.28%
Annual Premium Adjustment	$252.96		$228.48

Rates based on 17 covered employees

Original: 33.72%

Group Voluntary Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Mutual of Omaha		EQUITABLE	Renaissance DENTAL · VISION · LIFE · DISABILITY
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week		All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week
Employee	**Current**		**Proposed**	**Proposed**
Employee Max Benefit Amount	$300,000, in increments of $10,000 Not to exceed 5X annual salary		$300,000, in increments of $10,000 Not to exceed 5X annual salary	$300,000, in increments of $10,000 Not to exceed 5X annual salary
Employee Guarantee Issue	$70,000 Not to exceed 5X annual salary		$70,000	$70,000
Age Reduction Schedule	Reduces to 65% at age 70; Reduces to 45% at age 75		Reduces to 65% at age 70; Reduces to 45% at age 75	Reduces to 35% at age 70; Reduces to 20% at age 75
Spouse				
Spouse Max Benefit Amount	$100,000, in increments of $5,000 Not to exceed 100% employee benefit		$100,000, in increments of $5,000 Not to exceed 100% employee benefit	$100,000, in increments of $5,000 Not to exceed 100% employee benefit
Spouse Guarantee Issue	$20,000 Not to exceed 100% employee benefit		$20,000	$20,000
Age Reduction Schedule	Terminates at EE age 70		Reduces to 65% at age 70; Reduces to 45% at age 75	Reduces to 65% at age 65; Terminates at EE termination or age 70
Child(ren)				
Child Max Benefit Amount	$10,000, in increments of $2,000 Not to exceed 100% employee benefit		$10,000, in increments of $2,000 Not to exceed 100% employee benefit	$10,000, in increments of $2,000 Not to exceed 100% employee benefit
Child Guarantee Issue	Live Birth-26 Years: $10,000		Live Birth-14 Days: $500 15 Days-26 Years: $10,000	Live Birth-6 Months: $500 6 Months-26 Years: $10,000
Child Maximum Age	26		26	26
Features				
Accelerated Death Benefit	Included		Included	Included
Waiver of Premium	Included		Included	Included
Travel Assist	Excluded		Included	Included
EAP	Excluded		Excluded	Included
Annual Enrollment Provision	Included		Included	Excluded
Portability	Included		Included	Included
Conversion	Included		Included	Included
Participation Requirement	Current		Greater of 4 lives or 20%	Greater of 10 lives or 20%
Rate Guarantee	24 Months		24 Months	24 Months
Rate Per $1,000	**Current**	**Renewal**	**Proposed**	**Proposed**
< 25	$0.108	$0.108	$0.108	$0.108
25-29	$0.108	$0.108	$0.108	$0.108
30-34	$0.108	$0.108	$0.108	$0.108
35-39	$0.193	$0.193	$0.193	$0.193
40-44	$0.250	$0.250	$0.250	$0.250
45-49	$0.448	$0.448	$0.448	$0.448
50-54	$0.788	$0.788	$0.788	$0.788
55-59	$1.468	$1.468	$1.468	$1.468
60-64	$2.205	$2.205	$2.205	$2.205
65-69	$3.622	$3.622	$3.622	$3.622
70-74	$5.407	$5.407	$5.407	$5.407
75+	$5.407	$5.407	$5.407	$5.407
Child Life Rates	$0.174	$0.174	$0.174	$0.174
AD&D Rates (EE, SP, CH)	$0.034, $0.034, $0.044	$0.034, $0.034, $0.044	$0.034	$0.034, $0.044, $0.044

Package Pricing

Group Voluntary Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Mutual of Omaha		Principal	Guardian	unum
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week		All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week
Employee	**Current**		**Proposed**	**Proposed**	**Proposed**
Employee Max Benefit Amount	$300,000, in increments of $10,000 Not to exceed 5X annual salary		$300,000, in increments of $10,000	$300,000, in increments of $10,000	$300,000, in increments of $10,000 Not to exceed 5X annual salary
Employee Guarantee Issue	$70,000 Not to exceed 5X annual salary		Under age 70: $100,000 Age 70 and up: $10,000	$70,000	$70,000
Age Reduction Schedule	Reduces to 65% at age 70; Reduces to 45% at age 75		Reduces to 65% at age 65; Reduces to 50% at age 70	Reduces to 65% at age 70; Reduces to 30% at age 75	Reduces to 65% at age 70; Reduces to 20% at age 75
Spouse					
Spouse Max Benefit Amount	$100,000, in increments of $5,000 Not to exceed 100% employee benefit		$100,000, in increments of $5,000 Not to exceed 100% employee benefit	$100,000, in increments of $5,000 Not to exceed 100% employee benefit	$100,000, in increments of $5,000
Spouse Guarantee Issue	$20,000 Not to exceed 100% employee benefit		Under age 70: $20,000 Age 70 and up: $10,000	$25,000	$15,000
Age Reduction Schedule	Terminates at EE age 70		Reduces to 65% at age 65; Reduces to 50% at age 70	Spouse coverage terminates at age 70	Reduces to 65% at age 70; Reduces to 20% at age 75
Child(ren)					
Child Max Benefit Amount	$10,000, in increments of $2,000 Not to exceed 100% employee benefit		$2,000, $4,000, or $10,000 Not to exceed 100% employee benefit	$10,000, in increments of $1,000 Not to exceed 100% employee benefit	$10,000, in increments of $1,000
Child Guarantee Issue	Live Birth-26 Years: $10,000		Live Birth-13 Days: $1,000 15 Days-26 Years: $10,000	Live Birth-13 Days: $500 14 Days-26 Years: $10,000	Live Birth-14 Days: $1,000 15 Days-26 Years: $1,000-$10,000
Child Maximum Age	26		26	26	26
Features					
Accelerated Death Benefit	Included		Included	Included	Included
Waiver of Premium	Included		Included	Included	Included
Travel Assist	Excluded		Included	Excluded	Excluded
EAP	Excluded		Excluded	*Included	Excluded
Annual Enrollment Provision	Included		Included	Included	Excluded
Portability	Included		Included	Included	Included
Conversion	Included		Included	Included	Included
Participation Requirement	Current		Greater of 5 lives or 20%	Greater of 4 lives or 30%	Greater of 10 lives or 20%
Rate Guarantee	24 Months		24 Months	24 Months	24 Months
Rate Per $1,000	**Current**	**Renewal**	**Proposed**	**Proposed**	**Proposed**
< 25	$0.108	$0.108	$0.137	$0.083	$0.100 / $0.143
25-29	$0.108	$0.108	$0.137	$0.083	$0.110 / $0.176
30-34	$0.108	$0.108	$0.164	$0.096	$0.180 / $0.261
35-39	$0.193	$0.193	$0.222	$0.131	$0.240 / $0.376
40-44	$0.250	$0.250	$0.337	$0.179	$0.380 / $0.541
45-49	$0.448	$0.448	$0.499	$0.284	$0.590 / $0.846
50-54	$0.788	$0.788	$0.784	$0.467	$0.830 / $1.195
55-59	$1.468	$1.468	$1.229	$0.701	$1.260 / $1.858
60-64	$2.205	$2.205	$1.884	$0.848	$1.570 / $2.515
65-69	$3.622	$3.622	$2.891	$1.344	$1.940 / $3.111
70-74	$5.407	$5.407	$4.691	$2.694	$3.550 / $5.699
75+	$5.407	$5.407	$4.691	$2.694	$12.550 / $20.156
Child Life Rates	$0.174	$0.174	$0.200	$0.161	$0.342
AD&D Rates (EE, SP, CH)	$0.034, $0.034, $0.044	$0.034, $0.034, $0.044	$0.032	$0.032	$0.046, $0.051, $0.080

*Included with purchase of 3 or more lines

Group Short Term Disability Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	EQUITABLE	Renaissance DENTAL · VISION · LIFE · DISABILITY	Principal	unum
	Proposed	Proposed	Proposed	Proposed
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week
Definition of Earnings	Base Salary excluding bonus/overtime/commissions	Base Salary excluding bonus/overtime/commissions	Base Salary + Bonus + Commission	Base Salary excluding bonus/overtime/commissions
Definition of Disability	Loss of duties AND earnings	Loss of duties AND earnings	Loss of duties OR earnings	Loss of duties AND earnings
Benefits				
Elimination Period/Accident	14 Days	14 Days	14 Days	14 Days
Elimination Period/Illness	14 Days	14 Days	14 Days	14 Days
Income Benefit (% of Earnings)	60%	60%	60%	60%
Maximum Weekly Benefit	$1,250	$1,250	$1,250	$1,250
Benefit Duration	11 Weeks	11 Weeks	11 Weeks	11 Weeks
Features				
Pre-Existing Condition Limitation	None	3 months prior / 12 months insured	None	None
Partial Disability	Included	Excluded	Included	Excluded
Survivor Benefit	Excluded	Excluded	Excluded	Excluded
Rehabilitation Benefit	Included	Included	Included	Included
Participation Requirement	100%	100%	100%	100%
Rate Guarantee	24 Months	24 Months	24 Months, unless earnings change by >25%	24 Months
Monthly Premium	Proposed	Proposed	Proposed	Proposed
Rate Per $10	$0.155	$0.155	$0.280	$0.180
Monthly Volume	$10,135	$10,135	$10,135	$10,134
Total Monthly Premium	$157.09	$157.09	$283.78	$182.41
Total Annual Premium	$1,885.11	$1,885.11	$3,405.36	$2,188.94

Rates based on 17 covered employees

Package Pricing

Short Term Disability Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Guardian
	Proposed
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week
Definition of Earnings	Base Salary excluding bonus/overtime/commissions
Definition of Disability	Loss of duties
Benefits	
Elimination Period/Accident	14 Days
Elimination Period/Illness	14 Days
Income Benefit (% of Earnings)	60%
Maximum Weekly Benefit	$1,250
Maximum Benefit Duration	11 Weeks
Features	
Pre-Existing Condition Limitation	3 months prior / 12 months insured
Partial Disability	Included
Survivor Benefit	Excluded
Rehabilitation Benefit	Included
Participation Requirement	Greater of 4 lives or 30%
Rate Guarantee	24 Months
Rate Per $10 Weekly Benefit	**Proposed**
< 20	$0.259
20-24	$0.259
25-29	$0.351
30-34	$0.518
35-39	$0.407
40-44	$0.259
45-49	$0.278
50-54	$0.333
55-59	$0.407
60+	$0.592

Group Long Term Disability Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Mutual of Omaha		EQUITABLE	Renaissance DENTAL · VISION · LIFE · DISABILITY	Principal	unum
	Current		Proposed	Proposed	Proposed	Proposed
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week		All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week	All active full-time employees living in the United States working 30 or more hours per week
Definition of Earnings	Base Salary excluding bonus/overtime/commissions		Base Salary excluding bonus/overtime/commissions	Base Salary excluding bonus/overtime/commissions	Base Salary + Bonus + Commission	Base Salary excluding bonus/overtime/commissions
Definition of Disability	Loss of duties AND earnings		Loss of duties AND earnings	Loss of duties AND earnings	Loss of duties OR earnings	Loss of duties AND earnings
Benefits						
Elimination Period	90 Days		90 Days	90 Days	90 Days	90 Days
Income Benefit (% of Earnings)	60%		60%	60%	60%	60%
Maximum Monthly Benefit	$6,000		$6,000	$6,000	$6,000	$6,000
Own Occupation Period	2 Years		2 Years	2 Years	2 Years	2 Years
Benefit Duration	RBD to Social Security Natural Retirement Age		ADEA1 w/Social Security Natural Retirement Age	Social Security Natural Retirement Age (SSNRA)	Social Security Natural Retirement Age (SSNRA)	Social Security Natural Retirement Age (SSNRA)
Limitations						
Pre-Existing Condition Limitation	3 months prior / 12 months insured		3 months prior / 12 months insured	3 months prior / 12 months insured	3 months prior / 12 months insured	3 months prior / 12 months insured
Mental Health	24 Months		24 Months	24 Months	24 Months	24 Months
Substance Abuse	24 Months		24 Months	24 Months	24 Months	24 Months
Features						
Rehabilitation Benefit	Included		Included	Included	Included	Included
Return to Work Incentive	Included		Included	Included	Included	Included
Survivor Benefit	Included		Included	Included	Included	Included
Family/Dependent/Child Care Benefit	Included		Included	Excluded	Excluded	Excluded
Partial Disability	Included		Included	Excluded	Included	Excluded
Waiver of Premium	Included		Included	Included	Included	Excluded
W-2 Preparation	Included		Included	Included	Included	Excluded
FICA Match	Included		Included	Included	Included	Excluded
Portability	Excluded		Excluded	Excluded	Excluded	Excluded
Conversion	Excluded		Excluded	Excluded	Included	Excluded
Benefit Taxation	Taxable		Taxable	Taxable	Taxable	Taxable
Participation Requirement	Current		100%	100%	100%	100%
Rate Guarantee	24 Months		24 Months	24 Months	24 Months, unless earnings change by >25%	24 Months
Monthly Premium	**Current**	**Renewal**	**Proposed**	**Proposed**	**Proposed**	**Proposed**
Rate per $100	$0.410	$0.410	$0.410	$0.369	$1.030	$0.410
Monthly Volume	$73,199	$73,199	$73,199	$73,199	$73,199	$73,199
Total Monthly Premium	$300.12	$300.12	$300.12	$270.10	$753.95	$300.12
Total Annual Premium	$3,601.39	$3,601.39	$3,601.39	$3,241.25	$9,047.40	$3,601.41
Rate Adjustment	0.00%		0.00%	-10.00%	151.22%	0.00%
Annual Premium Adjustment	$0.00		$0.00	-$360.14	$5,446.01	$0.02

Rates based on 17 covered employees

Package Pricing

Long Term Disability Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2026

INSURANCE COMPANY	Guardian
	Proposed
Eligible Class	All active full-time employees living in the United States working 30 or more hours per week
Definition of Earnings	Base Salary excluding bonus/overtime/commissions
Definition of Disability	Loss of duties
Benefits	
Elimination Period	90 Days
Income Benefit (% of Earnings)	60%
Maximum Monthly Benefit	$6,000
Own Occupation Period	2 Years
Benefit Duration	Social Security Natural Retirement Age (SSNRA)
Limitations	
Pre-Existing Condition Limitation	3 months prior / 12 months insured
Mental Health	24 Months
Substance Abuse	24 Months
Features	
Rehabilitation Benefit	Included
Return to Work Incentive	Included
Survivor Benefit	Included
Family/Dependent/Child Care Benefit	Included
Partial Disability	Included
Waiver of Premium	Excluded
W-2 Preparation	Included
FICA Match	Included
Portability	Excluded
Conversion	Excluded
Benefit Taxation	Taxable
Participation Requirement	Greater of 4 lives or 30%
Rate Guarantee	24 Months
Rate per $100 Covered Payroll	**Proposed**
<20	$0.075
20-24	$0.075
25-29	$0.091
30-34	$0.175
35-39	$0.308
40-44	$0.449
45-49	$0.665
50-54	$0.898
55-59	$1.098
60+	$1.114

Proposal Information and Assumptions

Grandfathered Status:
Plans that relinquish grandfathered status must immediately implement the following changes:

- **Have an expanded internal and external claims/appeals process**
- **Federally mandated preventive care must be covered at no cost sharing in-network**
- **Implement patient protections (any in-network PCP, ER paid in-network, no referral/authorization to in-network OB/GYN or pediatrician)**
- **In-network out of pocket maximum is restricted**
- **Include clinical trials coverage**
- **Small employer plans to include the essential health benefits package (unless retaining a transitional plan)**
- **Fully insured plans are guarantee issue and renewable**
- **Fully insured plans may not discriminate in favor of highly compensated individuals (on hold until regulations are released)**

The information provided herein is a summary description of coverage terms and is intended for informational, illustrative and comparison purposes only. It is not intended to alter or expand rights or liabilities set forth in the official plan documents/contracts. It is not an offer to contract nor are there any express or implied guarantees. This information may be amended or withdrawn by the carrier or TPA in the event of a change in any item upon which it is based and where such change could affect the risk to be assumed. Final terms and conditions shall be based upon information provided in the application including but not limited to final enrollment, contribution levels and condition disclosure information.

This document is not intended to be taken as advice regarding any individual situation and should not be relied upon as such. ClarkAdamson LLC shall have no obligation to update this publication and shall have no liability to you or any other party arising out of this publication or any matter contained herein. Any statements concerning actuarial, tax, accounting, or legal matters are based solely on our experience as consultants and are not to be relied on as actuarial, accounting, tax or legal advice for which you should consult your own professional advisors. Any modeling analytics or projections are subject to inherent uncertainty and the analysis could be materially affective if any underlying assumptions, conditions, information or factors are inaccurate or incomplete or should change.

CA CLARK | ADAMSON INSURANCE

ClarkAdamson LLC Compensation Disclosure

You are a valued client, and we take pride in providing you with exceptional service. As an independent broker, we offer you superior service and competitive pricing by searching for and identifying the coverage from the insurer that best meets your needs.

Commission: Our firm does not charge a fee for placing your policy. We are paid a commission by the insurer that is part of, not added to, your premiums. The amount of commission earned is according to standard commission scheduled established by each insurer we work with.

Our firm may also receive additional incentive compensation or bonuses for various reasons from an insurer. Incentive commission amount and type may vary but does not affect the price of your premiums.

Client Fees: We do not charge you any fee for placement of your policy, and we are compensated by the insurer in the manner described generally above. However, we may charge fees, previously disclosed to you, for certain professional services not including the placement of your policy.

Scope of Services: Our firm works with a number of competing insurers, and we will attempt to obtain quotes from the insurers that we believe to be suitable based on the preferences and needs that you have communicated to us. However, we cannot obtain quotes from all insurers with products suiting your needs. We will attempt to answer any questions you may have regarding the quotes, insurers or policies that we obtain, but be aware that you make the final decision on which insurance product and coverage amount you need and will purchase.

Additional Information: For more information, specific details or answers to any questions about our service, fees, or compensation please contact us at 940-600-1307 or www.ClarkAdamson.com .

Thank you for choosing us to assist you with your insurance needs. We value your trust and appreciate your business. Please let us know if there is anything we can do to serve you better.

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