Group Benefits Proposal
Prepared For
City of Glen Rose
Effective Date October 1, 2025

CA CLARK | ADAMSON
INSURANCE

Claims versus Premiums
Prepared For
City of Glen Rose
Reporting Dates October 2022 - June 2025

2022 - 2023

Month	Membership	Premiums	Claims	Loss Ratio
Oct-22	18	$10,582	$829	8%
Nov-22	18	$10,582	$1,140	11%
Dec-22	18	$10,582	$14,400	136%
Jan-23	18	$10,582	$12,094	114%
Feb-23	18	$10,582	$608	6%
Mar-23	17	$10,159	$12,579	124%
Apr-23	17	$10,159	$6,047	60%
May-23	17	$10,159	$5,886	58%
Jun-23	17	$10,159	$14,181	140%
Jul-23	17	$10,159	$5,786	57%
Aug-23	16	$9,735	$21,743	223%
Sep-23	17	$10,159	$7,325	72%
		$123,598	$102,619	83%

2023 - 2024

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

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				
Aug-25				
Sep-25				
		$102,828	$12,826	12%

Plan Year	Billed Premium	Claims Paid	Loss Ratio
2022 - 2023	$123,598	$102,619	83%
2023 - 2024	$128,031	$101,903	80%
2024 - 2025	$102,828	$12,826	12%
Total	$354,457	$217,348	61%

CLARK | ADAMSON INSURANCE

Group Medical Proposal
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INSURANCE COMPANY			BlueCross BlueShield of Texas			BlueCross BlueShield of Texas			
			Current			Current		Proposed	Proposed
In-Network Benefits			PCP & Referral Required			PCP & Referral Required			
Type of Plan - Plan Name			B660ADT - HMO 2025 HDHP HSA QUALIFIED			S642ADT - HMO 2025		B661CHC - PPO 2025 HDHP HSA QUALIFIED	S9L9CHC - PPO 2025
Network			Blue Advantage			Blue Advantage		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
Individual			$7,500	N / A		$3,850	N / A	$7,500 / $15,000	$3,850 / $7,700
Family			$15,000	N / A		$11,550	N / A	$15,000 / $30,000	$11,550 / $23,100
Coinsurance Percentage			100%	N / A		70%	N / A	100% / 100%	70% / 50%
Maximum Out of Pocket									
Individual			$7,500	N / A		$9,100	N / A	$7,500 / $15,000	$9,100 / Unlimited
Family			$15,000	N / A		$18,200	N / A	$15,000 / $30,000	$18,200 / Unlimited
Office Visit									
Preventive Care			Covered 100%			Covered 100%		Covered 100%	Covered 100%
Primary Care Physician			Ded.			$55 Copay		Ded.	$55 Copay
Specialist			Ded.			$100 Copay		Ded.	$100 Copay
Virtual Visits			Ded.			$55 Copay		Ded.	$55 Copay
Urgent Care Facility Copay			Ded.			$100 Copay		Ded.	$100 Copay
Lab & Xray			Ded.			Lab: Ded. + 30% X-ray: $150 Copay + Ded. + 30%		Ded.	Lab: Ded. + 30% X-ray: $150 Copay + Ded. + 30%
Imaging - CT/PET scans, MRI			Ded.			$300 Copay		Ded.	$300 Copay
Mental Health Outpatient			Ded.			OV: $55 Copay Outpatient: Ded. + 30%		Ded.	OV: $55 Copay Outpatient: Ded. + 30%
Hospital & Emergency Room									
Inpatient Hospital Expenses			Ded.			$350 Copay + Ded. + 30%		Ded.	$350 Copay + Ded. + 30%
Outpatient Surgery Facility			Ded.			$300 Copay + Ded. + 30%		Ded.	$300 Copay + Ded. + 30%
Emergency Room Facility			$750 Copay + Ded.			$750 Copay + Ded. + 30%		$750 Copay + Ded.	$750 Copay + Ded. + 30%
Prescription Drugs						Preferred / Participating			Preferred / Participating
Prescription Deductible			Included with Medical			Not Applicable		Included with Medical	Not Applicable
Tier 1			Ded.			$0 / $10		Ded.	$0 / $10
Tier 2			Ded.			$10 / $20		Ded.	$10 / $20
Tier 3			Ded.			$50 / $70		Ded.	$50 / $70
Tier 4			Ded.			$100 / $120		Ded.	$100 / $120
Specialty Drugs			Ded.			Tier 5: $150 / Tier 6: $250		Ded.	Tier 5: $150 / Tier 6: $250
Mail Oder (90 Day Supply)			Ded.			$0 / $30 / $150 / $300		Ded.	$0 / $30 / $150 / $300
Monthly Premiums			Current	Renewal		Current	Renewal	Proposed	Proposed
Employee Only	18	17	$521.97	$610.40	1	$594.08	$691.82	$953.46	$1,054.85
Employee & Spouse	1	1	$1,043.94	$1,220.80	0	$1,188.16	$1,383.64	$1,906.92	$2,109.70
Employee & Child(ren)	1	1	$1,043.94	$1,220.80	0	$1,188.16	$1,383.64	$1,906.92	$2,109.70
Employee & Family	0	0	$1,565.91	$1,831.20	0	$1,782.24	$2,075.46	$2,860.38	$3,164.55
	20	19			1				
Total Monthly Premium			$10,961.37	$12,818.40		$594.08	$691.82	$20,022.66	$1,054.85
Total Annual Premium			$131,536.44	$153,820.80		$7,128.96	$8,301.84	$240,271.92	$12,658.20
Rate Adjustment			16.94%			16.45%		82.67%	77.56%
Combined Annual Premium			Current $138,665.40			Renewal $162,122.64		Proposed $252,930.12	
Total Rate Adjustment			16.92%					82.40%	
Total Annual Premium Adjustment			$23,457.24					$114,264.72	

Group Medical Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY			BlueCross BlueShield of Texas				aetna			
			Current			Current	Proposed		Proposed	
In-Network Benefits			PCP & Referral Required			PCP & Referral Required				
Type of Plan - Plan Name			B660ADT - HMO 2025 HDHP HSA QUALIFIED			S642ADT - HMO 2025	AFA OAAS 7500 HSA 100% E CY V25 - EPO		AFA OAAS 3500 80% CY V25 - EPO	
Network			Blue Advantage			Blue Advantage	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
Individual			$7,500	N / A		$3,850	N / A	$7,500	N / A	$3,500	N / A
Family			$15,000	N / A		$11,550	N / A	$15,000	N / A	$7,000	N / A
Coinsurance Percentage			100%	N / A		70%	N / A	100%	N / A	80%	N / A
Maximum Out of Pocket											
Individual			$7,500	N / A		$9,100	N / A	$7,500	N / A	$7,000	N / A
Family			$15,000	N / A		$18,200	N / A	$15,000	N / A	$14,000	N / A
Office Visit											
Preventive Care			Covered 100%			Covered 100%	Covered 100%		Covered 100%		
Primary Care Physician			Ded.			$55 Copay	Ded.		$35 Copay		
Specialist			Ded.			$100 Copay	Ded.		$75 Copay		
Virtual Visits			Ded.			$55 Copay	Ded.		PCP: $35 Copay Specialist: $75 Copay		
Urgent Care Facility Copay			Ded.			$100 Copay	Ded.		$75 Copay		
Lab & Xray			Ded.			Lab: Ded. + 30% X-ray: $150 Copay + Ded. + 30%	Ded.		Ded. + 20%		
Imaging - CT/PET scans, MRI			Ded.			$300 Copay	Ded.		Ded. + 20%		
Mental Health Outpatient			Ded.			OV: $55 Copay Outpatient: Ded. + 30%	Ded.		OV: No Charge Outpatient: Ded. + 20%		
Hospital & Emergency Room											
Inpatient Hospital Expenses			Ded.			$350 Copay + Ded. + 30%	Ded.		Ded. + 20%		
Outpatient Surgery Facility			Ded.			$300 Copay + Ded. + 30%	Ded.		Ded. + 20%		
Emergency Room Facility			$750 Copay + Ded.			$750 Copay + Ded. + 30%	Ded.		$300 Copay + Ded. + 20%		
Prescription Drugs						Preferred / Participating					
Prescription Deductible			Included with Medical			Not Applicable	Included with Medical		Not Applicable		
Tier 1			Ded.			$0 / $10	Ded.		$3		
Tier 2			Ded.			$10 / $20	Ded.		$10		
Tier 3			Ded.			$50 / $70	Ded.		$50		
Tier 4			Ded.			$100 / $120	Ded.		$80		
Specialty Drugs			Ded.			Tier 5: $150 / Tier 6: $250	Ded.		Preferred: 20% up to $250 Non Preferred: 40% up to $500		
Mail Oder (90 Day Supply)			Ded.			$0 / $30 / $150 / $300	Ded.		$6 / $20 / $100 / $160		
Monthly Premiums			Current	Renewal		Current	Renewal	Proposed		Proposed	
Employee Only	18	17	$521.97	$610.40	1	$594.08	$691.82	$587.19		$725.46	
Employee & Spouse	1	1	$1,043.94	$1,220.80	0	$1,188.16	$1,383.64	$1,478.64		$1,847.47	
Employee & Child(ren)	1	1	$1,043.94	$1,220.80	0	$1,188.16	$1,383.64	$1,178.75		$1,470.01	
Employee & Family	0	0	$1,565.91	$1,831.20	0	$1,782.24	$2,075.46	$2,032.66		$2,544.76	
	20	19			1						
Total Monthly Premium			$10,961.37	$12,818.40		$594.08	$691.82	$12,639.62		$725.46	
Total Annual Premium			$131,536.44	$153,820.80		$7,128.96	$8,301.84	$151,675.44		$8,705.52	
Rate Adjustment			16.94%			16.45%		15.31%		22.11%	
Combined Annual Premium			Current $138,665.40			Renewal $162,122.64		Proposed $160,380.96			
Total Rate Adjustment			16.92%					15.66%			
Total Annual Premium Adjustment			$23,457.24					$21,715.56			

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

Aetna offers a one-time admin credit of $400 per enrolled employee on the second month's billing statement.

Group Medical Proposal
Prepared for
City of Glen Rose
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INSURANCE COMPANY		aetna®		aetna®		aetna®		aetna®		aetna®	
		Proposed		Proposed		Proposed		Proposed		Proposed	
In-Network Benefits											
Plan Name - Type of Plan		AFA CPOSII 1500 80/50 CY V25 - PPO		AFA CPOSII 2750 70/50 CY V25 - PPO		AFA CPOSII 4000 80/50 CY V25 - PPO		AFA CPOSII 3000 HSA 100/50 T CY V25 - PPO		AFA CPOSII 5500 HSA 100/50 E CY V25 - PPO	
Network		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
Individual		$1,500	$3,000	$2,750	$5,500	$4,000	$8,000	$3,000	$10,000	$5,500	$10,000
Family		$3,000	$9,000	$5,500	$16,500	$8,000	$24,000	$6,000	$30,000	$11,000	$30,000
Coinsurance Percentage		80%	50%	70%	50%	80%	50%	100%	50%	100%	50%
Maximum Out of Pocket											
Individual		$5,500	$13,000	$6,750	$20,500	$7,350	$23,000	$3,750	$20,000	$7,500	$20,000
Family		$11,000	$39,000	$13,500	$61,500	$14,700	$69,000	$7,500	$60,000	$15,000	$60,000
Office Visits											
Preventive Care		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician		$25 Copay		$40 Copay		$35 Copay		Ded.		Ded.	
Specialist		$75 Copay		$80 Copay		$75 Copay		Ded.		Ded.	
Virtual Visits		PCP: $25 Copay Specialist: $75 Copay		PCP: $40 Copay Specialist: $80 Copay		PCP: $35 Copay Specialist: $75 Copay		Ded.		Ded.	
Urgent Care Facility Copay		$75 Copay		$100 Copay		$75 Copay		Ded.		Ded.	
Lab & Xray		Ded. + 20%		Ded. + 30%		Ded. + 20%		Ded.		Ded.	
Imaging - CT/PET scans, MRI		Ded. + 20%		Ded. + 30%		Ded. + 20%		Ded.		Ded.	
Mental Health Outpatient		OV: No Charge Outpatient: Ded. + 20%		OV: No Charge Outpatient: Ded. + 30%		OV: No Charge Outpatient: Ded. + 20%		Ded.		Ded.	
Hospital & Emergency Room											
Inpatient Hospital Expenses		Ded. + 20%		Ded. + 30%		Ded. + 20%		Ded.		Ded.	
Outpatient Surgery Facility		Ded. + 20%		Ded. + 30%		Ded. + 20%		Ded.		Ded.	
Emergency Room Facility		$300 Copay + Ded. + 20%		$300 Copay + Ded. + 30%		$300 Copay + Ded. + 20%		$500 Copay + Ded.		$500 Copay + Ded.	
Prescription Drugs											
Prescription Deductible		Not Applicable		Not Applicable		Not Applicable		Included with Medical		Included with Medical	
Tier 1		$3		$3		$3		$3 after Ded.		$3 after Ded.	
Tier 2		$10		$10		$10		$10 after Ded.		$10 after Ded.	
Tier 3		$45		$50		$50		$50 after Ded.		$50 after Ded.	
Tier 4		$75		$80		$80		$80 after Ded.		$100 after Ded.	
Speciality Drugs		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non Preferred: 40% up to $500		Preferred: 20% up to $250 Non-Preferred: 40% up to $500		Preferred: 20% up to $250 after Ded. Non Preferred: 40% up to $500 after Ded.		Preferred: 20% up to $250 after Ded. Non Preferred: 40% up to $500 after Ded.	
Mail Order (90 Day Supply)		$6 / $20 / $90 / $150		$6 / $20 / $100 / $160		$6 / $20 / $100 / $160		($6 / $20 / $100 / $160) after Ded.		($6 / $20 / $100 / $200) after Ded.	
Monthly Premiums		Proposed		Proposed		Proposed		Proposed		Proposed	
Employee Only	18	$872.47		$776.73		$747.75		$769.40		$678.10	
Employee & Spouse	1	$2,245.85		$1,984.23		$1,906.91		$1,964.65		$1,721.14	
Employee & Child(ren)	1	$1,783.83		$1,578.02		$1,516.96		$1,562.54		$1,370.26	
Employee & Family	0	$3,099.39		$2,734.67		$2,627.31		$2,707.46		$2,369.38	
	20										
Total Monthly Premium		$19,734.14		$17,543.39		$16,883.37		$17,376.39		$15,297.20	
Total Annual Premium		$236,809.68		$210,520.68		$202,600.44		$208,516.68		$183,566.40	
Rate Adjustment		70.79%		51.83%		46.12%		50.38%		32.39%	
Annual Premium Adjustment		$98,154.28		$71,865.28		$63,945.04		$69,861.28		$44,911.00	

Aetna offers a one-time admin credit of $400 per enrolled employee on the second month's billing statement.

Group Medical Proposal
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City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY		UnitedHealthcare		UnitedHealthcare		UnitedHealthcare		UnitedHealthcare		UnitedHealthcare	
		Proposed		Proposed		Proposed		Proposed		Proposed	
In-Network Benefits											
Plan Name - Type of Plan		DX9S - Rx K35S - PPO		DX97 - Rx K35S - PPO		DYAE - Rx K35S - PPO		DX83 - Rx K35S - PPO HDHP HSA QUALIFIED		DX8V - Rx K35S - PPO HDHP HSA QUALIFIED	
Network		Choice Plus		Choice Plus		Choice Plus		Choice Plus		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
Individual		$1,000	$10,000	$3,000	$10,000	$4,000	$10,000	$3,500	$10,000	$5,000	$10,000
Family		$3,000	$20,000	$9,000	$20,000	$8,000	$20,000	$7,000	$20,000	$10,000	$20,000
Coinsurance Percentage		80%	50%	80%	50%	80%	50%	100%	70%	100%	70%
Maximum Out of Pocket											
Individual		$2,500	Unlimited	$6,000	Unlimited	$6,200	Unlimited	$6,500	Unlimited	$6,500	Unlimited
Family		$7,500	Unlimited	$12,000	Unlimited	$12,400	Unlimited	$13,000	Unlimited	$13,000	Unlimited
Office Visits											
Preventive Care		Covered 100%		Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Primary Care Physician		Under age 19: No Copay Age 19 or above: $10 Copay		Under age 19: No Copay Age 19 or above: $15 Copay		Under age 19: No Copay Age 19 or above: $10 Copay		Ded.		Ded.	
Specialist		Designated: $40 Copay Network: $80 Copay		Designated: $50 Copay Network: $100 Copay		Designated: $40 Copay Network: $80 Copay		Ded.		Ded.	
Virtual Visits		No Copay		No Copay		No Copay		Ded.		Ded.	
Urgent Care Facility Copay		$25 Copay		$25 Copay		$25 Copay		Ded.		Ded.	
Lab & Xray		$40 Copay		Ded. + 20%		$40 Copay		Ded.		Ded.	
Imaging - CT/PET scans, MRI		Ded. + 20%		Ded. + 20%		Ded. + 20%		Ded.		Ded.	
Mental Health Outpaitent		OV: $30 Copay Outpatient: Ded. + 20%		OV: $30 Copay Outpatient: Ded. + 20%		OV: $30 Copay Outpatient: Ded. + 20%		Ded.		Ded.	
Hospital & Emergency Room											
Inpatient Hospital Expenses		Ded. + 20%		Ded. + 20%		Ded. + 20%		Ded.		Ded.	
Outpatient Surgery Facility		Ded. + 20%		Ded. + 20%		Ded. + 20%		Ded.		Ded.	
Emergency Room Facility		$500 Copay + Ded. + 20%		$500 Copay + Ded. + 20%		$500 Copay + Ded. + 20%		Ded.		Ded.	
Prescription Drugs											
Prescription Deductible		Not Applicable		Not Applicable		Not Applicable		Included with Medical		Included with Medical	
Tier 1		$10		$10		$10		$10 after Ded.		$10 after Ded.	
Tier 2		$40		$40		$40		$40 after Ded.		$40 after Ded.	
Tier 3		$125		$125		$125		$125 after Ded.		$125 after Ded.	
Tier 4		$300		$300		$300		$300 after Ded.		$300 after Ded.	
Speciality Drugs		$10 / $40 / $125 / $500		$10 / $40 / $125 / $500		$10 / $40 / $125 / $500		($10 / $40 / $125 / $500) after Ded.		($10 / $40 / $125 / $500) after Ded.	
Mail Order (90 Day Supply)		$25 / $100 / $312.50 / $750		$25 / $100 / $312.50 / $750		$25 / $100 / $312.50 / $750		($25 / $100 / $312.50 / $750) after		($25 / $100 / $312.50 / $750) after	
Monthly Premiums		Proposed		Proposed		Proposed		Proposed		Proposed	
Employee Only	18	$1,192.18		$1,056.11		$1,075.08		$1,129.19		$1,041.50	
Employee & Spouse	1	$2,384.36		$2,112.22		$2,150.16		$2,258.38		$2,083.00	
Employee & Child(ren)	1	$2,384.36		$2,112.22		$2,150.16		$2,258.38		$2,083.00	
Employee & Family	0	$3,576.54		$3,168.33		$3,225.24		$3,387.57		$3,124.50	
	20										
Total Monthly Premium		$26,227.96		$23,234.42		$23,651.76		$24,842.18		$22,913.00	
Total Annual Premium		$314,735.52		$278,813.04		$283,821.12		$298,106.16		$274,956.00	
Rate Adjustment		126.99%		101.08%		104.70%		115.00%		98.30%	
Annual Premium Adjustment		$176,080.12		$140,157.64		$145,165.72		$159,450.76		$136,300.60	

Voluntary Group Dental Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY		Mutual of Omaha	
Type of Plan - Plan Name		PPO	
Benefits		Current	
In Network / Out of Network		In Network	Out of Network
Annual Maximum Benefit		$1,000	
Individual Annual Deductible		$50	
Family Annual Deductible		$150	
Preventive		100%	
Basic		80%	
Major		50%	
Endodontics		Major	
Periodontics		Periodontal Maintenance: Basic All Other Periodontics: Major	
Implants		Not Covered	
Orthodontia		Child only up to age 26: 50%	
Orthodontia Lifetime Maximum		$1,000	
Rollover Benefit		Included	
Reimbursement Method		Negotiated Rate	90% R&C
Waiting Period		None	
Network		Mutual of Omaha	
Website		www.mutualofomaha.com/dental	
Participation		Current	
Rate Guarantee		12 Months	
Monthly Premium		Current	Renewal
Employee Only	9	$27.81	$28.64
Employee & Spouse	0	$62.50	$64.38
Employee & Child(ren)	2	$77.76	$80.09
Employee & Family	5	$109.18	$112.46
	16		
Total Monthly Premium		$951.71	$980.24
Total Annual Premium		$11,420.52	$11,762.88
Rate Adjustment		3.00%	
Annual Premium Adjustment		$342.36	

Voluntary Group Vision Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY		Mutual of Omaha		Mutual of Omaha	
Type of Plan - Plan Name		12/12/24/12		12/12/12/12	
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 $37
		One Every 12 Months		One Every 12 Months	
Materials Benefit - Lenses		$25 Copay	Up to $64	$25 Copay	Up to $64
		One Every 12 Months		One Every 12 Months	
Materials Benefit - Frames		$130 Allowance + 20% off over allowance	Up to $58	$200 Allowance + 20% off over allowance	Up to $79
		One Every 24 Months		One Every 12 Months	
Contact Lenses (instead of lenses & frames)		Elective: $40 (Fit & Eval) $130 Allowance Necessary: Covered in full	Elective: Up to $104 Necessary: Up to $210	Elective: $40 (Fit & Eval) $200 Allowance Necessary: Covered in full	Elective: Up to $160 Necessary: Up to $210
		One Every 12 Months		One Every 12 Months	
Extras		Savings on laser correction, lens options, additional complete pair eyeglasses, additional conventional contact lenses once funded benefit used		Savings on laser correction, lens options, additional complete pair eyeglasses, additional conventional contact lenses once funded benefit used	
Provider Network		EyeMed		EyeMed	
Website		www.mutualofomaha.com/vision		www.mutualofomaha.com/vision	
Participation		Current		Greater of 5 lives or 71%	
Rate Guarantee		12 Months		12 Months	
Monthly Premium		Current	Renewal	Proposed	
Employee Only	9	$5.49	$5.49	$8.10	
Employee & Spouse	1	$12.61	$12.61	$14.88	
Employee & Child(ren)	2	$13.98	$13.98	$16.50	
Employee & Family	7	$21.34	$21.34	$23.84	
	19				
Total Monthly Premiuim		$239.36	$239.36	$287.66	
Total Annual Premium		$2,872.32	$2,872.32	$3,451.92	
Rate Adjustment		0.00%		20.18%	
Annual Premium Adjustment		$0.00		$579.60	

Rate Guarantee to 10/01/2026

Group Basic Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY	Mutual of Omaha	
Benefits	**Current**	
Eligible Class	All active full-time employees living in the United States working 40 or more hours per week	
Benefit Amount	$40,000	
Guarantee Issue Amount	$40,000	
Age Reduction Schedule	Reduces to 65% at age 65; Reduces to 50% at age 70	
Features		
Accelerated Death Benefit	Included	
Waiver of Premium	Included	
Travel Assist	Included	
EAP	Included	
Portability	Excluded	
Conversion	Included	
Participation Requirement	100%	
Rate Guarantee	12 Months	
Monthly Premium	**Current**	**Renewal**
Life Rate per $1,000	$0.138	$0.138
AD&D Rate per $1,000	$0.034	$0.034
Monthly Volume	$780,000	$780,000
Total Monthly Premiuim	$134.16	$134.16
Total Annual Premium	$1,609.92	$1,609.92
Rate Adjustment	0.00%	
Annual Premium Adjustment	$0.00	

Rates based on 20 covered employees

Rate Guarantee to 10/01/2026

Group Voluntary Life and AD&D Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY	Mutual of Omaha	
Eligible Class	All active full-time employees living in the United States working 40 or more hours per week	
Employee	**Current**	
Employee Max Benefit Amount	$300,000, in increments of $10,000 Not to exceed 5X annual salary	
Employee Guarantee Issue	$70,000 Not to exceed 5X annual salary	
Age Reduction Schedule	Reduces to 65% at age 70; Reduces to 45% at age 75	
Spouse		
Spouse Max Benefit Amount	$100,000, in increments of $5,000 Not to exceed 100% employee benefit	
Spouse Guarantee Issue	$20,000 Not to exceed 100% employee benefit	
Age Reduction Schedule	Terminates once employee reaches age 70	
Child(ren)		
Child Max Benefit Amount	$10,000, in increments of $2,000 Not to exceed 100% employee benefit	
Child Guarantee Issue	$10,000 Not to exceed 100% employee benefit	
Child Maximum Age	26	
Features		
Accelerated Death Benefit	Included	
Waiver of Premium	Included	
Travel Assist	Excluded	
EAP	Excluded	
Annual Enrollment Provision	Included	
Portability	Included	
Conversion	Included	
Participation Requirement	Current	
Rate Guarantee	12 Months	
Rate Per $1,000	**Current**	**Renewal**
< 25	$0.108	$0.108
25-29	$0.108	$0.108
30-34	$0.108	$0.108
35-39	$0.193	$0.193
40-44	$0.250	$0.250
45-49	$0.448	$0.448
50-54	$0.788	$0.788
55-59	$1.468	$1.468
60-64	$2.205	$2.205
65-69	$3.622	$3.622
70+	$5.407	$5.407
Child Life Rates	$0.174	$0.174
AD&D Rates (EE, SP, CH)	$0.34, $0.34, $0.44	$0.34, $0.34, $0.44

Rate Guarantee to 10/01/2026

Group Short Term Disability Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

		Voluntary
INSURANCE COMPANY	Mutual of Omaha	Mutual of Omaha
	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
Definition of Earnings	Base Salary excluding bonus/overtime/commissions	Base Salary excluding bonus/overtime/commissions
Definition of Disability	Loss of duties AND earnings	Loss of duties AND earnings
Benefits		
Elimination Period/Accident	14 Days	14 Days
Elimination Period/Illness	14 Days	14 Days
Income Benefit (% of Earnings)	60%	60%
Maximum Weekly Benefit	$1,000	$1,000
Benefit Duration	11 Weeks	11 Weeks
Features		
Pre-Existing Condition Limitation	None	3 months prior / 6 months insured
Partial Disability	Included	Included
W-2 Preparation	Included	Included
Benefit Taxation	Taxable	Taxable
Participation Requirement	100%	Greater of 10 lives or 50%
Rate Guarantee	24 Months	24 Months
Monthly Premium	**Proposed**	**Proposed**
Rate Per $10	$0.160	$0.290
Monthly Volume	$12,991	$12,991
Total Monthly Premiuim	$207.86	$376.74
Total Annual Premium	$2,494.27	$4,520.87

Rates based on 20 covered employees

Group Long Term Disability Proposal
Prepared for
City of Glen Rose
Effective Date October 1, 2025

INSURANCE COMPANY	Mutual of Omaha	
	Current	
Eligible Class	All active full-time employees living in the United States working 40 or more hours per week	
Definition of Earnings	Base Salary excluding bonus/overtime/commissions	
Definition of Disability	Loss of duties AND earnings	
Benefits		
Elimination Period	90 Days	
Income Benefit (% of Earnings)	60%	
Maximum Monthly Benefit	$6,000	
Own Occupation Period	2 Years	
Benefit Duration	Greater of 3.5 Years OR to 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 Care Benefit	Excluded	
Partial Disability	Included	
Waiver of Premium	Included	
W-2 Preparation	Included	
FICA Match	Included	
Portability	Excluded	
Conversion	Excluded	
Benefit Taxation	Taxable	
Participation Requirement	Current	
Rate Guarantee	12 Months	
Monthly Premium	**Current**	**Renewal**
Rate per $100	$0.410	$0.410
Monthly Volume	$96,630	$96,630
Total Monthly Premiuim	$396.18	$396.18
Total Annual Premium	$4,754.19	$4,754.19
Rate Adjustment	0.00%	
Annual Premium Adjustment	$0.00	

Rates based on 20 covered employees

Rate Guarantee to 10/01/2026

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.

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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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