



2025 - 2026 Employee Benefits Guide

An overview of the wide array of benefits offered by City of Neosho to help you enjoy increased well-being and financial security.



Introduction

As an employee of City of Neosho, enjoying your work and making valuable contributions to our city are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2025 - 2026 plan year, City of Neosho has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and City of Neosho is offering an overall benefits package that can be shaped and molded by you to fit your needs.

Here is a list of benefits that are **100% paid by City of Neosho** for you as a valued employee:

- Anthem Medical** - Base Plan (100% Employee Only Cost/50% of Dependent Cost)
- Mutual of Omaha** - Group Life (\$25,000 Death Benefit Employee Only)
- Delta Dental** - (100% Employee Only Cost)
- Delta Vision** - (100% Employee Only Cost)
- MASA Ambulance Benefits** - Emergent Plan (100% Employee & Dependent Cost)

This benefits booklet is a summary description of your City of Neosho benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.

Questions regarding benefits & additional pricing:

Medical Insurance - Sylvia Stapleton /417-623-7500/sstapleton@theinsurancenter.com

All other benefits - Tana Wise/417-451-4244/tanawise@ibcneosho.com

Agent contact - Phil Wise/417-312-3044/pwise@theinsurancenter.com

Anthem Medical



Summary of Coverage

BASE PLAN - Blue Preferred 1500 (Freeman, COX)	In-Network	Out-of-Network
Deductible	\$1,500 person / \$3,000 family	\$4,500 person / \$9,000 family
Out-of-Pocket	\$4,000 person / \$8,000 family	\$18,000 person / \$36,000 family
Coinsurance	20%	50%
Office Visit/Specialist Visit	\$30/\$70	Ded + Coin
Preventative Care	No Charge	Ded + Coin
Diagnostic Test (x-ray, bloodwork)	No Charge	Ded + Coin
Imaging (CT,PET scans, MRI's)	Ded + Coin	Ded + Coin
Emergency Room	\$300/visit	Covered as In-Network
Urgent Care	\$50/visit	Ded + Coin
Prescription Drug	\$10,\$35,\$75,25% coins up to \$350	50% Coin

BUY UP PLAN - Blue Access 1500 (Freeman, Mercy, COX)	In-Network	Out-of-Network
Deductible	\$1,500 person / \$3,000 family	\$4,500 person / \$9,000 family
Out-of-Pocket	\$4,000 person / \$8,000 family	\$18,000 person / \$36,000 family
Coinsurance	20%	50%
Office Visit/Specialist Visit	\$30/\$70	Ded + Coin
Preventative Care	No Charge	Ded + Coin
Diagnostic Test (x-ray, bloodwork)	No Charge	Ded + Coin
Imaging (CT,PET scans, MRI's)	Ded + Coin	Ded + Coin
Emergency Room	\$300/visit	Covered as In-Network
Urgent Care	\$50/visit	Ded + Coin
Prescription Drug	\$10,\$35,\$75,25% coins up to \$350	50% Coin

PER PAY COST	BASE	BUY UP
Employee Only	\$0.00	\$6.81
Employee + Spouse	\$159.40	\$173.00
Employee + Child(ren)	\$119.55	\$131.45
Employee + Family	\$278.95	\$297.66



Medical plan info



Annual Deductible

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).



Out-of-Pocket Maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays and coinsurance. *Except for Grandfathered medical plans



Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount, and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.



Plan Type

- PPO – A network of doctors, hospitals and other health care providers

MASA Emergency Transport



Summary of Coverage

MASA Medical Transport Solutions
Any Ground. Any Air. Anywhere.™

EMERGENT PLUS MEMBERSHIP BENEFITS

Emergent Air Transportation		In the event of a serious medical emergency, Members have access to emergency air transportation into a medical facility or between medical facilities. Please see your Member Services Agreement for the complete terms, conditions and limitations of this benefit.
Emergent Ground Transportation		In the event of a serious medical emergency, Members have access to emergency ground transportation into a medical facility or between medical facilities. Please see your Member Services Agreement for the complete terms, conditions and limitations of this benefit.
Non-Emergent Inter-Facility Transportation		In the event that a member is in stable condition in a medical facility but requires a heightened level of care that is not available at their current medical facility, Members have access to non-emergent air or ground transportation between medical facilities. Please see your Member Services Agreement for the complete terms, conditions, and limitations of this benefit.
Repatriation/Recuperation		In the event that a Member is hospitalized more than 100-miles from their home, Members have access to air or ground medical transportation into a medical facility closer to Member's home for the purposes of recuperation. Please see your Member Services Agreement for the complete terms, conditions and limitations of this benefit.

EMERGENCY TRANSPORTATION COSTS

- MASA MTS is here to protect its members and their families from the shortcomings of health insurance coverage by providing them with comprehensive financial protection for lifesaving emergency transportation services, both at home and away from home.
- Many American employers and employees believe that their health insurance policies cover most, if not all ambulance expenses. The truth is, they DONOT!
- Even after insurance payments for emergency transportation, you could receive a bill up to \$5,000 for ground ambulance and as high as \$70,000 for air ambulance. The financial burdens for medical transportation costs are very real.



HOW MASA IS DIFFERENT

Across the US there are thousands of ground ambulance providers and hundreds of air ambulance carriers. **ONLY MASA** offers comprehensive coverage since MASA is a **PAYER** and not a **PROVIDER**!

ONLY MASA provides over 2 million members with coverage for **BOTH ground ambulance and air ambulance transport, REGARDLESS of which provider transports them.**

Members are covered **ANYWHERE** in all 50 states and Canada!

Worldwide coverage is also available with our Platinum Membership.

Additionally, MASA provides a repatriation benefit: if a member is hospitalized more than 100 miles from home, MASA can arrange and pay to have them transported to a hospital closer to their place of residence.



PER PAY COST	Emergent	Platinum
Employee Only	\$0.00	\$12.50
Employee + Spouse	\$0.00	\$12.50
Employee + Child(ren)	\$0.00	\$12.50
Employee + Family	\$0.00	\$12.50

Delta Dental



Summary of Coverage

City of Neosho	Delta Dental PPO™ Network	Delta Dental Premier® Network	Out-of-Network
	Based on applicable PPO Maximum Plan Allowance - No balance billing	Based on applicable Premier Maximum Plan Allowance - No balance billing	Based on applicable Maximum Plan Allowance for Out-of-Network dentist - Balance billing is possible
Preventive services <ul style="list-style-type: none"> • Bitewing x-rays, one set per benefit period • Emergency palliative treatment • Full-mouth x-rays (pano), once in any 36 month period • Oral examinations, twice in any benefit period • Periapical x-rays, as required • Periodontal Maintenance, twice in any benefit period (subject to your prophylaxis frequency limitation) • Prophylaxis (cleanings), twice in any benefit period • Sealants for dependent children under age 16, once in 5 years • Space Maintainers for dependent children under age 16, once in 5 years • Topical fluoride treatments for dependent children under age 16, once in any benefit period 	100%	100%	100%
Basic services <ul style="list-style-type: none"> • Fillings • Simple Extractions 	80%	80%	80%
Major services <ul style="list-style-type: none"> • Bridges, once in 7 years • Crowns, Inlays, Onlays, once in 7 years • Dentures, once in 7 years • Endodontics • General Anesthesia • Implants, as well as bone grafts, are a covered benefit. Limited to once in 7 years. • Non-Surgical Periodontics • Oral Surgery (excluding extractions) • Surgical Extractions • Surgical Periodontics 	50%	50%	50%
Orthodontia <ul style="list-style-type: none"> • Orthodontia for dependent children under age 19 (lifetime maximum) 	50% up to \$1,000 No deductible	50% up to \$1,000 No deductible	50% up to \$1,000 No deductible
Calendar year deductible (Applied to Basic and Major services)	\$50 individual 3X family	\$50 individual 3X family	\$50 individual 3X family
Annual maximum (Applied to Preventive, Basic and Major services)	\$2,000	\$2,000	\$2,000
Dependent age limit: 26			
Added features included <ul style="list-style-type: none"> • MAXRollover 			

Coverage tier	Per pay period pricing
Employee	\$0.00
Employee + Spouse	\$13.83
Employee + Child(ren)	\$17.76
Employee + Family	\$35.11



Dental plan info

Summary of coverage

Dental coverage is similar to regular medical insurance—you pay a premium and then your insurance will cover part or all of the cost for many dental services.

Preventative care

Professional dental care can diagnose or help prevent common dental problems, including toothaches, inflamed gums, tooth decay, bad breath and dry mouth. If conditions like these remain untreated, they can worsen into painful and expensive problems, such as gum disease or even tooth loss.

Diagnostic care

Additionally, dental health professionals are able to spot more serious health issues, including some types of cancer. That makes it even more important to see a dentist regularly.

Great for families

This coverage is also great for families. Since dental work can be very expensive, proactive dental care, such as routine cleanings, can help save children from costly issues as they age.

Specialized treatments

With dental insurance, you're investing in your smile and overall health. Beyond cleanings and routine care, dental coverage may also help pay for more specialized treatments, such as root canals or fillings.

Routine care

Dental coverage allows you to visit a dentist whenever you need to inexpensively receive preventive and diagnostic care.

See everything your plan covers by reviewing the benefits statement and overview. Reach out to HR with any questions.

Delta Vision



Summary of Coverage

Vision care services	In-network member cost	Out-of-network member reimbursement
Exam services		
Exam with dilation as necessary	\$10 copay	Up to \$40
Retinal imaging	Up to \$39	Not covered
Contact lens fit and follow-up		
Fit and Follow-up Standard	\$30 allowance	Not covered
Fit and Follow-up Premium	10% off retail price less \$30 allowance	Not covered
Frames		
Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$52
Lenses		
Single Vision	\$25 copay	Up to \$20
Bifocal	\$25 copay	Up to \$40
Trifocal	\$25 copay	Up to \$60
Lenticular	\$25 copay	Up to \$100
Progressive - Standard	\$75 copay	Up to \$40
Progressive - Premium tier 1/2/3	\$110/\$120/\$135 copay	Up to \$40
Progressive - Premium tier 4	\$90 copay; 20% off retail price less \$120 allowance	Up to \$40
Lens Options		
Photochromic - Non-glass	\$60 copay	Not covered
Polycarbonate - Std – Children under 20	\$0 copay	Not covered
Polycarbonate - Standard	\$40	Not covered
Anti reflective coating - Standard	\$45	Not covered
Anti reflective coating - Premium tier 1/2/3	\$57/\$68/80% of charge	Not covered
Scratch coating - Standard plastic	\$15	Not covered
Tint - Solid or gradient	\$15	Not covered
UV treatment	\$15	Not covered
All other lens options	20% off retail price	Not covered
Contact lens		
Contacts - Conventional	\$25 copay; 15% off balance over \$130 allowance	Up to \$78
Contacts - Disposable	\$25 copay; plus balance over \$130 allowance	Up to \$78
Contacts - Medically necessary	\$25 copay; \$250 allowance	Up to \$250
Other		
Hearing Care from Amplifon NetworkCare	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
Frequencies (Plan allows member to receive either contacts and frame, or frames and lens services)		
Exam	Once every calendar year	
Frame	Once every other calendar year	
Lenses	Once every calendar year	
Contacts	Once every calendar year	

Where allowances are shown you are responsible for all charges in excess the allowance in addition to the applicable copay. Allowances are paid only once during the benefit period and must be fully utilized at time of purchase. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits for Medically Necessary Contact Lenses are limited to conditions of aphakia, keratoconus or severe anisometropia. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. The percentage discounts and flat dollar fixed pricing for certain lens options and retinal imaging are discount features, not insured benefits, and may be subject to change. You are responsible for paying the cost of such items directly to the provider. For out of network benefits you are responsible for paying the provider in full at the time of service and submitting a request for reimbursement.

THIS IS A SNAPSHOT OF YOUR BENEFITS REFER TO YOUR CERTIFICATE OF COVERAGE FOR FULL COVERAGE DETAILS, LIMITATIONS AND EXCLUSIONS. For a copy of your Certificate of Coverage consult your employer or plan administrator. DeltaVision® is underwritten by Advantica Insurance Company, a Delta Dental of Missouri Company. Customer service and network administration for DeltaVision are provided through an agreement with EyeMed Vision Care, LLC and claims processing through First American Administrators, Inc., an affiliate of EyeMed. EyeMed Vision Care® is a registered trademark of EyeMed Vision Care, LLC. Delta Dental and DeltaVision are registered trademarks of the Delta Dental Plans Association.

	Per pay period pricing
Employee	\$0.00
Employee + Spouse	\$2.72
Employee + Child(ren)	\$3.50
Employee + Family	\$6.52



Vision plan info

Summary of coverage

Similar to other forms of insurance, with vision care you pay a premium and the insurance company will cover part or all of your vision costs.

Preventative care

Vision coverage is important because an eye doctor can catch eye issues before they worsen. A visit with your eye doctor can determine whether you need corrective lenses and, if so, the correct prescription. Other eye concerns that will be addressed in an eye exam include checking for conditions or diseases—such as glaucoma and cataracts—which can lead to vision loss.

Coverage

Vision coverage does not usually cover surgeries or experimental vision services. However, vision insurance may help lower the costs of some procedures, such as laser eye surgery, even if it's not 100% covered. This will depend on the plan.

Plans

Vision plans typically cover things like eyeglass frames, lenses, contacts and annual eye exams. In most cases, plans have a set dollar amount that they will pay for certain items. For instance, a plan may pay up to \$130 for frames, and anything over that amount is discounted. Although, your plan specifics may vary.

Diagnostic care

Eye doctors can even help detect some types of cancer, making regular visits even more important.

Review your benefits statement to see everything your vision plan covers. Reach out to HR with any questions.

Allstate Accident



Summary of Coverage

BENEFIT AMOUNTS

Benefits are paid once per accident unless otherwise noted here or in the brochure

BASE POLICY BENEFITS		PLAN 1	PLAN 2
Accidental Death	Employee	\$40,000	\$60,000
	Spouse	\$20,000	\$30,000
	Children	\$10,000	\$15,000
Common Carrier Accidental Death (fare-paying passenger)	Employee	\$200,000	\$300,000
	Spouse	\$100,000	\$150,000
	Children	\$50,000	\$75,000
Dismemberment ¹	Employee	\$40,000	\$60,000
	Spouse	\$20,000	\$30,000
	Children	\$10,000	\$15,000
Dislocation or Fracture ¹	Employee	\$4,000	\$6,000
	Spouse	\$4,000	\$6,000
	Children	\$4,000	\$6,000
Initial Hospitalization Confinement (pays once)		\$1,000	\$1,500
Hospital Confinement (pays daily)		\$200	\$300
Intensive Care (pays daily)		\$400	\$600
Ambulance Services	Ground	\$200	\$300
	Air	\$600	\$900
Medical Expenses (pays up to amount shown)		\$500	\$750
Outpatient Physician's Treatment (pays per visit)		\$50.00	\$75.00
BENEFIT ENHANCEMENT RIDER		PLAN 1	PLAN 2
Hospital Admission (pays once/year)		\$500	\$500
Lacerations (pays once/year)		\$50	\$50
Burns	< 15% body surface	\$100	\$100
	15% or more	\$500	\$500
Skin Graft (% of Burns Benefit)		50%	50%
Brain Injury Diagnosis (pays once)		\$150	\$150
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) (pays once/accident/year)		\$50	\$50
Paralysis (pays once)	Paraplegia	\$7,500	\$7,500
	Quadriplegia	\$15,000	\$15,000
Coma with Respiratory Assistance (pays once)		\$10,000	\$10,000
Open Abdominal or Thoracic Surgery		\$1,000	\$1,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Surgery	\$500	\$500
	Exploratory	\$150	\$150
Ruptured Disc Surgery		\$500	\$500
Eye Surgery		\$100	\$100
General Anesthesia		\$100	\$100
Blood and Plasma		\$300	\$300
Appliance		\$125	\$125
Medical Supplies		\$5	\$5
Medicine		\$5	\$5
Prosthesis	1 device	\$500	\$500
	2 or more devices	\$1,000	\$1,000
Physical Therapy (pays daily)		\$30	\$30
Rehabilitation Unit (pays daily)		\$100	\$100
Non-Local Transportation		\$400	\$400
Family Member Lodging (pays daily)		\$100	\$100
Post-Accident Transportation (pays once/year)		\$200	\$200
Accident Follow-Up Treatment (pays daily)		\$50	\$50

¹Up to amount shown; see Injury Benefit Schedule on reverse. Multiple losses from same injury pay only up to amount shown above.

Coverage Tier	PLAN 1 Per pay period cost	PLAN 2 Per pay period cost
Employee	\$9.00	\$12.34
Employee + Spouse	\$17.72	\$24.80
Employee + Child(ren)	\$21.39	\$30.30
Employee + Family	\$26.37	\$37.6

Allstate Cancer



Summary of Coverage

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN 1	PLAN 2
Continuous Hospital Confinement (daily)	\$200	\$300
Government or Charity Hospital (daily)	\$200	\$300
Private Duty Nursing Services (daily)	\$200	\$300
Extended Care Facility (daily)	\$200	\$300
At Home Nursing (daily)	\$200	\$300
Hospice Care Center (daily) or Hospice Care Team (per visit)	\$200 \$200	\$300 \$300
RADIATION/CHEMOTHERAPY/RELATED BENEFITS	PLAN 1	PLAN 2
Radiation/Chemotherapy for Cancer ¹ (every 12 months)	\$10,000	\$15,000
Blood, Plasma, and Platelets ² (every 12 months)	\$10,000	\$15,000
Hematological Drugs ² (every 12 months)	\$200	\$300
Medical Imaging ¹ (every 12 months)	\$500	\$750
SURGERY AND RELATED BENEFITS	PLAN 1	PLAN 2
Surgery ³	\$3,000	\$4,500
Anesthesia (% of surgery benefit)	25%	25%
Bone Marrow or Stem Cell Transplant (once/year)		
1. Autologous	\$1,000	\$1,500
2. Non-autologous (cancer or specified disease treatment)	\$2,500	\$3,750
3. Non-autologous (Leukemia)	\$5,000	\$7,500
Ambulatory Surgical Center (daily)	\$500	\$750
Second Opinion	\$400	\$600
MISCELLANEOUS BENEFITS	PLAN 1	PLAN 2
Inpatient Drugs and Medicine (daily)	\$25	\$25
Physician's Attendance (daily)	\$50	\$50
Ambulance (per confinement)	\$100	\$100
Non-Local Transportation ⁴ (coach fare or amount shown per mile*)	0.40/Mile	0.40/Mile
Outpatient Lodging (daily; limit \$2,000/12 mo. period)	\$50	\$50
Family Member Lodging (daily per trip; max. 60 days) and Transportation (coach fare or amount shown per mile**)	\$50 0.40/Mile	\$50 0.40/Mile
Physical or Speech Therapy (daily)	\$50	\$50
New or Experimental Treatment ² (every 12 months)	\$5,000	\$5,000
Prosthesis ³ (per amputation)	\$2,000	\$2,000
Hair Prosthesis (every 2 years)	\$25	\$25
Nonsurgical External Breast Prosthesis ⁴	\$50	\$50
Anti-Nausea Benefit ⁴ (once per calendar year)	\$200	\$200
Waiver of Premium (employee only)	Yes	Yes
OPTIONAL/ADDITIONAL BENEFITS	PLAN 1	PLAN 2
Cancer Initial Diagnosis (one-time benefit)	\$2,000	\$5,000
Wellness Benefit	\$50	\$50

¹Pays actual cost up to amount listed. ²Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. ³Pays actual charges up to amount listed. ⁴At least 70 miles away, up to 700 miles. ******Transportation up to 700 miles per continuous hospital confinement.

Coverage Tier	PLAN 1 Per pay period cost	PLAN 2 Per pay period pricing
Employee	\$10.93	\$16.75
Employee + Spouse	\$16.78	\$25.77
Employee + Child(ren)	\$15.52	\$24.00
Employee + Family	\$21.36	\$33.01

Allstate Critical Illness



Summary of Coverage

BENEFIT AMOUNTS

†Covered dependents receive 50% of your benefit amount

INITIAL CRITICAL ILLNESS BENEFITS†		PLAN 3
Heart Attack (100%)		\$20,000
Stroke (100%)		\$20,000
Major Organ Transplant (100%)		\$20,000
End Stage Renal Failure (100%)		\$20,000
Coronary Artery Bypass Surgery (25%)		\$5,000
Waiver of Premium (employee only)		Yes
SECOND EVENT BENEFITS†		PLAN 3
Second Event Initial Critical Illness (same amount as Initial Critical Illness)		Yes
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS II†		PLAN 3
Advanced Alzheimer's Disease (25%)		\$5,000
Advanced Parkinson's Disease (25%)		\$5,000
Benign Brain Tumor (100%)		\$20,000
Coma (100%)		\$20,000
Complete Blindness (100%)		\$20,000
Complete Loss of Hearing (100%)		\$20,000
Paralysis (100%)		\$20,000
OPTIONAL/ADDITIONAL BENEFIT		
Wellness Benefit (per year)		\$50
OPTIONAL/ADDITIONAL RIDER BENEFITS		PLAN 3
Second Evaluation Benefit (Critical Illness Enhancement) Rider -		
Second Consultation		\$1,000
Non-Local Transportation ¹ (per trip or mile)	Air Fare	\$500
	Personal Vehicle	\$0.50
Outpatient Lodging ² (daily)		\$100
Family Member Lodging ² (daily) and Transportation ¹ (per trip or mile)	Air Fare	\$500
	Personal Vehicle	\$0.50

¹Limit of \$5,000/12 month period. ²Limit of \$1,000/12 month period.

TOBACCO & NON-TOBACCO AGE BANDED RATES

3 Plan options - \$20,000 w/cancer, \$10,000 w/cancer, \$20,000 w/o cancer



Group Life Insurance

Summary of Coverage (Employer Paid)

Plan Features	Basic Life - Group
Employee benefit amount	\$25,000
AD&D benefit	\$25,000
The following shows how much benefits are reduced at certain ages.	
Age band	Benefit Reduction
at age 70	to 65%
at age 75	to 50%

Group life is 100% covered by the employer with the option of employees adding voluntary life. Employees must fill out an EOI form if they exceed the guaranteed issue amount or are no longer eligible for guaranteed issue underwriting.

Life insurance isn't a fun thing to think about, but, if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you—your designated beneficiary would collect a financial benefit upon your death.

Group life insurance coverage is a employer-sponsored safety net in case the worst happens, with no out-of-pocket costs to you. If you believe you need additional coverage, you may wish to enroll in voluntary life insurance as well.



Voluntary Life Insurance

Summary of Coverage

Plan Features	Voluntary Life
Employee guaranteed issue benefit amount	\$100,000
Minimum benefit amount	\$10,000
Maximum benefit amount	5x salary or \$500,000
AD&D benefit	1x base amount selected
Spouse/Child guaranteed issue benefit amounts	\$25,000/\$10,000

Employees must fill out an EOI (Evidence of Insurability) form if they exceed the guaranteed issue amount. Employee, spouse and children must also fill out an EOI form if no longer eligible for guaranteed issue. Benefits reduce at certain ages (refer to schedule in contract).

Voluntary life insurance is similar to group life insurance, except it is paid for by you. It can provide additional financial security to you family in case the worst happens.

With voluntary life insurance, you pay a monthly premium and then your beneficiaries receive a guaranteed amount in the event of your death. Plans are typically flexible and allow you to set your contribution and payment amounts, allowing you more control.

While this type of insurance isn't fun to think about, it can be a vital lifeline for your family.



Mutual of Omaha Short-Term Disability Insurance

Summary of Coverage

Plan Features	Short Term Disability
Employee benefit amount	60% of weekly gross income
Maximum benefit amount	\$1,200 weekly
Elimination period (Accident)/(Sickness)	choose 7/7 days or 14/14 days
Benefit duration	up to 25 weeks

Disability insurance is coverage that provides you with income protection should you be unable to work due to an injury or illness. With disability coverage, you are compensated for a portion of your lost income.

Short-term disability (STD) coverage begins within one to 15 days of the event causing your disability. The coverage allows you to continue to receive pay at a fixed weekly amount or a set percentage of your income.

STD typically lasts for about 10 to 26 weeks, although this varies by policy. When STD coverage ends, long-term disability (LTD) coverage typically takes effect.



Mutual of Omaha Long-Term Disability Insurance

Summary of Coverage

Plan Features	Long Term Disability
Employee benefit amount	equivalent to 60% of monthly gross income
Maximum benefit amount	\$6,000
Elimination period	180 Days
Benefit duration	disabilities prior to age 62 pay benefits to age 65, or your Social Security Normal Retirement Age or 3.5 years, whichever is longest
Benefit duration	at age 62 (and older), the benefit period will be based on a reduced duration schedule

Disability insurance is coverage that provides you with income protection should you be unable to work due to an injury or illness. With disability coverage, you are compensated for a portion of your lost income.

Long-term disability (LTD) coverage is a type of disability insurance that pays you a set percentage of your regular income after a specified waiting period. For example, if you're covered under short-term disability (STD) insurance as well, the LTD insurance would kick in once the STD policy is exhausted, typically after three to six months.

The length of LTD plans varies—some may be limited to a period between two and 10 years, while other plans continue paying out until age 65.

Legal Shield Legal Plan



Summary of Coverage

LegalShield Legal Plan

Expected and unexpected legal issues arise every day. But with a LegalShield Legal Plan, a small monthly fee gets you access to advice and counsel on an unlimited number of personal legal issues from lawyers with an average of 19 years experience.

Advice & Consultation Advice
Toll-free phone consultations with your Provider Law Firm for any personal legal matter, even on pre-existing conditions

Letters and Phone Calls on Your Behalf
Available at the discretion of your Provider Lawyer

Contract and Document Review
Contract/document review up to 15 pages each

24/7 Emergency Assistance
After-hours legal consultation for covered legal emergencies. Specific coverage depends on plan, such as: if you're arrested or detained, if you're seriously injured, if you're served with a warrant, or if the state tries to take your child(ren).

Family Matters (family plan only) Uncontested Name Change Assistance*
One (1) uncontested name change prepared per member year by Provider Law Firm

Uncontested Adoption Representation*
Representation by your Provider Law Firm for uncontested adoption proceedings

Uncontested Separation/Divorce Representation*
Representation by your Provider Law Firm for uncontested legal separation, uncontested civil annulment and uncontested divorce proceedings

Representation Trial Defense Services
Assistance if you or your spouse are named defendant or respondent in a covered civil action filed in court

Year	Pre-Trial Time	Trial Time	Total
1	2.5	57.5	60
2	3	117	120
3	3.5	176.5	180
4	4	236	240
5	4.5	295.5	300

Your Plan Covers:

Family Plan:

- The member
- The member's spouse/
domestic partner
- Never-married dependent children under age 26 living at home
- Dependent children under age 18 for whom the member is legal guardian
- Never married, dependent, children who are full-time college students up to age 26
- Physically or mentally disabled children living at home

Individual Plan:
An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

*These services are available 90 consecutive days from the effective date of your membership. For detailed information about the legal services provided for personal matters by the LegalShield contract, go to <http://www.legalshield.com/info/legalplan>. Business issues are not included; however, plans providing those services are available.

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City of Neosho

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