2025 BENEFITS GUIDE

City of Niceville

Acentria Insurance

Health	United Healthcare	United Healthcare	United Healthcare	United Healthcare
Cost share	Contributory	Contributory	Contributory	Contributory
	DZ06/BWNP/EKM2	DZEF/BWNU/EKMY	DU63/BWOY/EKRF	DU64/BWNW/EKR5
Plan	Health 1	Health 2	Health 3	Health 4
Primary Care office visit	$25.00	$35.00	$35.00	$40.00
Specialist Care Office visit	$60.00	$65.00	$50.00	$100.00
Cal. Year Ded. (in/out of Network)	S $750/$1000 F $2250/$3000	S $2000/$6000 F $6000/$18000	S $5000 per Person F $10000 per Family OON - Combined w/ INN	S $3000/$6000 F $9000/$18000
Co- insurance (in/out)	80/50	70/50	70/50	80/50
Max Out of Pocket (in/out of Network)	S $3500/$5000 F $7000/$10000	S $6350/$13000 F $12700/$26000	S $6350/$10000 F $12700/$20000	S $6350/$15000 F $12700/$30000
Pharmacy Option	15/30/50	10/35/70	10/50/80	10/30/50
ER Co-pay	$200.00	$300.00	Deductible + Co-Insurance	$400.00
Phy Services at Hos and ER	Deductible + Co-Insurance	Deductible + Co-Insurance	Deductible + Co-Insurance	Deductible + Co-Insurance
Hospital Co-pay	$900 copayment	$100 Per Admission Deductible + Deductible + CoInsurance	Deductible + Co-Insurance	$500 Per Admission Deductible + Deductible + CoInsurance
Employee Cost per pay period:	Health 1	Health 2	Health 3	Health 4
Employee	54.35Weekly	27.12Weekly	$0.00	19.73 Weekly
Family	350.62 Weekly	263.47 Weekly	176.71 Weekly	239.72 Weekly

Humana Dental Traditional Preferred

FL TRP U&C+ 100/80/50

City of Niceville

FLORIDA

Services	In-network dentist Network: PPO/Traditional Preferred		Out-of-network dentist U&C 90	
Deductible (excludes orthodontia services)	Individual: $50	Family: $150	Individual: $50	Family: $150
	Deductible applies to all services excluding preventive services.			
Annual maximum (excludes orthodontia services)	$1,000 + extended annual maximum (see section below)			
Preventive services	100% no deductible		100% no deductible	
INCLUDES: **3** Routine Exams and Cleanings, Up to **4** X-rays and **4** Periodontal Cleanings Per Year				
Basic services	80% after deductible		80% after deductible	
INCLUDES: Fillings, Extractions, Stainless Steel Crowns, Endodontics & Periodontics				
Major services	50% after deductible		50% after deductible	
INCLUDES: Crowns, Inlays/Onlays, Bridges, Dentures, Implants				

Waiting periods

Employer-sponsored funding: 5+ enrolled employees

Enrollment type[2]	Preventive	Basic	Major	Orthodontia
Initial enrollment, open enrollment and timely add-on	No	No	No	Not available

[2] Late applicant enrollment will have the following waiting periods: 12 months basic & major services.

Questions?

Visit **Humana.com** or call **866-427-7478**
Monday – Saturday, 8 a.m. – 11 p.m., and
Sunday, 11 a.m. – 8 p.m., Eastern time.
Find a dentist at **Humana.com/findadentist.**

Register today!

Register or sign in to MyHumana at **Humana.com** to view your coverage details, ID cards, manage claims, find a dentist and more!

This is a snapshot designed for quick reference. Please refer to the full benefit summary provided by the carrier for more detailed plan information including limitations and exclusions.

Humana Vision 130x

City of Niceville

FLORIDA

Services	In-network provider (Member cost)	Out-of-network provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
Retinal imaging*[1]	Up to $39	Not covered
Contact lens exam[2]		
Standard contact lens fit and follow-up*	Up to $40	Not covered
Premium contact lens fit and follow-up*	10% off retail	Not covered
Frames[3]	$130 allowance, 20% off balance over $130	$65 allowance
Standard plastic lenses		
Single vision	$25	Up to $25
Bifocal	$25	Up to $40
Trifocal	$25	Up to $60
Lenticular	$25	Up to $100
Lens options[4]		

Lens option costs may vary by provider. Members may contact their participating provider to determine if costs listed in the full benefit summary are available.

Contact lenses[5] (applies to materials only)		
Conventional	$130 allowance, 15% off balance over $130	$104 allowance
Disposable	$130 allowance	$104 allowance
Medically necessary	$0	$200 allowance
Frequency		
Examination	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Diabetic eye care: Care and testing for diabetic members		

Questions?

Visit **Humana.com** or call **877-398-2980**
Monday – Saturday, 8 a.m. – 11 p.m., and
Sunday, 11 a.m. – 8 p.m., Eastern time.
Find a vision provider at **Humana.com/find-care**.

Register today!

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Humana

City of Niceville

DENTAL AND VISION RATES PER PAY PERIOD

(All pricing is per week)

Dental Cost October 1, 2025

Employee	$ 5.92
Employee/Spouse	$ 13.00
Employee Child(ren)	$ 14.77
Full Family	$ 23.26

Vision Cost October 1, 2025

Employee	$ 1.30
Employee/Spouse	$ 2.59
Employee Child(ren)	$ 2.93
Full Family	$ 4.33

Employee can apply for up to $300,000 not to exceed 5x earnings, in increments of $10,000

City of Niceville

Premium Calculation Sheet

Rates Effective October 1, 2025

Eligibility: All Active Full Time Employees working a minimum of 30 hours per week.

Guaranteed Issue Limit: $80,000

Employee Supplemental Life - Current Weekly Cost by Age Band

Current Monthly Rates per $1,000:

	0.090	0.090	0.100	0.140	0.190	0.280	0.490	0.790	0.990	1.790	3.890	14.590
Coverage	**Age<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$10,000	0.21	0.21	0.23	0.32	0.44	0.65	1.13	1.82	2.28	4.13	8.98	33.67
$20,000	0.42	0.42	0.46	0.65	0.88	1.29	2.26	3.65	4.57	8.26	17.95	67.34
$30,000	0.62	0.62	0.69	0.97	1.32	1.94	3.39	5.47	6.85	12.39	26.93	101.01
$40,000	0.83	0.83	0.92	1.29	1.75	2.58	4.52	7.29	9.14	16.52	35.91	134.68
$50,000	1.04	1.04	1.15	1.62	2.19	3.23	5.65	9.12	11.42	20.65	44.88	168.35
$60,000	1.25	1.25	1.38	1.94	2.63	3.88	6.78	10.94	13.71	24.78	53.86	202.02
$70,000	1.45	1.45	1.62	2.26	3.07	4.52	7.92	12.76	15.99	28.92	62.84	235.68
$80,000	1.66	1.66	1.85	2.58	3.51	5.17	9.05	14.58	18.28	33.05	71.82	269.35
$90,000	1.87	1.87	2.08	2.91	3.95	5.82	10.18	16.41	20.56	37.18	80.79	303.02
$100,000	2.08	2.08	2.31	3.23	4.38	6.46	11.31	18.23	22.85	41.31	89.77	336.69
$110,000	2.28	2.28	2.54	3.55	4.82	7.11	12.44	20.05	25.13	45.44	98.75	370.36
$120,000	2.49	2.49	2.77	3.88	5.26	7.75	13.57	21.88	27.42	49.57	107.72	404.03
$130,000	2.70	2.70	3.00	4.20	5.70	8.40	14.70	23.70	29.70	53.70	116.70	437.70
$140,000	2.91	2.91	3.23	4.52	6.14	9.05	15.83	25.52	31.98	57.83	125.68	471.37
$150,000	3.12	3.12	3.46	4.85	6.58	9.69	16.96	27.35	34.27	61.96	134.65	505.04
$160,000	3.32	3.32	3.69	5.17	7.02	10.34	18.09	29.17	36.55	66.09	143.63	538.71
$170,000	3.53	3.53	3.92	5.49	7.45	10.98	19.22	30.99	38.84	70.22	152.61	572.38
$180,000	3.74	3.74	4.15	5.82	7.89	11.63	20.35	32.82	41.12	74.35	161.58	606.05
$190,000	3.95	3.95	4.38	6.14	8.33	12.28	21.48	34.64	43.41	78.48	170.56	639.71
$200,000	4.15	4.15	4.62	6.46	8.77	12.92	22.62	36.46	45.69	82.62	179.54	673.38
$210,000	4.36	4.36	4.85	6.78	9.21	13.57	23.75	38.28	47.98	86.75	188.52	707.05
$220,000	4.57	4.57	5.08	7.11	9.65	14.22	24.88	40.11	50.26	90.88	197.49	740.72
$230,000	4.78	4.78	5.31	7.43	10.08	14.86	26.01	41.93	52.55	95.01	206.47	774.39
$240,000	4.98	4.98	5.54	7.75	10.52	15.51	27.14	43.75	54.83	99.14	215.45	808.06
$250,000	5.19	5.19	5.77	8.08	10.96	16.15	28.27	45.58	57.12	103.27	224.42	841.73
$260,000	5.40	5.40	6.00	8.40	11.40	16.80	29.40	47.40	59.40	107.40	233.40	875.40
$270,000	5.61	5.61	6.23	8.72	11.84	17.45	30.53	49.22	61.68	111.53	242.38	909.07
$280,000	5.82	5.82	6.46	9.05	12.28	18.09	31.66	51.05	63.97	115.66	251.35	942.74
$290,000	6.02	6.02	6.69	9.37	12.72	18.74	32.79	52.87	66.25	119.79	260.33	976.41
$300,000	6.23	6.23	6.92	9.69	13.15	19.38	33.92	54.69	68.54	123.92	269.31	1,010.08

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____	X	_____	=	_____	÷ 1,000 =	_____	X 12 ÷ 52 =	_____
Benefit Amount		Rate (See top row above)		Subtotal		Monthly Cost		Weekly Cost

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.
Any applicable age-related benefit reductions are not included.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

Spouse can apply for up to $150,000 not to exceed 50% of employee amount

City of Niceville
Premium Calculation Sheet
Rates Effective October 1, 2025

UnitedHealthcare

Guaranteed Issue Limit: $25,000

Spouse Supplemental Life - Current Weekly Cost by Age Band

Current Monthly Rates per $1,000:

	0.090	0.090	0.100	0.140	0.190	0.280	0.490	0.790	0.990	1.790	3.890	14.590
Coverage	**Age<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$5,000	0.10	0.10	0.12	0.16	0.22	0.32	0.57	0.91	1.14	2.07	4.49	16.83
$10,000	0.21	0.21	0.23	0.32	0.44	0.65	1.13	1.82	2.28	4.13	8.98	33.67
$15,000	0.31	0.31	0.35	0.48	0.66	0.97	1.70	2.73	3.43	6.20	13.47	50.50
$20,000	0.42	0.42	0.46	0.65	0.88	1.29	2.26	3.65	4.57	8.26	17.95	67.34
$25,000	0.52	0.52	0.58	0.81	1.10	1.62	2.83	4.56	5.71	10.33	22.44	84.17
$30,000	0.62	0.62	0.69	0.97	1.32	1.94	3.39	5.47	6.85	12.39	26.93	101.01
$35,000	0.73	0.73	0.81	1.13	1.53	2.26	3.96	6.38	8.00	14.46	31.42	117.84
$40,000	0.83	0.83	0.92	1.29	1.75	2.58	4.52	7.29	9.14	16.52	35.91	134.68
$45,000	0.93	0.93	1.04	1.45	1.97	2.91	5.09	8.20	10.28	18.59	40.40	151.51
$50,000	1.04	1.04	1.15	1.62	2.19	3.23	5.65	9.12	11.42	20.65	44.88	168.35
$55,000	1.14	1.14	1.27	1.78	2.41	3.55	6.22	10.03	12.57	22.72	49.37	185.18
$60,000	1.25	1.25	1.38	1.94	2.63	3.88	6.78	10.94	13.71	24.78	53.86	202.02
$65,000	1.35	1.35	1.50	2.10	2.85	4.20	7.35	11.85	14.85	26.85	58.35	218.85
$70,000	1.45	1.45	1.62	2.26	3.07	4.52	7.92	12.76	15.99	28.92	62.84	235.68
$75,000	1.56	1.56	1.73	2.42	3.29	4.85	8.48	13.67	17.13	30.98	67.33	252.52
$80,000	1.66	1.66	1.85	2.58	3.51	5.17	9.05	14.58	18.28	33.05	71.82	269.35
$85,000	1.77	1.77	1.96	2.75	3.73	5.49	9.61	15.50	19.42	35.11	76.30	286.19
$90,000	1.87	1.87	2.08	2.91	3.95	5.82	10.18	16.41	20.56	37.18	80.79	303.02
$95,000	1.97	1.97	2.19	3.07	4.17	6.14	10.74	17.32	21.70	39.24	85.28	319.86
$100,000	2.08	2.08	2.31	3.23	4.38	6.46	11.31	18.23	22.85	41.31	89.77	336.69
$105,000	2.18	2.18	2.42	3.39	4.60	6.78	11.87	19.14	23.99	43.37	94.26	353.53
$110,000	2.28	2.28	2.54	3.55	4.82	7.11	12.44	20.05	25.13	45.44	98.75	370.36
$115,000	2.39	2.39	2.65	3.72	5.04	7.43	13.00	20.97	26.27	47.50	103.23	387.20
$120,000	2.49	2.49	2.77	3.88	5.26	7.75	13.57	21.88	27.42	49.57	107.72	404.03
$125,000	2.60	2.60	2.88	4.04	5.48	8.08	14.13	22.79	28.56	51.63	112.21	420.86
$130,000	2.70	2.70	3.00	4.20	5.70	8.40	14.70	23.70	29.70	53.70	116.70	437.70
$135,000	2.80	2.80	3.12	4.36	5.92	8.72	15.27	24.61	30.84	55.77	121.19	454.53
$140,000	2.91	2.91	3.23	4.52	6.14	9.05	15.83	25.52	31.98	57.83	125.68	471.37
$145,000	3.01	3.01	3.35	4.68	6.36	9.37	16.40	26.43	33.13	59.90	130.17	488.20
$150,000	3.12	3.12	3.46	4.85	6.58	9.69	16.96	27.35	34.27	61.96	134.65	505.04

***Spouse rate is based on Employee's age.**

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____ (Benefit Amount) X _____ (Rate) = _____ (Subtotal) ÷ 1,000 = _____ (Monthly Cost) X 12 ÷ 52 = _____ (Weekly Cost)

(See top row above)

Dependent Child(ren) Supplemental Life - Current Weekly Cost:

Monthly Rate per $1,000	$10,000
$0.070	0.162

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Employee can apply for up to $300,000 not to exceed 5x earnings, in increments of $10,000

City of Niceville
Premium Calculation Sheet
Police and Fire
Rates Effective October 1, 2025

UnitedHealthcare

Guaranteed Issue Limit: $80,000

Eligibility: All Active Full Time Police/Fire Employees working a minimum of 30 hours per week.

Employee Supplemental Life - Current Weekly Cost by Age Band

Current Monthly Rates per $1,000:

	0.090	0.090	0.100	0.140	0.190	0.280	0.490	0.790	0.990	1.790	3.890	14.590
Coverage	**Age<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$10,000	0.21	0.21	0.23	0.32	0.44	0.65	1.13	1.82	2.28	4.13	8.98	33.67
$20,000	0.42	0.42	0.46	0.65	0.88	1.29	2.26	3.65	4.57	8.26	17.95	67.34
$30,000	0.62	0.62	0.69	0.97	1.32	1.94	3.39	5.47	6.85	12.39	26.93	101.01
$40,000	0.83	0.83	0.92	1.29	1.75	2.58	4.52	7.29	9.14	16.52	35.91	134.68
$50,000	1.04	1.04	1.15	1.62	2.19	3.23	5.65	9.12	11.42	20.65	44.88	168.35
$60,000	1.25	1.25	1.38	1.94	2.63	3.88	6.78	10.94	13.71	24.78	53.86	202.02
$70,000	1.45	1.45	1.62	2.26	3.07	4.52	7.92	12.76	15.99	28.92	62.84	235.68
$80,000	1.66	1.66	1.85	2.58	3.51	5.17	9.05	14.58	18.28	33.05	71.82	269.35
$90,000	1.87	1.87	2.08	2.91	3.95	5.82	10.18	16.41	20.56	37.18	80.79	303.02
$100,000	2.08	2.08	2.31	3.23	4.38	6.46	11.31	18.23	22.85	41.31	89.77	336.69
$110,000	2.28	2.28	2.54	3.55	4.82	7.11	12.44	20.05	25.13	45.44	98.75	370.36
$120,000	2.49	2.49	2.77	3.88	5.26	7.75	13.57	21.88	27.42	49.57	107.72	404.03
$130,000	2.70	2.70	3.00	4.20	5.70	8.40	14.70	23.70	29.70	53.70	116.70	437.70
$140,000	2.91	2.91	3.23	4.52	6.14	9.05	15.83	25.52	31.98	57.83	125.68	471.37
$150,000	3.12	3.12	3.46	4.85	6.58	9.69	16.96	27.35	34.27	61.96	134.65	505.04
$160,000	3.32	3.32	3.69	5.17	7.02	10.34	18.09	29.17	36.55	66.09	143.63	538.71
$170,000	3.53	3.53	3.92	5.49	7.45	10.98	19.22	30.99	38.84	70.22	152.61	572.38
$180,000	3.74	3.74	4.15	5.82	7.89	11.63	20.35	32.82	41.12	74.35	161.58	606.05
$190,000	3.95	3.95	4.38	6.14	8.33	12.28	21.48	34.64	43.41	78.48	170.56	639.71
$200,000	4.15	4.15	4.62	6.46	8.77	12.92	22.62	36.46	45.69	82.62	179.54	673.38
$210,000	4.36	4.36	4.85	6.78	9.21	13.57	23.75	38.28	47.98	86.75	188.52	707.05
$220,000	4.57	4.57	5.08	7.11	9.65	14.22	24.88	40.11	50.26	90.88	197.49	740.72
$230,000	4.78	4.78	5.31	7.43	10.08	14.86	26.01	41.93	52.55	95.01	206.47	774.39
$240,000	4.98	4.98	5.54	7.75	10.52	15.51	27.14	43.75	54.83	99.14	215.45	808.06
$250,000	5.19	5.19	5.77	8.08	10.96	16.15	28.27	45.58	57.12	103.27	224.42	841.73
$260,000	5.40	5.40	6.00	8.40	11.40	16.80	29.40	47.40	59.40	107.40	233.40	875.40
$270,000	5.61	5.61	6.23	8.72	11.84	17.45	30.53	49.22	61.68	111.53	242.38	909.07
$280,000	5.82	5.82	6.46	9.05	12.28	18.09	31.66	51.05	63.97	115.66	251.35	942.74
$290,000	6.02	6.02	6.69	9.37	12.72	18.74	32.79	52.87	66.25	119.79	260.33	976.41
$300,000	6.23	6.23	6.92	9.69	13.15	19.38	33.92	54.69	68.54	123.92	269.31	1,010.08

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____	X	_____	=	_____	÷ 1,000 =	_____	X 12 ÷ 52 =	_____
Benefit Amount		Rate (See top row above)		Subtotal		Monthly Cost		Weekly Cost

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Apply for up to $300,000 not to exceed 5x earnings, in increments of $10,000

City of Niceville
Premium Calculation Sheet
Rates Effective October 1, 2025

UnitedHealthcare

Guaranteed Issue Limit: $25,000

Spouse Supplemental Life - Current Weekly Cost by Age Band

Current Monthly Rates per $1,000:	0.090	0.090	0.100	0.140	0.190	0.280	0.490	0.790	0.990	1.790	3.890	14.590
Coverage	**Age<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$5,000	0.10	0.10	0.12	0.16	0.22	0.32	0.57	0.91	1.14	2.07	4.49	16.83
$10,000	0.21	0.21	0.23	0.32	0.44	0.65	1.13	1.82	2.28	4.13	8.98	33.67
$15,000	0.31	0.31	0.35	0.48	0.66	0.97	1.70	2.73	3.43	6.20	13.47	50.50
$20,000	0.42	0.42	0.46	0.65	0.88	1.29	2.26	3.65	4.57	8.26	17.95	67.34
$25,000	0.52	0.52	0.58	0.81	1.10	1.62	2.83	4.56	5.71	10.33	22.44	84.17
$30,000	0.62	0.62	0.69	0.97	1.32	1.94	3.39	5.47	6.85	12.39	26.93	101.01
$35,000	0.73	0.73	0.81	1.13	1.53	2.26	3.96	6.38	8.00	14.46	31.42	117.84
$40,000	0.83	0.83	0.92	1.29	1.75	2.58	4.52	7.29	9.14	16.52	35.91	134.68
$45,000	0.93	0.93	1.04	1.45	1.97	2.91	5.09	8.20	10.28	18.59	40.40	151.51
$50,000	1.04	1.04	1.15	1.62	2.19	3.23	5.65	9.12	11.42	20.65	44.88	168.35
$55,000	1.14	1.14	1.27	1.78	2.41	3.55	6.22	10.03	12.57	22.72	49.37	185.18
$60,000	1.25	1.25	1.38	1.94	2.63	3.88	6.78	10.94	13.71	24.78	53.86	202.02
$65,000	1.35	1.35	1.50	2.10	2.85	4.20	7.35	11.85	14.85	26.85	58.35	218.85
$70,000	1.45	1.45	1.62	2.26	3.07	4.52	7.92	12.76	15.99	28.92	62.84	235.68
$75,000	1.56	1.56	1.73	2.42	3.29	4.85	8.48	13.67	17.13	30.98	67.33	252.52
$80,000	1.66	1.66	1.85	2.58	3.51	5.17	9.05	14.58	18.28	33.05	71.82	269.35
$85,000	1.77	1.77	1.96	2.75	3.73	5.49	9.61	15.50	19.42	35.11	76.30	286.19
$90,000	1.87	1.87	2.08	2.91	3.95	5.82	10.18	16.41	20.56	37.18	80.79	303.02
$95,000	1.97	1.97	2.19	3.07	4.17	6.14	10.74	17.32	21.70	39.24	85.28	319.86
$100,000	2.08	2.08	2.31	3.23	4.38	6.46	11.31	18.23	22.85	41.31	89.77	336.69
$105,000	2.18	2.18	2.42	3.39	4.60	6.78	11.87	19.14	23.99	43.37	94.26	353.53
$110,000	2.28	2.28	2.54	3.55	4.82	7.11	12.44	20.05	25.13	45.44	98.75	370.36
$115,000	2.39	2.39	2.65	3.72	5.04	7.43	13.00	20.97	26.27	47.50	103.23	387.20
$120,000	2.49	2.49	2.77	3.88	5.26	7.75	13.57	21.88	27.42	49.57	107.72	404.03
$125,000	2.60	2.60	2.88	4.04	5.48	8.08	14.13	22.79	28.56	51.63	112.21	420.86
$130,000	2.70	2.70	3.00	4.20	5.70	8.40	14.70	23.70	29.70	53.70	116.70	437.70
$135,000	2.80	2.80	3.12	4.36	5.92	8.72	15.27	24.61	30.84	55.77	121.19	454.53
$140,000	2.91	2.91	3.23	4.52	6.14	9.05	15.83	25.52	31.98	57.83	125.68	471.37
$145,000	3.01	3.01	3.35	4.68	6.36	9.37	16.40	26.43	33.13	59.90	130.17	488.20
$150,000	3.12	3.12	3.46	4.85	6.58	9.69	16.96	27.35	34.27	61.96	134.65	505.04

***Spouse rate is based on Employee's age.**

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____ (Benefit Amount) X _____ (Rate, See top row above) = _____ (Subtotal) ÷ 1,000 = _____ (Monthly Cost) X 12 ÷ 52 = _____ (Weekly Cost)

Dependent Child(ren) Supplemental Life - Current Weekly Cost:

Monthly Rate per $1,000	$10,000
$0.070	0.162

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.
Any applicable age-related benefit reductions are not included.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

City of Niceville
Summary of Benefits
Short Term Disability Insurance

UnitedHealthcare

Effective Date	October 1, 2025
Eligibility	All Active Full Time Employees working a minimum of 30 Hours per week.
Voluntary STD Benefit	60.0% of your weekly Earnings to a maximum of $1,000 per week. Minimum Benefit: $25 Earnings are defined in the UnitedHealthcare contract with your employer.
Elimination Period	Short Term Disability Insurance benefit begins on the 8th day after your accident or 8th day of sickness.
Benefit Duration	Up to 13 weeks
Lump Sum Survivor Benefit	Lesser of $3,000 or 3 weeks Gross
Offsets	As described later in this summary, your weekly Short Term Disability benefit may be reduced by other income you receive.
Other limitations to enrollment	If you enroll during this enrollment period, your coverage is provided to you on a guaranteed basis - no medical information is required. If you enroll after this enrollment period, (or any time after you first become eligible), evidence of insurability will be required for all coverage amounts. Subject to any preexisting condition limitations. You must be Actively at Work with your employer on the day your coverage takes effect. This coverage, like most group benefit Insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.

Eligibility: All Active Full Time Employees working a minimum of 30 Hours per week.

Employee Voluntary Short Term Disability - Current Weekly Cost by Age Band

Current Monthly Rates per $10:		0.522	0.518	0.480	0.404	0.463	0.414	0.501	0.586	0.694	0.777
Annual Earnings	*Weekly Benefit*	*Age* **<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65+**
$20,000	**$230.77**	2.78	2.76	2.56	2.15	2.47	2.20	2.67	3.12	3.70	4.14
$25,000	**$288.46**	3.47	3.45	3.20	2.69	3.08	2.76	3.34	3.90	4.62	5.17
$30,000	**$346.15**	4.17	4.14	3.83	3.23	3.70	3.31	4.00	4.68	5.54	6.21
$35,000	**$403.85**	4.86	4.83	4.47	3.77	4.31	3.86	4.67	5.46	6.47	7.24
$40,000	**$461.54**	5.56	5.52	5.11	4.30	4.93	4.41	5.34	6.24	7.39	8.28
$45,000	**$519.23**	6.25	6.21	5.75	4.84	5.55	4.96	6.00	7.02	8.32	9.31
$50,000	**$576.92**	6.95	6.90	6.39	5.38	6.16	5.51	6.67	7.80	9.24	10.34
$55,000	**$634.62**	7.64	7.59	7.03	5.92	6.78	6.06	7.34	8.58	10.16	11.38
$60,000	**$692.31**	8.34	8.28	7.67	6.45	7.40	6.61	8.00	9.36	11.09	12.41
$65,000	**$750.00**	9.03	8.97	8.31	6.99	8.01	7.17	8.67	10.14	12.01	13.45
$70,000	**$807.69**	9.73	9.65	8.95	7.53	8.63	7.72	9.34	10.92	12.94	14.48
$75,000	**$865.38**	10.42	10.34	9.59	8.07	9.25	8.27	10.01	11.70	13.86	15.52
$80,000	**$923.08**	11.12	11.03	10.22	8.61	9.86	8.82	10.67	12.48	14.78	16.55
$85,000	**$980.77**	11.81	11.72	10.86	9.14	10.48	9.37	11.34	13.26	15.71	17.59

If your annual earnings are not shown above, use the formula below to calculate the cost of coverage:

$_____ ÷ 52 = $_____ x 60.0% = $_____

Annual Earnings | Weekly Earnings | Benefit % | Weekly Benefit ($1,000 Benefit Maximum)

Covered Weekly Benefit used below is the lesser of the calculated Weekly Benefit or the Benefit Maximum

$_____ x _____ ÷ 10 = $_____ x 12 ÷ 52 = $_____

Covered Weekly Benefit | Rate | Monthly Cost | Weekly Cost

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.

City of Niceville
Summary of Benefits
Long Term Disability Insurance

UnitedHealthcare

Effective Date	October 1, 2025
Eligibility	All Active Full Time Employees working a minimum of 30 Hours per week.
Voluntary LTD Benefit	60% of your Monthly Earnings to a maximum of $6,000 per month. Minimum Benefit: Greater of $100 or 10% of gross monthly benefit Guaranteed Issue Benefit: $6,000 Earnings are defined in the UnitedHealthcare contract with your employer.
Elimination Period	90 days of Disability
Definition of Disability	Residual
Own Occupation Period	24 months (2 year) own occupation
Earnings Test	80% Own Occupation / 60% Any Occupation
Requires Loss of Earnings/Duties	Loss of Earnings and Duties
	Disability is defined in the UnitedHealthcare contract with your employer.
Maximum Benefit Duration	5 Year w/Reducing Benefit

Age at Disability	*Maximum Benefit Period*
Age 60 or Less	60 Months
Age 61	48 Months
Age 62	42 Months
Age 63	36 Months
Age 64	30 Months
Age 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
Age 69 and over	12 Months

Survivor Income Benefit	3 months Gross
Work Incentive Benefit	12 months
Mental and Nervous Limitation	24 months lifetime
Substance Abuse Limitation	24 months lifetime
Subjective Symptoms Limitation	No Limit
Pre-existing Conditions Exclusion	3 month look back; 12 month after effective date
Offsets	In addition, as described below within the Important Details, your monthly Long-Term Disability benefit may be reduced by other income you receive.

Eligibility: All Active Full Time Employees working a minimum of 30 Hours per week.

Employee Voluntary Long Term Disability - Current Weekly Cost by Age Band

Current Monthly Rates per $100:		0.081	0.087	0.120	0.215	0.296	0.520	0.746	1.035	1.334	1.334
Annual Earnings	*Monthly Benefit*	*Age <25*	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$20,000	$1,000.00	0.31	0.33	0.46	0.83	1.14	2.00	2.87	3.98	5.13	5.13
$25,000	$1,250.00	0.39	0.42	0.58	1.03	1.42	2.50	3.59	4.98	6.41	6.41
$30,000	$1,500.00	0.47	0.50	0.69	1.24	1.71	3.00	4.30	5.97	7.70	7.70
$35,000	$1,750.00	0.55	0.59	0.81	1.45	1.99	3.50	5.02	6.97	8.98	8.98
$40,000	$2,000.00	0.62	0.67	0.92	1.65	2.28	4.00	5.74	7.96	10.26	10.26
$45,000	$2,250.00	0.70	0.75	1.04	1.86	2.56	4.50	6.46	8.96	11.54	11.54
$50,000	$2,500.00	0.78	0.84	1.15	2.07	2.85	5.00	7.17	9.95	12.83	12.83
$55,000	$2,750.00	0.86	0.92	1.27	2.27	3.13	5.50	7.89	10.95	14.11	14.11
$60,000	$3,000.00	0.93	1.00	1.38	2.48	3.42	6.00	8.61	11.94	15.39	15.39
$65,000	$3,250.00	1.01	1.09	1.50	2.69	3.70	6.50	9.32	12.94	16.67	16.67
$70,000	$3,500.00	1.09	1.17	1.62	2.89	3.98	7.00	10.04	13.93	17.96	17.96
$75,000	$3,750.00	1.17	1.25	1.73	3.10	4.27	7.50	10.76	14.93	19.24	19.24
$80,000	$4,000.00	1.25	1.34	1.85	3.31	4.55	8.00	11.48	15.92	20.52	20.52
$85,000	$4,250.00	1.32	1.42	1.96	3.51	4.84	8.50	12.19	16.92	21.81	21.81
$90,000	$4,500.00	1.40	1.51	2.08	3.72	5.12	9.00	12.91	17.91	23.09	23.09
$95,000	$4,750.00	1.48	1.59	2.19	3.93	5.41	9.50	13.63	18.91	24.37	24.37
$100,000	$5,000.00	1.56	1.67	2.31	4.13	5.69	10.00	14.35	19.90	25.65	25.65

If your annual earnings are not shown above, use the formula below to calculate the cost of coverage:

$_____ (Annual Earnings) ÷ 12 = $_____ (Monthly Earnings)

$6,000.00 Benefit Maximum ÷ 60% Benefit = **$10,000.00 Maximum Covered Monthly Earnings**

The lesser of the calculated Monthly Earnings or the Maximum Covered Monthly Earnings is used for the Covered Monthly Earnings below.

$_____ (Covered Monthly Earnings) x _____ (Rate) = _____ (Subtotal) ÷100 = $_____ (Monthly Cost) x 12 ÷ 52 = $_____ (Weekly Cost)

(See top row above)

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.

UnitedHealthcare

City of Niceville
Summary of Benefits: Accident Protection Plan
Plan Effective Date: 10/01/2025

Class 1 - All Active Full Time Employees working a minimum of 30 hours per week

Benefits Payable*	Maximum Amount Payable per Insured	
**All Benefits are payable once per covered accident unless otherwise noted*	Option A	Option B
Accidental Death & Dismemberment (Spouse Benefit is 100% of EE; Child benefit 50% of EE)		
Death & Dismemberment		
- Life	$30,000	$50,000
Emergency Room Treatment *(1 per covered accident)*	$150	$200
Physician Office/Telemedicine/Urgent Care *(1 per covered accident)*	$150	$200
Hospital Care		
Hospital Admission *(1 per covered accident)*	$1,200	$1,500
Hospital Confinement *(up to 365 days per accident; starting Day 2 of Confinement)*	$300	$400
Hospital ICU Admission *(1 per covered accident)*	$2,400	$3,000
Hospital ICU Confinement *(up to 30*	$750	$1,000
Major Diagnostic Exam *(1 per accident)*		
- MRI; CT; PET; EEG; ImPACT; or SPECT scan	$250	$325
Minor Diagnostic Exam *(1 per accident)*		
- X-ray; or a laboratory test	$75	$100

Also pays a benefit for other services such as Chiropractic, Bites and Stings, Burns, Dislocations, Emergency Dental, Fractures, Lacerations, Puncture Wounds, and Surgeries. Includes additional benefits including family care, lodging, pet boarding, residence and vehicle modification and includes a Wellness benefit.

Accident Protection Plan Cost Summary

Weekly Rates	Voluntary *	
Quoted Rates - Per Employee Per Pay Period (52)	Option A	Option B
Employee Only	$1.83	$2.40
Employee & Spouse	$2.92	$3.82
Employee & Children	$4.29	$5.66
Employee & Spouse & Children	$6.41	$8.45

This is a snapshot designed for quick reference. Please refer to the full benefit summary provided by the carrier for more information regarding these benefits.

UnitedHealthcare

City of Niceville
Summary of Benefits: Critical Illness Protection
Plan Effective Date: 10/01/2025

Maximum Benefit Amount	Option A	Option B
Employee	$10,000	$30,000
Spouse	$10,000	$30,000
Child(ren)	$5,000	$15,000

Covered Conditions ** Not eligible for the Reoccurence benefit	Percentage of Insured's Maximum Benefit Amount Payable
Cancer Conditions	
Invasive Cancer	100%
Non-invasive Cancer	25%
Skin Cancer	$250
Vascular Conditions	
Coronary Artery Disease Minor (Stent or Angioplasty)	25%
Coronary Artery Disease Major (Bypass Surgery)	50%
Heart Attack	100%
Ruptured Aneurysm	100%
Stroke	100%
Sudden Cardiac Arrest	100%
Organ Failure Conditions	
Bone Marrow Disease	100%
Chronic Renal Failure**	100%
Heart Failure**	100%
Major Organ Failure (Liver, Lung, Pancreas, Small Bowel)	100%

Additional Conditions	
Addison's Disease**	25%
Benign Brain Tumor	100%
Crohn's Disease**	25%
Myasthenia Gravis**	25%
Severe Burns**	100%
Systemic Lupus Erythematosus**	25%
Systemic Sclerosis (Scleroderma)**	25%
Childhood Disease Conditions**	
Cerebral Palsy	100% of Dependent Child Benefit
Childhood Diabetes	100% of Dependent Child Benefit
Cleft Lip / Palate	100% of Dependent Child Benefit
Congenital Heart Disease	100% of Dependent Child Benefit
Cystic Fibrosis	100% of Dependent Child Benefit
Down Syndrome	100% of Dependent Child Benefit
Muscular Dystrophy	100% of Dependent Child Benefit
Sickle Cell Anemia	100% of Dependent Child Benefit
Spina Bifida	100% of Dependent Child Benefit
Neurological Disease Conditions (diagnosis only)**	
Alzheimer's Disease	25%
Amyotrophic Lateral Sclerosis (ALS)	25%
Huntington's Disease	25%
Multiple Sclerosis	25%
Parkinson's Disease	25%

Employee Paid Weekly Premium	Option 1: EE $10,000/ SP $10,000/ CH $5,000 *			
	EE Only	EE + SP	EE + CH	EE + SP + CH
Age Range	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco
Under 25	$0.44	$0.83	$0.78	$1.18
25-29	$0.53	$1.06	$0.88	$1.41
30-34	$0.67	$1.38	$1.02	$1.73
35-39	$0.92	$1.92	$1.27	$2.26
40-44	$1.43	$2.86	$1.78	$3.21
45-49	$2.38	$4.57	$2.72	$4.92
50-54	$3.69	$7.11	$4.04	$7.45
55-59	$5.49	$10.02	$5.84	$10.36
60-64	$7.87	$14.42	$8.22	$14.77
65-69	$11.56	$19.62	$11.91	$19.96
70-74	$16.71	$26.82	$17.05	$27.16
75+	$21.23	$34.62	$21.58	$34.96

Employee Paid Weekly Premium	Option 2: EE $30,000/ SP $30,000/ CH $15,000 *			
	EE Only	EE + SP	EE + CH	EE + SP + CH
Age Range	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco	Uni-Tobacco
Under 25	$1.32	$2.49	$2.35	$3.53
25-29	$1.59	$3.18	$2.63	$4.22
30-34	$2.01	$4.15	$3.05	$5.19
35-39	$2.77	$5.75	$3.81	$6.78
40-44	$4.29	$8.58	$5.33	$9.62
45-49	$7.13	$13.71	$8.17	$14.75
50-54	$11.08	$21.32	$12.12	$22.36
55-59	$16.48	$30.05	$17.52	$31.08
60-64	$23.61	$43.27	$24.65	$44.31
65-69	$34.68	$58.85	$35.72	$59.88
70-74	$50.12	$80.45	$51.16	$81.48
75+	$63.69	$103.85	$64.73	$104.88

***Cost Includes Wellness Benefit**

This is a snapshot designed for quick reference. Please refer to the full benefit summary provided by the carrier for more information regarding these benefits.

UnitedHealthcare

City of Niceville
Summary of Benefits: Hospital Indemnity Protection Plan
Plan Effective Date: 10/01/2025

Your Hospital Indemnity Protection Plan highlights:

Eligibility: All Active Full Time Employees working a minimum of 30 hours per week.

Plan Benefits	Benefit Amount Option A	Benefit Amount Option B
Hospital Admission *Payable for Injury or sickness, on the day of admission.* ***(up to 3 times per plan year)***	$1,000	$1,500
Hospital Confinement *Payable once per day of confinement for an injury or sickness, beginning on day 2.* ***(up to 364 Days per plan year)***	$150	$200
ICU Confinement *Payable once per day of confinement for an injury or sickness, beginning on day 2.* ***(up to 364 Days per plan year)***	$150	$200
ICU Admission *Payable for Injury or sickness, on the day of admission.* ***(up to 3 times per plan year)***	$1,000	$1,500

Hospital Indemnity Cost Summary (Current Weekly rates)

Weekly Rates	Voluntary *	
Quoted Rates - Per Employee Per Pay Period (52)	Option A	Option B
Employee Only	$2.48	$3.47
Employee & Spouse	$5.97	$8.41
Employee & Children	$4.68	$6.63
Employee & Spouse & Children	$8.70	$12.35

*Cost Includes Wellness Benefit

This is a snapshot designed for quick reference. Please refer to the full benefit summary provided by the carrier for more information regarding these benefits.