UNIVERSITY ATHLETIC ASSOCIATION INC.

2026

EMPLOYEE BENEFITS GUIDE

EMPOWERING OUR TEAM WITH WINNING BENEFITS

Inside the Guide

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If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D Notice on page 35 for more details.

FLORIDA™
ATHLETICS

A Championship Experience with Integrity.

UAA STRATEGIC PURPOSE

Provide a championship experience with integrity on and off the field for student-athletes and the Gator Nation.

UAA VISION STATEMENT (Be the Model Collegiate Athletics Program.)

Be the model collegiate athletics program, combining excellence and integrity in academics, athletics, and fan engagement to elevate the UF brand.

UAA CORE VALUES

Passion

- We give everything we have for the people and the place we love.
- We love what we do and why we do it.

Integrity

- We act in a fair, ethical, and honest manner.
- We do things the right way every day.

Excellence

- We strive to perform and achieve at the highest level in all that we do.
- We continuously improve and demand a higher level of performance than what is necessary.

Respect

- We treat each other with fairness, honesty, kindness, and civility.

Innovation

- We find creative solutions and embrace change.

Teamwork

- We promote cooperation by sharing information and working to understand each other's perspective.
- We display loyalty as we work together to create a successful experience for student-athletes, employees, and fans.

Eligibility

University Athletic Association offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs. In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Eligible Employees:

All full-time employees (INTERNS, TEAMS, SRADMIN and COACHES) working a regular schedule of 30 hours or more are eligible to enroll in UAA benefits.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner*, and children up to age 26 (up to age 30 for medical only). If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children, and children obtained through court-appointed legal guardianship.

*For domestic partner coverage, you must first complete a Domestic Partnership affidavit.

When Coverage Begins:

Eligible employees have 30 days from date of hire to enroll. The next opportunity to enroll is within 30 days of a qualified life event (i.e. marriage, birth, etc.) or during our annual open enrollment, with those benefits becoming effective January 1st of the upcoming year.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

You must notify Human Resources within 30 days of a qualifying life event. Depending on the type of event, you may need to provide proof of the event, such as a marriage certificate. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualifying life event).

When Coverage Ends:

If you leave the UAA, your medical, dental, vision, voluntary accident, hospital indemnity, and critical illness benefits end the last day of the month that you terminate. All other benefits end on your last day.

About Your Payroll Deductions

Our plan allows you to make Medical, HSA, FSA, Dental, Vision, Voluntary Accident, Voluntary Hospital Indemnity and Voluntary Critical Illness elections on a pre-tax* basis. Voluntary Life insurance is deducted on an after-tax basis. Deductions are made from your payroll for the current month's premiums.

*Domestic partner benefits are not eligible as a pre-tax benefit. The difference in premium costs for the domestic partner coverage will be added to the employee's taxable income. Contact human resources for more details.

Benefit Resource Center

Need Help? The BRC is Here!!

It doesn't matter if you're a new hire or celebrating your 15th year with the same company, benefits and claims can be tricky to navigate. Our Benefits Specialists can help you: choose the right plan, translate confusing jargon and answer questions about which benefits your employer offers. Plus, they can work directly with insurance carriers to resolve issues related to claims and denials of service—and more!

Benefit Resource Center

BRCSouth@usi.com | Toll Free: 855-874-0835

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

How to Enroll

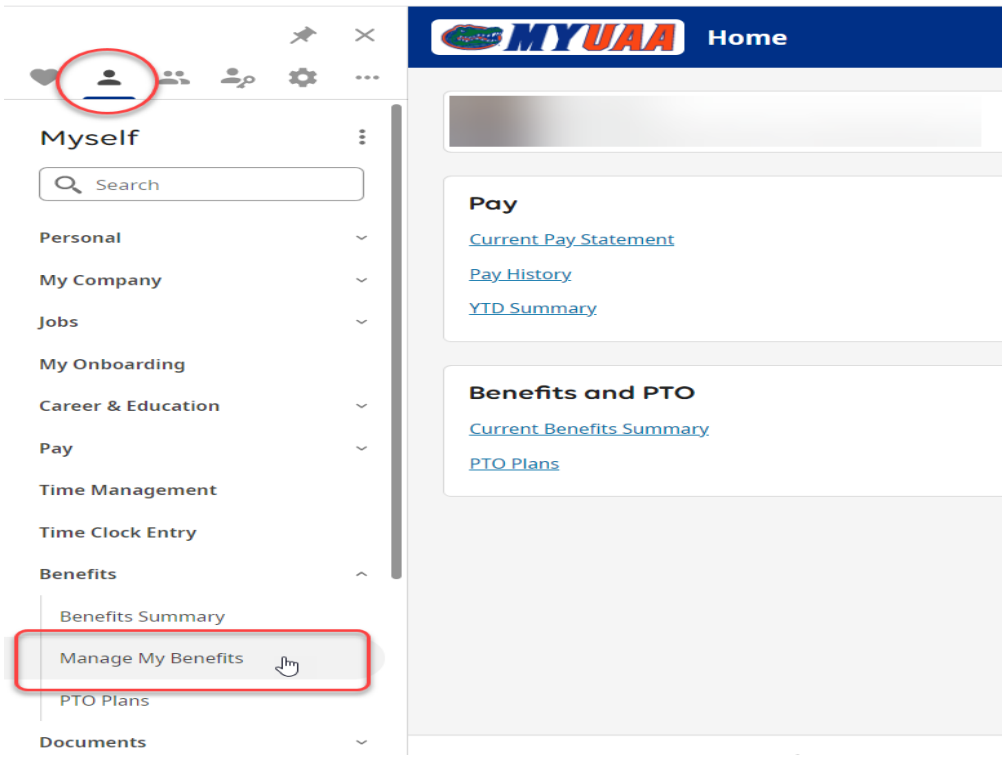
Your benefits enrollment will be completed in the myUAA Employee Portal, the University Athletic Association's employee system. The way you access myUAA will depend on where you are logging in at:

1. If you are at work, you will access myUAA through the Swamp icon on your desktop.
On the Swamp, go to the menu header for **Applications**, then select **myUAA—Employee Portal.**

2. When you are not on the UAA network go to: www.FloridaGators.com/myUAA

Select the 'UAA EMAIL LOGIN' option and enter your UAA username and password (the same ones you use to login to your work computer).

Once you are in myUAA, click on 'Menu,' hover over 'Myself' then select 'Manage My Benefits.'



You will be prompted to review and/or add any applicable dependents (you must enter the date of birth and SSN for dependents)* and then you will utilize the 'Update Cart' options to navigate through the benefit options.
**For newborns, enter in a dummy SSN until you are able to log back in to the system to update their record with the real SSN (ex. 123-45-6789).*

When you have completed your selections, you will need to confirm and submit them. You will not be able to change any selections after submission. If you're not ready to finalize your selections, you can save where you are at, just be sure to go back in within your first 30-days of employment (or before Open Enrollment ends) to submit. If you miss the deadline, your next opportunity to enroll or change your benefits will be during next open enrollment (late fall) with those changes taking effect the first of the following year or if you experience a qualifying life event (i.e. loss of coverage, marriage, birth, etc.).

If you have any questions, please do not hesitate to contact HR for assistance.
352.375.4683 ext 6300 or hr@gators.ufl.edu

Medical

For most people, medical insurance is no longer a “want” – it’s a need. We’ve all seen the cost of medical care skyrocket over the years, so we need insurance to help protect not only our physical fitness – but our financial fitness, as well. University Athletic Association offers two medical plans through Florida Blue.

- A High Deductible Health Plan (HDHP)
- A traditional copay PPO plan

Benefits will vary depending on the plan you and your family choose. The HDHP requires you to pay the negotiated rates out of pocket until the deductible is met and allows you to elect an HSA account. Both plans are open access meaning members can use doctors and facilities in or out of the Blue Options network. If a member uses care out-of-network, their out-of-pocket costs will be higher than with a participating Florida Blue provider.

On the following pages, you can compare the plans. If enrolling in a medical plan, be sure to select the one that best suits you and your dependents needs.

Florida Blue Member Resources

Health Coaches are available 24/7 for general health and prevention questions or for education and support on medical issues.

Care Consultants can help you understand your condition, plus help you explore your treatment options so you are able to make the choices that are best for you.

The **Healthy Addition** program is a prenatal education and early intervention program designed to provide expecting moms information for a healthy pregnancy and delivery.

Blue 365 – As a member of Florida Blue, you automatically have access to the tools and discounted offers available through Blue 365. Take advantage of the **Florida Blue Member Discounts**. Vision care, Hearing care and aids, Fitness Club memberships, exercise footwear, weight loss management, alternative medicine such as acupuncture, massage therapy, stress management. Sign up to receive personalized news.

Visit a **Florida Blue Center** – They provide an interactive environment where you can have face-to-face consultations, take advantage of basic health screenings and wellness events. After you become enrolled check out the website at www.floridablue.com

After you receive your Florida Blue ID card, you can register for immediate access to Your Member Account At www.floridablue.com where you can:

- Find in-network doctors, hospitals, and pharmacies near you
- Find out about Florida Blue’s health and wellness programs
- Review your coverage
- Order your prescription through Florida Blue Home Delivery Pharmacy
- Estimate your health care cost
- View and print your Florida Blue Claims
- View and print your plan certificate and summary of plan benefits
- Manage your health with WebMD
- Take a health assessment and get confidential results about your overall health, plus health improvement suggestions. Choose from a variety of online programs designed to help you achieve your health and wellness goals

Florida Blue

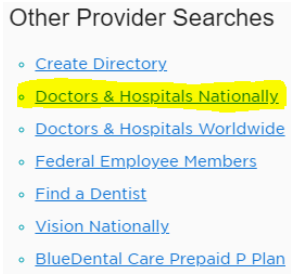
Finding A Provider

Finding a doctor in Florida

- Go to www.bcbsfl.com
- Click on “Find a Doctor” and select the Blue Options Network

Finding a Doctor outside of Florida

- Scroll to the bottom of the page and click on “Doctors and Hospitals Nationally”
- Follow the prompts to search for doctors by area and specialty



Prescription Coverage

Benefits Coverage	High Deductible 05182/05183 In-Network	Copay 05781 In-Network
Retail Pharmacy (30 Day Supply)		
Generic (Tier 1)	$10 copay after deductible	$10 copay
Preferred (Tier 2)	$30 copay after deductible	$50 copay
Non-Preferred (Tier 3)	$50 copay after deductible	$80 copay
Specialty Drugs (Tier 4)	Included in tiers above	$250 copay
Mail Order Pharmacy (90 Day Supply)		
Generic (Tier 1)	$25 copay after deductible	$25 copay
Preferred (Tier 2)	$75 copay after deductible	$125 copay
Non-Preferred (Tier 3)	$125 copay after deductible	$200 copay

Medical/Rx Payroll Contributions

Employee Contributions (Semi-Monthly, 24 per year)				
	High Deductible 05182/05183		Copay 05781	
	Employee Pays	UAA Pays	Employee Pays	UAA Pays
Employee	$31.53	$322.27	$60.20	$360.40
Employee & Spouse	$83.89	$758.17	$203.48	$797.54
Employee & Child(ren)	$82.20	$597.10	$167.52	$640.03
Employee & Family	$109.22	$1,022.95	$293.50	$1,052.41

Medical Comparison

Florida Blue Group #14694				
Benefits Coverage	**High Deductible 05182/05183**		**Copay 05781**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**
Annual Deductible				
Individual	$2,500	$5,000	$1,500	$4,500
Individual + 1/Family	$5,000*	$10,000*	$4,500	$13,500
Coinsurance	10%	40%	30%	50%
Maximum Out-of-Pocket				
Individual	$5,000	$10,000	$5,500	$11,000
Individual + 1/Family	$10,000 Max per person: $6,850	$20,000	$11,000	$22,000
Physician Office Visit				
Primary Care	VCP: Covered 100% after deductible 10% after deductible	40% after deductible	VCP: Covered 100% $30 copay	50% after deductible
Specialty Care	VCP: Covered 100% after deductible 10% after deductible	40% after deductible	VCP: $20 copay $55 copay	50% after deductible
Preventive Care				
Adult & Child Periodic Exams	Covered 100%	40% after deductible	Covered 100%	50% (deductible waived)
Diagnostic Services				
In-Network Lab	Quest		Quest	
X-ray & Lab Tests	VCP: Covered 100% after deductible ICL: Covered 100% after deductible IDTC: 10% after deductible	40% after deductible	VCP: $20 copay ICL: Covered 100% IDTC: $50 copay	50% after deductible
Complex Radiology	10% after deductible	40% after deductible	$250 copay	50% after deductible
Urgent Care Facility	VCP: Covered 100% after deductible 10% after deductible	10% after deductible	VCP: Covered 100% $60 copay	$60 copay after deductible
Emergency Room Facility Charges	10% after deductible		$250 copay	

*High Deductible Family Deductible and Out of Pocket Maximum are Non-Embedded
Non-Embedded: All family member's out-of-pocket expenses count toward the family deductible/out-of-pocket maximum until it is met.
VCP: Value Choice Provider
ICL: Independent Clinical Lab
IDTC: Independent Diagnostic Testing Center
ASC: Ambulatory Surgical Center
PAD: Per Admission Deductible

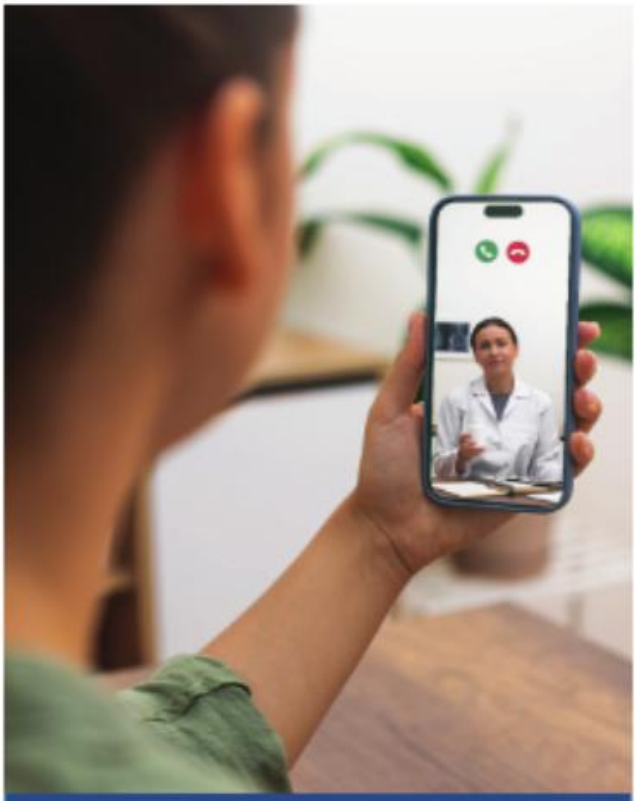
This is not a complete list of benefits. For more information, please refer to the Summary of Benefits for Covered Services

Telehealth

Florida Blue
Your Health Solutions Partner

Virtual care when you're not able to see your doctor.

Convenient care from home or on the go!



When life is moving at full speed, unexpected health issues can suddenly slow us down.

When you or a family member on your plan needs medical attention, and you're not able to see your regular health care provider, BlueVirtualCare is here to help you get the care you need.

A virtual visit typically costs less than a trip to urgent care or the ER. Plus, you can use BlueVirtualCare from wherever you are in the U.S. by simply logging in to your member account, on the web, or the Florida Blue app. We're here to help make things easier so you can focus on what matters most — your health and well-being.

BLUE VirtualCare

BlueVirtualCare is here if you need it.

Log in to your member account, on the web, or Florida Blue app, and go to **Find & Get Care**.

Select **Find a Doctor & More**, click on **Find Virtual Care**, then select **BlueVirtualCare**.

It's that easy!

Telehealth (continued)

Care options available through BlueVirtualCare.

General medicine: When your primary care doctor isn't available, get 24/7 virtual care for you and family members covered on your plan. No appointment necessary!

- **Video visit with board-certified doctors** about common conditions, including allergies, bronchitis, cold, flu, migraine, pink eye, sinus infections, stomach ailments, and urinary tract infections.
- **A doctor assesses your symptoms**, provides a treatment plan, and sends prescriptions, if needed, to the in-network pharmacy of your choice.

Behavioral and mental health: When you aren't able to see your mental health provider, or have not found a licensed professional through Florida Blue's mental health care partner Lucet,[1] BlueVirtualCare offers:

- **Talk therapy:** For those age 10 years and older, you can schedule a video appointment with a licensed therapist, all from the comfort and privacy of home. Weekday, evening, and weekend appointments are available.[2]
- **Psychiatry:** For adults age 18 years and older, talk via video with a psychiatrist to manage your mental health condition with ongoing medication management.

Dermatology: Worried about a change in your skin, hair, or nails? Upload a photo, and a board-certified dermatologist will evaluate it and respond within 72 hours — no appointment, video visit, or referral required.

[1]Florida Blue contracts with New Directions Behavioral Health, L.L.C., (d/b/a Lucet), and its affiliates, to provide behavioral health services. Florida Blue and Florida Blue Medicare are Independent Licensees of the Blue Cross and Blue Shield Association.

[2]Children age 10 – 17 years old need parental or guardian consent.

BlueVirtualCare is a telemedicine service provided by American Well Corporation (Amwell®), an independent company contracted by Florida Blue to provide services for eligible members with non-emergent health concerns. Amwell is only available in the U.S.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

For long-term mental health care and ongoing support, Lucet can help Florida Blue members find and schedule a new patient in-person or virtual visit with an in-network mental health professional. To get started, call Lucet at 1-866-287-9569 or log in to your Florida Blue member account, go to Find & Get Care where you can find and schedule a visit with a behavioral or mental health provider.

BlueVirtualCare does not offer a crisis hotline. Appointments must be scheduled.

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Employee Assistance Program

Sometimes life can be challenging. That's why University Athletic Association provides an Employee Assistance Program (EAP) to all employees through the Standard -- at no cost to you. The EAP is designed to provide prompt, confidential help with a range of personal and family issues that may affect all of us from time to time. This benefit is available for you and your immediate family.

EAP and Work-Life Benefits:

From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- 24/7 contact with the program's master's-level counselors available
- Your program includes up to three counseling sessions per issue
- Reach out through the mobile app or by phone, online, live chat, and email
- EAP services can help with:
    - Depression, grief, loss and emotional wellbeing
    - Family, marital and other relationship issues
    - Life improvement and goal-setting
    - Addictions such as alcohol and drug abuse
    - Stress or anxiety with work or family
    - Financial and legal concerns
    - Identity theft and fraud resolution
    - Online will preparation and other legal documents
- WorkLife Services are included with the Employee Assistance Program:

The Standard

Contact **EAP**

888.293.6948
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

Dental

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler, and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease and is an important part of maintaining your health.

University Athletic Association offers you a dental plan through MetLife. This plan has a PPO network of dentists to allow you to see the provider of your choice; however, you will receive the largest discount if you utilize the In-Network providers. Providers who are part of the PPO network will accept the negotiated charges on file with MetLife. To find a provider participating provider visit http://metlife.com/insurance/dental-insurance/. The Metlife Dental PPO plan utilizes the **PDP Plus Network**.

MetLife Dental PPO – PDP Plus Network		
Benefits Coverage	In-Network	Out of Network
Calendar Year Deductible – Waived for Preventive Services		
Individual / Family	$50 per family member (3 max)	$50 per family member (3 max)
Annual Maximum		
Per Person / Family	$2,000 Preventive Does Not Apply	$1,500 Preventive and Orthodontia Does Not Apply
Preventive Exams Cleanings X-Rays	100%	100% Subject to balance billing
Basic Fillings Root Canals Periodontics Extractions	10% after deductible	20% after deductible Subject to balance billing
Major Crowns Bridges Dentures	40% after deductible	50% after deductible Subject to balance billing
Orthodontia		
Benefit Percentage	50%	50%
Dependent Child(ren)	Children to age 19	Children to age 19
Lifetime Maximum	$1,000	$1,000

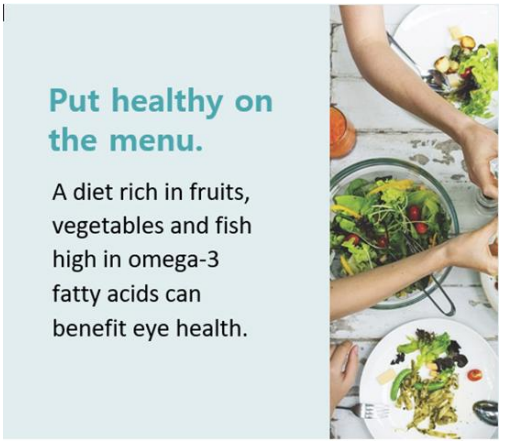
Employee Contributions (Semi-Monthly, 24 per year)		
	Employee Pays	UAA Pays
Employee	$7.12	$9.69
Employee & Spouse	$18.66	$16.91
Employee & Child(ren)	$20.80	$18.32
Employee & Family	$29.52	$26.17

MetLife

Vision

As a part of keeping up with your overall health, University Athletic Association feels that vision is a critical component of maintaining a healthy well-being. To assist employees in this endeavor, University Athletic Association offers vision coverage through Superior Vision (Superior National Network).

Superior Vision allows members to access thousands of participating retail and independent providers. To find a participating provider visit www.superiorvision.com.



Superior National Network Group #38830		
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits
Benefit Frequency		
Exams, Lenses/Contacts, Frames	Once every 12 months	
Benefit Coverage		
Exams	$10 copay	Up to $33
Lenses (Single, Bifocal, Trifocal) Single Bifocal Trifocal	$25 copay	 Up to $28 Up to $40 Up to $53
Frames	$130 allowance, 20% discount off balance	Up to $60
Contacts *In Lieu of Eyeglass lenses*	$130 allowance	Up to $100
Laser Vision Correction	Discounts Available	

The Benefit Summary is available in the myUAA Employee Portal under ManageMyBenefits>Documents

Employee Contributions (Semi-Monthly, 24 per year)	
	Employee Pays
Employee	$3.46
Employee & Spouse	$6.54
Employee & Child(ren)	$6.86
Employee & Family	$9.60

SuperiorVision™

Health Savings Account (HSA)

For employees enrolled in the High Deductible Health Plan, you have the option to open a Health Savings Account (HSA). This option is not available on the Copay plan due to IRS regulations. Your designated payroll contributions to your HSA will be deducted pre-tax on each paycheck (26 pay periods a year). UAA employee accounts are held with Optum Financial.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes.
- Interest in your account grows tax free; and
- You don’t pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

What Can I Use the Money For?

Once the funds become available, you can use it to pay medical, prescription, dental, or vision related expenses - which includes anything that applies toward your deductible, dental work, vision related expenses and allowable over the counter medications. If you cannot claim a child as a dependent on your tax returns, you cannot spend HSA dollars on services for that child. Please refer to the IRS website (www.irs.gov) for the most up to date list of allowable expenses.

How Do I Pay For These Expenses?

You will utilize the Optum debit card to pay for the service at your appointment. You can request a second card for a dependent. Reimbursement is also available through the website at https://www.optumbank.com if you do not use your debit card for the transaction.

2026 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

FOR THE 2026 TAX YEAR:

- $4,400 Individual
- $8,750 Family
- If you are age 55 or over, you may contribute an extra $1,000 catch up contribution.

The amount contributed can be changed throughout the year by submitting a life event in the myUAA Employee Portal under Manage My Benefits or by contacting HR for assistance.

Are there investment options on the HSA?

When you reach a balance of $1,500 in your account, you can invest the amount over the $1,500 in mutual funds.

What if I don't use all my money by the end of the year?

Your HSA is a personal account and the funds in the account roll over from year to year. If you leave the UAA, all money remaining in your account goes with you. The account and funds are always yours. There is no 'use it or lose it' rule.

Optum

Flexible Spending Accounts

Health Care Flexible Spending Accounts

You may elect to deposit pre-tax dollars into a Health Care FSA. These funds can be used to pay for eligible health, dental and vision care expenses for each calendar year. Due to the pre-tax benefit, for every $100 contributed, you will see a difference in your net pay of $65-$78, saving you $22-$35 per every $100 in expenses. The FSA differs from the HSA in that: you must use the FSA funds by the end of the year or you lose it (though the UAA does offer a grace period in which you can continue to incur charges through March 15th of the following year to use your FSA balance); you may not change your FSA elections during the year unless you experience a qualifying event; and the dollar amount you elect during Open Enrollment is available for your use on day one.

***If you have a Healthcare FSA, you can not have an HSA.**

Limited Purpose - Medical Flexible Spending Account

A Limited Purpose Flexible Spending Account is specifically designed to coordinate with a Health Savings Account as well as enrollment in a high deductible health plan. When you enroll in both types of accounts (a Health Care FSA and a Health Savings Account) the FSA account becomes LIMITED. This means you cannot use the funds in your FSA for expenses that apply toward your medical deductible (i.e. doctor copays, prescriptions, etc.), but can be used for dental and vision expenses.

Dependent Care Flexible Spending Accounts

The Dependent Care FSA is another opportunity to deposit pre-tax dollars into an account to be used specifically for child or elder care expenses such as preschool tuition, after school programs, childcare centers, adult day care centers, and summer day camps for children under 13. Please note, with the Dependent Care FSA, the funds are only available as you contribute to the account via payroll deduction. Like the FSA, you may not change your election during the year unless you experience a qualifying event.

How does the card work?

You will use one debit card for both HSA and FSA expenses. If you have an HSA and a limited FSA, the account utilizes a logical stacking order. This means the FSA funds are automatically utilized first for eligible expenses (since it is a "use it or lose it" account) then the HSA is utilized. For example, since the FSA with the HSA becomes LIMITED to dental and vision, the FSA is used first, whenever there is a dental or vision claim and the HSA is used first for all other claim types. Once the FSA funds are depleted, the HSA will then also cover dental and vision expenses.

Interns & Post-Graduate Assistants are not eligible to elect FSA Accounts.

2026 FSA Contribution Limits

- Healthcare/Limited Purpose FSA: $3,400
- Dependent Care FSA: $7,500, or $3,750 for married individuals filing separately.

Optum

FEATURE	HSA	Limited FSA	FSA	Dependent Care FSA
Tax-free in: pre-tax contributions	X	X	X	X
Tax-free out: when used to pay for qualified expenses	X	X	X	X
Entire annual election amount available in January of benefit plan year		X	X	
Funds are available as you contribute via payroll deductions	X			X
Account balance rolls over year to year	X			
Pay for medical, dental and vision expenses	X		X	
Pay for dental and vision expenses (no medical expenses)		X		
Must enroll in a high deductible health plan to participate	X			
Account grows with tax-free interest and investment returns	X			
You can start, stop or change your contributions at any time during the year	X			
Account is portable (i.e. take it with you if you leave or retire)	X			
Pay for eligible child and elder care expenses				X
Unused funds are forfeited at the end of the year		X	X	X
Only available if eligible for an HSA		X		
2026 Annual maximum contribution (for individual coverage)	$ 4,400.00	$3,400	$3,400	$7,500.00
2026 Annual maximum contribution (for employee +1/family coverage)	$ 8,750.00	$3,400	$3,400	$7,500.00
Additional catchup contribution if over 55	$ 1,000.00			

Life and AD&D

Basic Life Insurance and Accidental Death & Dismemberment

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.

University Athletic Association provides Basic Life and AD&D Insurance to all eligible employees at no cost to you. This benefit is $50,000 of coverage ($25,000 for employees 70+).

Employee-Paid Term Life Insurance

In addition to the company paid life and AD&D, University Athletic Association provides employees who work at least 30 hours a week, the opportunity to purchase additional Life and AD&D insurance through the Standard for you and your family.

In order to purchase group voluntary life insurance for your spouse and eligible children, you must buy coverage for yourself and your dependents may not have more coverage than you have on yourself.

*Rates increase according to age bracket. Employee/Spouse coverage will decrease to 50% at age 70.

If you do not enroll in voluntary life insurance when you are a new hire, evidence of insurability may be required for any future elections.

Spouse Life: As a new hire, you are able to purchase Spouse life up to the Guarantee Issue Amount without answering medical questions. Evidence of insurability is required for any amounts over the Guarantee Issue Amount. Spouse rates are based on spouse's age.

Child Life: Child life is always guarantee issue. No evidence of insurability would be required.

Benefit Details	Employee Life and AD&D	Spouse Life and AD&D	Child(ren) Life and AD&D
Maximum Life Insurance	A minimum of $10,000 to a maximum of $500,000 in $10,000 increments	A minimum of $5,000 to a maximum of $250,000 in $5,000 increments	$1,000 increments to a maximum of $20,000.
Guarantee Issue Amount	$150,000	$50,000	$20,000

AGE	Monthly Premium / $1,000*	Age	Monthly Premium / $1,000*
Under 30	$0.078	**55 to 59**	$0.584
30 to 34	$0.086	**60 to 64**	$0.803
35 to 39	$0.101	**65 to 69**	$1.34
40 to 44	$0.117	**70+**	$2.541
45 to 49	$0.203		
50 to 54	$0.296	**Child(ren)**	$0.12

***Payroll deductions are made semi-monthly**

Disability Insurance

Disability insurance helps replace a major portion of your income when you are sick or injured and unable to work. Some people think of it as “paycheck protection.” Others view it as a way to protect their home since a mortgage payment is often a family’s most significant monthly expense. Having disability insurance can provide a sense of security, knowing that if the unexpected should happen, you’ll still receive a monthly income.

If you think about it, everything you have today - your home, car, groceries, savings - basically your lifestyle, depends on your ability to earn an income. Most people are quick to insure their possessions, such as their home and car. And they generally have life insurance that would provide for their family. But the one thing that makes all this possible is – your income. It’s your most important asset. So, protecting it with disability insurance isn’t just a good decision – it’s essential.

Long Term Disability

Should you become unable to work due to a non-work related sickness or injury, University Athletic Association provides eligible employees with Long Term Disability Benefits at no cost to you.

- 60% of salary up to a maximum of $15,000 per month
- Benefits will begin on the 90th day following a non-work related accident or illness in which there is a loss of earnings or ability to perform duties.
- This benefit will pay you until you are no longer disabled or until you reach Social Security Normal Retirement Age.
- Pre-existing Condition limitation: 3 months prior look-back for conditions treated, 12 month exclusion.

***Note: The pre-existing condition limitation only applies to new enrollees.**

Voluntary Accident Insurance

The Standard offers Voluntary Accident Insurance. Voluntary Accident provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accident death and dismemberment. Payments are made directly to you and not to an insurance company. The benefit summaries are available in the myUAA Employee Portal under ManageMyBenefits>Documents.

Benefits	
Ambulance	$400 Ground, $1,500 Air
Blood, Plasma and Platelets	$500
Burns	To $1,125 for 2nd degree burns; To $12,500 for 3rd degree burns; Skin Graft - 25% of benefit payable for Burns
Chiropractic Services (Per Visit)	$50 up to 6 days
Coma	$10,000
Concussion	$175
Dental Injury	$300 for Crown; $100 for Extraction
Diagnostic Exams	$200
Dislocation	To $3,200 for Non-surgical; To $6,400 for Surgical; Partial - 25% of full dislocation
Emergency Treatment	$200
Eye Injury	$275
Fractures	To $4,000 for Non-surgical; To $8,000 for Surgical repair; Chip fracture: 25% of non-surgical benefit
Hospital Confinement (Per Day)	$350, 365 days maximum
Intensive Care Unit (ICU) Confinement per Day	$400, 15 days maximum
Initial Intensive Care Unit (ICU) Hospital Admission	$1,500
Initial Hospital Admission	$1,250
Lacerations	To $500
Lodging (Per Day)	$175 per day up to 30 days if more than 100 miles from residence
Physical Therapy (Per Session)	$65, 6 sessions maximum
Physician Visit	$200 Initial
Surgery	Up to $350 for Exploratory; $750 for Knee Cartilage; $2,000 for Abdominal or Thoracic; $750 for Ruptured Disc, Tendon, Ligament, or Rotator cuff
Transportation	$150 per day up to 30 days if more than 100 miles from residence
X-Rays	$50
Employee AD&D	$50,000
Spouse AD&D	$25,000
Child AD&D	$12,500

Accident Plan Premiums				
Semi-Monthly Deductions (24 x per year)	**EE**	**EE + Spouse/DP**	**EE + Child(ren)**	**EE + Family**
	$4.11	$7.65	$10.56	$16.02

Voluntary Critical Illness

The Standard offers Voluntary Critical Illness which provides a fixed, lump –sum benefit upon diagnosis of a critical Illness, which can include heart attack, stroke, paralysis, and more. The benefit summaries are available in the myUAA Employee Portal under ManageMyBenefits>Documents. Payments are made directly to you and not to an insurance company and can be used for any reason.

Diagnosis	Benefit
Alzheimer's	100%
Benign Brain Tumor	100%
Carcinoma in Situ – Partial Benefit	25%
Coronary Disease – Partial Benefit	25%
Heart Attack	100%
Life Threatening Cancer	100%
Major Organ Failure	100%
Paralysis	100%
Stroke	100%

Critical Illness Plan	
Your Spouse/Domestic Partner is eligible for up to 100% of the employee's enrolled amount. Eligible children are automatically eligible for 50% of the employee's enrolled coverage at no cost.	
Enrollment Options (Payout Levels)	$10,000 or $20,000
Pre-Existing Condition Clause	Critical Illness coverage through the Standard will now be offered with no pre-existing condition limitation.
Wellness Benefit (Health Screening)	$50

Semi-Monthly Premiums – Employee						
Benefit Amount	**Age 18-29**	**Age 30-39**	**Age 40-49**	**Age 50-59**	**Age 60-69**	**Age 70+**
$10,000	$1.40	$2.16	$4.46	$9.28	$17.21	$44.01
$20,000	$2.79	$4.30	$8.92	$18.57	$34.42	$88.02

Semi-Monthly Premiums – Spouse						
Benefit Amount	**Age 18-29**	**Age 30-39**	**Age 40-49**	**Age 50-59**	**Age 60-69**	**Age 70+**
$10,000	$1.40	$2.16	$4.46	$9.28	$17.21	$44.01
$20,000	$2.79	$4.30	$8.92	$18.57	$34.42	$88.02

Voluntary Hospital Indemnity

Voluntary hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to the insured following a hospitalization that meets the criteria for benefit payment. The benefit summaries are available in the myUAA Employee Portal under ManageMyBenefits>Documents. Payments are made directly to you and not to an insurance company and can be used for any reason.

Benefits	
Hospital Admission Benefit	
One Daily Benefit per Coverage Year	$1,000
Hospital Critical Care Admission Benefit	
One Daily Benefit per Coverage Year	$1,000
Hospital Room & Board Benefits	
Room & Board Benefits Per Day (365 Daily Benefits per Coverage Year)*	$100
Hospital Critical Care Unit Benefits	
Critical Care Unit Benefits per Day (30 Daily Benefits Per Coverage Year)	$100
Nursery Unity Benefit	
Ten Daily Benefits per Coverage Year	$50
Health Maintenance Screening Benefit	
Annual benefit when insured receives one of the twenty-two covered screening tests	$50
*In no event will the Daily Benefits exceed 365 daily benefits per Coverage year.	
**Wellness Care means medical examinations and procedures that are preventive in nature and not for the treatment of injury or sickness	

Hospital Indemnity Plan Premiums				
Semi-Monthly Deductions (24 x per year)	**EE**	**EE + Spouse/DP**	**EE + Child(ren)**	**EE + Family**
	$5.23	$9.00	$7.39	$13.15

Voluntary Pet Insurance

Pet Insurance Should be a Walk in the Park

Affordable Pet Insurance Options Provided by Spot are Here.

Up to 20% Savings for University Athletic Association Employees*

- 10% employee discount (the discount applies to all eligible pets, not just the first pet)
- 10% multi-pet discount on all additional pets

Get Coverage For:

Accidents

Injuries, Swallowed Objects, Toxic Ingestions

Behavioral Issues

Excessive Licking, Separation Anxiety, Destructive Chewing

Illnesses

Cancer, Respiratory Infection, Diabetes

Hereditary Conditions

Accidents or Illnesses

Preventive Coverage

Available for an additional cost. Discounts do not apply.

vetAccess™

But Wait, There's More…

With a plan provided by Spot, you get access to a 24/7 pet telehealth line, provided by PetAccess™, to answer your pet questions.

Get an employee discount when you sign-up!

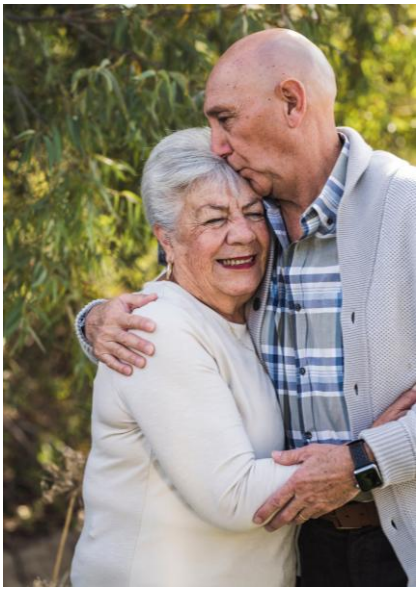
https://spotpet.link/uaa

Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits, and exclusions may apply. For all terms and conditions visit spotpetins.com/sample-policy. Preventive Care reimbursements are based on a schedule. Accident & Illness coverage reimbursements are based on the invoice. Products, schedules, discounts, and rates may vary and are subject to change. More information is available at checkout.

Insurance plans are underwritten by United States Fire Insurance Company (NAIC #21113. Morristown, NJ). Insurance plans are marketed and produced by Spot Insurance Services, LLC. (NPN # 19246385). EBF_202208Insurance plans are underwritten by United States Fire Insurance Company (NAIC #21113. Morristown, NJ). Insurance plans are marketed and produced by Spot Insurance Services, LLC. (NPN # 19246385). emp_temp_202208"

spot pet insurance

Retirement Plan Information



The University Athletic Association, Inc.'s retirement plan is a Money Purchase Pension Plan. It is a qualified plan, authorized under IRS section 401(a). It is a defined contribution plan in which the UAA defines the contribution that will be made into the plan and not the benefit that will be paid out of the plan.

Participation

Employees that have attained the age of 21 and worked 1,000 hours within the one-year period beginning with their date of hire, become a pension plan participant the first of the quarter (January 1, April 1, July 1 or October 1) following the employee's anniversary.

Contribution

Any **participant** that completes 1,000 hours within the calendar year, will be eligible for a plan year contribution. Contributions are made in January based on 10% of eligible earnings for the prior calendar year.

Vesting

Each calendar year in which the **participant** works at least 1,000 hours will count toward the employee's vesting. Vesting is the percentage of your pension balance you would be eligible to receive at anytime that you become eligible for a distribution. (i.e. reach age 59 ½, separation, retirement, death). Vesting schedule is below:

1 year of service	2 years of service	3 years of service	4 years of service	5 years of service
0% vested	20% vested	40% vested	70% vested	100% vested

Example: Pat Smith is hired January 15, 2025. On January 15, 2026, Pat, who is 21 years old, will have reached their one-year anniversary. During that year (January 15, 2025-January 14, 2026), Pat worked at least 1,000 hours. Pat becomes a participant in the pension plan on April 1, 2026. Pat works 1,000 hours in 2026 and will receive a pension contribution in January 2027 based on 10% of Pat's eligible compensation earned in 2026. Since Pat is now a participant in the plan, once she works 1,000 hours in 2026, she will be 20% vested.

Account Access

All participants may access their account balance, designate beneficiaries and request distributions (upon eligibility) directly on the Fidelity NetBenefits website at www.netbenefits.com/atwork. To log in, select either REGISTER AS NEW USER, or if you already have an account with Fidelity, use your existing login information.

Distributions

You are only eligible to take out all, or a portion, of your money from the pension plan when you separate employment from the UAA, unless you meet the following exception:

When an employee attains the age of 59-1/2 years and has five (5) or more years of vested participation they are eligible to take one (1) in-service distribution per calendar year. The employee may request this distribution anytime through their Fidelity NetBenefits account.

In the event of your death, your vested balance would be payable to your beneficiary. Please be sure to designate your pension beneficiary on the Fidelity NetBenefits website.

Complete plan information and documents are available on the Fidelity NetBenefits website.

403(b) Retirement Account

A 403(b) is a valuable investment account where you can save pre-tax dollars for your retirement.

In addition to the UAA employer funded pension plan, benefit-eligible employees may choose to contribute to a 403(b) retirement savings account via payroll deduction. Log on to the Fidelity NetBenefits website **anytime throughout the year** to set up, monitor, and manage your voluntary 403(b) retirement savings account.

- To begin, visit www.netbenefits.com/atwork and select either **REGISTER AS A NEW USER**, or if you already have an account with Fidelity, use your existing login information.
    - **NOTE:** Deferrals are made as a percentage of your base compensation. For example, someone with a salary of $35,000 that chooses to contribute 5% towards their retirement, will contribute $1,750 per year, or $67.31 per paycheck, based on 26 annual pay periods.
    - Your election percentage will be transmitted to payroll and automatically deducted. You may log into your Fidelity NetBenefits account to change or stop your contribution at any time.
- Not sure what investment to select? Need help with the website? No problem, feel free to schedule a one-on-one appointment or call our Fidelity Representatives, Gene Varela or JT Carpenter, at (800) 642-7131. There is no cost for either. The reps are there to make this as easy as possible to get you saving towards your retirement.
- FYI, eligible employees can also view their UAA Pension account by logging on to Fidelity NetBenefits and clicking on the pension link.

Leave Accruals and Paid Time Off

Vacation Leave

Full-time employees accrue 6.77 hours of vacation leave per pay period. This is the equivalent of 22 days each year. Employees who work in a .75 position accrue time proportionately based on the hours worked. Employees may carry over a maximum of 352 hours of vacation leave per fiscal year (July 1st to June 30th). All hours over the 352 limit not used by June 30th will convert to sick leave.

Sick Leave

Full-time employees accrue 4 hours of sick leave per pay period. This is the equivalent of 13 days each year. Employees who work in a .75 position accrue sick leave proportionately based on the hours worked.

Bereavement & Other Leave Types

For bereavement and other types of leave, please refer to the Employee Handbook on the Swamp intranet or in the myUAA Employee Portal (MyCompany>Company Info).

Catastrophic Leave Pool

In addition to a generous paid time off policy and long-term disability coverage, the UAA also offers the ability to utilize hours from our Catastrophic Leave Pool. If an employee who accrues leave is out of work with a qualifying illness or injury and has exhausted all of their accrued annual/sick time, they have the option to request hours from the Catastrophic Pool to retain 100% of their pay.

Payment of Leave upon Separation

For TEAMS/SRADMIN employees, the current accrued and unused balance of vacation leave will be paid out upon voluntary separation from employment (or if applicable disability), based on years of full–time service.
1-5 years = up to 80 hours, **6-9 years** = up to 160 hours, and **10+ years** = up to 200 hours
There is no vacation leave payout for time limited positions such as Interns, Graduate Student Coaches, or Post-Graduate Assistants.

Holidays

The UAA observes 14 paid holidays each year. Some holidays are not observed on the traditional date so an alternate date will be scheduled. The alternate date will be deemed the holiday for purposes of calculating holiday pay.

New Year's Day	UF Homecoming Parade Day***
Martin Luther King Jr's Birthday	Veterans Day***
Memorial Day	Thanksgiving Day
Juneteenth	Day after Thanksgiving
Independence Day	December Holiday Closure Period: **3 days**
Labor Day	Christmas Day

*Coaches and OPS Employees do not accrue leave.
****Interns are not eligible for leave payout**
***The UAA offices will remain open on Homecoming and Veterans Day. During the December Closure Period these holidays will be observed in addition to Christmas Day and New Year's Day. The alternate dates for Homecoming and Veterans Day will be deemed the holiday for purposes of calculating holiday pay.

Important Contacts

Have Questions? Need Help?

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0835 or via e-mail at BRCSouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Carrier Customer Service

	CARRIER	PHONE NUMBER	WEBSITE
Medical	**Florida Blue**	(800) 267-3156	www.floridablue.com
Dental	**MetLife**	(800) 942-0854	www.metlife.com
Vision	**Superior Vision**	(800) 507-3800	www.superiorvision.com
Health Savings Account (HSA) **Flexible Spending Account (FSA)**	**Optum Financial**	(877) 292-4040	www.optum.com/financial
Employee Assistance Program (EAP)	**The Standard**	(888) 293-6948	www.healthadvocate.com/standard3
Life and AD&D **Long Term Disability** **Accident** **Critical Illness** **Hospital Indemnity**	**The Standard**	(888) 937-4783	www.standard.com
Durable Medical Equipment / Home Health Services	**CareCentrix**	(866) 776-4617 (800) 808-1902	www.carecentrix.com
Lab Provider	**Quest Diagnostics**	(866) 697-8378	www.questdiagnostics.com
Pet Insurance	**Spot**	(800) 905-1595	https://spotpet.link/uaa
403(b)	**Fidelity**	(800) 642-7131	www.fidelity.com

Human Resources Contact Information

Mailing Address: PO Box, 14485, Gainesville, FL 32604-2485

Employee Website: www.FloridaGators.com/myUAA

HR Telephone: 352-375-4683, ext. 6300

HR Email: HR@gators.ufl.edu

HR Fax: 352-375-8432

Benefit Coordinator: Kevin Church KevinCh@gators.ufl.edu 352-692-6938

403B, Pension & Payroll: Raven Simmons RavenS@gators.ufl.edu 352-692-6955

Required Notifications

Important Legal Notices Affecting Your Health Plan Coverage

The Women's Health Cancer Rights Act of 1998 (WHRCA)

The Women's Health and Cancer Rights Act of 1998 requires University Athletic Association to notify you, as a participant or beneficiary of the University Athletic Association Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical compilations of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information at 352-692-6364

Newborns Act Disclosure – Federal

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact Human Resources.

Michelle's Law Disclosure

Under the ACA, dependent children are covered by the group health plan until age 26. University Athletic Association group health plan extends dependent coverage beyond the ACA requirements, to age 30, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Florida Blue at 800-830-1501

Visit - the Centers for Medicare and Medicaid Services at CMS at www.cms.gov - for more information about your rights under federal law.

IMPORTANT: Information regarding Critical Illness and Hospital Indemnity. This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****. Contact information for questions or complaints is available at the end of the notice.*

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:

  Marketing purposes

  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Medicare Part D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University Athletic Association and about your options under Medicare's prescription drug Plan. If you are considering joining, you should compare your current coverage including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. University Athletic Association has determined that the prescription drug overage offered by the Welfare Plan for Employees of University Athletic Association under the Express Scripts options are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You should also know that if you drop or lose your coverage with University Athletic Association and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

When can you join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current University Athletic Association coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current University Athletic Association coverage, be aware that you and your dependents will be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug Plan?
You should also know that if you drop or lose your current coverage with University Athletic Association and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…
Contact our office for further information (see contact information below). NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Carrier Name changes. You also may request a copy of this notice at any time.

Medicare Part D (continued)

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	01/01/2026
Name/Entity of Sender:	University Athletic Association
Contact Position/Office:	Tatia Miller
Address:	121 Gale Lemerand Dr, Gainesville, FL 32611
Phone Number:	(352) 692-6364

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Teammate Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Teammate Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20250 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area**.**

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the Teammate, coverage is considered affordable if the Teammate's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the Teammate's household income. [12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your Teammate contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2026, through July 31, 2026. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2026, through March 31, 2026. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2026. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2026 and July 31, 2026, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2026, and July 31, 2026, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2026 and July 10, 2026, you can request this special enrollment in the employment-based health plan through September 8, 2026. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2026.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name University Athletic Association	**4. Employer Identification Number (EIN)** 59-6002050	
5. Employer Address 121 Gale Lemerand Dr - Ben Hill Griffin Stadium	**6. Employer phone number** 352-692-6364	
7. City Gainesville	**8. State** FL	**9. ZIP code** 32611
10. Who can we contact about employee health coverage at this job? Tatia Miller		
11. Phone number (if different from above)	**12. Email address** tatiam@gators.ufl.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  All employees. Eligible employees are:
  Full-time working at least 30 hours per week.

- With respect to dependents:
  We do offer coverage. Eligible dependents are:
  Spouse, domestic partner, unmarried and married children up to age 26, must not be eligible for Medicare, and must not have coverage under another plan.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notes

This brochure summarizes the benefit plans that are available to UAA eligible Teammates and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.