PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

# 2026 – 2027 Student Health Insurance Plan Hofstra University – Zucker School of Medicine

## Who can enroll?

All registered School of Medicine students are required to have health insurance coverage, either through this Student Health Plan or through another individual or family plan. Students will be automatically enrolled in and charged premium for the Student Health Plan unless proof of comparable coverage is provided by completing a waiver by the waiver deadline date. Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26.

## Plan resources at your fingertips

| | |
|---|---|
| Enroll or waive coverage | **gallagherstudent.com/hofstra** |
| View benefits, submit a claim and download your ID card via My Account | **uhcsr.com/myaccount or uhcsr.com** |
| Find an in-network provider | **Choice Plus** |
| Find a prescription drug provider | **Optum Rx** |
| Value-added benefits and services (Student Assist[1], HealthiestYou[2], UHC Global[3]) | **uhcsr.com/myaccount or uhcsr.com** |
| If you need language assistance | **Language Assistance** |

## Coverage Periods, Deadline Dates, Plan Cost and Premium Rates

The Total Cost of the plan noted below includes premium and fees.

| Total Plan Cost and Coverage Dates | Annual |
|---|---|
| Coverage dates | 8-1-2026 to 7-31-2027 |
| Student | $7,550.00 |
| Spouse | $7,550.00 |
| One Child | $7,550.00 |
| Two or More Children | $15,100.00 |
| Spouse and Two or More Children | $22,650.00 |

See the information below for the breakdown of premium and fees.

| *Premium Rates | Annual Premium |
|---|---|
| Student | $7,437.62 |
| Spouse | $7,437.62 |
| One Child | $7,437.62 |
| Two or More Children | $14,875.24 |
| Spouse and Two or More Children | $22,312.86 |

Rates are subject to regulatory approval and may change.

*The premium is for the insurance coverage underwritten by UnitedHealthcare Insurance Company of New York and does not include the following fees:

- Annual **Service fee of $2.38 for UHC Global administration of the Assistance and Evacuation Benefits.
- Annual **Service fee of $110.00 charged by or at the direction of the school you are receiving coverage through to cover the costs of services provided by a non-insurer vendor or consultant.

**Note: Fees are prorated for the coverage dates other than annual.

### Hofstra Student Health Services

The Student Health Services is the University's on-campus health facility. It is open Monday – Friday: 9 a.m. to 7 p.m., Saturday & Sunday: 10 a.m. to 6 p.m. You can call to make an appointment or make an appointment through your Hofstra portal. For more information, call the Health Services at 516-463-6745. In the event of an emergency, call 911 or public safety at 516-463-6789.

# Plan highlights

## Metallic Level: Silver with actuarial value of 75.740%

| Benefits | In Network Participating Provider Member Cost-Share | Out-of-Network Non-Participating Provider Member Cost-Share |
|---|---|---|
| **Overall Plan Maximum** | **There is no overall maximum dollar limit on the Policy** | |
| **Plan Deductible** | $450 Per Member, Per Plan Year<br>$900 For all Members in a Family, Per Plan Year | $1,500 Per Member, Per Plan Year<br>$3,000 For all Members in a Family, Per Plan Year |
| **Out-of-Pocket Maximum**<br>*After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any applicable benefit maximums. Refer to the plan certificate for details about how the Out-of-Pocket Maximum applies.* | $9,000 Per Member, Per Plan Year<br>$18,000 For all Members in a Family, Per Plan Year | $20,000 Per Member, Per Plan Year<br>$40,000 For all Members in a Family, Per Plan Year |
| **Coinsurance**<br>*All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.* | 20% of Allowed Amount for Covered Medical Expenses | 50% of Allowed Amount for Covered Medical Expenses |
| **Prescription Drugs**<br>*UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply.* | Prescription Drug Deductible: $100<br>$20 Copayment for Tier 1<br>$70 Copayment for Tier 2<br>$90 Copayment for Tier 3<br>Up to a 30-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP)<br>after Deductible | Prescription Drug Deductible: $100<br>$20 Copayment for Generic Drugs<br>$70 Copayment for Brand Name Drugs<br>Up to a 30-day supply per prescription<br>after Deductible |
| **Preventive Care Services**<br>*Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see https://www.healthcare.gov/preventive-care-benefits/ for complete details of the services provided for specific age and risk groups.* | Covered in full | 30% of Allowed Amount<br>after Deductible |
| **The following services have per service copays**<br>*This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.* | Office Visits: $30 Copayment<br>not subject to Deductible<br>Urgent Care Center: $30 Copayment<br>after Deductible<br>Emergency Care in an Emergency Department: $200 Copayment<br>after Deductible<br>Copayment waived if admitted to Hospital | Urgent Care Center: $30 Copayment<br>after Deductible<br>Emergency Care in an Emergency Department: $200 Copayment<br>after Deductible<br>Copayment waived if admitted to Hospital |

# Questions about your plan?

Contact Customer Service at **1-800-767-0700** or at **www.gallagherstudent.com/hofstra**

[1]Student Assist services are provided through OptumHealth Behavioral Solutions and OptumHealth Care Solutions, UnitedHealth Group companies. The Student Assist is not a substitute for medical attention. If you have an emergency medical condition, you should call 911 or your local emergency services number. [2]HealthiestYou and the HealthiestYou logo are trademarks of Teladoc Health, Inc., and may not be used without written permission. HealthiestYou does not replace the primary care physician. HealthiestYou does not guarantee that a prescription will be written. HealthiestYou operates subject to state regulation and may not be available in certain states. HealthiestYou does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. HealthiestYou physicians reserve the right to deny care for potential misuse of services. [3]Non-Insurance Travel Assistance services are provided by or through United Healthcare Services, Inc., and affiliates under the UnitedHealthcare Global brand.  This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy 2026-822-1. For further details of the coverage including costs, benefits, exclusions, any reductions or limitations and the terms under which the coverage may be continued in force, please refer to uhcsr.com. NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance Policy issued by UnitedHealthcare. This document is a summary only and does not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant Policy of insurance. This document is not an insurance Policy document and your receipt of this document does not constitute the issuance or delivery of a Policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

United Healthcare

POLICY NUMBER: 2026-822-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC 1 6/22/2026

1. Coverage Periods, Deadline Dates, Plan Cost and Premium Rates
- Annual total plan cost rates are updated
- Annual **Service fee updated from $135.00 to $110.00

2. Schedule of Benefits:
- Plan Deductible: In-network Family deductible updated to $900 / Out-of-Network Family Deductible updated to $3,000
- Out of Pocket Maximum: In-network Family deductible out-of-pocket max updated to $18,000 / Out-of-Network Family out-of-pocket max updated to $40,000