

The Columbia Plan
Member Responsibility - 2026-2027 Plan Year
www.aetnastudenthealth.com/columbia

Fall - August 15 - December 31, 2026
Spring/Summer -
January 1 - August 14, 2027

Plan Features	IN-NETWORK Amount You Pay	OUT-OF-NETWORK Amount You Pay
Deductible per individual	NONE	\$750
Annual Out-of-Pocket Max (Integrated maximum for Preferred Care only. Includes Preferred copays, Preferred coinsurance, Preferred pharmacy copays)	\$3,500 (In-Network Only)	\$7,000 (Non-Preferred Only)
Coinsurance	10%	30% and 40%
Maximum coverage per condition	Unlimited	Unlimited
Office Visit	In-Network	Out-of-Network*
Preventive	\$0	30% after deductible
Physician (copay does not apply on-campus)	\$30	30% after deductible
Testing	In-Network	Out-of-Network*
Lab/diagnostic test/preadmission testing	\$30	30% after deductible
High cost advanced imaging services	10%	40% after deductible
ADD/LD/neuropsych testing	\$20	30% after deductible
Inpatient	In-Network	Out-of-Network*
Inpatient hospital stay - facility fee	10%	40% after deductible
Inpatient hospital stay - physician fee	10%	40% after deductible
Emergency/Urgent	In-Network	Out-of-Network*
Emergency Room - inclusive of facility and physician fees (Co-Pay Waived if Admitted to the Hospital)	\$150	\$150
Ambulance	\$50	\$50
Urgent care center	\$60	30% after deductible
Outpatient/Other	In-Network	Out-of-Network*
Outpatient surgery - facility fee	10%	40% after deductible
Outpatient surgery - physician fee	10%	40% after deductible
Acupuncture	\$30	30% after deductible
Chiropractor	\$30	30% after deductible

Outpatient/Other	In-Network	Out-of-Network*
Physical Therapy - outpatient	\$30	30% after deductible
Durable medical equipment	10%	40% after deductible
Dental injury only	10%	40% after deductible
Removal of impacted wisdom teeth	10%	40% after deductible
Termination of pregnancy	Covered in full	30% after deductible
Behavioral Health	In-Network	Out-of-Network*
Mental Health - outpatient in-network, first 10 visits \$0 copay - copay for subsequent visits	\$20	30% after deductible
Mental Health - inpatient	10%	40% after deductible
Substance Abuse - outpatient	\$20	30% after deductible
Substance Abuse - inpatient	10%	40% after deductible
Prescription Coverage	In-Network	Out-of-Network*
Contraceptives: Generics & Brands without a generic equivalent or alternative	\$0	30%
Zero Copay Pharmacy List	\$0	30%
Generic drugs	\$15	30%
Preferred Brand drugs	\$50	30%
Non-Preferred Brand drugs	\$75	30%
Mail Order Pharmacy (90 day supply)		
Contraceptives: Generics & Brands without a generic equivalent or alternative	\$0	30%
Zero Copay Pharmacy List	\$0	30%
Generic drugs	\$37.50	30%
Preferred Brand drugs	\$125.00	30%
Non-Preferred Brand drugs	\$187.50	30%

Travel and Lodging Expenses for You to travel at least 100 miles from Your location to another state to access Covered Services when not available due to a law or regulation in the state where You are located - reimbursed up to \$3,000 per plan year.