

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

Fall Term
August 15 - December 31, 2026 (\$2,218)
Spring/Summer Term
January 1 - August 14, 2027 (\$3,605)

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 at Student Health on Haven)	\$30	30% after deductible
Testing	In-Network	Out-of-Network*
Lab/diagnostic test/preadmission testing	\$30	30% after deductible
High cost advanced imaging (PET Scan, MRI, CAT Scan, etc)	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 (First 10 in-network visits \$0 co-pay - co-pay 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 and Brands without a generic equivalent or alternative	\$0	30%
Zero Co-Pay 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)	In-Network	Out-of-Network*
Contraceptives: Generics and Brands without a generic equivalent or alternative	\$0	30%
Zero Co-Pay 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	Other Covered Services	
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 the state where You are located - reimbursed up to \$3,000 per plan year.		