# The Columbia Plan
# Member Responsibility - 2020-2021 Plan Year
# www.aetnastudenthealth.com/columbia

**Fall**
**August 15 - December 31, 2020 ($1,400)**

**Spring/Summer**
**January 1 - August 14, 2021 ($2,276)**

| Plan Features | IN-NETWORK Amount You Pay | OUT-OF-NETWORK Amount You Pay |
|---|---|---|
| Deductible per individual | NONE | $600 |
| Annual Out-of-Pocket Max (Integrated maximum for Preferred Care only. Includes Preferred copays, Preferred coinsurance, Preferred parmacy copays) | $3000 (In-Network Only) | $6000 (Non-Preferred Only) |
| Coinsurance | 10% | 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 | 10% | 40% after deductible |
| High cost imaging | 10% | 40% after deductible |
| ADD testing/treatment | 10% | 40% 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 | 10% | 10% after deductible |
| 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 - outpatient | $30 | 30% after deductible |
| Chiropractor | $30 | 30% after deductible |
| 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 | $20 | 30% after deductible |
| Mental Health - inpatient | 10% | 40% after deductible |
| Substance abuse inpatient | 10% | 40% after deductible |
| Substance abuse outpatient | $20 | 30% after deductible |
| **Prescription Coverage** | **In-Network** | **Out-of-Network*** |
| Contraceptives: Generics and Brands without a generic equivalent or alternative | $0 | 30% |
| Generic drugs | $15 | 30% |
| Preferred Brand drugs | $50 | 30% |
| Non-Preferred Brand drugs | $75 | 30% |

COLUMBIA HEALTH

**The Allowed Amount for Non-Participating providers is 105% of the Medicare rate.*
*Please see the Plan Design and Benefit Summary for more information.*