The Columbia Plan Member Responsibility - 2024-2025 Plan Year www.aetnastudenthealth.com/columbia	Fall - August 15 - December 31, 2024 Spring/Summer - January 1 - August 14, 2025	
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	**$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%	10%
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 availible due to a law or regulation in the the state where You are located - reimbursed up to $3,000 per plan year.

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