

Columbia University Student Health Insurance Plan
Member Responsibility - 2019-2020 Plan Year
www.aetnastudenthealth.com/columbia

Fall
 August 15 - December 31, 2019 (\$1304)

Spring/Summer
 January 1 - August 14, 2020 (\$2129)

Plan Features	IN-NETWORK	OUT-OF-NETWORK
Deductible per individual	NONE	\$600
Annual Out-of-Pocket Max (Integrated maximum for Preferred Care only. Includes Preferred copays, Preferred coinsurance, Preferred pharmacy 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
Termination of pregnancy	10%	40% after deductible
Removal of impacted wisdom teeth	10%	40% after deductible
Dental injury only	10%	40% 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%

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