Service Station Dealers & Automotive Services of Greater NY

Inter-City Insurance Fund

January 2025 Oxford Medical Election Form

Full Name	Station Name	Effective Date	
Home Address	City	State	Zip
Email Address	Home Phone Number	Fax Number	

Plan Features	Gold Freedom PPO		Gold Liberty EPO*	Silver Liberty EPO*	Silver Metro*
	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network Only
Benefit Period	January 1, 2025 – December 31, 2025				
Deductible (Indiv / Family)	$1,500 / $3,000	$4,000 / $8,000	$1,250 / $2,500	$4,500 / $9,000	$3,750 / $7,500
Deductible Type	Embedded		Embedded	Embedded	Embedded
Out-of-Pocket Max (Indiv / Family)	$7,250 / $14,500	$10,500 / $21,000	$7,000 / $14,000	$9,200 / $18,400	$9,200 / $18,400
Out-of-Pocket Type	Embedded	Aggregate	Embedded	Embedded	Embedded
Part D Creditable	Creditable		Creditable	Creditable	Creditable
Referral Needed	No		No	No	Yes
Network	Freedom	N/A	Liberty	Liberty	Metro
Primary Care Visit	$25 Copay	40% after Deductible	$30 Copay	$30 Copay	$30 Copay
Specialist Visit	$40 Copay	40% after Deductible	$60 Copay	$60 Copay	$80 Copay
Diagnostic Lab	50% after Deductible	Not Covered	50% after Deductible	50% after Deductible	50% after Deductible
X-Ray	$25 Copay after Deductible	40% after Deductible	$35 Copay after Deductible	50% after Deductible	40% after Deductible
Complex Imaging	$100 Copay after Deductible	40% after Deductible	$100 Copay after Deductible	50% after Deductible	40% after Deductible
Hospital Outpatient Surgery in Office/Facility	$150 after Deductible	40% after Deductible	$150 after Deductible	50% after Deductible	40% after Deductible
Hospital Outpatient Surgery in Hospital	$250 after Deductible	40% after Deductible	$250 after Deductible	50% after Deductible	40% after Deductible
Hospital Inpatient Services	20% Co-insurance after Deductible	40% after Deductible	$500/Day after Deductible, $2000 max	50% after Deductible	40% after Deductible
Emergency Room	$500 Copay	$500 Copay	$500 Copay	50% after Deductible	50% after Deductible
RX Deductible – per person	$150 –Tier 2 & 3	Not Covered	$200 – Tier 2 & 3	$200 – Tier 2 & 3	$200 – Tier 2 & 3
Retail Pharmacy	$10 / $40 / $80		$10 / $50 / $90	$10 / $50 / $90	$10 / $65 / $95
Mail Order Pharmacy	$25 / $100 / $200		$25 / $125 / $225	$25 / $125 / $225	$25 / $162.50 / $237.50

Monthly Premium and Plan Selection ***Note: Liberty & Metro plans – exclude CVS pharmacy***

	Gold Freedom PPO	Gold Liberty EPO*	Silver Liberty EPO*	Silver Metro*
Single	❑ **$1,376.18**	❑ **$1,268.53**	❑ **$1,071.54**	❑ **$954.08**
EE/Spouse	❑ **$2,712.37**	❑ **$2,497.06**	❑ **$2,103.08**	❑ **$1,868.15**
EE/Child(ren)	❑ **$2,311.51**	❑ **$2,128.50**	❑ **$1,793.62**	❑ **$1,593.94**
Family	❑ **$3,848.12**	❑ **$3,541.31**	❑ **$2,979.88**	❑ **$2,645.12**

Waiver of Coverage

☐ I hereby waive coverage for myself and/or dependents in the Inter-City Insurance Fund medical plans

*If you elect the Gold EPO, Silver EPO or Silver Metro plan, you must select a primary care physician. If you do not elect a PCP, one will be elected for you. Please visit Oxford at https://www.oxhp.com/secure/providerSearch/content_doctor.html to find a network provider and note below:

Name	Relationship	SSN	Date of Birth	PCP Name	PCP Number
	Subscriber				

"By Signing below, in order to avoid cancellation, I agree to pay all insurance premiums by the end of the billing month."

Signature Date

Please return completed form via Secure Fax to: (914) 962-0108.
If you have any questions, please call (866) 573-4768 ext. 2481