



Service Station Dealers &
Automotive Services of Greater NY

Inter-City Insurance Fund

March 2025 Emblem Medical Election Form



EmblemHealth[®]

Full Name Station Name Effective Date

Home Address City State Zip

Email Address Home Phone Number Fax Number

Plan Features	Platinum Premier		Gold Premier		Silver Premier		Bronze Premier	Bronze Plus H.S.A
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Deductible / Maximum Period	3/1 – 2/28		3/1 – 2/28		3/1 – 2/28		3/1 – 2/28	3/1 – 2/28
Network	Select Care		Select Care		Select Care		Select Care	Select Care
PCP Selection & Referrals	Not Required		Not Required		Not Required		Not Required	Not Required
Part D Creditable	Creditable		Creditable		Creditable		Creditable	Creditable
Plan Year Deductibles (Indiv / Family)	\$250 / \$500	\$4,000 / \$8,000	\$500 / \$1,000	\$6,000 / \$12,000	\$5,800 / \$11,600	\$8,000 / \$16,000	\$7,600 / \$15,200	\$7,800 / \$15,600
Deductible Type	Embedded		Embedded		Embedded		Embedded	Embedded
Plan Year Out-of-Pocket Max (Indiv / Family)	\$2,550 / \$5,100	\$10,000 / \$20,000	\$8,000 / \$16,000	\$12,000 / \$24,000	\$9,200 / \$18,400	\$18,000 / \$36,000	\$9,200 / \$18,400	\$8,200 / \$16,400
Maximum Type	Embedded		Embedded		Embedded		Embedded	Embedded
Primary Care Visit	\$0 first 3 Visits then \$10 Copay	50% after Ded	\$0 first 3 Visits then \$25	50% after Ded	\$0 first visit, then \$35 Copay	50% after Ded	\$0 first visit, then 50% after Ded	50% after Ded
Specialist Visit	\$35 Copay	50% after Ded	\$50 Copay	50% after Ded	\$75 Copay	50% after Ded	50% after Ded	50% after Ded
Telemedicine Services	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge	\$0 Copay after Ded
Diagnostic Lab in PCP Office	\$10 Copay	50% after Ded	\$25 Copay	50% after Ded	\$35 Copay	50% after Ded	30% after Ded	30% after Ded
Diagnostic Lab in Specialist Office	\$35 after Ded	50% after Ded	\$50 after Ded	50% after Ded	\$75 after Ded	50% after Ded	50% after Ded	50% after Ded
X-Ray in PCP Office	\$10 after Ded	50% after Ded	\$25 after Ded	50% after Ded	\$35 after Ded	50% after Ded	30% after Ded	30% after Ded
X-Ray in Specialist	\$35 after Ded	50% after Ded	\$50 after Ded	50% after Ded	\$75 after Ded	50% after Ded	50% after Ded	50% after Ded
Hospital Outpatient Surgery	\$250 after Ded	50% after Ded	\$350 after Ded	50% after Ded	\$450 after Ded	50% after Ded	50% after Ded	50% after Ded
Hospital/Maternity Inpatient Services,	20% after Ded	50% after Ded	30% after Ded	50% after Ded	40% after Ded	50% after Ded	50% after Ded	50% after Ded
Mental Health Office Visit	\$0 first 3 Visits then \$10 Copay	50% after Ded	\$0 first 3 Visits then \$25 Copay	50% after Ded	\$0 first Visit then \$35 Copay	50% after Ded	\$0 first visit then 50% after Ded	50% after Ded
Ambulance Services	\$250 after Ded		\$350 after Ded		\$450 after Ded		50% after Ded	50% after Ded
Emergency Room	20% after Ded		30% after Ded		40% after Ded		50% after Ded	50% after Ded
Urgent Care	\$100 after Ded	50% after Ded	\$100 after Ded	50% after Ded	\$100 after Ded	50% after Ded	50% after Ded	\$100 after Ded
Prescription Drug Coverage								
Rx Plan Year Deductible	\$100 / \$200	N/A	\$150 / \$300	N/A	\$250 / \$500	N/A	Combined with Med, Tier 2 & 3	Combined with Medical, all tiers
Retail	\$5 / \$30 after Ded / \$75 after Ded	N/A	\$6 / \$40 after Ded / \$80 after Ded	N/A	\$20 / \$40 after Ded / \$115 after Ded	N/A	\$50 / 50% after Ded / 50% after Ded	\$35 / \$65 / \$115 after Ded
Mail Order	\$12.50 / \$75 after Ded / \$187.50 after Ded	N/A	\$15 / \$100 after Ded / \$200 after Ded	N/A	\$50 / \$100 after Ded / \$287.50 after Ded	N/A	\$125 / 50% after Ded / 50% after Ded	\$87.50 / \$162.50 / \$287.50 after Ded
MONTHLY PREMIUM AND PLAN SELECTION								
Single	<input type="checkbox"/> \$1,710.53		<input type="checkbox"/> \$1,377.22		<input type="checkbox"/> \$1,172.42		<input type="checkbox"/> \$1,021.95	<input type="checkbox"/> \$1,031.52
EE/Spouse	<input type="checkbox"/> \$3,328.06		<input type="checkbox"/> \$2,661.44		<input type="checkbox"/> \$2,251.84		<input type="checkbox"/> \$1,950.90	<input type="checkbox"/> \$1,970.04
EE/Child(ren)	<input type="checkbox"/> \$2,842.80		<input type="checkbox"/> \$2,276.17		<input type="checkbox"/> \$1,928.01		<input type="checkbox"/> \$1,672.22	<input type="checkbox"/> \$1,688.48
Family	<input type="checkbox"/> \$4,702.96		<input type="checkbox"/> \$3,753.03		<input type="checkbox"/> \$3,169.35		<input type="checkbox"/> \$2,740.51	<input type="checkbox"/> \$2,767.78

- CVS/Target is NOT an EmblemHealth participating pharmacy.
- Please visit EmblemHealth at <https://www.emblemhealth.com/Members> to find in network providers.
- EmblemHealth transaction/enrollment form must be completed in addition to medical election form for any changes.

“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

www.emblemhealth.com