Service Station Dealers & Automotive Services of Greater NY

Inter-City Insurance Fund

Oxford Health Plans®

January 2024 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 Gated EPO*	Silver Metro*
	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network Only
Benefit Period	January 1, 2024 – December 31, 2024				
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	$9,450 / $18,900	$9,450 / $18,900
Out-of-Pocket Type	Embedded	Aggregate	Embedded	Embedded	Embedded
Part D Creditable	Creditable		Creditable	Creditable	Creditable
Referral Needed	No		Yes	Yes	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***

Single	❑ **$1,318.02**	❑ **$1,165.21**	❑ **$977.57**	❑ **$888.22**
EE/Spouse	❑ **$2,606.04**	❑ **$2,300.42**	❑ **$1,925.14**	❑ **$1,746.44**
EE/Child(ren)	❑ **$2,219.63**	❑ **$1,959.86**	❑ **$1,640.87**	❑ **$1,488.97**
Family	❑ **$3,700.86**	❑ **$3,265.35**	❑ **$2,730.57**	❑ **$2,475.93**

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 Gated 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