Inter-City Insurance Fund
July 2023 UBF/Aetna-Meritain Medical Election Form

Service Station Dealers & Automotive Services of Greater NY

MERITAIN HEALTH An Aetna Company

_____
| Full Name | Station Name | Effective Date |

_____
| Home Address | City | State | Zip |

_____
| Email Address | Home Phone Number | Fax Number |

Plan Features	UBF/Aetna-Meritain - Sterling plan	
	In-Network	**Out-of-Network**
Benefit Period	CALENDAR YEAR (1/1-12/31) – Renewal 7/1	
Coverage Maximum	None, however, *Copays are associated to the 1st $30,000 in paid claims annually, then member will be responsible for 40% of each claim*	You will pay the most. Plan pays 100% of Medicare fee. Provider may also balance bill – difference between the provider's charge and what the plan pays
Part D Creditable	Non-Creditable	
Referral Needed	No	
Network	Aetna Choice POS II Open Access	N/A
Primary Care Visit, including Preventive Care	$5 Copay *	See Above
Specialist Visit	$45 Copay *	See Above
Hospital Outpatient Surgery	$500 Copay *	See Above
Hospital Inpatient Services	$500 Copay *	See Above
Emergency Room / Urgent Care	**ER:** $250 Copay **ER Transportation:** covered up to $1,500 **Urgent care:** $55 Copay *	See Above
Outpatient Lab, X-ray, Advanced Radiology	$5 Copay *	See Above
Specialty Rx	Not covered	
Retail & Mail Order Pharmacy	**Retail**: $5 Generic ** $30 Brand Name ** **Mail Order:** $30 Generic** $70 Brand Name*** **Max of $5,000, then Copay plus 40% ***Max of $5,000, then $50 plus 40%	Not Covered

Monthly Premium and Plan Selection	
Single	**$768.00**
Double: EE plus 1	**$1,507.00**
Family	**$2,135.00**

- The POS (Point of Service) medical plan, through United Benefit Fund / Aetna-Meritain Networks, deliver in-network only benefits with limited out of network coverage.
- Please visit Aetna-Meritain at https://www.aetna.com/docfind/custom/mymeritain to find a network provider or call (800) 343-3140.
- Birth Certificates must be submitted for all dependents, marriage licenses must be submitted for all spouses.
- **UBF enrollment form must be completed in addition to this medical election form**.

**"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