UnitedHealthcare
Oxford 6055 Operations
P.O. Box 30979
Salt Lake City, UT 84130-0979

UnitedHealthcare®
Oxford

12/17/2018

3511095BR0016038-21706-01
CLAUDE SIMON
71 TONJES RD
CALLICOON NY 12723-5729

12/17/2018

Important Tax Information
Under federal health reform law, individuals must have health insurance called minimum essential coverage. They must report this to the Internal Revenue Service (IRS) when they file their taxes. If they don't have coverage or it's not reported, they may have to pay a fee to the IRS. To show the IRS that you had coverage with UnitedHealthcare, we are sending Form 1095-B.

What is minimum essential coverage?
Minimum essential coverage may include health insurance through a government-sponsored program, eligible employer-sponsored plan, individual market plan or other coverage designated by the Department of Health and Human Services. Your UnitedHealthcare plan is minimum essential coverage.

What is Form 1095-B?
This is the IRS form you will use when you prepare your tax return to show you had minimum essential coverage. The form shows this information about your health insurance:

- Type of coverage you have
- Period of coverage
- Who was covered (including Dependents)

Why did you get more than one Form 1095-B?
You may have been covered under more than one policy during the year. You will get a separate Form 1095-B for each policy.

How will the IRS know who has health insurance?
Under IRS rules, health insurance issuers, such as UnitedHealthcare, must report who had coverage to the IRS. The IRS matches the information we send with the information taxpayers put on their tax return to determine who had minimum essential coverage.

Will dependents over age 18 covered under your plan get a separate copy of this form?
Dependents over age 18 covered under your plan will **not** get a separate copy of Form 1095-B. You should give a copy to individuals covered under your plan, if they need it for their records.

What if you had minimum essential coverage with another company?
You should receive a form 1095 from any other company that provided you minimum essential coverage.

What if you didn't have minimum essential coverage for the entire year?
If you didn't have minimum essential coverage for the entire year, you may have to pay a fee when you file your tax return. If you had a gap in coverage for less than three months, you may not have to pay a fee. If the gap was longer than three months and you couldn't afford coverage, you may qualify for an exemption. For more information on exemptions, visit HealthCare.gov.

Can you get this form electronically?
We encourage you to choose to get this form electronically. For more information about electronic delivery, please visit oxfordhealth.com.

Will this form be sent again next year?
You will get a form 1095 every year (to use when preparing your tax return) from any company that provided you minimum essential coverage.

Questions?
If you have any questions, please call us toll-free at the phone number on your health plan ID card. TTY users can dial **711**.

Sincerely,
UnitedHealthcare

Enclosure: Form 1095-B

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ **Do not attach to your tax return. Keep for your records.**
▶ **Go to *www.irs.gov/Form1095B* for instructions and the latest information.**

☐ VOID
☐ CORRECTED

560118

OMB No. 1545-2252

2018

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
CLAUDE		SIMON	***-**-1158	
4 Street address (including apartment no.) 71 TONJES ROAD	**5** City or town CALLICOON		**6** State or province NY	**7** Country and ZIP or foreign postal code UNITED STATES 12723
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ▶ B			**9** Reserved	

Part II Information about Certain Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
VERATEX			13-2804148
12 Street address (including room or suite no.) 534 WEST 42ND STREET SUITE 8	**13** City or town NEW YORK	**14** State or province NY	**15** Country and ZIP or foreign postal code 10036

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
Oxford Health Insurance, Inc.		22-2797560	800-444-6222
19 Street address (including room or suite no.) 601 Brooker Creek Blvd	**20** City or town Oldsmar	**21** State or province FL	**22** Country and ZIP or foreign postal code UNITED STATES 34677

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s) First name, middleinitial, last name			(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	d) Covered all 12 months	(e) Months of coverage											
						Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 CLAUDE		SIMON	***-**-1158		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that the individuals in your tax family (yourself, spouse, and dependents) had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision*.

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families* or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

CAUTION *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Other designated minimum essential coverage

TIP *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part also may be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN isn't entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095B* for instructions and the latest information.

☐ VOID

☐ CORRECTED

560118

OMB No. 1545-2252

2018

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
CAROLYN		SIMON	***-**-3469	
4 Street address (including apartment no.) 71 TONJES ROAD	**5** City or town CALLICOON		**6** State or province NY	**7** Country and ZIP or foreign postal code UNITED STATES 12723
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ▶ B			**9** Reserved	

Part II Information about Certain Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
VERATEX			13-2804148
12 Street address (including room or suite no.) 534 WEST 42ND STREET SUITE 8	**13** City or town NEW YORK	**14** State or province NY	**15** Country and ZIP or foreign postal code 10036

Part III Issuer or Other Coverage Provider (see instructions)

16 Name			17 Employer identification number (EIN)	18 Contact telephone number
Oxford Health Insurance, Inc.			22-2797560	800-444-6222
19 Street address (including room or suite no.) 601 Brooker Creek Blvd	**20** City or town Oldsmar		**21** State or province FL	**22** Country and ZIP or foreign postal code UNITED STATES 34677

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s) First name, middleinitial, last name			(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	d) Covered all 12 months	(e) Months of coverage											
						Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 CAROLYN		SIMON	***-**-3469		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2 HENRY		SIMON	***-**-1405		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3 CHARLES		SIMON	***-**-4825		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60704B

Form **1095-B** (2018)

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that the individuals in your tax family (yourself, spouse, and dependents) had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision*.

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families* or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

CAUTION *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Other designated minimum essential coverage

TIP *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part also may be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN isn't entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.