



Atlanta, GA 30374-0376

www.uhceservices.com

Due Date: 02/01/2026

NEW YORK NY 10022-4145

082399914800100000009464488353999498332



Expanding digital solutions – choose paperless invoicing

We appreciate this opportunity to help streamline administrative efficiencies and reduce paper mailings. Our records show that you are still receiving a paper invoice from us. Did you know that you can view your monthly invoice online and further reduce the amount of paper mail that you receive and handle?

Advantages of using the benefits administration website

In addition to being a resource for your specific plan information and covered employee population, **uhceservices.com** offers easy access to your premium invoices and payments. In the Billing and Payment Center of the website, you can:

- View invoices, payments, balances and statements
- Request “Bill vs. Paid” report
- Manage banking information

To go paperless and turn off delivery of your monthly premium invoice by U.S. Mail, please call the customer service phone number on this invoice to have **Electronic Invoice Delivery Only** selected.

Not registered yet?

Visit us at **uhceservices.com** and register using your Customer ID.

Once registered, you can:

- Sign up for paperless billing
- View, manage and pay your bill
- Make eligibility changes
- Request health plan ID cards and more

Easy access to your invoices and payments

- Sign in to **uhceservices.com** to view or print your company's monthly premium invoice
- For help signing in or registering on the website, call **1-866-908-5940**, TTY **711**, 8 a.m. to 8 p.m. ET, Monday – Friday

United
Healthcare

Invoice No: 350197149819
Invoice Date: 01/07/2026
Bill Group: 263066
Coverage Period: 02/01/2026 - 02/28/2026
Due Date: 02/01/2026

Summary

Description	Employee Count	Total Volume (000's)	Net Amount
312068-ALL ELIGIBLE EMPLOYEES			
NY P FRDM NG 20/40/100 PPO 26			
Employee	1		\$1,703.99
Employee & Child(ren)	1		\$2,896.79
Subtotal, NY P FRDM NG 20/40/100 PPO 26	2		\$4,600.78
Dental Voluntary P3366			
Employee	2		\$131.46
Subtotal, Dental Voluntary P3366	2		\$131.46
Subtotal 312068-ALL ELIGIBLE EMPLOYEES			\$4,732.24
Adjustments			
Account Adjustments			\$0.00
Current Adjustments			\$0.00
Subtotal, Adjustments			\$0.00
Subtotal Plan Charges			\$4,732.24
Grand Total			\$4,732.24

Questions? We're here to help.



Toll free 1-866-764-7736



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Consolidated Customer No: 9742999921
VERATEX
Customer No: 1351166

Invoice No: 350197149819
Invoice Date: 01/07/2026
Bill Group: 263066
Coverage Period: 02/01/2026 - 02/28/2026
Due Date: 02/01/2026

Details

Current Detail - 2/01-2/28/2026								Adjustment Detail			Totals
Policy No.	Name	Plan	ID	Coverage	Status	Vol (000's)	Charge Amount	Period	Code	Amount	Total
312068	D'alessio, Claudio	Dental Voluntary P3366	*****505900	E	A		\$65.73				\$1,769.72
312068	D'alessio, Claudio	NY P FRDM NG 20/40/100 PPO 26	*****505900	E	A		\$1,703.99				
312068	Simon, Carolyn	NY P FRDM NG 20/40/100 PPO 26	*****765600	EC	A		\$2,896.79				\$2,896.79
312068	SIMON, CLAUDE	Dental Voluntary P3366	*****036900	E	A		\$65.73				\$65.73
Subtotal Plan Charges							\$4,732.24	\$0.00			\$4,732.24
Grand Total											\$4,732.24

Coverage Type				Status		Code	
E	Employee Only	E4D	Employee and Four Dependents	A	Active	ADD	Retroactive Addition
ES	Employee and Spouse	E5D	Employee & One or More Dependent	C	Cobra	TRM	Retroactive Termination
ESC	Employee and Family	E6D	Employee & Two or More Dependents	P	Pre 65 Retiree	CHG	Retroactive Change
EC	Employee and Child(ren)	E7D	Employee & Three or More Dependents	R	Post 65 Retiree		
E1D	Employee and One Dependent	E8D	Employee & Four or More Dependents	S	Surviving Insured		
E2D	Employee and Two Dependents	E9D	Employee & Five or More Dependents				
E3D	Employee and Three Dependents						

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Invoice No: 835399949833
Invoice Date: 01/07/2026
Consolidated Customer No: 9742999921
Coverage Period: 02/01/2026 - 02/28/2026
Due Date: 02/01/2026

About Your Bill

Employee and dependent information contained on this invoice is based on the most current information provided by you in your capacity as Plan Administrator to Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company of New York.

Payment is due in full on or before 02/01/2026. If full payment is not received by the end of your grace period, your coverage may be terminated as stated in your policy requirements. For more information about grace periods, please see your plan documents (for example: Group Policy).

Your payment can take up to 10 days to post to your account. If we receive it after the Invoice Date, you'll see it in your next bill.

Eligibility Changes

Please be advised that we are not able to process eligibility changes sent with your payment.

See your plan documents for more information on how to make any policy, employee, and dependent changes.

Questions about your bill?

If you have any questions, please call us toll-free at 1-866-764-7736, TTY 711, 8 a.m. - 8 p.m. ET, Monday – Friday. Please have your billing customer number and bill group number available when you call.

Underwritten by Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company of New York

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