



Manage your Account: uhceservices.com

Invoice No: 350191548440
Invoice Date: 08/07/2023
Customer No: 1351166
Bill Group No: 263066
Coverage Period: 09/01/2023 - 09/30/2023
Due Date: 09/01/2023

DPS\$\$\$\$PKG
VERATEX
CLAUDE SIMON
PO BOX 682
NEW YORK NY 10108-0682

Account Summary

Previous Balance	\$3,891.79
Payments (-)	\$0.00
Account Adjustments (+/-)	\$0.00
Current Charges (+)	\$3,891.79
Total Balance Due	\$7,783.58

Thank you for your business.

About Your Payment

We offer several payment options to help you manage your account.

Pay Online. Go to uhceservices.com to make a one-time payment or schedule monthly payments directly from your bank account.

Pay By Phone. Call **1-888-201-4216**, TTY 711, 24 hours a day, 7 days a week, to make a payment directly from your bank account.

Pay By Check. Send a check to the address listed below. Checks returned for lack of funds or checks that can't be cashed for any reason are not considered payment.

Payment is due in full on or before the due date above. If full payment is not received by the end of your grace period, your coverage may be terminated as stated in your policy requirements. If a premium payment is deposited late, it does not automatically mean we will accept the premium.

Please detach and return with your payment.

Customer Name	Customer Number	Payment Due Date	Invoice #
VERATEX	1351166	09/01/2023	350191548440

Send payment to:

Minimum Amount Due: \$7,783.58

UHS Premium Billing
PO BOX 94017
Palatine, IL 60094-4017

Amount Enclosed

350198159400100000007783583501915484408

Invoice No: 350191548440
Invoice Date: 08/07/2023
Bill Group: 263066
Coverage Period: 09/01/2023 - 09/30/2023
Due Date: 09/01/2023

Summary

Description	Employee Count	Total Volume (000's)	Net Amount
312068-ALL ELIGIBLE EMPLOYEES NY P FRDM NG 20/40/100 PPO 23			
Employee	1		\$1,441.40
Employee & Child(ren)	1		\$2,450.39
Subtotal, NY P FRDM NG 20/40/100 PPO 23	2		\$3,891.79
Subtotal 312068-ALL ELIGIBLE EMPLOYEES			\$3,891.79
312068-ALL ELIGIBLE EMPLOYEES			
Adjustments			
Account Adjustments			\$0.00
Current Adjustments			\$0.00
Subtotal, Adjustments			\$0.00
TOTAL	2		\$3,891.79

Questions? We're here to help.



Toll free 1-888-201-4216



uhceservices.com

Invoice No: 350191548440

Invoice Date: 08/07/2023

Bill Group: 263066

Coverage Period: 09/01/2023 - 09/30/2023

Due Date: 09/01/2023

Details

Current Detail - 9/01-9/30/2023								Adjustment Detail			Totals
Policy No.	Name	Plan	ID	Coverage	Status	Vol (000's)	Charge Amount	Period	Code	Amount	Total
312068	D'alessio, Claudio	NY P FRDM NG 20/40/100 PPO 23	*****505900	E	A		\$1,441.40				\$1,441.40
312068	Simon, Carolyn	NY P FRDM NG 20/40/100 PPO 23	*****765600	EC	A		\$2,450.39				\$2,450.39
Total										\$0.00	\$3,891.79

Coverage Type	Status	Code
E Employee Only	A Active	ADD Retroactive Addition
ES Employee and Spouse	C Cobra	TRM Retroactive Termination
ESC Employee and Family	P Pre 65 Retiree	CHG Retroactive Change
EC Employee and Child(ren)	R Post 65 Retiree	
E1D Employee and One Dependent	S Surviving Insured	

Questions? We're here to help.



Toll free 1-888-201-4216



uhceservices.com

Invoice No: 350191548440
Invoice Date: 08/07/2023
Bill Group: 263066
Coverage Period: 09/01/2023 - 09/30/2023
Due Date: 09/01/2023

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.

Payment is due in full on or before 09/01/2023. 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 send all employee and dependent changes right away so they can be included on your next invoice.

We are not able to process eligibility changes sent with your payment. Please visit uhceservices.com to update eligibility information.

Please visit uhceservices.com to make eligibility changes, view and pay your bill, request paperless billing, request health plan ID cards and more!

Questions about your bill?

Call 1-888-201-4216, TTY 711, 8 a.m. - 5 p.m. ET.
Please have your billing customer number and bill group number available when you call.

Underwritten by Oxford Health Insurance, Inc.

Questions? We're here to help.



Toll free 1-888-201-4216



uhceservices.com



IMPORTANT NOTICE

Your Responsibility under New York Labor Law Section 217

You are responsible to notify all certificate holders of this termination. Certificate holders includes any employees and dependents who currently have Oxford¹ coverage, and any former employers and dependents who have COBRA and/or state continuation coverage underwritten by Oxford.

IMPORTANT: If you are replacing the terminating Oxford coverage with similar coverage for the same classes of employees and former employees (individuals who were eligible will remain eligible), you do not need to provide a notice of termination to the certificate holder.

In accordance with the provisions of Labor Law, section 217(4) and the provisions of 11 N.Y.C.R.R. Part 55, Labor Law section 217(3) (requiring notice to employees) shall not be deemed to apply if, at least 10 days prior to the date of the intended termination, as specified in this notice of intent to terminate, the policyholder has:

- (1) taken necessary steps whereby the intended termination is rendered null and void; or
- (2) contracted with another insurer to replace the existing insurer for the providing of similar coverage for the same certificate holders and filed an affidavit with the Commissioner of Labor and Superintendent of Insurance to that effect.

(i) Affidavits filed with the Commissioner of Labor shall refer to Labor Law, section 217, and be addressed to:

Director of Labor Standards
Department of Labor
Agency Building 12
State Office Building Campus
Albany, NY 12240

(ii) Affidavits filed with the Superintendent of Insurance shall refer to Labor Law, section 217 and 11 N.Y.C.R.R. Part 55, and shall be addressed to:

Chief, Health Bureau
New York State Insurance Department
One Commerce Plaza
Albany, NY 12257

If you are not replacing your terminated Oxford coverage, you must provide a copy of our termination notice and a letter from you to the certificate holders advising them of the termination of coverage to each of your affected employees as follows:

- At least **nine days** prior to the actual termination date, the notice and letter must be given to certificate holders either by hand-delivering them at their place of employment (this includes placing them in an employee's pay envelope), or mailing them to a certificate holder's last known residential address; and
- At least **nine days** prior to the actual termination date, you must post our notice of termination and the letter from you to your certificate holders advising them of the termination of coverage in conspicuous locations where you believe they will be noticed by the certificate holders.

Rights of certificate holders under the terminating policy: Oxford will not be liable for claims incurred past the termination date except when the certificate holder is eligible for extended benefits or conversion coverage. For more information and the time frames for requesting extended benefits or conversion coverage, please see the Certificate of Coverage.