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United
Healthcare



Invoice No: 350195182530

Invoice Date: 03/07/2025

Bill Group: 263066

Coverage Period: 04/01/2025 - 04/30/2025

Due Date: 04/01/2025

Summary

Description	Employee Count	Total Volume (000's)	Net Amount
312068-ALL ELIGIBLE EMPLOYEES			
NY P FRDM NG 20/40/100 PPO 25			
Employee	1		\$1,566.10
Employee & Child(ren)	1		\$2,662.36
Subtotal, NY P FRDM NG 20/40/100 PPO 25	2		\$4,228.46
Dental Voluntary P9398			
Employee	2		\$130.16
Employee & Child(ren)	1		\$131.37
Subtotal, Dental Voluntary P9398	3		\$261.53
Subtotal 312068-ALL ELIGIBLE EMPLOYEES			\$4,489.99
Adjustments			
Account Adjustments			\$0.00
Current Adjustments			\$0.00
Subtotal, Adjustments			\$0.00
Subtotal Plan Charges			\$4,489.99
Grand Total			\$4,489.99

Questions? We're here to help.



Toll free 1-866-764-7736

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Invoice No: 350195182530
 Invoice Date: 03/07/2025
 Bill Group: 263066
 Coverage Period: 04/01/2025 - 04/30/2025
 Due Date: 04/01/2025

Details

Current Detail - 4/01-4/30/2025								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 25	*****505900	E	A		\$1,566.10				\$1,631.18
312068	D'alessio, Claudio	Dental Voluntary P9398	*****505900	E	A		\$65.08				
312068	Simon, Carolyn	NY P FRDM NG 20/40/100 PPO 25	*****765600	EC	A		\$2,662.36				\$2,793.73
312068	Simon, Carolyn	Dental Voluntary P9398	*****765600	EC	A		\$131.37				
312068	SIMON, CLAUDE	Dental Voluntary P9398	*****036900	E	A		\$65.08				\$65.08
Subtotal Plan Charges							\$4,489.99			\$0.00	\$4,489.99
Grand Total											\$4,489.99

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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069IMBSTDARDBW0009001-11369-04

VERATEX

Customer Numbers: 1351166;09S0588

Invoice No: 835399991600

Invoice Date: 03/07/2025

Consolidated Customer No: 9742999921

Coverage Period: 04/01/2025 - 04/30/2025

Due Date: 04/01/2025



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 04/01/2025. 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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Toll free 1-866-764-7736



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