

# FAX

**To: 20220908-112257-582**

Company:

Fax: 2814993197

Phone:

**From: umr\_rm@uhc.com**

Fax:

Phone:

E-mail: UMR\_RM@UHC.COM

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## NOTES:




## Fax Information

To: 2814993197  
From: UMR  
Fax Number: 715-841-7569  
Date & Time: 09/08/2022 11:22:57

## Important Notes

Visit [www.umar.com](http://www.umar.com) to access interactive claim, benefits and eligibility, providing you with access copies of the Explanation of benefit documents, downloading capabilities and easy sorting of information.

## Need more information?

 Call 877-303-2414. When prompted for the employee's member ID, enter the following six digit **passcode: 565665**, followed by the pound sign. You will then be connected with a customer service representative. This passcode is valid only one time and expires two weeks after the date of this fax.

*Disclaimer:* Every effort is made to be sure that the information given to you today is accurate. If a conflict exists between the information provided to you and the terms of the plan, the terms of the plan will control. Final determination of coverage and patient responsibility is made at the time the claim is received and processed.

The information contained in this fax transmission is intended solely for the individual named above and may contain confidential and/or privileged information. Therefore, this fax must be secured and protected in accordance with state and federal laws regarding the treatment of confidential information, medical privacy or other requirements (legal or business practice). If you, the reader of this fax cover sheet, are not the individual named above or an authorized representative of the individual named above, you are hereby notified that any review, dissemination, use, copying or retention of this fax or any part of the information herein is strictly prohibited.

If you have received this fax in error, please notify the sender immediately by phone and destroy this fax.

Thank you.

Eligibility & Benefits Fax



Employee name:

Sheriff Olaleye

Employee ID:

21213115

Patient name:

Sheriff Olaleye

Patient birth date:

03/08/1976

Provider Network:

Unitedhealthcare Dental

Provider Network URL:

<http://www.yourdentalplan.com/dentistsearch>

Group number:

76414056

Employer:

FieldCore Service, Inc.

Effective date:

01/01/2022

Termination Date:




N/A












Covered **Basic:** Single X-rays, Biopsy Exams, Space Maintainers, After Hours Visits. Covered **Major:** Occlusal Guards, Core Builds, Relines, Rebases, Denture Repairs, Denture Adjustments. **Ortho:** no age limit. **Habit:** Habit Appliances are covered under Orthodontia benefit. Excluded: Teledentistry, Localized Delivery, Antimicrobial Agents









| Preventive And Diagnostic      |                |           |
|--------------------------------|----------------|-----------|
| TRADITIONAL                    |                |           |
| Benefit Period: 01/01 - 12/31  |                |           |
| Benefit                        | Benefit Max    | Met       |
| Individual deductible          | Not Applicable |           |
| Individual out-of-pocket       | Not Applicable |           |
| Individual lifetime deductible | Not Applicable |           |
| Family deductible              | Not Applicable |           |
| Family out-of-pocket           | Not Applicable |           |
| Benefit level                  | 100%           |           |
| Benefit level variance         | yes            |           |
| Individual annual maximum      | \$2,500.00     | \$1640.82 |
| Individual lifetime maximum    | Not Applicable |           |

| Basic                          |                |           |
|--------------------------------|----------------|-----------|
| TRADITIONAL                    |                |           |
| Benefit Period: 01/01 - 12/31  |                |           |
| Benefit                        | Benefit Max    | Met       |
| Individual deductible          | \$50.00        |           |
| Individual out-of-pocket       | Not Applicable |           |
| Individual lifetime deductible | Not Applicable |           |
| Family deductible              | \$150.00       | MET       |
| Family out-of-pocket           | Not Applicable |           |
| Benefit level                  | 80%            |           |
| Benefit level variance         | yes            |           |
| Individual annual maximum      | \$2,500.00     | \$1640.82 |
| Individual lifetime maximum    | Not Applicable |           |

| Major                          |                |     |
|--------------------------------|----------------|-----|
| TRADITIONAL                    |                |     |
| Benefit Period: 01/01 - 12/31  |                |     |
| Benefit                        | Benefit Max    | Met |
| Individual deductible          | \$50.00        |     |
| Individual out-of-pocket       | Not Applicable |     |
| Individual lifetime deductible | Not Applicable |     |
| Family deductible              | \$150.00       | MET |
| Family out-of-pocket           | Not Applicable |     |
| Benefit level                  | 50%            |     |
| Benefit level variance         | no             |     |

|   |                |   |
|---|----------------|---|
|  Individual annual maximum   | \$2,500.00     |  \$1640.82 |
|  Individual lifetime maximum | Not Applicable |   |

| Orthodontic   |                |   |   |  |
|---|----------------|---|---|--|
| TRADITIONAL   |                |   | Benefit Period: 01/01 - 12/31   |  |
| Benefit   | Benefit Max    | Met   |   |  |
|  Individual deductible       | \$50.00        |  |   |  |
|  Individual out-of-pocket    | Not Applicable |   |   |  |
| Individual lifetime deductible  | Not Applicable |   |   |  |
|  Family deductible           | \$150.00       | MET   |  |  |
|  Family out-of-pocket        | Not Applicable |   |   |  |
|  Benefit level               | 50%            |   |   |  |
|  Benefit level variance      | no             |   |   |  |
|  Individual annual maximum   | Not Applicable |   |   |  |
|  Individual lifetime maximum | \$2,500.00     |  |   |  |

| Limits   |             |         |                               |   |
|--|-------------|---------|-------------------------------|---|
| *Applied limits not available  |             |         |                               |   |
| TRADITIONAL  |             |         | Benefit Period: 01/01 - 12/31 |   |
| Benefit  | Benefit Max | Applied | Age Limit                     | Special Limit                                   |
|  Examination       | 2 per year  |         | none                          | none  |
|  Cleaning         | 2 per year  |         | none                          | none  |
|  Bitewings        | 1 per year  |         | none                          | none  |
|  Fluoride         | 1 per year  |         | to age 18                     | none  |
|  Panoramic x-ray  | 36 months   |         | none                          | none  |
|  Full mouth x-ray | 36 months   |         | none                          | none  |
|  Sealants*        | 36 months   |         | to age 15                     | teeth<br>2,3,14,15,18,19,30 & 31                |
| Crowns*  | 60 months   |         | none                          | none  |
| Bridges*   | 60 months   |         | none                          | none  |
| Dentures*  | 60 months   |         | none                          | none  |
|  Orthodontics*    | none        |         | none                          | employee, spouse, & children - age limits apply |

| Claim Submission  |  |
|---|--|
| UMR   |  |
|  PO Box 30541                  |  |
|  Salt Lake City, UT 84130-0541 |  |