University of New England Low (Core) Option Group Number: 6392 -500 3

Effective January 1, 202 4

## Outline of Coverage Delta Dental PPO Plus Premier Network



Northeast Delta Dental

Read Your Dental Plan Description Carefully >This Outline of C overage provides a	very brief descripti on of the important features of your	dental benefits plan . This is not the
insurance contract, and only the actual policy provisions will control. The Dental Pl	an Description itself sets forth in detail the rights and obligation	ns of both you and your ins urance
company. It is therefore important that you READ YOUR Dental Plan Description	CAREFULLY! Not all time limitations and exclusions are s	hown herein. Benefit percentages
shown are based on the actual charges submitted up to the Maximum Allowable Cha	UJH IRU SDUWLFLSDWLQJ GHQWLVW	V RU '-Hpla0otivo/ipDatinloH-dQenv11/s130.0@ V DO

Diagnostic / Preventive (Coverage A)	Basic Restorative (Coverage B)	Major Restorative (Coverage C)	
No Deductible	Calendar Year Deductible per Person /Family: \$25/\$75		

DIAGNOSTIC:

Evaluations twice in a 12 -month period; this includes

periodic, limited, problem -