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 Plan Description itself sets forth in detail the rights and obligations 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 shown herein. Benefit percentages shown are based on the actual charges submitted up to the Maximum Allowable Cha U J H I R U S D U W L F L S D W L Q J G H Q W L V W V R U ' H O W D ' H Q W D O @ V D O participating dentists.

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 -

Fluoride once in a 12-month period to age 19

Space maintainers to age 16

Sealant application to permanent molars, once in a 3 - yea r period per tooth, for children to age 19