University of New England
High Option
Group Number: 6392-5004
Effective January 1, 2024

Outline of Coverage
Delta Dental PPO Plus Premier Network

Northeast Delta Dental

Read Your Dental Plan Description Carefully—This Outline of Coverage provides a very brief description 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 insurance 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 Charge for participating dentists, or Delta Dental's allowance for non-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-mo.55ibh8(a)p11(O)-7(r)5(soi3(i)o