Dental Plans

Leidos offers two different types of dental plan options. Depending on where a participant lives, he or she may be able to choose between:

- The **Leidos Dental PPO Plan***, which allows participants to see any dentist they want; and
- **Dental Health Maintenance Organizations** (DHMOs), which have a network of dentists that participants can choose from to provide all of their care.

*The Leidos Dental PPO Plan is self-insured by Leidos, which means that Leidos fully funds the plan.

Eligibility

A Leidos employee is eligible to enroll in Leidos benefit programs under the following conditions:

Employee Eligibility	
Type of Coverage	**Eligibility Requirements**
Dental Program	• Must be an active, regular full-time employee working at least 30 hours per week; or • Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and • Must live in the geographic area served by a particular plan.

Dependents

Participants may also enroll their eligible dependents in some Leidos benefit programs. Dependents that are eligible to be enrolled in these programs are:

- The participant's legal spouse or registered domestic partner (See "**Registered Domestic Partners**"
- Each child of the participant or registered domestic partner* younger than age 26**, including:
  - A natural child or stepchild***;
  - An adopted child (coverage begins as of the earlier of the date the child was placed in the participant's home or the date of final adoption); and

- Any other child who depends on the participant for support and lives with the participant in a parent-child relationship, if the participant provides proof of legal guardianship.

- Unmarried children, age 26 and older who are incapable of self-sustaining employment because they are mentally or physically disabled, as long as:
  - The mental or physical disability existed while the child was covered under the plan and began before age 26;
  - The child is primarily dependent on the participant for support; and
  - The participant provides periodic evidence of incapacity.

Participants must notify the Leidos Employee Services, in writing, within 31 days of any change in dependent eligibility.

Important: If a Participant's Spouse, Registered Domestic Partner or Dependent Is a Leidos Employee

No one can receive "double coverage" under Leidos' benefit programs. Therefore, participants may not cover a spouse, registered domestic partner or dependent child if that spouse, registered domestic partner or child is also a Leidos employee and has elected his or her own coverage.

If a participant and his or her spouse or registered domestic partner are both Leidos employees, each can choose individual coverage or one can cover the other as a dependent — but not both.

If the participant has children, only the participant or spouse or registered domestic partner can choose coverage for dependent children.

Registered Domestic Partners

The participant may enroll his or her registered domestic partner and the registered domestic partner's eligible dependent children in participating medical, dental and vision plans in which the participant is enrolled.

For purposes of Leidos coverage, a registered domestic partnership is a committed same-sex or opposite-sex relationship, in which registered domestic partners:

- Live together at the same address and have lived together continuously for at least one year;
- Are not legally married to one another or anyone else;
- Do not have another registered domestic partner and have not signed a registered domestic partner declaration with another within the past year;
- Are mentally competent to consent to a contract or affidavit;
- Are not related by blood in such a way as would prohibit legal marriage; and
- Are jointly responsible for each other's common welfare and are financially interdependent.

A *Declaration of Domestic Partnership* must be completed, notarized and submitted with any other required documents in order to enroll a registered domestic partner. The Declaration must be presented to insurers upon request. Contact Leidos Employee Services for additional information on enrolling in registered domestic partner coverage. The *Declaration of Domestic Partnership* form can be found on the Prism Benefits hub.

Registered domestic partner coverage is different from spouse coverage. For instance:

- Participant contributions for registered domestic partner coverage and their eligible children must be paid on an after-tax basis;
- The value of benefits provided to a registered domestic partner and/or his or her eligible children is considered taxable income. As a result, the Leidos employee must pay any state, federal, FICA and other applicable tax withholding in the form of imputed income. This amount is based on the value of the coverage Leidos provides to the partner.

Dependent Eligibility Verification (DEV) Process

As a government contractor, the company is required by the Defense Contract Audit Agency (DCAA) to demonstrate that our claims for benefit costs are legitimate and ensure that we provide health and welfare benefit coverage only to eligible dependents of our employees. This ongoing verification also assures that the company does not bill the customer for medical costs associated with ineligible dependents.

To support this ongoing effort, the company maintains a Dependent Eligibility Verification (DEV) program which is administered by a third-party administrator, Budco. Throughout the year, Budco verifies that any dependent added to our plans is, in fact, eligible for coverage. This includes dependents who are enrolled as a result of new employees joining the company, a qualifying life event (i.e., marriage, birth), as well as new dependents added to our plans during the annual Open Enrollment (OE) period in the fall.

In addition to the ongoing verification process, the company is also required to perform random dependent verifications - even if an employee's dependents were previously verified. This is necessary in order to ensure that a dependent's eligibility remains unchanged.

If an employee receives a request from Budco to verify current dependents, even if the dependent has been verified before, it is critical that the request is not ignored. Failure to provide the requested documentation within the specified timeframe will result in the dependent(s) being deemed ineligible and removed from our plans.

Covering ineligible dependents is a violation of the company's Code of Conduct and could expose the company to sanctions from the government. The company's eligibility verification process helps ensure that we are compliant with our requirements as a government contractor.

Questions about the dependent eligibility verification program may be directed to Budco at 866-488-2001, or Leidos Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

How the Dental Plans Work

Leidos offers participants a choice when it comes to choosing the type of dental plan that works best for the participant and his or her family.

With the **Leidos Dental PPO Plan**, a participant can use any dentist he or she wants. However, when a participant uses dentists who participate in the Delta Dental PPO (Plus Premier) network, he or she will receive a higher level of benefits and pay lower out-of-pocket costs. This is because the Delta Dental PPO (Plus Premier) (www.deltadentalva.com) network providers have agreed to charge lower, negotiated fees for services. When a participant uses dentists outside the Delta Dental PPO (Plus Premier) network, he or she will receive a lower level of benefits and pay higher total out-of-pocket costs.

A **Dental Health Maintenance Organization (DHMO)** works just like a health maintenance organization, or HMO. There is no deductible, and there are no claim forms to file. Participants must choose a network provider, who will coordinate and provide dental care services at a fixed cost. If a participant does not coordinate his or her care through the primary care dentist, the plan will not pay benefits. DHMOs are available only in areas where there are participating dentists.

Please carefully review the sections pertaining to what the dental plans will and will not cover to find information on the dental plan exclusions. Additionally, the individual dental plan carriers should be contacted for information on the specific exclusions for dental work in progress.

Comparing the Dental Plans

The chart below provides an overview of covered dental services in the **Leidos Dental PPO Plan** and the **DHMOs**. For a complete list of DHMO benefits, a participant should refer to the plan's certificate of coverage.

Leidos Benefits Summary Plan Description

Download the Leidos Dental Plans Table

Dental Benefits				
	Leidos DENTAL PPO PLAN (Administered by Delta Dental)	**AETNA DMO Plan 58**	**CIGNA DENTAL F1-09**	**CIGNA INTERNATIONAL DENTAL**
Group Number:	700273	698685-51	3174168	00666
Member Services Phone #:	800-237-6060	877-238-6200	800-244-6224	800-441-2668 or 302-797-3100 (collect)
Plan Web Site Address:	**Delta Dental** (www.DeltaDentalVA.com)	**Aetna** (www.aetna.com)	**CIGNA** (www.cigna.com)	**CIGNA International Expatriates** (www.cignaenvoy.com)
Availability:	Nationwide	Nationwide except for Alabama, Alaska, Arkansas, Louisiana, Maine, Mississippi, New Hampshire, North Dakota, South Carolina, South Dakota Vermont and Wyoming. Service area based on dental plan's zip code eligibility criteria.	Nationwide except for Alaska, Hawaii, Maine, North Dakota, New Mexico, South Dakota, and Wyoming. Service area based on dental plan's zip code eligibility criteria.	Available for participants on International Assignments of 6 months or more
Choice of Dentist:	Any dentist. Using a PPO dentist results in higher benefit levels.	Select a dentist from a list of participating dentists in your area.	Select a dentist from a list of participating dentists in your area.	Any Dentist – Online directory available to search for Dentists in 450+ countries.

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F1-09	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	**NETWORK***	**OUT-OF-NETWORK****			
Annual deductible	$50 per person		No deductible	No deductible	$50 per person/ $150 per family
Annual maximum benefit	$1,500 per person		No maximum	No maximum	$1,500 per person
Preventive Services***	**Plan pays:**		**Plan pays 100% after:**		
Periodic oral examination	100% Not subject to deductible (2 per participant per calendar year)	100% of R&C Not subject to deductible (2 per participant per calendar year)	$0 copay	$0 copay	$0 copay (2 per participant per calendar year)
Prophylaxis/ Cleanings, Adult/Child including scaling and polishing (2 per year)	100% of R&C (2 per participant per calendar year)	100% of R&C (2 per participant per calendar year)	$0 copay (Limit 2 per calendar year)	$0 copay (Limit 2 per participant per calendar year; routine cleaning with no active periodontal disease; age frequency)	$0 copay (2 per participant per calendar year)
X-rays — Complete series	100% (1 per participant every 3 years)	100% of R&C (1 per participant every 3 years)	$0 copay	$0 copay (1 per participant every 3 years)	$0 copay (1 per participant every 3 years)
X-rays – One Set Bitewings	100% (2 per participant per calendar year)	100% of R&C (2 per participant per calendar year)	$0 copay	$0 copay (no limitation)	$0 copay (2 per participant per calendar year)
Topical application of sodium or stannous fluoride	100% (ages 18 and younger; 1 per participant per calendar year)	100% of R&C (ages 18 and younger; 1 per participant per calendar year)	$0 copay	$0 copay (Limit 2 per calendar year)	$0 copay (To age 18, 1 per participant per calendar year)

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F1-09	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	**NETWORK***	**OUT-OF-NETWORK ****			
Diagnostic Services	**Plan pays:**		**Plan pays 100% after:**		
Diagnostic X-rays	90%	80% of R&C	$0 copay	$0 copay	$0 copay
Single Film	90%	80% of R&C	$0 copay	$0 copay	$0 copay
Fissure Sealant, per tooth	90% (ages 13 and younger; once every 3 calendar years)	80% of R&C (ages 13 and younger; once every 3 calendar years)	$5 copay (up to age 15)	$0 copay	$0 copay (ages 13 and younger, 1 per tooth every 3 years)
Oral Surgery					
Simple Extraction	90%	80% of R&C	$0 copay (Extraction, erupted, exposed root)	$12 copay	Plan pays 80%
Surgical Extraction	90%	80% of R&C	$28 copay	$21 copay	Plan pays 80%
Impactions	90%	80% of R&C	$46 soft tissue; $58 partially; $100 completely	$15-$100 copay	Plan pays 80%
General Anesthesia (only for surgical extractions)	90%	80% of R&C	General Anesthesia (deep sedation) or Conscious IV Sedation (first 30 min): $165 copay; $70 copay for each additional 15 min	When medically necessary $190 copay (first 30 min); $84 copay for each additional 15 min	Plan pays 80% when determined to be medically necessary

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F1-09	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	**NETWORK***	**OUT-OF-NETWORK ****			
Fillings					
Amalgam Restoration of Primary Teeth/Permanent Teeth	90%	80% of R&C	$0 copay	$0 copay	Plan pays 80%
Composite Restoration	90%	80% of R&C	$0-$50 copay depending on type	$0-$115 copay	Plan pays 80%
Endodontics					
Root Canal Therapy	90%	80% of R&C	Anterior: $70 copay; Bicuspid: $85 copay; Molar: $240 copay	$14 - $370 copay (varies by tooth type)	Plan pays 80%
Pulpotomy	90%	80% of R&C	$14 copay	$21 copay	Plan pays 80%
Apicoectomy and Retro Fill	90%	80% of R&C	Anterior: $85 copay; Bicuspid (1 root): $85 copay; Molar (1st root): $90 copay; each additional root $55 copay	$58 - $220 copay	Plan pays 80%
Periodontics					
Periodontal Planning and Root Scaling	90%	80% of R&C	$55 copay	$80 - $165 copay	Plan pays 80%
Gingivectomy (per quadrant)	90%	80% of R&C	$100 copay (Limit 1 per quadrant every 3 years)	$105 - $220 copay per quadrant	Plan pays 80%

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F1-09	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	**NETWORK***	**OUT-OF-NETWORK ****			
Restorative Services	**Plan pays:**		**Plan pays 100% after:**		
Crowns – per unit	60%	50% of R&C	$180 - $220 copay depending on type	$335 - $415 copay	Plan pays 50%
Bridges – per unit	60%	50% of R&C	$210 copay per unit	$345 - $380 copay	Plan pays 50%
Stainless Steel Crowns	90%	80% of R&C	$50 copay	$12 copay	Plan pays 50%
Recementation	**Plan pays:**		**Plan pays 100% after:**		
Inlay	90%	80% of R&C	$10 copay	$12 copay	Plan pays 50%
Crown	60%	50% of R&C	$10 copay	$12 copay	Plan pays 50%
Bridge	60%	50% of R&C	$15 copay	$12 copay	Plan pays 50%
Prosthetics (Dentures)	**Plan pays:**		**Plan pays 100% after:**		
Complete Upper or Lower Denture	60%	50% of R&C	$275 copay	$575 copay	Plan pays 50% (1 per participant every 5 years)
Partial Upper or Lower Denture	60%	50% of R&C	$275 copay	$370 copay	Plan pays 50%
Denture and Partial Adjustment	60%	50% of R&C	$10 copay	$39 copay	Plan pays 50%
Denture Reline	90%	80% of R&C	$45 copay (chair side) $85 copay (laboratory)	$14 copay (chairside)	Plan pays 50%
Denture Duplication	60%	50% of R&C	Not covered	Not covered	Not covered
Denture and Partial Repairs	90%	80% of R&C	$25 - $86 copay	$65 copay	Plan pays 80%

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F1-09	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	**NETWORK***	**OUT-OF-NETWORK ****			
Prosthetics (Dentures) continued	**Plan pays:**		**Plan pays 100% after:**		
Adding Teeth or Clasps to Partial Denture – per unit	90%	80% of R&C	$35 - $40 copay	$65 - $85 copay	Plan pays 80%
Orthodontia	**Plan pays:**		**Plan pays 100% after:**		
Full Banded Case	50% up to a separate $1,500 lifetime maximum per participant: annual deductible applies; includes invisible braces	50% up to a separate $1,500 lifetime maximum per participant ; annual deductible applies; includes invisible braces	$1,545 copay, plus $30 orthodontic screening exam; $150 diagnostic records; $275 retention fee. Other fees may apply per Aetna's Dental Care Schedule	$2,184 (child) to $2,904 (adult) copay, plus $345 retention fee; $68 per-orthodontic treatment visit; $195 orthodontic treatment plan & records; $480 (child) $500 (adults); Other fees may apply per CIGNA's patient charge scheduled.	50% after separate $50 lifetime deductible; $1,500 lifetime maximum; includes invisible braces
Partial banded case	50% up to a separate $1,500 lifetime maximum per participant	50% up to a separate $1,500 lifetime maximum per participant	Not covered	Varies	50% after separate $50 lifetime deductible; $1,500 lifetime maximum; includes invisible braces
Annual maximum benefit	$1,500 per person		No maximum	No maximum	N/A

* Covered services received from a network provider will be paid based on the negotiated rate.

** Covered services received from an out-of-network provider will be paid based on the reasonable and customary (R&C) limit.

*** Preventive services are not subject to the annual deductible.

**** Participants are advised to refer to the Evidence of Coverage, contact the individual dental plan carrier and obtain a predetermination of benefits for services in excess of $150.

Leidos Dental PPO Plan

The Leidos Dental PPO Plan allows participants to choose any provider they wish and receive benefits. Whether a participant sees a **network provider** or an **out-of-network provider**, the plan covers a broad range of dental services and supplies. More information on the Leidos dental plans:

Paying for Care

This section will help participants understand how they pay for care under the Leidos Dental PPO Plan.

Employee Contributions

Leidos and participants share the cost of coverage. Each month, a participant who enrolls in the Leidos Dental PPO Plan contributes a set dollar amount to help pay for the cost of the plan. The contribution amount will vary based on the coverage level the participant has elected: employee only, employee plus spouse, employee plus one or more children or family coverage. These contributions are taken automatically from the participant's paycheck on a pre-tax basis. Premiums for domestic partners are paid by the participant on an after-tax basis.

Annual Deductible

The "deductible" is the initial $50 each participant must pay for dental services he or she receives each calendar year before the plan begins to pay benefits.

Coinsurance

"Coinsurance" is the percentage of eligible expenses a participant pays for dental services once he or she meets the deductible.

Annual Maximum Benefit

The annual maximum benefit is the total amount a plan will pay for covered dental services for a participant each plan year. Once a participant meets this yearly maximum, the plan will not pay any more benefits until the next plan year.

Each year, the Leidos Dental PPO Plan will pay a maximum of $1,500 per participant.

Note: There is a separate $1,500 lifetime maximum for orthodontic services per participant.

Plan Design

This section will help participants understand how the Leidos Dental PPO Plan pays benefits.

Network Benefits

If a participant goes to a network dentist, he or she saves money because dentists in the network have agreed to charge discounted fees. For most services, the participant must first meet the $50 **annual deductible**. Then, whenever the participant receives dental services, the Leidos Dental PPO Plan pays a percentage of the cost. The participant pays the remaining amount (the **coinsurance**).

There are no claim forms to file because the Delta Dental PPO (Plus Premier) network dentist submits claims for the participant.

Out-of-Network Benefits

When a participant uses a dentist who does not participate in the Delta Dental PPO (Plus Premier) network, that dentist is considered to be out of network.

For most services, each participant must first meet the $50 **annual deductible**. Then, whenever the participant receives dental services, the Leidos Dental PPO Plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage (the **coinsurance**) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own **claims** for reimbursement from the Leidos Dental PPO Plan. Check with your provider for information on their payment and claim filing policies.

Reasonable and Customary Limit

The reasonable and customary limit is the maximum amount the Leidos Dental PPO Plan will pay for a covered service, based on what dentists in the participant's geographic area charge for similar services. The determination of what the reasonable and customary limit is for a specific dental procedure is within the sole discretion of Delta Dental and is not subject to challenge or review.

What the Leidos Dental PPO Plan Covers

The Leidos Dental PPO plan includes only services in the list below.

Preventive Services

The Leidos Dental PPO Plan covers the following preventive services:

- Oral exam (two per participant per calendar year);
- Teeth cleaning (prophylaxis treatment to include scaling and polishing; two per participant per calendar year);
- Topical fluoride (limited to participants ages 18 and under; one per participant per calendar year);
- Bitewing X-rays (two per participant per calendar year);
- Full mouth X-rays (one per participant every 36 consecutive months); and
- Emergency treatment to relieve dental pain when no other definitive dental services are performed (not including X-rays)

Diagnostic Services

The Leidos Dental PPO Plan covers the following diagnostic services:

- Diagnostic X-rays used to diagnose a condition;
- Single X-ray films;
- Additional X-ray films;
- Fissure sealants (limited to participants ages 13 and under; once per participant every three calendar years);
- Simple extractions;
- Surgical extractions (soft tissue impaction, partial bony impaction, complete bony impaction);
- Impactions;
- General anesthesia — only eligible in conjunction with the following:
    - Removal of one or more impacted teeth on the same day;
    - The extraction of five or more teeth;
    - More than one surgical extraction involving more than one quadrant on the same day

- Amalgam restoration of primary or permanent teeth;
- Composite restoration;
- Root canal therapy — any X-ray, test, lab exam, or follow-up care is part of the allowance for root canal therapy and not a separate dental service;
- Pulp capping;
- Pulpotomy;
- Apicoectomy and retro fill;
- Apicoectomy and retro fill on separate appointment;
- Subgingival curettage;
- Gingivectomy; and
- Space maintainers, fixed unilateral (limited to non-orthodontic treatment)

Restorative Services

The Leidos Dental PPO Plan also provides benefits for the following restorative services:

- Crowns (including, but not limited to, porcelain with gold, cast gold);
- Bridges;
- Stainless steel crowns;
- Recementation:
    - Inlay;
    - Crown; or
    - Bridge;
- Complete upper or lower denture;
- Partial upper or lower denture;
- Denture and partial adjustments;
- Denture reline;
- Denture duplication;
- Denture and partial repairs; and
- Adding teeth or clasps to partial denture

Orthodontic Services

The Leidos Dental PPO Plan covers the following orthodontic services:

- X-rays and records;
- Initial banding;
- Periodic visits for comprehensive (usually 24 months) treatment for adults and children;

- Interceptive (extension of preventive orthodontics that may localize tooth movement) treatment; and
- Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Important: Temporomandibular Joint Dysfunction (TMJ) Appliances

The Leidos Dental PPO Plan will cover TMJ appliances if the participant's medical plan does not cover them. In such a case, the plan will cover TMJ appliances at 50% after the deductible, and subject to the annual benefit maximum.

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures or bridgework will be covered under the Leidos Dental PPO Plan. However, to be covered by the plan, satisfactory proof must be given that:

- The replacement or addition of teeth is required to replace those that were extracted after the present teeth or bridgework was installed, and the participant must have been covered when the tooth was extracted;
- The present denture or bridgework cannot be made serviceable and must be at least five years old; or
- The present denture is a temporary one and cannot be made permanent, so a permanent denture is needed. The participant must have been covered under this plan when the original tooth was extracted, and replacement must take place within 12 months from the date the temporary one was first installed.

Predetermination of Benefits

If a participant needs extensive dental work and the total charges will be in excess of $250, a Predetermination of Benefits is strongly recommended. This will help the participant and his or her dentist understand what is covered under the plan and what the participant's share of the costs will be before services are provided.

To request an advanced claims review, dentists may submit their treatment plan to Delta Dental for review and estimation of coverage before procedures are started. Delta Dental advises the patient and the dentist of what services are covered and what the payment would be. The actual payment for these predetermined services depends on eligibility, any plan limitations, coordination of benefits and the remaining maximum at the time services are performed.

A predetermination plan is subject to change based on the dentist’s participation status at the time of treatment and does not guarantee direct payment. Of course, predetermination is optional, but it is strongly recommended for dental services expected to exceed $250.

What the Leidos Dental PPO Plan Does Not Cover

The Leidos Dental PPO Plan does not cover, or provide any payment for, the following:

- Services and supplies not necessary, as determined by Delta Dental, for the diagnosis, care or treatment of the disease or injury involved. This applies even if the service or supply is prescribed, recommended or approved by the person's attending physician or dentist;
- Care, treatment, services or supplies that are not prescribed, recommended and approved by the person's attending dentist;
- Initial bridges and dentures for the replacement of missing teeth, which were already missing prior to the effective date of coverage in Leidos' plan;
- Services or supplies that are determined by Delta Dental to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if:
    - Insufficient outcomes data is available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
    - Approval has not been granted for marketing, if required by the **Food and Drug Administration** (www.fda.gov);
    - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
    - The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes;
- Services of a resident physician or intern rendered in that capacity;
- Charges that are not reasonable, as determined by Delta Dental;
- Charges that are made only because there is health coverage;
- Charges that a covered person is not legally obliged to pay;
- Services and supplies that are furnished or paid for, or for which benefits are provided or required:
    - By reason of the past or present service of any person in the armed forces of a government; or
    - Under any law of a government (this does not include a plan established by a government for its own employees or their dependents or by Medicaid);

- Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to repair an injury that occurs while the person is covered under this plan. Surgery must be performed:
    - In the calendar year of the accident that causes the injury; or
    - In the next calendar year; and
- Acupuncture therapy, including when it is:
    - Performed by a physician; and
- As a form of anesthesia in connection with surgery that is covered under this plan;.
- Orthodontic services and supplies for:
    - Retreatment
    - Changes in treatment required by an accident
    - Maxillofacial surgery
    - Myofunctional therapy
    - Treatment for cleft palate (unless for a child under 18)
    - Treatment of micrognathia (abnormal smallness of jaws) or macroglossia (congenital enlargement of tongue)
    - Treatment of primary or transitional dentition
- Dental expense not specifically described in the plan

Important: Malocclusion (Occlusal Guards)

The Leidos Dental PPO Plan will not cover Occlusal Guards since the participant's medical plan already provides coverage for them.

Filing Claims

If a participant receives dental care from an out-of-network provider, he or she may need to submit their own claim. To do so, complete a **Delta Dental claim form**. Submit all claims to:

Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018-8542

If a participant has concerns about how a claim has been administered or wishes to appeal a claims decision, information on relevant procedures is available in "**Claims Appeal and Review Procedures Under ERISA**" in the Plan Information section.

Coordination of Benefits

If a participant or a participant's dependents are covered under another dental plan, then that plan and the Leidos Dental PPO Plan will work together to pay up to 100% of the charges or the normal level of benefits, whichever is less.

When the Leidos Dental PPO Plan is the primary plan, benefits are paid without regard to any other plans. The participant is responsible for coordinating any benefits by submitting the Explanation of Benefits and itemized bill to the secondary plan.

Determining Which Plan Pays First

Leidos uses the following insurance industry guidelines for determining the primary and secondary payers for employees and dependents.

Employees

The plan that covers the participant as an employee is the primary payer. The plan that covers the participant as a dependent is the secondary payer.

Dependents

For an employee's spouse or registered domestic partner, a plan that covers the spouse or registered domestic partner as an employee is the primary payer for his or her claims. If an employee has elected coverage for his or her spouse or registered domestic partner as a dependent and the spouse or registered domestic partner has coverage through another employer, the Leidos Dental PPO Plan is the secondary payer.

For an employee's dependent children, the plan of the parent whose birthday occurs first in the calendar year is usually the primary payer. If an employee's spouse's or registered domestic partner's plan does not follow this "birthday rule," then the "gender rule" applies. That is, the plan covering the child's father as an employee pays first.

In the case of divorced or separated parents, benefits are determined in the following order:

- The plan of the parent who has financial responsibility by court decree;
- The plan of the stepparent who is the spouse or registered domestic partner of the parent who has custody of the child; and
- The plan of the parent who does not have custody of the child.

When none of these rules establishes order, benefits are paid first by the plan that has covered the person for the longer period of time, except that a plan that covers a laid-off or retired employee is secondary to a plan that covers a person as an active employee.

Dental Health Maintenance Organizations (DHMOs)

A DHMO is a network of dentists and specialists who provide dental care services at a fixed cost. With the DHMO, a participant does not have to meet a deductible or file any claim forms. The DHMO is available only in areas where there are participating dentists.

How the DHMOs Work

When a participant enrolls in a DHMO, he or she, as well as his or her dependents, must choose a primary care dentist. Each covered person may select his or her own primary care dentist. This primary care dentist will provide all routine dental care and will refer the participant to a network specialist whenever he or she needs specialty care.

For routine dental care — such as check-ups or fillings — a participant should make an appointment with his or her primary care dentist. When the participant goes in for the visit, he or she will pay the required copayment for covered services. The participant does not have to file a claim form after receiving care.

If a participant receives dental care without going through his or her primary care dentist first, or if the participant's care is not authorized by the plan, the DHMO will not pay any benefits. The participant will pay the full cost of any out-of-network or unauthorized care.

Choosing a Primary Care Dentist

The participant and each dependent must select a primary care dentist from the DHMO's network of providers.

Each participant can change his or her primary care dentist at any time during the year. To select or change a primary care dentist, a participant can call the Member Services number on the back of his or her ID card.

ID Cards

Participants enrolled in the Cigna DHMO plan will receive an ID card in the mail. This ID card contains important information about the participant, as well as about the benefits under the plan.

Participants enrolled in the Aetna DMO plan will not receive an ID card. However, Aetna will mail out a welcome letter that will contain the participant ID number and information regarding Aetna Navigator. The participant can register on the website and print out a paper ID card if they so choose.

What the DHMOs Cover

The DHMOs generally cover preventive, basic and major services. The DHMOs also generally cover orthodontiaservices.

Refer to a DHMO's certificate of coverage for a complete list of what is covered by the plan.

DHMO Benefit Charts and Evidences of Coverage

For highlights of each DHMO, participants can use the following links:

DHMO Benefit Charts		
Dental Plan	**Benefit Summary**	**Detailed Plan Information**
Aetna DMO®	**2018 Summary**	**Evidence of Coverage**
CIGNA Dental	**2018 Summary**	**Evidence of Coverage**
CIGNA International Dental Plan	**2018 Summary**	**Evidence of Coverage**

Continuing Dental Coverage After Plan Coverage Ends

A federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA) enables a participant and his or her covered dependents to continue dental insurance if their coverage ends due to a reduction of work hours or termination of employment (other than for gross misconduct). Federal law also enables a participant's dependents to continue dental insurance if their coverage stops due to the participant's death or entitlement to Medicare; divorce; legal separation; or when the child no longer qualifies as an eligible dependent. The participant must elect coverage according to the rules of the Leidos health care plans. Continuation is subject to federal law, regulations, and interpretations.

For more information about participants' rights under COBRA, the participant should refer to "**Continuing Health Care Coverage Through COBRA**" in the Plan Information section.

Participants in a DHMO should refer to that plan's certificate of coverage booklet for more information.