

**Leidos  
2025 Plan Year  
Benefit Verification**

PLAN NAME:  
PROVIDER:

High PPO Plus Premier  
Leidos Dental Plan Administered by Delta Dental of Virginia

MEMBER SERVICES PHONE #:

800.237.6060

PLAN WEBSITE ADDRESS:

<https://www.leidos.com/benefitspd/>

AVAILABILITY:

Nationwide

CHOICE OF DENTIST:

Any dentist. Utilizing in-network dentist results in higher benefit levels

Benefit Attribute	2025 Plan Year - In-Network - Employee Pays	2025 Plan Year - Out of Network - Employee Pays*
<b>DEDUCTIBLE AND MAXIMUM AMOUNTS:</b>		
Deductible per calendar year		\$50
Annual Maximum Benefit		\$2,000
<b>PREVENTIVE SERVICES</b>		
Oral Exam (twice per calendar year)	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
Teeth Cleaning (Prophylaxis/Treatment, to include Scaling and Polishing) (twice per year)	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
Periodontal Maintenance (Four visits per calendar year, less the number of regular teeth cleanings)	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
Topical Fluoride		Under age 19; Twice per calendar year; Not subject to deductible
Bitewing X-rays		Twice per calendar year
Full Mouth X-rays		Once every 60 months
<b>DIAGNOSTIC SERVICES</b>		
Diagnostic X-rays	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
Single Film	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
Each Additional Film	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
Fissure Sealant - per Tooth, Under Age 16, Once every 3 years	Covered 100% Not subject to deductible or annual maximum benefit	Covered 100% of non-par allowance Not subject to deductible or annual maximum benefit
<b>ORAL SURGERY</b>		
Simple Extraction	10%	20% of non-par allowance
Surgical Extraction	10%	20% of non-par allowance
Impactions	10%	20% of non-par allowance
General Anesthesia (only provided for surgical extractions)	10%	20% of non-par allowance
<b>RESTORATIVE</b>		
Amalgam Restoration of Primary Teeth	10%	20% of non-par allowance
Permanent Teeth	10%	20% of non-par allowance
Composite Restoration	10%	20% of non-par allowance

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<b>ENDODONTICS</b>		
Root Canal Therapy	10%	20% of non-par allowance
Pulp Capping	10%	20% of non-par allowance
Pulpotomy	10%	20% of non-par allowance
Apicoectomy and Retro Fill	10%	20% of non-par allowance
Apicoectomy and Retro Fill on Separate Appointment	10%	20% of non-par allowance
<b>PERIODONTICS</b>		
Subgingival Curettage (per quadrant)	10%	20% of non-par allowance
Gingivectomy (per quadrant)	10%	20% of non-par allowance
<b>CROWNS AND BRIDGES</b>		
Crowns - per unit	40%	50% of non-par allowance
Bridges (pontics) - per unit	40%	50% of non-par allowance
Stainless Steel Crowns	10%	20% of non-par allowance
Recementation		
Inlay	10%	20% of non-par allowance
Crown	10%	30% of non-par allowance
Bridge	10%	30% of non-par allowance
Implants	40%	50% of non-par allowance
<b>PROSTHETICS - DENTURES</b>		
Complete Upper or Lower Denture	40%	50% of non-par allowance
Partial Upper or Lower Denture	40%	50% of non-par allowance
Denture and Partial Adjustments	40%	50% of non-par allowance
Denture Reline	40%	50% of non-par allowance
Denture Duplication	40%	50% of non-par allowance
Denture and Partial Repairs	10%	20% of non-par allowance
Adding Teeth or Clasps to Partial Denture - per unit	10%	20% of non-par allowance
<b>TMJ/BRUXISM</b>	40%	50% of non-par allowance
<b>ORTHODONTIA</b>		
	Orthodontia services available to adults and children.	
Full Banded Case	50% up to \$2,000 lifetime maximum. Annual deductible does not apply.	
Partial Banded Case	50% up to \$2,000 lifetime maximum. Annual deductible does not apply.	
Invisible Braces; e.g. <i>Invisalign</i>	50% up to \$2,000 lifetime maximum. Annual deductible does not apply.	
Self-administered (or any type of "do it yourself") orthodontics; e.g. <i>SmileDirectClub</i>	Not Covered	

**Contact dental plan on coverage availability for dental work already in progress.**

\*If you go to an out-of-network dentist, Delta Dental bases its payment on the non-participating plan allowance for covered benefits. Members are responsible for the difference between the out-of-network dentist's charges and the non-participating plan allowance. All members may be responsible for their deductible, coinsurance and amounts exceeding the plan maximums.