Leidos Benefits Summary Plan Description

Dental Plans

Leidos offers two types of dental plans. A participant may be able to choose between the following plans depending on home zip code:

- The **Leidos Dental PPO (Plus Premier) Plans**, which allow participants to see any dentist; and
- **Dental Maintenance Organization** (DMO), which has a network of dentists that participants can choose from to provide all of their care.

Eligibility

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

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; Must live in the geographic area served by a particular plan.

Dependents

Participants may also enroll their eligible dependents in the Leidos dental plans. Eligible dependents include:

- 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, age26 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 update enrollment in Workday within 31 days of any change in dependent eligibility. For questions on enrollment, please contact Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

Important: Double coverage is not allowed under Leidos' benefit programs. Therefore, participants may not cover a spouse, registered domestic partner or dependent child who 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.

Registered Domestic Partners

The participant may enroll his or her registered domestic partner and the registered domestic partner's eligible dependent children in 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 contractor affidavit;
- Are not related by blood in such away as would prohibit legal marriage; and
- Are jointly responsible for each other's common welfare and are financially interdependent.

Employees must provide proof of Domestic Partnership Registration from a state or local domestic partner registry or submit a notarized *Declaration of Domestic Partnership* and any other required documents in order to enroll a registered domestic partner. The Declaration must be presented to insurers upon request. Contact Employee Services for additional information on enrolling a registered domestic partner.

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, Leidos 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, Alight. Throughout the year, Alight 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 (e.g., 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 Alight 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 Alight at 866-851-0731, or 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 the type of dental plan that works best for the participant and his or her family.

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

A **Dental Maintenance Organization (DMO)** 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. DMOs 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.

Leidos Dental PPO (Plus Premier) Plans

Leidos offers two Dental PPO (Plus Premier) plan options: the Dental PPO High and the Dental PPO Low. These plans allow participants to choose any provider they wish and receive benefits.

Whether a participant sees a network provider or an out-of-network provider, the plans cover a broad range of dental services and supplies.

Paying for Care

This section will help participants understand how they pay for care under the Leidos Dental PPO (Plus Premier) plans.

Employee Contributions

Leidos and participants share the cost of coverage. Each pay period, a participant who enrolls in the Leidos Dental PPO (Plus Premier) plans 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 basic and major dental services each calendar year before the plan begins to pay benefits.

Coinsurance

Coinsurance is the percentage of eligible expenses a participant pays for dental services after the deductible is met.

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. Preventive care and diagnostic services (typically x-rays, exams and cleanings) do not count against the annual benefit maximum.

The Dental PPO Low Plan will pay a maximum of $1,000 per participant, per plan year.

The Dental PPO High Plan will pay a maximum of $2,000 per participant, per plan year. **Note:** There is a separate $2,000 lifetime maximum for orthodontic services per participant.

Plan Design

This section will help participants understand how the Leidos Dental PPO (Plus Premier) Plan pays benefits.

Network Benefits

By visiting a network dentist, a participant 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 (Plus Premier) Plans pay a percentage of the cost. The participant pays the remaining amount (the coinsurance).

Participants have access to both of Delta's PPO and Premier networks. Thus, participants have a wider selection of in-network dentists. However, participants will generally have a higher out-of-pocket cost if they use a dentist in the Delta Dental Premier network. For more information, visit https://deltadentalva.com/members/leidos

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 basic and major services, each participant must first meet the $50 annual deductible. Note that the in-network and out-of-network dental deductible cross accumulates. This means that the deductible for in-network services will satisfy the deductible for out-of-network services (or vice versa). Once the deductible is satisfied, the Leidos Dental PPO (Plus Premier) Plans pay a percentage of the cost of services, up to the non- participating provider allowance. The participant pays the remaining percentage (the coinsurance) plus any amount above the non-participating provider allowance.

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

Non-Participating Provider Allowance

Delta Dental's Non-Participating Provider Allowance is the maximum amount the Leidos Dental PPO (Plus Premier) Plan will pay for a covered service rendered by an out-of-network provider. The allowance for a specific dental procedure is within the sole discretion of Delta Dental and is not subject to challenge or review.

Prevention First Program

Under the Prevention First Program, your preventive care and diagnostic services (typically X-rays, exams and cleanings) do not count against your Delta Dental annual benefits maximum. This means that the costs for preventive care are excluded from your annual allowance.

Healthy Smile, Healthy You Program

Members with the following conditions are eligible for an additional cleaning and exam beyond your plan limit per benefit period:

- Diabetes
- Pregnancy
- Certain high-risk cardiac conditions
- Cancer treatment
- Weakened immune system
- Kidney failure or dialysis

In addition, members with the following conditions are also eligible for fluoride applications and sealants beyond the Plan's age limitation: cancer, pregnancy, weakened immune system, kidney failure or dialysis.

Delta Dental's Special Health Care Needs Benefit

Members with special health care needs such as physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires specialized services or programs may receive the following additional benefits:

- Extra exam benefit for additional consultations with the dentist to help the member understand what to expect prior to treatment
- Up to four dental cleanings per year
- Treatment delivery modification including anesthesia for patients with sensory sensitivities, behavioral challenges and severe anxiety

Visit https://deltadentalva.com/special-health-care-needs-resources for instructions on how to utilize this benefit.

Delta Dental TeleDentistry Service

Employees and their dependents enrolled in Delta Dental can access a dentist through Delta Dental — Virtual Visits when their dentist is not available.

TeleDentistry is a safe and effective way to receive dental care and avoid the emergency room. Members can use TeleDentistry for:

- a dental emergency,
- access to a dentist after hours, or
- a consult while traveling

The TeleDentistry service can be accessed in all 50 states. A consultation counts as a problem-focused oral exam. Members can conveniently access TeleDentistry by a smartphone, tablet or computer with audio/visual capabilities. Visit DeltaDentalVA.com or call (866) 256-2101 for more information.

What the Leidos Dental PPO (Plus Premier) Plan Covers

The Leidos Dental PPO (Plus Premier) plan includes only services in the list below.

- Preventive and Diagnostic Services
- Basic Services
- Major Services
- Orthodontic Services

Preventive and Diagnostic Services

The Leidos Dental PPO (Plus Premier) Plans cover 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 age 18 and under; two per participant per calendar year);
- Bitewing X-rays (two per participant per calendar year);
- Full mouth X-rays (one per participant every 60 consecutive months);
- Diagnostic X-rays used to diagnose a condition;
- Single X-ray films;
- Additional X-ray films;

- Sealants and preventive resin restorations (limited to participants under the age of 16; once per participant every three calendar years); and
- Palliative emergency treatment of dental pain- minor procedure
- Space maintainers, fixed unilateral (limited to non-orthodontic treatment)

Basic Services

The Leidos Dental PPO (Plus Premier) Plans cover the following basic services:

- 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 three 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
- Recementation:
    - Inlay;
    - Crown; or
    - Bridge
- Stainless steel crowns
- Adjustments to complete and partial dentures;
- Repairs to complete and partial dentures
- Adding teeth or clasps to partial denture

Major Services

The Leidos Dental PPO (Plus Premier) Plans also provide benefits for the following restorative services:

- Crowns (including, but not limited to, porcelain with gold, cast gold);
- Bridges;
- Complete upper or lower denture;
- Partial upper or lower denture;
- Denture reline;
- Implants;
- Temporomandibular Joint (TMJ) Dysfunction

Orthodontic Services

The Leidos Dental PPO **High Plan** covers the following orthodontic services:

- X-rays and records;
- Initial banding;
- Periodic visits for comprehensive(usually24months) 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 retainers(s))

Temporomandibular Joint Dysfunction (TMJ) Appliances

The Leidos Dental PPO (Plus Premier) Plans cover TMJ appliances. The plan will cover TMJ appliances at 60% in-network/ 50% out- of-network under the PPO High Plan and 50% in-network/40% out-of- network under the PPO Low Plan. This is covered subject to the deductible and annual benefit maximum.

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 the 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 (Plus Premier) Plan Does Not Cover

The Leidos Dental PPO (Plus Premier) Plans do not cover, or provide any payment for the following unless specifically identified as a covered benefit:

- 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; 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; or
    - Approval has not been granted for marketing, if required by the Food and Drug Administration (www.fda.gov); or
    - 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
- Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting;
- Services provided by someone other than a licensed dentist or a qualified dental hygienist working under the supervision of a dentist;

- 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 that Delta Dental determines are for correcting congenital malformations; also, surgery for cosmetic purposes;
- Dental expense not specifically described in the plan;
- Services for injuries or conditions that may be covered under workers' compensation or similar employer liability laws or other medical plan coverage;
- Services provided before the date the participant enrolled under the Plan. Except as otherwise provided under the Plan, benefits for a course of treatment that began before the participant was enrolled under the Plan;
- Dental services provided after the date you are no longer enrolled or eligible for coverage, except as otherwise provided under the Plan;
- Prescription and non-prescription drugs, pre-medications, preventive control programs, oral hygiene instructions and relative analgesia, except as provided for under the Plan;
- General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit;
- Splinting or devices used to support, protect or immobilize oral structures that have loosened or been re-implanted, fractured or traumatized;
- Charges to complete a claim form, copy records, or respond to Delta Dental's request for information;
- Charges for failure to keep a scheduled appointment;
- Services or treatment provided to an immediate family member by the treating Dentist. This would include the Dentist's parent, spouse or child;
- Dental services and supplies for the replacement device or repeat treatment for lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices);
- Services billed under multiple procedure codes in which Delta Dental, in its sole discretion, determines that the service was either a component part of or inclusive of a more comprehensive or primary procedure code. This exclusion is subject to any and all internal and external appeals available. Delta Dental bases its payment on the Plan Allowance for the primary code, not the Plan Allowance for the underlying component code;
- Services billed under a dental procedure code that Delta Dental, in its sole discretion, determines should have been billed under a code that more accurately describes the dental service. Delta Dental bases its payments in its determination of the more accurate dental service code;
- Amounts that exceed the Plan Allowance for covered benefits;

- Replacement retainers
- A Dental Service that Delta Dental, in its sole discretion after consultant review by a licensed Dentist, determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Dental Necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry. All Dental Services are subject to established internal and external appeal processes available to you
- Dental Services for the diagnosis or treatment of illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical or major medical plan.
- Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges for X-ray interpretation
- Dental Services to the extent that benefits are available or would have been available if you had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or Dental Services for which you would not be obligated to pay in the absence of the coverage under this EOC or any similar coverage.
- Amounts assessed on Dental Services and/or supplies by state or local regulation.

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
5415 Airport Road NW
Roanoke, VA 24012

The participant may also download the claim form by visiting https://deltadentalva.com/members/leidos. The form can be submitted via email to CustomerService.HelpDesk@DeltaDentalVA.com. Participants must submit all claims for dental benefits within twelve (12) months of the date services are completed. For orthodontic services, a claim for benefits should be filed at the time of banding.

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 (Plus Premier) 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 (Plus Premier) 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. The Plan without a coordination provision is always the primary Plan; otherwise:

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 (Plus Premier) 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 the primary payer. If both parents have the same birthday, the Plan that covered the parent longer is primary. 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, the primary plan is determined in the following order:

- The plan of the parent who has financial responsibility by court decree;
- If there is no court order, the Plan of the natural parent with legal custody.
- If one parent re-marries or both parents re-marry, the Plan of the natural parent with legal custody

is the primary plan. The Plan of the child's custodial step-parent is the secondary plan. Plan benefits for the child's parent without legal custody are determined third. The non-custodial step-parent's plan benefits are determined fourth.

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.

ID Cards

ID cards are issued for members who are new to the plan or who have made plan changes to their previous enrollment. New cards are not issued at the beginning of each benefit year. If needed, members can access and print ID cards by logging into their account on DeltaDentalVA.com.

Dental Maintenance Organization (DMO)

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

How the DMO Plan Works

Participants, including dependents, who enroll in a DMO plan 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 when specialty care is needed.

For routine dental care — such as check-ups or fillings — a participant should make an appointment with the primary care dentist. When visiting a dentist, the participant 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 DMO plan 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 DMO'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, participants can call the Member Services number on their ID card.

ID Cards

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

What the DMO Plans Cover

The DMO plans cover preventive, basic and major services as well as orthodontia services.

Refer to the DMO's Benefit Summary or Evidence of Coverage for a complete list of what is covered by the plan.

Out-of-network coverage

Out-of-network coverage is provided only for services shown in the list of eligible dental services included in the Aetna DMO Schedule of Benefits. The “Amount payable by Aetna” applies only to eligible dental services provided by out-of-network providers. The amounts shown are not copayments, they are the maximum amounts that we pay under your plan for the listed eligible dental service.

When you get eligible dental services:

- You pay your out-of-network deductible
- You are responsible for any amounts above the maximum

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

Comparing the Dental Plans

The chart below provides an overview of covered dental services in the PPO and DMO plans. For a complete list of benefits, a participant should refer to the plans' Certificate of Coverage.

Dental Benefits				
	Delta Dental PPO (Plus Premier) Low Plan	**Delta Dental PPO (Plus Premier) High Plan**	**Aetna DMO**	**Cigna Global Dental**
Group Number:	700273	700273	698685-51	0666A
Member Services Phone:	800-237-6060	800-237-6060	877-238-6200	800-441-2668 or 302-797-3100 (collect)
Plan Website	https://deltadentalva.com/members/leidos	https://deltadentalva.com/members/leidos	www.aetna.com	www.cignaenvoy.com
Availability:	Nationwide. Also available in Puerto Rico, Guam and U.S. Virgin Islands	Nationwide. Also available in Puerto Rico, Guam and U.S. Virgin Islands	Nationwide except for Alabama, Alaska, Arkansas, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, South Dakota, Vermont and Wyoming. Service area based on dental plan's zip code eligibility criteria[5].	Available for participants on international assignments of 6 months or more
Choice of Dentist:	Any dentist	Any dentist	Select a dentist from a list of participating dentists in your area[5]	Any Dentist – Online directory available to search for dentists in 450+ countries
Annual Deductible	$50 per person	$50 per person	No deductible	$25 per person $75 per family
Annual Maximum Benefit	$1,000 per person	$2,000 per person	N/A	$1,500 per person

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna Global Dental
Preventive Services[3]	**Plan pays:**				**Plan pays 100% After**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Periodic Oral Examination (2 per participant per calendar year)	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible	$0 Copay	$0 copay
Prophylaxis / Cleaning, including scaling and polishing (2 per year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	$0 copay (Limit 2 per calendar year)	$0 copay (2 per participant per calendar year)
X-rays – Complete Series	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	$0 copay	$0 copay (1 per participant every 3 years)
X-rays – Bitewings (One Set)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	$0 copay	$0 copay (2 per participant per calendar year)
Topical application of fluoride	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	$0 copay	$0 copay (Up to age 18; 1 per participant per calendar year)

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna Global Dental
Diagnostic Services[4]	**Plan pays:**				**Plan pays 100% After**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Diagnostic X-rays	100%	100%	100%	100%	$0 Copay	$0 Copay
Single Film	100%	100%	100%	100%	$0 Copay	$0 Copay
Fissure Sealant (per tooth; once every 3 calendar years)	100% (under age 16)	100% (under age 16)	100% (under age 16)	100% (under age 16)	$5 copay (under age 16)	$0 Copay
Oral Surgery	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Simple Extraction	80%	70%	90%	80%	$0 Copay	Plan pays 80%
Surgical Extraction	80%	70%	90%	80%	$28 Copay	Plan pays 80%
Impactions	80%	70%	90%	80%	$46 soft tissue; $58 partially bony; $100 completely bony	Plan pays 80%
General Anesthesia (only for Surgical Extraction)	80%	70%	90%	80%	General Anesthesia (deep sedation) or Conscious IV Sedation (first 15 min): $104 copay; $83 copay for each additional 15 min	Plan pays 80% when determined to be medically necessary
Fillings	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Amalgam Restoration of Primary Teeth/Permanent Teeth	80%	70%	90%	80%	$0 Copay	Plan pays 80%
Composite Restoration	80%	70%	90%	80%	$0-50 Copay	Plan pays 80%

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna Global Dental
Endodontics	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Root Canal Therapy	80%	70%	90%	80%	Anterior: $70 Copay; Bicuspid: $85 Copay; Molar: $240 Copay	Plan pays 80%
Pulpotomy	80%	70%	90%	80%	$14 Copay	Plan pays 80%
Apicoectomy and Retro Fill	80%	70%	90%	80%	Anterior $85 copay; Bicuspid (1st root) $85 copay; Molar (1st root) $90 Copay; each additional root $55 copay	Plan pays 80%
Periodontics	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Periodontal Planing and Root Scaling	80%	70%	90%	80%	$55 Copay 4 separate quadrants per calendar year	Plan pays 80%
Gingivectomy (per quadrant)	80%	70%	90%	80%	$100 Copay	Plan pays 80%
Restorative Services	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Crowns (per unit)	50%	40%	60%	50%	$176 - $220 copay depending on type	Plan pays 50%
Bridges (per unit)	50%	40%	60%	50%	$210 copay per unit	Plan pays 50%
Stainless Steel Crowns	80%	70%	90%	80%	$35-$50 copay	Plan pays 50%
Recementation	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Inlay	80%	70%	90%	80%	$10 copay	Plan pays 50%
Crown	80%	70%	90%	80%	$10 copay	Plan pays 50%
Bridge	80%	70%	90%	80%	$15 copay	Plan pays 50%

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna Global Dental
Prosthetics (Dentures)	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Complete Upper or Lower Denture	50%	40%	60%	50%	$275 Copay	Plan pays 50% (1 per participant every 5 years)
Partial Upper or Lower Denture	50%	40%	60%	50%	$275 - $403 Copay	Plan pays 50%
Denture and Partial Adjustment	80%	70%	90%	80%	$10 Copay	Plan pays 50%
Denture Reline	50%	40%	60%	50%	$45 Copay (Chair Side) $85 Copay (Laboratory)	Plan pays 50%
Denture Duplication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not covered
Denture and Partial Repairs	80%	70%	90%	80%	$20 - $86 Copay	Plan pays 80%
Adding Teeth or Clasps to Partial Denture (per unit)	80%	70%	90%	80%	$35 - $40 Copay	Plan pays 80%
Orthodontia	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Full-Banded Case	Not covered	Not Covered	50% up to a separate $,2,000 lifetime max per participant; includes invisible braces; Not subject to deductible	50% up to a separate $2,000 lifetime max per participant; includes invisible braces; Not subject to deductible	$2,000 Member Copay	Plan pays 50% after separate $50 lifetime deductible; $1,500 lifetime max coverage; includes invisible braces
Partial-Banded Case	Not Covered	Not Covered	50% up to a separate $2,000 lifetime max per participant includes invisible braces; Not subject to deductible	50% up to a separate $2,000 lifetime max per participant; includes invisible braces; Not subject to deductible	Not covered	Plan pays 50% after separate $50 lifetime deductible; $1,500 lifetime max includes invisible braces

[1]Covered services received from a network provider will be paid based on the negotiated rate.
[2]Covered services received from an out-of-network provider will be paid based on Non-Participating Provider Allowance.
[3]Preventive services are not subject to the annual deductible and annual benefit maximum.
[4]Diagnostic services are not subject to the annual benefit maximum.
[5]Services provided by a non-participating dental provider may be available in the case of an emergency condition.

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 healthcare 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.