Leidos
2026 Plan Year
Benefit Verification

PLAN NAME:	**High PPO Plus Premier**
PROVIDER:	**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	2026 Plan Year - In-Network - Employee Pays	2026 Plan Year - Out of Network - Employee Pays*
DEDUCTIBLE AND MAXIMUM AMOUNTS:		
Deductible per calendar year	$50	
Annual Maximum Benefit	$2,500	
PREVENTIVE SERVICES		
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	
DIAGNOSTIC SERVICES		
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
ORAL SURGERY		
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
RESTORATIVE		
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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ENDODONTICS		
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
PERIODONTICS		
Subgingival Curettage (per quadrant)	10%	20% of non-par allowance
Gingivectomy (per quadrant)	10%	20% of non-par allowance
CROWNS AND BRIDGES		
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
PROSTHETICS - DENTURES		
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
TMJ/BRUXISM	40%	50% of non-par allowance
ORTHODONTIA	Orthodontia services available to adults and children.	
Full Banded Case	50% up to $2,500 lifetime maximum. Annual deductible does not apply.	
Partial Banded Case	50% up to $2,500 lifetime maximum. Annual deductible does not apply.	
Invisible Braces; e.g. *Invisalign*	50% up to $2,500 lifetime maximum. Annual deductible does not apply.	
Self-administered (or any type of "do it yourself") orthodontics; e.g. *SmileDirectClub*	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**