LEIDOS
2027 Plan Year Benefit Summary

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	In Network – Employee Pays	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 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
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 or annual maximum benefit	
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 (1st and 2nd Molars only), 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 or three or more simple extractions during the same visit)	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 (Primary Teeth only)	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	40%	50% of non-par allowance
Adding Teeth or Clasps to Partial Denture - per unit	40%	50% 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.

Plan includes Special Health Care Needs coverage, which provides coverage for general anesthesia and other delivery modifications such as nitrous oxide.

***When seeking services from an out-of-network provider, you will be responsible for the difference between Delta Dental's payment and the non-participating provider's charges (balance billing), even for diagnostic and preventive services.**