Schedule of Benefits

(GR-9N-S-01-001-01 PA)

Employer: **Leidos, Inc.**

Group Policy Number: **GP-698685**

Effective Date: **January 1, 2018**
Schedule: 1A
Cert Base: 1

For: DMO Dental Plan

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Managed Dental Plan

Schedule of Managed Dental Benefits *(GR-9N-22-005-02 PA)*

This Schedule Applies To Covered Expenses Provided By Network Providers.

Dental Emergency Maximum: $100

Dental Care Schedule

The following dental care schedule shows services that require a **copay**; and the **copay** amount.

Dental services that are considered **covered expenses** as shown in the dental care schedule must be given by **network providers**, at the dental office location. The exceptions to this rule are when **Aetna** approves referral care, or for out-of-area emergency dental care.

If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition, then the charge will be considered to have been made for a service that would have produced professionally acceptable result, as determined by **Aetna**.

This Schedule Applies to Services Provided by Network Providers

Primary Care Dentist Services *(GR-9N-S-22-010-01)*

Visits and Exams	Copayment Amount
Oral examination	$0
Emergency palliative treatment	$10
Prophylaxis (cleaning), (limited to 2 treatments per year)	
Adult	$0
Child	$0
Topical application of fluoride	$0
Oral hygiene instruction	$0
Sealants, per tooth (limited to children under age 16)	$5

Pulp vitality test	$0
Consultation	$0
Diagnostic casts	$0

X-ays and Pathology

Bitewing x-rays	$0
Entire series, including bitewings, or panoramic film	$0
Vertical bitewing X-rays (limited to 1 set every 3 years)	$0
Periapical x-ray	$0
Intra-oral, occlusal view, maxillary or mandibular	$0
Extra-oral upper or lower jaw	$0
Accession of oral tissue	$0

Endodontics

Pulp cap	$0
Pulpotomy	$14
Root canal therapy, including necessary x-rays	
Anterior	$70
Bicuspid	$85

Restorations and Repairs (Copayments for crowns and pontics are per unit.) There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown with an asterisk.

Amalgam restoration	
1 surface	$0
2 surfaces	$0
3 surfaces	$0
4 or more surfaces	$0
Resin-based composite restoration (other than for molars)	
1 surface	$0
2 surfaces	$0
3 surfaces	$0
4 or more surfaces or incisal angle	$0
Resin-based composite crown, anterior	$50
Retention pins	$6
Stainless steel crowns, prefabricated, primary tooth	$35
Stainless steel crowns, prefabricated, permanent tooth	$50
Recementing inlays or crowns	$10
Recementing bridges	$15
Sedative filling	$3
Inlays metallic*	$180
Crowns	
Procelain	$210
Procelain with metal (includes abutments)*	$210
Metallic (full cast) (includes abutments)*	$210
Metallic (3/4 cast)*	$220
Cast post and core*	$70
Prefabricated post and core	$63
Core buildup including pins	$40
Pontics	
Metallic (full cast)*	$210
Porcelain with metal*	$210

Full mouth rehabilitation, per unit (This means 6 or more covered units of crowns and/or pontics under one treatment plan.) $125

Dentures and Partials - (Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.)

Complete, upper or lower	$275
Partial, upper or lower	
Resin base	$275
Cast metal base	$350
Immediate, upper or lower (does not include charge for reline)	$315
Adjust complete denture, upper or lower	$10
Adjust partial denture, upper or lower	$10
Repair broken acrylic, complete denture, upper or lower	$25
Replace one tooth on complete denture	$20
Repair resin denture base, cast frame, broken clasp	$35
Replace broken tooth, partial	$35
Add tooth to existing partial denture	$35
Add clasp to existing partial	$40
Replace all teeth and acrylic on cast metal framework	$86
Rebase, complete denture, upper or lower	$86
Rebase, partial denture, upper or lower	$45
Reline, complete denture, upper or lower (chairside)	$45
Reline, partial denture, upper or lower (chairside)	$85
Reline, complete denture, upper or lower (laboratory)	$85
Reline, partial denture, upper or lower (laboratory)	$60
Interim partial denture, upper or lower (stayplate), anterior only	$20
Tissue conditioning for dentures	

Periodontics

Scaling and root planing, per quadrant (limited to 4 separate quadrants per 12 months)	$55
Scaling and root planing - 1 to 3teeth per quadrant (limited to once per site every 12 months)	$33
Periodontal maintenance procedures following surgical therapy (limited to 2 per 12 months)	$30
Occlusal guard (for bruxism only)	$70
Full mouth debridement - once per lifetime	$60

Oral Surgery - Includes local anesthetics and routine post-operative care

Extraction - exposed root or erupted tooth	$0
Extraction - coronal remnants - deciduous tooth uncomplicated	$0
Surgical removal of erupted tooth	$28
Surgical removal of impacted tooth (soft tissue)	$46
Incision and drainage of intraoral abscess	$20
Mobilization of erupted or malpositioned tooth to aid eruption	$30
Biopsy of oral tissue	$30

Space Maintainers - (only when needed to preserve space resulting from premature loss of primary teeth) Includes all adjustments within six months after installation

Fixed	$60
Removable	$70
Recement space maintainer	$12
Removal of fixed space maintainer (by dentist who did not place appliance)	$12

Specialty Services

	Copayment Amount
Endodontics - Includes local anesthetics where necessary	
Apicoectomy/periradicular surgery	
Anterior	$85
Bicuspid, first root	$85
Molar, first root	$90
Each additional root	$55
Retrograde filling, per root	$40
Root amputation, per root	$70
Molar root canal therapy	$240
Retreatment of previous root canal therapy	
Anterior	$170
Bicuspid	$185
Molar	$340

Oral Surgery - Includes local anesthetics where necessary and post-operative care	
Surgical removal of residual tooth roots	$25
Frenectomy	$34
Alveoloplasty in conjunction with extractions - per quadrant	$25
Alveoloplasty not in conjunction with extractions - per quadrant	$40
Surgical removal of impacted tooth	
Partially bony	$58
Completely bony	$100
Completely bony with unusual surgical complications	$100

Periodontics	
Gingivectomy or gingivoplasty - per quadrant	$100
Gingivectomy or gingivoplasty	$38
Gingival flap procedure - per quadrant	$110
Gingival flap procedure - 1-3 teeth one per quadrant	$66
Occlusal adjustment (other than with an appliance or restoration)	
Limited	$10
Complete	$60
Osseous surgery (including flap entry and closure) - per quadrant	$300
Osseous surgery (including flap entry and closure)	$180
Surgical revision procedure, per tooth	$120
Pedicle soft tissue graft	$230
Free soft tissue graft (including donor site surgery)	$245
Subepithelial connective tissue graft	$138
Soft tissue allograft	$275
Combined connective tissue and double pedicle graft	$227
Clinical crown lengthening	$180

Orthodontics	
Orthodontic screening exam (when no Orthodontic Procedure is performed)	$30
Orthodontic diagnostic records	$150

Comprehensive orthodontic treatment of adolescent and adult dentition	$1,545
Orthodontic retention	$275

General Anesthesia and Intravenous Sedation (only when provided in conjunction with a covered surgical procedure)

Deep sedation/General Anesthesia	
First 30 minutes	$165
each additional 15 minutes	$70
Intravenous conscious sedation/analgesia	
First 30 minutes	$165
each additional 15 minutes	$70

This Schedule Applies to Covered Expenses Provided by Out-of-Network Providers.

Dental Care Schedule *(GR-9N-S-22-015-01)*

Out-of-Network Deductible	$100
Copayment	The **copayment** is the amount of charges that exceeds the benefits payable under this coverage.

This dental care schedule shows services that are covered and maximum charge eligible under the plan for each service. Dental services that are considered **covered expenses** as shown in the dental care schedule must be given by a licensed **dentist**, at the dental office location. You are responsible for any amount above the Amount Payable shown.

The next sentence applies if:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition,

then the charge will be considered to have been made for a service that would have produced a professionally acceptable result, as determined by **Aetna**.

This Schedule Applies to Services Provided by Out-of-Network Providers

Primary Care Dentist Services *(GR-9N-S-22-020-01)*

Type A Services

Visits and Exams	**Amount Payable by Plan**
Office visit for oral examination	$12
Emergency palliative treatment	$12
Prophylaxis (cleaning) (limited to 2 treatments per year)	
Adult	$26
Child	$14
Topical application of fluoride	$16
Oral hygiene instruction	$12

Sealants; per tooth (limited to children under age 16)	$10
Pulp vitality test	$8

Consultation	$12
Diagnostic	$20
X-Rays and Pathology	
Bitewing x-rays	$8
Entire series; including bitewings; or panoramic film	$14
Vertical Bitewing x-rays (limited to 1 set every 3 years)	$12
Periapical x-rays	$6
Intra-oral; occlusal view; maxillary or mandibular	$8
Extra-oral upper or lower jaw	$12
Biopsy and histopathologic examination of oral tissue	$27

Type B Services

	Amount Payable by Plan
Endodontics	
Pulp cap	$3
Pulpotomy	$27
Root canal therapy; including necessary x-rays	
Anterior	$80
Bicuspid	$96
Restorations and Repairs	
Amalgam restoration	
1 surface	$12
2 surfaces	$16
3 surfaces	$24
4 or more surfaces	$26
Resin-based composite restoration (other than for molars)	
1 surface	$12
2 surfaces	$16
3 surfaces	$26
4 or more surfaces or incisal angle	$30
Retention pins	$14
Stainless steel crowns	$26
Prefabricated resin crowns (excluding temporary crowns)	$60
Recementing inlays; crowns; bridges; space maintainers	$16
Tissue conditioning for dentures	$26
Periodontics	
Scaling and root planing (limited to 4 separate quadrants every 12 months)	$40
Periodontal maintenance procedures following surgical therapy (limited to 2 per 12 months)	$40
Oral Surgery - Includes local anesthetics and routine post-operative care	
Extraction - exposed root or erupted tooth	$27
Surgical removal of erupted tooth	$32
Surgical removal of impacted tooth (soft tissue)	$40
Excision of hyperplastic tissue	$32
Excision of pericoronal gingival	$40
Incision and drainage of abscess	$20
Crown exposure to aid eruption	$26
Removal of foreign body from soft tissue	$20
Suture of soft tissue injury	$20

Type C Services

	Amount Payable by Plan
Restorations	
Inlays	
1 surface	$60
2 surfaces	$80
3 or more surfaces	$80
Onlays	
2 surfaces	$80
3 surfaces	$80
4 or more surfaces	$80
Crowns (including build-ups when necessary)	$120
Resin	$120
Resin with noble metal	$120
Resin with base metal	$120
Porcelain	$120
Porcelain with noble metal	$120
Porcelain with base metal	$120
Base metal (full cast)	$120
Noble metal (full cast)	$120
Metallic (3/4 cast)	$27
Post and core	$27
Pontics	
Base metal (full cast)	$20
Noble metal (full cast)	$20
Porcelain with noble metal	$20
Porcelain with base metal	$20
Resin with noble metal	$20
Resin with base metal	$20
Dentures and Partials - (includes relines; rebases and adjustments within six months after installation)	
Full (Upper or Lower)	$120
Partial	$120
Stress breakers (per unit)	$40
Interim partial denture; (stayplates); anterior only	$40
Crown and bridge repairs	$27
Adding teeth to an existing denture	$40
Full and partial denture repairs	$27
Relining/rebasing dentures (includes adjustments within six months after installation)	$40
Occlusal guard (for bruxism only); (limited to 1 every 3 years)	$40
Space Maintainers - (only when needed to preserve space resulting from premature loss of primary teeth). - Includes all adjustments within six months after installation	
Fixed; band type	$40
Removable acrylic with round wire clasp	$32
Removable appliance to correct habits	$32
Fixed or cemented appliance to correct habits	$40
Removal of fixed space maintainer (by dentist who did not place appliance)	$16

Speciality Services

Type B Services

	Amount Payable by Plan
Endodontics - Includes local anesthetics where necessary.	
Apexification/recalcification - per visit	$32
Apicoectomy	
First root	$60
Each additional root	$40
Retrograde Filling	$14
Root Amputation	$27
Hemisection	$27
Oral Surgery - Includes local anesthetics where necessary and post-operative care	
Removal of residual root	$27
Removal of odontogenic cyst	$40
Closure of oral fistula	$48
Removal of foreign body from bone	$20
Sequestrectomy	$20
Frenectomy	$40
Transplantation of tooth or tooth bud	$48
Alveoplasty in conjunction with extractions - per quadrant	$27
Alveoplasty not in conjunction with extractions - per quadrant	$40
Removal of exostosis	$60
Sialolithotomy; removal of salivary calculus	$36
Closure of salivary fistula	$36
Periodontics	
Gingivectomy or gingivoplasty - per quadrant	$40
Gingivectomy or gingivoplasty - per tooth	$20
Gingival flap procedure - per quadrant	$60
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	$20
Entire month	$40

Type C Services

	Amount Payable by Plan
Endodontics - Includes local anesthetics where necessary	
Complex Molar Root Canal Therapy	$120
Oral Surgery - Includes local anesthetics where necessary and post-operative care	
Surgical removal of impacted tooth	
Partially Bony	$53
Completely Bony	$60
Completely Bony with unusual surgical complications	$64
Periodontics	
Osseous surgery (including flap entry and closure) - per quadrant	$80
Osseous surgery (including flap entry and closure) - 1 to 3 teeth per quadrant	$40
Clinical crown lengthening	$40
Orthodontics	
Comprehensive orthodontic treatment of adolescent and adult dentition	
Post Treatment Stabilization	
Lifetime Maximum:	$800

Expense Provisions *(GR-9N-S-09-05-01 PA)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions *(GR-9N-S-09-05-01 PA)*

Out-of-Network Calendar Year Deductible
This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Copayments and Benefit Deductible Provisions *(GR-9N-S-09-015-01 PA)*

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

General *(GR-9N-28-01-01-PA)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.