

## Leidos Benefits Summary Plan Description

### 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 Low Plan	Delta Dental PPO High Plan	Aetna DMO (Plan 58)	Cigna International Dental
<b>Group Number:</b>	700273	700273	698685-51	0666A
<b>Member Services Phone:</b>	800-237-6060	800-237-6060	877-238-6200	800-441-2668 or 302-797-3100 (collect)
<b>Plan Website</b>	<a href="http://www.DeltaDentalVA.com">www.DeltaDentalVA.com</a>	<a href="http://www.DeltaDentalVA.com">www.DeltaDentalVA.com</a>	<a href="http://www.aetna.com">www.aetna.com</a>	<a href="http://www.cignaenvoy.com">www.cignaenvoy.com</a>
<b>Availability:</b>	Nationwide	Nationwide	Nationwide except for Alabama, Alaska, Arkansas, Louisiana, Maine, Mississippi, New Hampshire, North Dakota, South Carolina, South Dakota Vermont and Wyoming. Service area based on dental plan's zip code eligibility criteria.	Available for participants on international assignments of 6 months or more
<b>Choice of Dentist:</b>	Any dentist	Any dentist	Select a dentist from a list of participating dentists in your area.	Any Dentist – Online directory available to search for Dentists in 450+ countries
<b>Annual Deductible</b>	\$50 per person	\$50 per person	No deductible	\$25 per person \$75 per family
<b>Annual Maximum Benefit</b>	\$1,000 per person	\$1,500 per person	N/A	\$1,500 per person

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

Covered Services						
	Delta Dental PPO Low Plan		Delta Dental PPO High Plan		Aetna DMO (Plan 58)	Cigna International Dental
<b>Diagnostic Services</b>	<b>Plan pays:</b>				<b>Plan pays 100% After</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Diagnostic X-rays</b>	100%	100% of R&C	100%	100% of R&C	\$0 Copay	\$0 Copay
<b>Single Film</b>	100%	100% of R&C	100%	100% of R&C	\$0 Copay	\$0 Copay
<b>Fissure Sealant (per tooth)</b>	100% (ages 13 and younger; once every three calendar years)	100% of R&C (ages 13 and younger; once every 3 calendar years)	100% (ages 13 and younger; once every three calendar years)	100% of R&C (ages 13 and younger; once every 3 calendar years)	\$5 copay (up to age 16)	\$0 Copay (1 per tooth every 3 years)
<b>Oral Surgery</b>	<b>Plan pays:</b>				<b>You pay:</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Simple Extraction</b>	80%	70%	90%	80% of R&C	\$0 Copay	Plan pays 80%
<b>Surgical Extraction</b>	80%	70%	90%	80% of R&C	\$28 Copay	Plan pays 80%
<b>Impactions</b>	80%	70%	90%	80% of R&C	\$46 soft tissue; \$58 partially; \$100 completely	Plan pays 80%
<b>General Anesthesia (only for Surgical Extraction)</b>	80%	70%	90%	80% of R&C	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
<b>Fillings</b>	<b>Plan pays:</b>				<b>You pay:</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Amalgam Restoration of Primary Teeth/Permanent Teeth</b>	80%	70%	90%	80% of R&C	\$0 Copay	Plan pays 80%
<b>Composite Restoration</b>	80%	70%	90%	80% of R&C	\$0-50 Copay	Plan pays 80%



Covered Services						
	Delta Dental PPO Low Plan		Delta Dental PPO High Plan		Aetna DMO (Plan 58)	Cigna International Dental
<b>Endodontics</b>	<b>Plan pays:</b>				<b>You pay:</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Root Canal Therapy</b>	80%	70%	90%	80% of R&C	Anterior: \$70 Copay; Bicuspid: \$85 Copay; Molar: \$240 Copay	Plan pays 80%
<b>Pulpotomy</b>	80%	70%	90%	80% of R&C	\$14 Copay	Plan pays 80%
<b>Apicoectomy and Retro Fill</b>	80%	70%	90%	80% of R&C	Anterior \$85 copay; Bicuspid (1 <sup>st</sup> root) \$85 copay; Molar (1 <sup>st</sup> root) \$90 Copay; each additional root \$55 copay	Plan pays 80%
<b>Periodontics</b>	<b>Plan pays:</b>				<b>You pay:</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Periodontal Planning and Root Scaling</b>	80%	70%	90%	80% of R&C	\$55 Copay	Plan pays 80%
<b>Gingivectomy (per quadrant)</b>	80%	70%	90%	80% of R&C	\$100 Copay (Limit 1 per quadrant every 3 years)	Plan pays 80%
<b>Restorative Services</b>	<b>Plan pays:</b>				<b>You pay:</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Crowns (per unit)</b>	50%	40%	60%	50% of R&C	\$176 - \$220 copay depending on type	Plan pays 50%
<b>Bridges (per unit)</b>	50%	40%	60%	50% of R&C	\$210 copay per unit	Plan pays 50%
<b>Stainless Steel Crowns</b>	80%	70%	90%	80% of R&C	\$35-\$50 copay	Plan pays 50%
<b>Recementation</b>	<b>Plan pays:</b>				<b>You pay:</b>	
	<b>In-Network*</b>	<b>Out-of-Network**</b>	<b>In-Network*</b>	<b>Out-of-Network**</b>		
<b>Inlay</b>	80%	70%	90%	80% of R&C	\$10 copay	Plan pays 50%
<b>Crown</b>	50%	40%	60%	50% of R&C	\$10 copay	Plan pays 50%
<b>Bridge</b>	50%	40%	60%	50% of R&C	\$15 copay	Plan pays 50%

Covered Services						
	Delta Dental PPO Low Plan		Delta Dental PPO High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Prosthetics (Dentures)	Plan pays:				You pay:	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**		
Complete Upper or Lower Denture	50%	40%	60%	50% of R&C	\$275 Copay	Plan pays 50% (1 per participant every 5 years)
Partial Upper or Lower Denture	50%	40%	60%	50% of R&C	\$275 Copay	Plan pays 50%
Denture and Partial Adjustment	50%	40%	60%	50% of R&C	\$10 Copay	Plan pays 50%
Denture Reline	50%	40%	60%	50% of R&C	\$45 Copay (Chair Side) \$85 Copay (Laboratory)	Plan pays 50%
Denture Duplication	50%	40%	60%	50% of R&C	Not Covered	Not covered
Denture and Partial Repairs	80%	70%	90%	80% of R&C	\$20 - \$86 Copay	Plan pays 80%
Adding Teeth or Clasps to Partial Denture (per unit)	80%	70%	90%	80% of R&C	\$35 - \$40 Copay	Plan pays 80%
Orthodontia	Plan pays:				You pay:	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**		
Full-Banded Case	Not covered	Not Covered	50% up to a separate \$1,500 lifetime max per participant; annual deductible applies; includes invisible braces	50% up to a separate \$1,500 lifetime max per participant; annual deductible applies; includes invisible braces	\$1,545 Copay, plus \$30 orthodontic screening exam; \$150 diagnostic records; \$275 retention fee. Other fees may apply per Aetna's Dental Care Schedule	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 \$1,500 lifetime max per participant	50% up to a separate \$1,500 lifetime max per participant	Not covered	Plan pays 50% after separate \$50 lifetime deductible; \$1,500 lifetime max includes invisible braces

\* Covered services received from a network provider will be paid based on the negotiated rate.

\*\* Covered services received from an out-of-network provider will be paid based on the reasonable and customary (R&C) limit.

\*\*\* Preventive services are not subject to the annual deductible.

