



Schedule of 2017 Dental Benefits

Two Tier

Coverage \ Option	D001	D002		D003		D004	
Network	Passive	Network	Out of Network	Network	Out of Network	Network	Out of Network
Deductible	N/A	Per Calendar Year		Per Calendar Year		Per Calendar Year	
• Individual	\$0	\$0	\$50	\$0	\$50	\$0	\$50
• Family	\$0	\$0	\$150	\$0	\$150	\$0	\$150
Diagnostic/Preventive	100%	100%	90%	90%	80%	90%	80%
Basic	100%	85%	75%	80%	50%	80%	50%
Major	80%	75%	50%	60%	50%	60%	50%
Implants	50%	50%		50%		50%	
Calendar Year Maximum	None	\$2,500		\$2,000		\$1,500	
Orthodontics	50%	85%	75%	50%		Not covered	
Orthodontic Lifetime Max	\$7,000	\$2,000		\$1,500		Not covered	
Monthly Contribution	PEPM	Per EE Per Month		Per EE Per Month		Per EE Per Month	
• Single	\$55.84	\$38.22		\$26.62		\$22.03	
• Family	\$139.61	\$95.54		\$66.58		\$55.10	

Summary of Covered Dental Procedures

Diagnostic/Preventive	Exams, x-rays, cleaning of teeth, topical application of fluoride solutions, and space maintainers (to preserve existing space). Deductible does not apply to diagnostic and preventive services and such charges do not add to the calendar year maximum.
Basic	Fillings, endodontics (root canals), oral surgery (including surgical preparation for dentures and general anesthesia for covered oral surgery when administered by a licensed dentist), periodontics (surgical and non-surgical treatment of the gums), and denture repair.
Major	Crowns, bridges, partial and complete dentures, and denture adjustments
Implants	Procedures performed by a Dentist for implant surgical placement and removal; Implant supported prosthetics; Implant connecting bars; Implant repair and re-cementation. <i>(General Anesthesia is not covered in connection with Implants.)</i>
Orthodontics	Procedures to correct abnormalities in positioning of teeth (braces) and treatment of malocclusion.

Note – This is a basic summary of dental benefits only. Please refer to the specific Dental booklet or contact the Fund Office at 800-457-3481 for information about applicable benefit limitations and exclusions.

- All services are subject to review for necessity of treatment and may be subject to limitations or exclusions.
- Participants should use a Delta Dental PPO or Premier Network Provider for the lowest possible out-of-pocket cost.
- The rates shown in this schedule apply for new dental coverage and coverage changes **effective January 1, 2017**. New rates will apply January 1, 2018, so please contact the Fund Office before confirming rates for new 2018 groups.

National IAM Benefit Trust Fund 1300 Connecticut Ave., NW, Suite 300 Washington, DC 20036	www.iambtf.org 800-457-3481 – Ask for Fund Reps Carla x542 or Georgia x549	For additional information, or to add or change Dental coverage, please contact the Fund Office
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