

Teamsters 206 Employers Trust

February 1, 2026 - **Comparison** Summary of Welfare Plan Benefits - Dental Plan A

Benefit/Plan Feature	Trust Plan	Kaiser Permanente
Annual Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Annual Benefit Maximum⁽¹⁾	\$1,250	\$1,500 (Part A not included)
Part A Benefits		
Oral Exams	Plan pays 80% after the deductible	\$0 (Preventive and Diagnostic Services are not subject to or counted toward the deductible or Benefit Maximum)
Fluoride Application		
X-Rays		
Cleanings		
Space Maintainers		
Tooth Sealants		
Part B Benefits		
Apicoectomy	Plan pays 80% after the deductible	Plan pays 80% after the deductible
Endodontics; Pulpal Therapy		
Extractions		
Fillings		
Oral Surgery		
Periodontics		
Anesthetics – for Surgical Procedures		

Benefit/Plan Feature	Trust Plan	Kaiser Permanente
Repair of Prosthetics		
Part C Benefits		
Crowns, Bridges	Plan pays 50% after the deductible	Plan pays 50% after the deductible
Inlays, Onlays		
Prosthetics		
Orthodontia Benefits – Part D		
Orthodontic Services and Supplies	Not covered	Not covered

1) Annual maximum does not apply to enrolled children under age 18.

IMPORTANT: This summary is intended for **comparison** purposes only and is not intended to be called upon as a complete explanation of your benefits. In cases of claim dispute, the actual plan document of each plan will. Dental Indemnity Plan benefit payments are based on Moda's Filed Fees, Usual, Customary, and Reasonable charges or scheduled benefits. Please contact Moda Health toll-free 1-800-452-1058, if you have questions.

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February 1, 2026 - **Comparison** Summary of Welfare Plan Benefits - Vision

Benefit/Plan Feature	Trust Plan VSP Vision Plan	
	Your vision plan is funded by the Teamsters 206 Employers Trust. Your benefits may vary, depending upon whether you choose to see a VSP [®] participating provider or non-participating provider.	
Annual Deductible	None	
	<u>VSP Network Doctor</u>	<u>Non-VSP Provider</u>
Eye Examinations:		
Exam Frequency	One each 12 consecutive months from your last date of service	One each 12 consecutive months from your last date of service
Benefit Allowance ⁽¹⁾	Paid in full	Up to \$50
Prescription Lenses (when vision exam indicates new lenses are necessary):	One pair per 12 consecutive months from your last date of service	One each 12 consecutive months from your last date of service
Single Vision Lenses	In full	Up to \$50
Lined Bifocals	In full	Up to \$75
Lined Trifocals	In full	Up to \$100
Contacts (in lieu of glasses)	Up to \$60 copay for contact lens exam (fitting and evaluation) \$155 allowance for contacts	

Benefit/Plan Feature	Trust Plan	
	VSP Vision Plan	
Frames – when lenses are prescribed	One each 24 consecutive months from your last date of service	One each 24 consecutive months from your last date of service
Frame Benefit Allowance	Covered up to \$155 allowance. (20 percent discount off any additional out-of-pocket costs.)	Up to \$70

1) Benefit Allowance does not apply to enrolled children under age 18.

Note: “In Full” refers to the full charge for lenses and frames which are necessary for visual welfare. Cosmetic “extras” and frames which exceed the plan allowance are not covered.

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Please contact the Plan Administrator at 503-238-6961 or toll-free 1-866-230-6313, if you have questions.

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February 1, 2026 - **Comparison** Summary of Welfare Plan Benefits - Life, AD&D, and Disability

Benefit/Plan Feature	Trust Plan
TERM LIFE AND AD&D	
Life Benefit Amount	\$4,000
Accident, Death & Dismemberment Amount	\$4,000
	<i>For Dismemberment: Scheduled benefit</i>
WEEKLY DISABILITY	
Weekly Benefit	\$200 for each of the first 13 weeks \$235 for each of the last 13 weeks
Benefits Begin:	
For disability due to accident:	1st day
For disability due to illness:	8th day
Maximum Benefit Period	26 weeks

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Please contact the Plan Administrator at 503-238-6961 or toll-free 1-866-230-6313 if you have questions.