

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

2025 Benefits Guide



Platinum Plus



WELCOME TO YOUR BENEFITS ENROLLMENT

Open Enrollment is your annual opportunity to review your health care needs, as well as those of your family, and make any changes to your Fund coverage, such as changing plans or adding or dropping dependents.

Please review this guide carefully. Inside you will find instructions on how to make enrollment changes and comparisons of the health plans available to you.

If you do not wish to make any changes to your existing health coverage from the Fund, no action on your part is required at this time.

When Is Open Enrollment?

Open Enrollment begins on December 1, 2024, and ends on January 31, 2025.

Important Deadlines

If you submit your Enrollment Form to the Fund Office by December 31, 2024, your changes will be effective January 1, 2025.

If you submit your Enrollment Form after December 31, 2024, but no later than January 31, 2025, your changes will be effective February 1, 2025.

If you do not submit your Enrollment Form by January 31, 2025, your elections from 2024 will continue into 2025. This means that unless you experience a qualified life event, your next chance to change your benefit elections will be during the next Open Enrollment period for coverage effective January 1, 2026.



For detailed benefits information, scan the QR code and search for the Comparison Summary for the Platinum Plus Plan or visit ufcwdrugtrust.org/documents.

Note that throughout this guide, QR codes are provided for you to access the documents section of our website, ufcwdrugtrust.org. Paper copies are also available from the Fund Office. If you have any questions, please contact the Fund Office at (323) 666-8910, ext. 501.

Sincerely,

The Board of Trustees

Southern California Drug Benefit Fund

HOW TO ENROLL

- 1. Think about how your 2025 health care needs might be different from last year.** For example, you started taking a new prescription, a new child is on the way, your spouse was offered health coverage by their employer, or you now qualify to choose an HMO for medical coverage. Changes in your life might mean that a different plan makes more sense for you next year.
- 2. Review plan changes.** Some plan details will be different in 2025. You can read about the changes on page 5.
- 3. Gather documents.** To enroll new dependents, you must submit documents—a marriage or birth certificate, for instance—to verify each dependent's eligibility.
- 4. Return your completed and signed Enrollment Form and Authorization for Payroll Deduction, as well as any required dependent verification documents, to the Fund Office.** You can return your enrollment materials in person or by mail.

Now is the time to act.

If you don't submit your Enrollment Form by January 31, 2025, your benefit elections for 2024 will carry over into 2025. You cannot enroll or make changes to your benefits midyear unless you experience a qualified life event, like getting married or adding a child to your family. Your next opportunity to review your benefits will be during the next Open Enrollment period in 2025.





WHAT'S NEW?

The following recent benefits changes will continue to be in effect for the 2025 plan year:

- **A new prescription drug formulary (a list of preferred prescription drugs).** You received information about this change during the summer. If a prescription you take was affected, Optum Rx communicated with you directly in the fall of this year. If you didn't receive a notice from Optum Rx, this change doesn't affect your current medications. If you did receive the notice, be sure to share the formulary with your doctor.



Scan the QR code and search for the Prescription Drug Formulary or visit ufcdrugtrust.org/documents.

- **Additional precautions for some drugs.** Effective October 1, 2024, the Fund introduced new practices for opioids, diabetes medications, and weight-loss drugs. Those measures include:
 - **Step therapy:** For some prescribed drugs, patients must first try lower-cost alternatives before the Plan will cover the more expensive drug. If the lower-cost drug fails to treat the condition, the Plan will cover the more expensive drug.
 - **Prior authorization:** Review and authorization by Optum Rx are required before treatment with some medications may begin.
 - **Quantity limits:** Some medications are restricted to a specific amount within a specified time period to promote appropriate usage and ensure effectiveness.
- **Expanded benefits for participants with diabetes and a high risk of complications.** The new Diabetes Management Program provides high-risk diabetes patients with individual coaching support. Participants in the program will receive a continuous glucose monitor or a blood glucose meter with lancets and strips, all at no cost.
- **One provider network for both medical and behavioral health care.** Effective June 1, 2024, the Indemnity Medical Plan's Anthem Blue Cross of California Prudent Buyer network (Anthem PPO) replaced Uprise Health as the PPO network for mental health and substance use disorder services, which include an EAP to further support your mental wellness. See page 7.

ELIGIBILITY

Maintaining Your Eligibility

To continue your eligibility, you must work at least 23 hours per week on average.

Midyear Changes

Life events may change what you need from your benefits or who is eligible for benefits through the Fund. A life event that allows you to enroll or make certain changes to your benefits midyear is called a **qualified life event**.

Examples of qualified life events include:

- Marriage, divorce, or legal separation
- The birth, adoption, placement for adoption, or change in custody of your child
- A covered dependent child reaches age 26
- The death of a dependent
- A change in employment status
- Your spouse or domestic partner gains or loses eligibility for health coverage through their employer
- You receive a court order to provide health care coverage to a dependent child via a Qualified Medical Child Support Order

If you experience a life event, please contact the Fund Office to determine whether you can enroll or make midyear changes to your coverage.



Do you not have enough hours for coverage?

You may be able to continue your eligibility by making a self-payment. Scan the QR code to use our secure online payment system.

Who You Can Cover

In addition to yourself, you may enroll eligible dependents in health care benefits through the Fund. Eligible dependents include:

- Your legal spouse or domestic partner
- Your children (biological, adopted or placed for adoption, stepchildren, and children of your legal domestic partner) who are under age 26, regardless of dependency or marital status, and certain foster children
- Your disabled children who:
 - were enrolled in Fund coverage and became physically or mentally disabled before reaching age 26;
 - are fully dependent on you for support due to the disability; and
 - are claimed as dependents on your federal tax return

Special Rules for Working Spouses and Domestic Partners Under the Indemnity Medical Plan

The **Working Spouse Rule** applies if your spouse's or domestic partner's employer offers health care coverage. If your spouse or domestic partner is offered health benefits through their employer but they do not enroll in a plan that is the most comparable (or best available) to the Fund's coverage, the benefits payable by this Fund for your enrolled spouse or domestic partner will be reduced by 60% under the Indemnity Medical Plan, and you will be responsible for paying the balance for covered services.

About the Working Spouse Rule

If your benefit is reduced by 60% due to the Working Spouse Rule, you will be responsible for paying the balance due to providers as a result of the reduction, and this balance owed to the provider will not count toward the out-of-pocket maximum, even if you use an in-network provider.

The Fund provides you and your family with **Dual Coverage** if both you and your spouse or domestic partner enroll in family coverage and are both covered as an employee and a dependent spouse or domestic partner under the Indemnity Medical Plan. With dual coverage, the Fund will coordinate to provide you 100% of benefits coverage. You and your spouse or domestic partner must both enroll each other as dependents, as well as your dependent child(ren).

YOUR MEDICAL PLAN CHOICES

You have three medical plans to choose from during Open Enrollment.

Each provides you with valuable, affordable coverage. Review each plan carefully to determine the best option for you and your family:

- Indemnity Medical Plan
- The Kaiser HMO
- The UnitedHealthcare (UHC) HMO

Exception: If you were hired after December 31, 2023, (and you are not a Kaiser employee) your only medical plan option is the Indemnity Medical Plan.



Compare your medical plan options.

Scan the QR code and search for the Comparison Summary for the Platinum Plus Plan or visit ufcwdrugtrust.org/documents.

Indemnity Medical Plan

The Indemnity Medical Plan is a preferred provider organization (PPO) plan. Under this plan, you have the flexibility to visit any doctor or facility you choose. However, you are covered at a higher level when you visit providers in the Anthem Blue Cross Prudent Buyer network.

The Indemnity Medical Plan is available in all 50 states, so if you travel frequently or if you cover a dependent who lives in another state, this plan may work in your favor.



Be sure to get your preventive care.

Scan the QR code and search for the Indemnity Medical Plan Preventive Care Guidelines or visit ufcwdrugtrust.org/documents.

Indemnity Medical Plan—Employee Assistance Program (EAP)

If you are enrolled in the Indemnity Medical Plan, you and your dependents also have access to free counseling via the Employee Assistance Program (EAP) through Anthem. Note that the Anthem EAP is not available to participants enrolled in Kaiser and UnitedHealthcare. However, Kaiser and UHC offer resources and support, as described on their respective websites.

The Anthem EAP is available 24/7 to help you with depression, anxiety, stress, grief, or any other life challenge or simply a routine life problem. It connects you with a board-certified mental health professional within minutes. Counselors can talk you through what is on your mind and, if necessary, refer you to a provider in your area. EAP clinicians are equipped to address:

- Mental health concerns
- Substance abuse
- Financial, marital, parenting, and work challenges
- Loss of a loved one
- Anything else on your mind

Up to three sessions per issue, per year, and per person are 100% paid by the Fund. If you need additional counseling, mental health and substance use disorder services are covered under the Indemnity Medical Plan; be sure to seek care from an in-network provider for the greatest benefit coverage. Your EAP counselor may be able to refer you to an in-network provider.

To connect with the EAP anytime, call (800) 999-7222 or go to anthem.com/ca/eap and use the code **So CA Drug** to log in.

Using in-network providers saves you money.

To find doctors and facilities in the Anthem Blue Cross Prudent Buyer Network, visit anthem.com/ca/find-care.

Kaiser HMO

The Kaiser HMO is a health maintenance organization (HMO) plan. It offers a managed approach to in-network health care but with less flexibility than the Indemnity Medical Plan.

For the Kaiser HMO you must designate a primary care physician (PCP). Your PCP manages all your care and refers you for any specialty care you may need. **Out-of-network care is not covered (except in emergencies).**

Kaiser does not operate in every state. Therefore, if you cover a dependent who lives in a state in which Kaiser does not operate, you may want to consider a different option.

Stay within the Kaiser network.

With the Kaiser HMO you are responsible for 100% of the cost of any non-emergency out-of-network care you receive. Find a network provider at [my.KP.org](https://my.kp.org).

UnitedHealthcare HMO

The UnitedHealthcare (UHC) plan is a health maintenance organization (HMO) plan. Like Kaiser, the UHC HMO requires that you designate a PCP and use in-network providers from the SignatureValue network to receive coverage. **Out-of-network care is not covered (except in emergencies).**

Use the SignatureValue network.

To search for a network provider, visit myUHC.com. Click on **Find a Provider**, then the type of provider you are looking for (Medical or Behavioral Health). Click on **Employer and Individual Plans** and **Shopping Around** to view your UHC plan options. Then scroll down to select **SignatureValue Plans**, choose your state, and select **SignatureValue HMO**.



MEDICAL PLAN COMPARISON

Below is a summary of how common medical needs are covered under each plan when you use in-network providers.

	Indemnity Medical Plan	Kaiser HMO	UnitedHealthcare HMO
Annual deductible In-network	None	None	None
Annual out-of-pocket maximum	None	\$1,500 individual \$3,000 family	\$800 individual \$2,400 family
Preventive care/ screenings/ immunizations	No charge	No charge	No charge
Physician and specialist visits	\$10 copay	No charge	No charge
Urgent care visit	\$10 copay	No charge	No charge
Emergency room visit	Plan pays 100% of Contract Rates	No charge	\$35 copay, waived if admitted
Hospital services	Plan pays 100% of Contract Rates, up to 120 days/disability, including ICU and childbirth. After 120 days, Plan pays 80% of Contract Rates	No charge	No charge
Telehealth visit	You pay \$0 (Anthem LiveHealth Online only)	No charge	No charge
Labs and X-rays	No charge	No charge	No charge



Compare your medical plan options.

For more comparison details, scan the QR code and search for the Comparison Summary for the Platinum Plus Plan or visit ufcwdrugtrust.org/documents.

TELEMEDICINE

Need care now, but it's not life-threatening? Skip the ER or urgent care waiting rooms and use the telemedicine feature of the medical plan you're enrolled in.

With telemedicine, your copay is \$0 for a video visit with a U.S.-licensed doctor or therapist for convenient, secure care through your phone or computer for:

- Non-emergency medical conditions such as the flu, sore throat, allergies, and ear, eye, or sinus infections
- Minor rashes
- Prescriptions sent directly to your pharmacy.

Here's how to get started, based on your medical plan:

How to Get Started

Anthem	Use Anthem LiveHealth Online for medical or behavioral health virtual visits.* Download the Sydney app and register with your Anthem ID number. Or visit livehealthonline.com .
Kaiser	Call the phone number on the back of your ID card, 24/7, or log in to your Kaiser account or the Kaiser app to make an appointment.
UHC	Call the phone number on the back of your ID card, 24/7, or log in to your UHC account or the UHC app to make an appointment.

* Not all Anthem providers are part of LiveHealth Online, and telemedicine is only covered through LiveHealth Online.

Anthem members can download the Sydney app from Google Play or the App store.



PRESCRIPTION DRUG COVERAGE

When you enroll in medical coverage, you are automatically enrolled in the Fund's prescription drug coverage. Prescription drug benefits are administered by Optum Rx. You must use the Fund's participating pharmacy network to fill your prescription.



Need the pharmacy list?

Scan the QR code to search for the Participating Pharmacy Directory on our website or visit ufcwdrugtrust.org/documents.

Exception: If you are a Kaiser employee enrolled in the Kaiser HMO, your prescription drug benefit is through Kaiser. You must use Kaiser pharmacies to fill your prescription.

Kaiser Employees Enrolled in Kaiser HMO

Your prescription drug plan features a \$5 copay for all covered medications for a supply of up to 100 days per prescription.

Other Members—Using Your Prescription Drug Plan through Optum Rx

Medications are divided into tiers. The tier under which the drug falls determines how much you're required to pay. The first two tiers, Formulary Generic Drugs and Preferred (Formulary) Brand Drugs, have the lowest cost to you. The formulary is a list of covered medications and is available on the Optum Rx portal to assist you, or your provider, in identifying the most cost-effective medication.

Tier 1 (Formulary Generic Drugs) are those that match brand-name drugs in ingredients, effectiveness, and safety. They are the lowest-cost option. If you choose a more expensive drug when there's a generic option available, you're responsible for 100% of the cost difference in addition to the copay.

Tier 2 (Preferred Brand Drugs) are brand-name drugs that are on the plan's formulary. They are covered, but you pay a higher copay than you would with a generic. If you choose a formulary brand-name drug when a generic equivalent is available, you're responsible for 100% of the cost difference in addition to the copay.

Tier 3 (Non-Preferred Brand Drugs) are brand-name drugs covered by the plan, but they are not on the formulary because they are not as cost efficient and/or clinically superior to their alternatives on the formulary. To avoid paying 100% of the cost difference between formulary and non-formulary drugs, always ask your doctor for generic and formulary brand-name options when available.

Specialty drugs are generally high-cost drugs used to treat complex, chronic conditions such as rheumatoid arthritis, multiple sclerosis, and cancer. Often they are medications that are given through injection or infusion. Preauthorization from Optum Rx is required for coverage. Call Optum Rx at (800) 788-7871.

Tier E (Excluded Drugs) are not covered by the Plan as there are other options available that are lower cost and clinically equivalent.

Register for convenient access.

Register on optumrx.com to check the drug formulary and how much your copay will be.

Kaiser employees can check on prescription drug coverage at my.kp.org.

PRESCRIPTION DRUG PLAN COMPARISON (PLATINUM PLUS)

	Indemnity Medical Plan	Kaiser HMO (Non-Kaiser Employees)	UnitedHealthcare HMO	Kaiser HMO (Kaiser Employees)
Pharmacy network	So CA Drug Fund participating pharmacies			Kaiser pharmacies
Maximum days supply	30 days per prescription; 90 days for maintenance medications (see the list at OptumRx.com)			100 days supply per prescription
Tier 1 Formulary Generic	\$5 copay			\$5 copay
Tier 2 Formulary Brand	\$5 copay/prescription if no generic equivalent is available. \$8 copay/prescription if a generic equivalent is available, but your doctor indicates "dispense as written." If a generic equivalent is available, and your doctor does not indicate "dispense as written," you must pay the cost difference between the generic drug and the brand-name drug plus the \$8 copay.			\$5 copay
Tier 3 Non-Formulary	\$5 copay/prescription			Not covered
Specialty drugs	Plan pays 80% of Optum Rx's Contract Rate. Authorization required through Optum Rx. For UHC enrollees: Injectables that are prescribed by UHC physicians and provided by UHC are covered at 100% by the UHC plan and are not covered under the Prescription Drug Plan through Optum Rx.			\$5 copay

YOUR DENTAL PLAN CHOICES

You can choose between two dental plans during Open Enrollment. Both plans cover preventive, basic, and major dental services.

Your dental coverage also provides benefits for orthodontic treatment. However, all orthodontic treatment plans must be approved by the Plan's orthodontic consultant before treatment begins in order for benefits to be paid. Contact the Fund Office for more information.

Indemnity Dental Plan

The **Indemnity Dental Plan** is a PPO plan with networks through Delta Dental. This plan gives you the flexibility to visit the dentist of your choice, with the highest level of benefits paid when you choose a dentist in the Delta Dental PPO network.

Once you meet your deductible, the Plan pays benefits up to \$1,800 per person for the year. This \$1,800 annual dollar limit (benefit maximum) does not apply to participants under age 19.

Benefits are paid according to the Indemnity Dental Schedule, established by the Trustees.



To view the Platinum Plus Indemnity Dental Schedule, scan the QR code for the documents section of our website or visit ufcwdrugtrust.org/documents.

United Concordia Dental HMO

The **United Concordia** plan is a dental HMO that requires you to select a network primary care dentist who will coordinate all your dental care, including referral to specialists when needed. Although the plan limits your choice of dentist, it also has no deductible and no annual benefit maximum (which means your expenses are lower).



To view United Concordia's user guide about procedures and copays, scan the QR code or visit unitedconcordia.com.



DENTAL PLAN COMPARISON

	Indemnity Dental Plan	United Concordia
Deductible	\$50 individual \$150 family	\$0
Annual benefit maximum	\$1,800 per person for adults age 19 and older (does not apply to children)	None
Covered charges	The plan pays the lower of the amount listed in the Indemnity Dental Schedule, Delta's Allowable Amounts (for Delta Dental dentists), or the dentist's billed charges (for non-Delta Dental dentists)	See United Concordia's dental schedule

ORTHODONTIC COVERAGE

Orthodontic benefits are provided according to whether you use a contracted orthodontist.

	Contracted Orthodontists	Non-Contracted Orthodontists
Precertification required	All treatment plans must be approved by the Plan's Orthodontic Consultant before treatment begins. If treatment begins before precertification, no benefits will be paid. Contact the Fund Office for more information.	
Full treatment	The Plan allowance is \$3,200. The Plan pays \$3,000 of the Contract Rate after your copay of \$200	Plan pays 80% of charges, up to a maximum of \$3,000
Limited treatment	Plan pays 80% of the Contract Rate. You are responsible for the balance of the Contract Rate	Plan pays 80% of charges, up to a maximum of \$2,600
Phase One Treatment	The Plan allowance is \$1,250. The Plan pays \$1,050 of the Contract Rate after your copay of \$200	Plan pays 75% of charges, up to a maximum of \$2,500
Development Supervision	The Plan allowance is \$270. The Plan pays \$220 after your copay of \$50	Plan pays 80% of charges, up to a maximum of \$270
Lifetime Maximum Benefit	\$3,000	\$3,000



VISION COVERAGE

For vision care, each enrolled person receives an annual allowance of \$135 per year to use toward an eye exam, lenses, and frames.

Note that if you enroll in the Kaiser HMO or the UnitedHealthcare HMO, your health plan coverage includes an annual routine vision exam.



LIFE INSURANCE

As a plan participant, your loved ones have income protection in the event of your death. Your life insurance benefit is equal to \$15,000 or your salary over the past 12 months, whichever is greater. A benefit of \$2,000 is payable in the event of the death of your dependent spouse, domestic partner, or child.

To ensure that your life insurance benefit is paid to the right person or people, you must have a beneficiary form on file with the Fund Office.



Need the form?

Scan the QR code to access the Beneficiary Designation Form to complete and return to the Fund Office or visit ufcwdrugtrust.org/documents.

DISCLOSURES

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Annual Notice: Women's Health and Cancer Rights Act (WHCRA)

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy is performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

The Indemnity Medical Plan, Kaiser, and UnitedHealthcare provide coverage for mastectomies and reconstructive surgeries as required by this legislation. This coverage is subject to a plan's deductibles, coinsurance, and copayment provisions.

For questions regarding this coverage, Indemnity Medical Plan participants can contact the Fund Office's Medical Claims Department at (323) 666-8910, ext. 503. Kaiser and UHC participants can contact the HMO plan for further information.

Availability of HIPAA Notice of Privacy Practices

The Southern California Drug Benefit Fund (the "Fund") maintains a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information ("PHI") will be used or maintained by the Fund.

To obtain a copy of the Fund's HIPAA Notice of Privacy Practices, write or call your UFCW Union Local Insurance office or the Eligibility Department of the Southern California Drug Benefit Fund at 2220 Hyperion Avenue, Los Angeles, CA 90027, (323) 666-8910, ext. 501. You can also obtain a copy of the "Notice of Privacy Practices" from ufcwdrugtrust.org.



Scan the QR code to access the Notice of Privacy Practices document or visit ufcwdrugtrust.org/documents.

To obtain the Kaiser or UnitedHealthcare (UHC) Notice of Privacy Practices, contact Kaiser or UHC directly at the address or phone number provided in the HMO's Evidence of Coverage (EOC).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid (called Medi-Cal in California) or CHIP, and you're eligible for health coverage from the Fund or another employer (for example, your spouse's employer), your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit healthcare.gov.

DISCLOSURES CONTINUED

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

- California residents can contact the Health Insurance Premium Payment (HIPP) Program for more information on eligibility by calling (916) 445-8322 or by emailing hipp@dhcs.ca.gov. You can also visit their website at <http://dhcs.ca.gov/hipp>.
- If you are not a California resident, go to <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf> for a list of states with a CHIP program, along with contact information. (This list is current as of July 31, 2024.)

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office (California residents can call Medi-Cal at (800) 880-5305), dial **(877) KIDS NOW**, or visit insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must generally request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in the Fund's plan, contact the Fund Office at (877) 999-8329. You may also contact the Department of Labor at askebsa.dol.gov or call **(866) 444-EBSA (3272)**.

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
(877) 267-2323, Menu Option 4, Ext. 61565

Check out our redesigned website at ufcwdrugtrust.org for information about your benefits, 24/7.

Be sure to register for the Participant Portal where you can:

- View your personalized benefits dashboard
- Update your contact information
- Get a pension estimate
- Confirm your health care and dependent coverage

Scan the QR code to access the Participant Portal or visit our website.



SOUTHERN CALIFORNIA DRUG BENEFIT FUND

Resources

Trust Fund Office	(877) 999-8329	ufcwdrugtrust.org
Anthem Blue Cross (Prudent Buyer PPO)	Call the number on the back of your member ID card	anthem.com/ca/find-care
BlueCard (Network outside California)	(800) 810-BLUE (2583)	bcbs.com
Anthem EAP	(800) 999-7222	anthem.com/ca/eap
Anthem LiveHealth Online (Telehealth)		livehealthonline.com
Kaiser	(800) 464-4000	kp.org my.KP.org
UnitedHealthcare HMO	(800) 624-8822	myUHC.com
Optum Rx	(800) 788-7871	optumrx.com
Delta Dental	(800) 765-6003	deltadentalins.com
United Concordia Dental HMO	(800) 332-0366	ucci.com

This document is only a summary of the health care plans offered by the Southern California Drug Benefit Fund. Your receipt of this document does not constitute a determination of your eligibility for benefits, and the Board of Trustees reserves the right to amend or terminate the health care plans summarized herein. For further information, you should refer to the Summary Plan Description and the Evidence of Coverage (EOC) booklets provided by Kaiser, UnitedHealthcare, and United Concordia.