

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

2025 Benefits Guide



Retirees



WELCOME TO YOUR BENEFITS ENROLLMENT

Open Enrollment is your annual opportunity to review your health care needs, and 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 Retiree 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 feel free to contact the Fund Office at (323) 666-8910, ext. 500.

Sincerely,

The Board of Trustees

Southern California Drug Benefit Fund

HOW TO ENROLL

- 1. Think about how your 2025 health care or prescription drug needs might be different from last year.** For example, you started taking a new prescription, or you or your spouse becomes eligible for Medicare. 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 Drug Pension Medical Deduction Authorization ("Revocable Authorization") form, 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 make midyear changes to your benefits 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 for non-Medicare retirees and their covered dependents will continue 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 notice with your doctor.



Scan the QR code and search for the Prescription Drug Formulary or visit ufcwdrugtrust.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 8.

ELIGIBILITY

You must have acquired a minimum sum of age and service credits when you retired to be eligible for full retiree health care benefits, as described in this guide. If you don't, you may be eligible for prorated retiree health care benefits. Contact the Fund Office for details about prorated health care benefits.

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, children of your legal domestic partner, and certain foster children) under age 19, or under age 24 if a full-time student.
- Your disabled children who:
 - were enrolled in Fund coverage and became physically and mentally disabled before reaching age 19 (or age 24 if a full-time student);
 - are fully dependent on you for support due to the disability; and
 - are claimed as dependents on your federal tax return

Special Rules to Cover Dependents

Your dependents are not eligible for coverage from this Fund if they have other health care coverage available to them, regardless of whether they actually enroll in the other coverage.

"Other coverage" includes any coverage available through the dependent's employment or retirement or from your employment, regardless of whether a premium is required for such coverage. "Other coverage" does not include Medicare, Medicaid, or Tricare. It is your responsibility to notify the Fund Office when other coverage becomes available to your dependent(s).

Your Costs for Retiree Coverage

The monthly cost for retiree health coverage is:

- \$20 per Medicare-eligible person
- \$60 per non-Medicare-eligible person

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 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 19 (or age 24 if a full-time student)
- 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 make midyear changes to your coverage.



MEDICAL PLAN OPTIONS FOR NON-MEDICARE PARTICIPANTS

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

Each provides you with valuable, affordable coverage. For all three medical plan options, office visits with in-network providers are covered after you pay a copay per visit. For other services, you must meet your annual deductible first then the plan begins sharing costs with you, as shown in the chart on page 10.

Review each plan carefully to determine the best option for you and your family:

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

If your spouse is eligible for Medicare before you

If your spouse and/or dependents are Medicare-eligible, they will be enrolled in the Medicare plan that is complementary to the Non-Medicare plan you choose. For the Indemnity Medical Plan, the complementary Medicare plan is the Anthem Medicare Preferred PPO. See page 14 for more information about Medicare plans.

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.

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](https://www.anthem.com/ca/eap) and use the code **So CA Drug** to log in.

Using network providers saves you money.

To find doctors and facilities in the Anthem Blue Cross Prudent Buyer Network, visit [anthem.com/ca/find-care](https://www.anthem.com/ca/find-care).

Kaiser HMO

The Kaiser HMO is a health maintenance organization 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) HMO is a health maintenance organization (HMO) plan. Like Kaiser, the UHC HMO requires that you designate a PCP and use in-network providers to receive coverage. However, you have a choice of three networks when you enroll in this plan:

- SignatureValue Harmony (only available in some service areas)
- SignatureValue Alliance (only available in some service areas)
- SignatureValue HMO

You and all of your covered dependents must enroll in the same network. If you live in the service area of either the **Harmony** or the **Alliance** network, you will have the lowest out-of-pocket costs when you choose a PCP in one of those networks. If you live in the Harmony or Alliance service area, and you choose a PCP from the **SignatureValue HMO** network, you will pay more.

If you do not live or work within the service area of the Harmony or the Alliance network, you may choose a PCP from the **SignatureValue HMO** network, and your benefits will be the same as those under the Harmony and Alliance networks. **Out-of-network care is not covered (except in emergencies).**

Use the SignatureValue networks.

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 your SignatureValue network: Alliance, Harmony, or SignatureValue HMO.

NON-MEDICARE ELIGIBLE 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	\$500 individual \$1,000 family	\$500 individual \$1,000 family	\$500 individual \$1,000 family
Annual out-of-pocket maximum (includes deductible)	\$2,000 individual \$6,000 family	\$2,000 individual \$4,000 family	\$2,000 individual \$4,000 family
Lifetime maximum	\$1 million individual \$2 million family	Unlimited	Unlimited
In-network PCP and specialist visits	\$20 copay	\$20 copay	\$20 copay; but if enrolled in SV HMO in an area where Alliance or Harmony is available, \$35 copay
Urgent care visit	\$20 copay	\$20 copay	Within your medical group: \$20 copay; outside of your medical group: \$50 copay; but if enrolled in SV HMO in an area where Alliance or Harmony is available, \$75 copay
Emergency room visit	You pay 20% after deductible	You pay 20% after deductible	\$100 copay; but if enrolled in SV HMO in an area where Alliance or Harmony is available, \$150 copay Copay waived if admitted.
Hospital services	You pay 20% after deductible and \$100 copay	You pay 20% after deductible	You pay 20% after deductible; but if enrolled in SV HMO in an area where Alliance or Harmony is available, you pay 25%
Telehealth visit	You pay \$0 (Anthem LiveHealth Online only)	You pay \$0	\$20 copay
Labs and X-rays	You pay 20% after deductible	Most X-rays and labs: \$10 copay after deductible MRI, most CT and PET scans: \$50 copay after deductible	You pay \$0

* If you live in the Harmony or Alliance network service areas and choose the SignatureValue (SV) HMO network during Open Enrollment, your cost-share will be higher.



Compare your medical plan options.

For more comparison details, scan the QR code to find the Comparison Summary for the Retiree Plan on our website 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.

Low-cost care: With telemedicine, your copay is \$0 for the Indemnity Medical Plan or the Kaiser HMO and \$20 for the UnitedHealthcare HMO for any 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. Regardless of the non-Medicare plan you select, 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.

Note: Your prescription drug plan has a separate calendar-year deductible from your medical plan.

Using Your Prescription Drug Plan

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 for you.

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 lower cost and clinically equivalent options available.

Register for convenient access.

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

Drug Coverage Highlights

Your prescription drug coverage is the same, regardless of the non-Medicare medical plan option you are enrolled in.

	Indemnity Medical Plan	Kaiser HMO	UnitedHealthcare HMO
Calendar-year deductible	\$50 per person		
Maximum benefit	\$25,000 per person per calendar year		
Tier 1 Formulary generic	\$12 copay after deductible		
Tier 2 Preferred brand	\$30 copay after deductible		
Tier 3 Non-preferred brand	\$50 copay after deductible		
Specialty drugs	20% coinsurance after deductible		

Copays are for a 30-day supply at participating pharmacies. 90-day supplies are available for maintenance medications.

MEDICAL PLAN OPTIONS FOR MEDICARE-ELIGIBLE PARTICIPANTS

If you are eligible for Medicare and enrolled in Part A and Part B, the Fund offers three Medicare Advantage Prescription Drug (MAPD) options for retiree health care for medical and prescription drug coverage.

Your plan options to choose from are:

- Anthem Medicare Preferred PPO
- Kaiser Senior Advantage HMO
- UHC Medicare Advantage HMO

Medicare Advantage plans replace Original Medicare and require you to use the plan's network of providers to receive the maximum benefit.

If your spouse isn't eligible for Medicare

If your dependents are not Medicare-eligible, they will be enrolled in the non-Medicare plan that is complementary to the Medicare plan you choose. For Anthem Medicare Preferred PPO, the complementary non-Medicare plan is the Indemnity Medical Plan. See page 8 for the benefits under the non-Medicare medical plan options.

Quick Comparison of Medicare Plan Choices

Deciding which Medicare plan is right for you may come down to which network your providers participate in.

	Anthem Medicare PPO	Kaiser Senior Advantage HMO	UHC Medicare Advantage HMO
Provider network	Flexibility to visit both in-network and out-of-network providers; you may have to submit a claim to Anthem for out-of-network providers	Must use the HMO's providers (doctors, hospitals, etc.) No coverage outside the HMO network (except for emergency services)	Must use the HMO's providers (doctors, hospitals, etc.) No coverage outside the HMO network (except for emergency services)
Primary care doctor selection required?	No	Yes	Yes
Referral needed to use a specialist?	No	Yes	Yes

Benefit Highlights

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

	Anthem Medicare PPO	Kaiser Senior Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Annual deductible	\$500 per person (in-network and out-of-network combined)	No	No
Annual out-of-pocket maximum	\$2,500 per person (includes deductible and prescription drugs; certain cost-sharing charges do not count toward the annual out-of-pocket maximum)	\$1,000 per person, including prescription drugs	\$6,700 per person, including prescription drugs
Lifetime maximum	Unlimited	Unlimited	Unlimited
In-network PCP and specialist visits	\$20 copay	\$20 copay	\$20 copay
Urgent care visit	\$20 copay (waived if admitted to hospital within 72 hours for the same condition)	\$20 copay	\$20 copay
Emergency room visit	\$120 copay (waived if admitted within 72 hours)	\$50 copay (waived if admitted within 24 hours)	\$50 copay (waived if admitted within 24 hours)
Hospital services	\$750 copay per admission after deductible The inpatient hospital out-of-pocket maximum is \$1,500 per year combined with inpatient mental health care (combined in-network and out-of-network)	\$500 copay per admission	\$500 copay per admission
Routine vision care	100% covered for routine vision exams and eyewear, limited to one exam per calendar year. Eyewear limited to \$100 maximum benefit every two calendar years	\$20 copay for eye examination. \$150 allowance for material every 24 months when prescribed by a Kaiser physician or optometrist	\$20 copay for eye examination. No copay for one pair of Medicare-covered eyeglasses after cataract surgery. No coverage for routine eyewear



Compare your medical plan options.

For more comparison details, scan the QR code to find the Comparison Summary for the Retiree Plan on our website or visit ufcwdrugtrust.org/documents.

Prescription Drug Coverage

If you take many prescription medications, you may want to compare your costs under each Medicare plan option and review their prescription drug formularies.

	Anthem Medicare PPO	Kaiser Senior Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Calendar-year deductible	None		
Formulary generic	\$0 copay for selected generics \$10 copay for other generics	\$10 copay	\$10 copay
Preferred brand	\$20 copay	\$25 copay	\$25 copay
Non-preferred brand	\$40 copay	Not covered	\$40 copay
Specialty drugs	\$100 copay	Certain specialty drugs covered	Certain specialty drugs covered
Pharmacy network	So CA Drug Fund participating pharmacies	Kaiser HMO pharmacies	UHC HMO participating pharmacies

Copays are for a 30-day supply at participating pharmacies. 90-day supplies are available for maintenance medications.

THINGS TO KNOW

Requirement to Enroll in Medicare Part A and Part B

Participants turning age 65 and becoming eligible for Medicare must enroll in both Medicare Parts A and B.

Participants who are younger than age 65 but who become eligible for Medicare because of a Social Security Disability Award or End Stage Renal Disease (ESRD) must notify the Fund Office when they become eligible for Medicare. If you don't notify the Fund Office of Medicare eligibility, you may be required to reimburse the Fund for any insurance premium overpayment.

Consequences of Enrolling in a Part D Plan (PDP) NOT Sponsored by the Fund

The Fund's Medicare Advantage Prescription Drug (MAPD) Plans (Anthem Medicare Preferred (PPO), Kaiser Senior Advantage HMO, and UnitedHealthcare Medicare Advantage HMO) provide prescription drug coverages at least as good as Medicare Part D coverage. Any Medicare participant who enrolls in a Part D Plan outside the Fund will be disenrolled from the Fund's MAPD plan and effectively lose all Fund coverage.

Notify the Fund Office If You Divorce or Terminate a Domestic Partnership

In the event of a divorce or termination of domestic partnership, you are required to immediately notify the Fund Office. You must also provide a copy of the Final Judgment of Dissolution of Marriage or proof of termination of domestic partnership as soon as you receive such documentation from the courts.

DISCLOSURES

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 Dept. 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 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 www.ufcdrugtrust.org.

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



To view the Notice of Privacy Practices, scan the QR code or visit ufcdrugtrust.org/documents.

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
Anthem EAP	(800) 999-7222	anthem.com/ca/eap
Anthem LiveHealth Online (Telehealth)		livehealthonline.com
BlueCard (Network outside California)	(800) 810-BLUE (2583)	bcbs.com
Optum Rx	(800) 788-7871	optumrx.com
Kaiser	(800) 464-4000	kp.org my.KP.org
UnitedHealthcare HMO	(800) 624-8822	myUHC.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.