SOUTHERN CALIFORNIA DRUG BENEFIT FUND

2026 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. It's also your chance to enroll if you haven't done so already.

Please review this guide carefully. It contains step-by-step instructions for enrolling or making changes to your benefits, along with detailed comparisons of the health plans available to you.

If you do not wish to enroll or 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 15, 2025, and ends on January 31, 2026.

Important Deadlines

If you submit your Enrollment Form to the Fund Office by December 31, 2025, your changes will be effective January 1, 2026.

If you submit your Enrollment Form after December 31, 2025, but no later than January 31, 2026, your changes will be effective February 1, 2026.

If you do not submit your Enrollment Form by January 31, 2026, your elections from 2025 will continue into 2026. This means that unless you experience a qualified life event, your next chance to enroll or change your benefit elections will be during the next Open Enrollment period for coverage effective January 1, 2027.

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

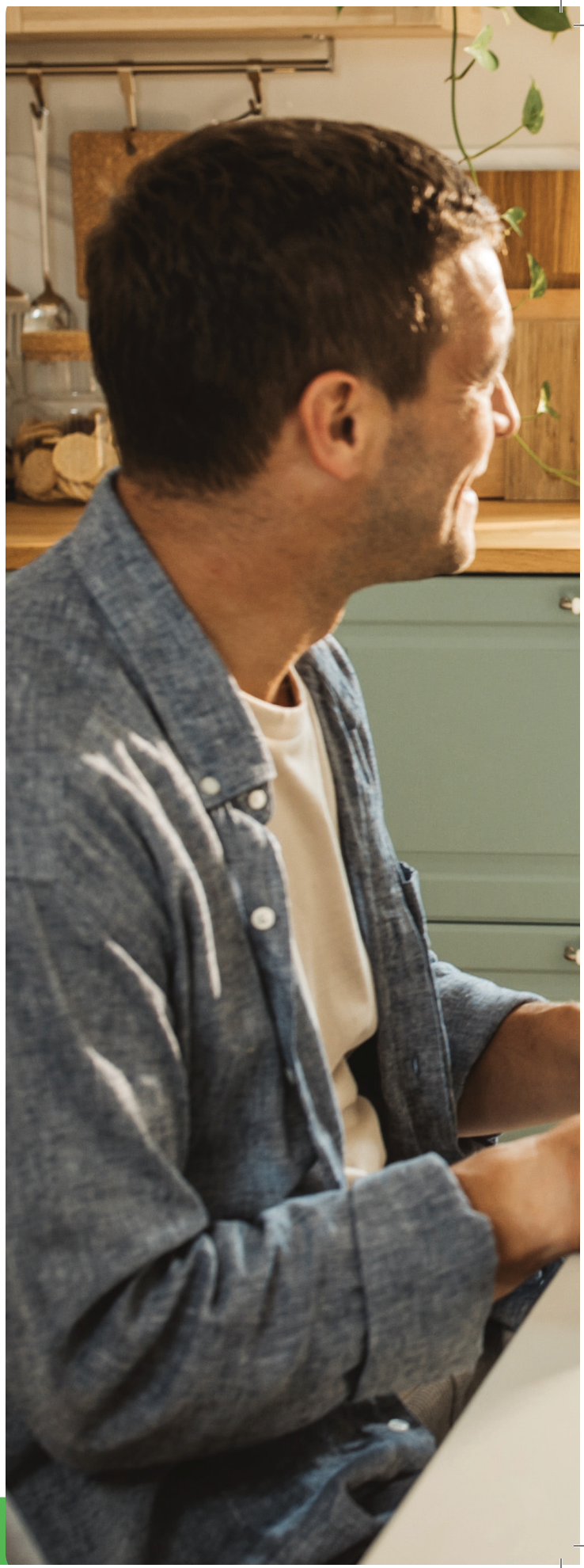
Southern California Drug Benefit Fund

HOW TO ENROLL

1. **Think about how your 2026 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 benefits offered in 2026.** Some plan details will be different in 2026.
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, 2026, your benefit elections for 2025 will carry over into 2026. 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.



ELIGIBILITY

Maintaining Your Eligibility

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

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

Qualified Life Events and Special Enrollment Rights

You may be able to enroll and/or make certain changes to your benefits midyear if you or one of your dependents has a special enrollment right due to a qualified life event.

Some examples of qualified life events include:

- Marriage or registration of domestic partnership
- The birth, adoption, or placement for adoption of your child
- The loss of health coverage through your spouse's employer due to termination of their employment
- Eligibility for Fund premium assistance through Medi-Cal or the California Health Insurance Premium Program (HIPP)

For detailed information about your special enrollment rights, please read the section called "Special Enrollment" beginning on page 27 of the Summary Plan Description & Plan Document for the Platinum Plus Plan (Effective January 1, 2025).

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

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. Furthermore, the balance owed to providers as a result of the 60% reduction will not count toward the out-of-pocket maximum, even if in-network providers are used.

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).

About the Working Spouse Rule

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

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
- Kaiser HMO
- UnitedHealthcare (UHC) HMO

Note: Unless you are a Kaiser Employee, you are not eligible to elect an HMO Plan until the second annual Open Enrollment after your date of hire.

Compare your medical plan options.

Scan the QR code and search for the Comparison Summary for the Platinum Plus Plans 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 pay the lowest copays/coinsurance when you visit providers in the Anthem Blue Cross Prudent Buyer network.

One major advantage to the Indemnity Medical Plan is that it's 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**.

Employee Assistance Program (EAP) for the Indemnity Medical Plan

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, those plans offer resources and support as described on their 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 and struggles
- Substance abuse and addictions
- Financial, marital, parenting, and work challenges
- Loss of a loved one
- Anything else on your mind

Up to three sessions per issue, per person, per year are 100% paid by the Plan. 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

Kaiser is a health maintenance organization (HMO) plan. It offers convenient access to any Kaiser provider or facility but less flexibility than the Indemnity Medical Plan.

Kaiser encourages you to designate a primary care physician (PCP), but you can change your PCP any time during the year. 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 enroll a dependent who lives in a state where Kaiser does not operate, you may want to consider a different option.

Annual Physical and Wellness Checkups at No Cost!

All medical plans pay 100% for preventive care services when you get them from in-network providers. Take advantage of this and take care of you and your family!

UnitedHealthcare HMO

The UnitedHealthcare (UHC) plan is a health maintenance organization (HMO) plan. 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).**

How to find network providers if you are a UHC member.

To search for a network provider, visit **myUHC.com**. Click on **Find a Provider**, then choose the type of provider you are looking for from the Medical or Behavioral Health Directory. Click on **Employer and Individual Plans**, then **Shopping Around**. On the list of plans, scroll down to select **SignatureValue Plans, California**, 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? Use telemedicine (virtual visits) to see a doctor quickly, free of charge!

Any Time Anywhere No Cost Care: You can see a U.S.-licensed doctor or therapist conveniently and securely on any smart device, regardless of where you are or the time of the day. The copay is $0.

- 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
- Mental health issues

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

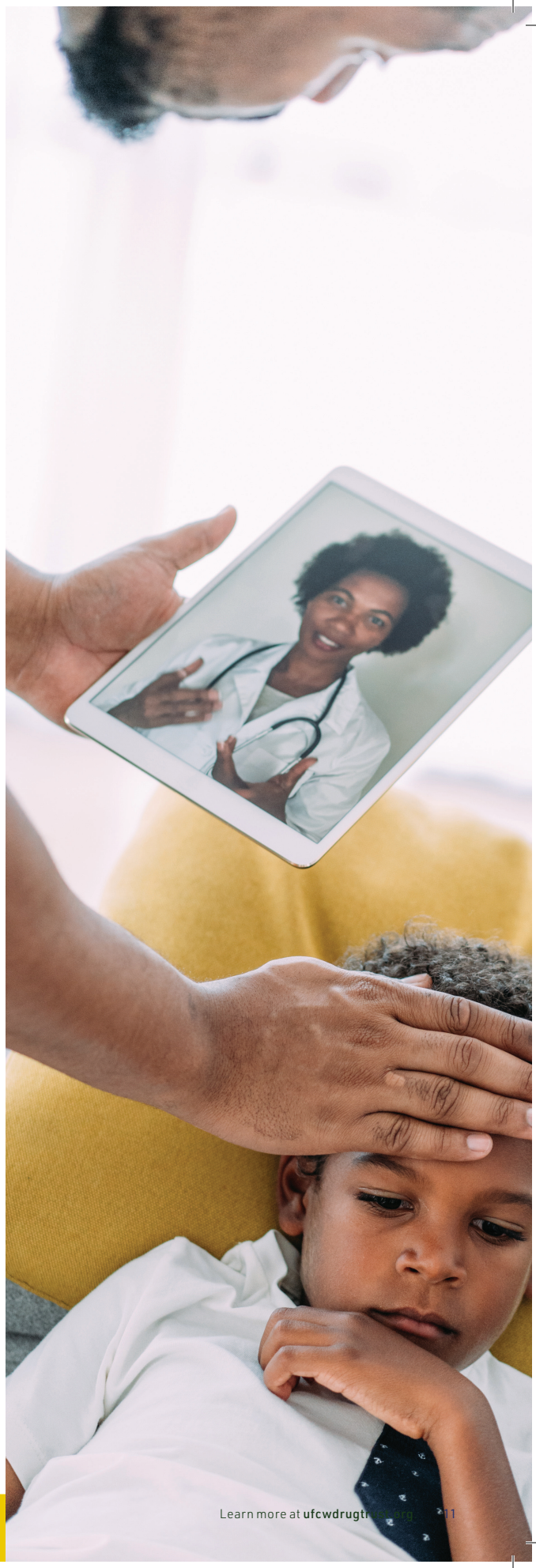
	How to Get Started
Indemnity Medical via Anthem	Use Anthem LiveHealth Online for medical or behavioral health virtual visits.* Download the Sydney app and register with your Anthem ID number or visit **livehealthonline.com**.
Kaiser	To make an appointment, log in to your **kp.org** account or the Kaiser app, or call the phone number on the back of your ID card.
UHC	To make an appointment, log in to your **myUHC.com** account or the UHC app, or call the phone number on the back of your ID card

* 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.

Download on the App Store

GET IT ON Google Play



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 OptumRx. You must use the Fund's participating pharmacy network to fill your prescription.

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. 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 OptumRx

The Prescription Drug Formulary

The formulary is a list of preferred prescription drugs. OptumRx makes updates to its formulary quarterly and every January 1. If a prescription you take is affected by an update, OptumRx will notify you by mail and suggest other clinically equivalent medications. Be sure to share the most current formulary with your doctor.

Using Your Prescription Drug Plan

Register for convenient access.

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

The OptumRx formulary divides drugs into tiers. Copays are the lowest for medications in Tier 1 and Tier 2, Formulary Generic Drugs and Preferred (Formulary) Brand Drugs. You should review the current formulary with your doctor to help identify 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 that 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 OptumRx is required for coverage. Call OptumRx at (800) 788-7871.

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

Additional Precautions for Some Drugs

The Fund's practices for opioids, diabetes medications, and weight-loss drugs include the following measures:

- **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 OptumRx 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.

Need the pharmacy network list?

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

PRESCRIPTION DRUG PLAN COMPARISON

	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
Generic (Tier 1)	$5 copay			$5 copay
Brand (Tiers 2 and 3)	$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
Specialty drugs	Plan pays 80% of OptumRx's Contract Rate. Authorization required through OptumRx. 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 OptumRx.			$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 lower expenses for you).

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

Note: You are permitted to opt out of dental benefits for yourself and/or your dependents if you wish.

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 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, 2025.)

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, 2025, 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 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.

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
OptumRx	(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 & Plan Document for the Platinum Plus Plan (SPD) and the Evidence of Coverage booklets provided by Kaiser, UnitedHealthcare, and United Concordia (EOCs). In case of any conflict between the information contained in this guide and the SPD and EOCs, the SPD and EOCs will control.