# SOUTHERN CALIFORNIA DRUG BENEFIT FUND

## 2026 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. 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 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 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

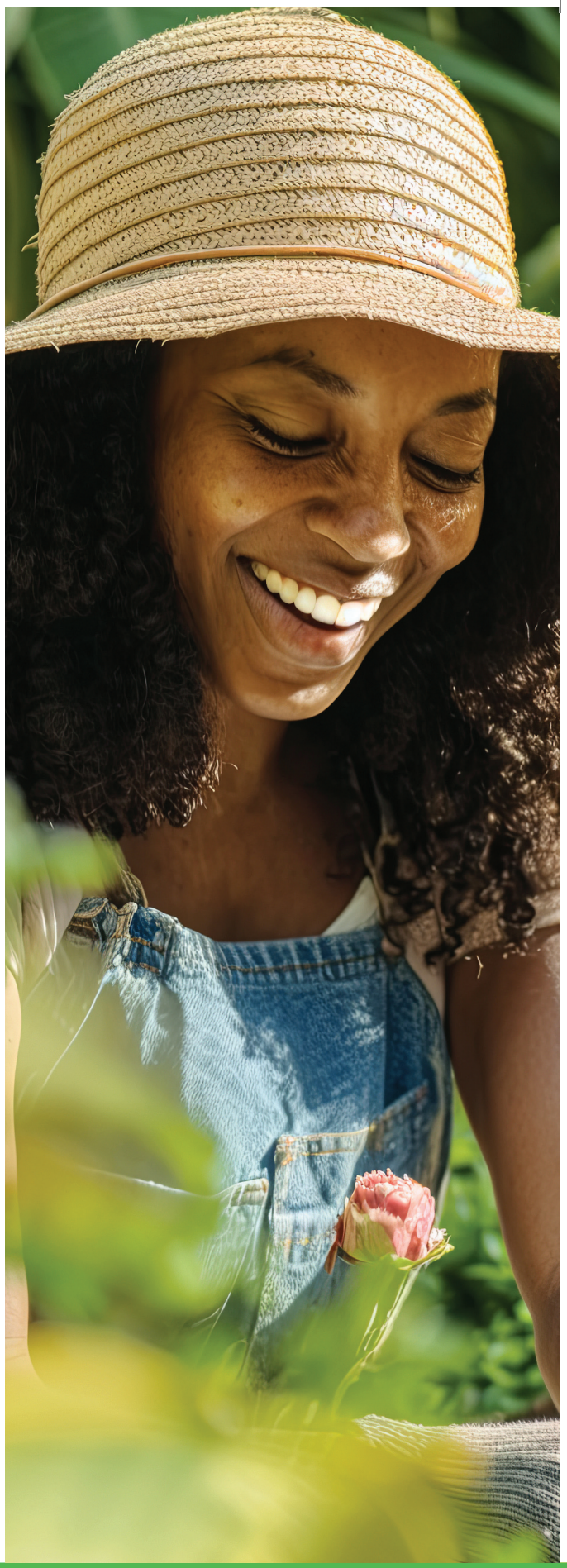
Southern California Drug Benefit Fund

# HOW TO ENROLL

1. **Think about how your 2026 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 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 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, 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

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.

**Your Costs for Retiree Coverage**

The monthly cost for retiree health coverage is:

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

## 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).

## 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)

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.

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

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

## 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.

For most services, you must meet your deductible before the plan begins paying benefits. After you meet your deductible, the plan pays 80% of the cost for most in-network services and 50% for most out-of-network services.

The **Indemnity Medical Plan** does not provide coverage for many services, such as adult vaccines, lab and x-rays related to physical exams, mental health care, hearing aids, dental and orthodontic care, and routine vision care. Furthermore, preventive care services (such as well visits and pap smears) are not covered at 100%.

**Before receiving care, please contact the Fund Office to determine whether the specific service is covered under the Indemnity Medical Plan.**

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.

**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.

**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.

### 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.

## 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. In-network preventive care is 100% covered with no deductible to meet. Before the plan will pay benefits for most non-preventive services, you must meet your deductible. Then the plan pays 80% of the cost for most in-network services. **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.

**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**.

## UnitedHealthcare HMO

The UnitedHealthcare (UHC) plan is a health maintenance organization (HMO) plan. The UHC HMO requires that you designate a PCP from one of the three networks below and use in-network providers to receive coverage.

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

You and all of your covered dependents must choose PCPs from 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 in copays and coinsurance. 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).**

In-network preventive care is 100% covered with no deductible to meet. Before the plan will pay benefits for most non-preventive services, you must meet your deductible. Then the plan begins sharing costs with you.

**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 your SignatureValue network: **SignatureValue Alliance HMO, SignatureValue Harmony HMO**, 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<br>$1,000 family | $500 individual<br>$1,000 family | $500 individual<br>$1,000 family |
| **Annual out-of-pocket maximum** | $2,000 individual<br>$6,000 family<br>(does not include the deductible) | $2,000 individual<br>$4,000 family<br>(includes deductible) | $2,000 individual<br>$4,000 family<br>(includes deductible) |
| **Lifetime maximum** | $1 million individual<br>$2 million family | Unlimited | Unlimited |
| **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<br>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<br>**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? Use telemedicine (virtual visits) to see a doctor quickly and lower your costs!

**Any Time Anywhere Low 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 for Indemnity Medical and Kaiser members and $20 for UHC members.

- 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.

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

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

## 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.

**Register for convenient access.**

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

## Using Your Prescription Drug Plan

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**.

## 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.)<br>No coverage outside the HMO network (except for emergency services) | Must use the HMO's providers (doctors, hospitals, etc.)<br>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, including the deductible and prescription drugs (note that 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 |
| **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<br>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<br>$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 who become 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 Insurance Award, End-Stage Renal Disease (ESRD), or ALS (also called Lou Gehrig's disease)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 participant who enrolls in a Medicare Part D Plan other than the Fund's MAPD Plan (i.e., outside the Fund) will be disenrolled from the Fund.

## 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.ufcwdrugtrust.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 **ufcwdrugtrust.org/documents**.

**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
- 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 |
| **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 |
| **OptumRx** | (800) 788-7871 | optumrx.com |
| **Kaiser** | (800) 464-4000 | kp.org<br>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 Comparison Summary for the Retiree Plan (the Summary) and the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare (EOCs). In case of any conflict between the information contained in this guide and the Summary and EOCs, the Summary and EOCs will control.