



2026 Health Plan Highlights

Below is a high-level comparison of the 2026 plan options. For more details, go to **My OC Benefits** at mybenefits.ocgov.com or call the Member Service Department for the plan you're considering.

Employees/Retirees Without Medicare

	CIGNA CHOICE HMO	CIGNA SELECT HMO	KAISER HMO	SHAREWELL PPO	WELLWISE PPO
Annual Deductible (the amount you pay before the plan pays benefits)	None	None	None	Network/non-network combined: \$5,000 Applies to: Medical and prescription drug claims	Network: \$500 individual/\$1,000 family Non-network: \$750 individual/\$1,500 family Applies to: Medical claims (not prescription drugs)
Annual Out-of-Pocket Maximum (the most you pay in a year)	\$1,000 individual \$2,000 family	\$750 individual \$1,500 family	\$1,500 individual \$3,000 family	Network: \$6,000 family Non-network: \$12,000 family	Network: \$2,500 individual/\$5,000 family Non-network (medical): \$5,000 individual/\$10,000 family Prescription drugs: \$4,100 individual/\$8,200 family
Office Visits	\$20 per visit	Primary care: \$5 per visit Specialist: \$10 per visit	\$20 per visit	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible	
Labs and X-rays	No charge	No charge	No charge	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible (complex imaging requires prior authorization, except in an emergency)	
Chiropractic Care	\$15 per visit (up to 30 visits/year)	\$10 per visit (unlimited visits)	\$15 per visit (up to 30 visits/year)	Network: 10% coinsurance after deductible (up to 25 visits/year, network and non-network combined) Non-network: 30% coinsurance after deductible (up to 25 visits/year, network and non-network combined)	
Inpatient Hospital	\$100 per admission	\$100 per admission	\$100 per admission	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible (50% if no pre-admission review)	

Employees/Retirees Without Medicare (continued)

	CIGNA CHOICE HMO	CIGNA SELECT HMO	KAISER HMO	SHAREWELL PPO	WELLWISE PPO
Emergency Room (as defined by the plan)	\$50 per visit	\$50 per visit	\$50 per visit	Network: 10% coinsurance after deductible Non-network: 10% coinsurance after deductible; member also pays for charges in excess of usual, reasonable, and customary amounts	
Urgent Care	\$25 per visit	\$25 per visit	\$20 per visit	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible	
Mental Health	Outpatient: \$20 per visit Inpatient: \$100 per admission	Outpatient: \$10 per visit Inpatient: \$100 per admission	Outpatient: \$20 per visit Inpatient: \$100 per admission	Network (outpatient): 10% coinsurance after deductible (prior authorization may be required) Non-network (outpatient): 30% coinsurance after deductible (prior authorization may be required) Network (inpatient): 10% coinsurance after deductible Non-network (inpatient): 30% coinsurance after deductible (50% if no pre-admission review)	
Prescription Drugs (other exclusions, limits, and requirements set by the plan)	Up to 30-day supply: Generic: \$10 Brand: \$30 Nonformulary: \$50 Up to 90-day supply: 2x copays noted above	Up to 30-day supply: Generic: \$10 Brand: \$30 Nonformulary: \$50 Up to 90-day supply: 2x copays noted above	Up to 100-day supply: Generic: \$10 Brand: \$30 Up to 30-day supply: Specialty: \$30	Network only: Through OptumRx 20% coinsurance after deductible with important requirements and considerations (refer to Plan Document and Summary of Benefits and Coverages (SBC))	Network only: Through OptumRx Deductible does not apply Tier 1: 20% coinsurance Tier 2: 25% coinsurance Tier 3: 30% coinsurance
Plan Contact Information	1-888-806-5042 7 days/week, 24 hours a day (closed holidays) cigna.com/countyoforange	1-888-806-5042 7 days/week, 24 hours a day (closed holidays) cigna.com/countyoforange	1-800-514-0985 7 days/week, 24 hours a day (closed holidays) my.kp.org/oc	Medical: Blue Shield 1-888-235-1767 blueshieldca.com/oc Pharmacy: OptumRx 1-800-573-3583 welcome.optumrx.com/countyoforange	Medical: Blue Shield 1-888-235-1767 blueshieldca.com/oc Pharmacy: OptumRx 1-800-573-3583 welcome.optumrx.com/countyoforange

Retirees With Medicare

	HUMANA RETIREE MEDICARE PPO	KAISER SENIOR ADVANTAGE HMO	SCAN RETIREE MEDICARE HMO	SHAREWELL RETIREE PPO	WELLWISE RETIREE MEDICARE PPO
Annual Deductible (the amount you pay before the plan pays benefits)	None	None	None	Network/non-network combined: \$5,000 Applies to: Medical and prescription drug claims	Network: \$500 individual Non-network: \$750 individual Applies to: Medical claims (not prescription drugs)
Annual Out-of-Pocket Maximum (the most you pay in a year)	Medical: \$3,400 Prescription drugs: \$2,100	Medical: \$1,000 individual Prescription drugs: \$2,100	Medical: \$3,000 Prescription drugs: \$2,100	Network: \$6,000 family Non-network: \$12,000 family	Network (medical): \$2,500 individual/\$5,000 family Network (prescription drugs): \$2,100 individual Non-network (medical): \$5,000 individual/\$10,000 family Non-network (prescription drugs): \$2,100 individual
Office Visits	Primary care: \$25 per visit Specialist: \$40 per visit	\$20 per visit	\$15 per visit	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible	
Inpatient Hospital	\$100 copay per day for days 1 – 5, then covered at 100%	\$100 per admission	\$100 per admission	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible (50% if no pre-admission review)	
Emergency Room (as defined by the plan)	\$65 per visit	\$50 per visit	\$50 per visit, waived if admitted	Network: 10% coinsurance after deductible Non-network: 10% coinsurance after deductible; member also pays for charges in excess of usual, reasonable, and customary amounts	
Prescription Drugs (other exclusions, limits, and requirements set by the plan)	Tier 1: \$0 Tier 2: \$40 Tier 3: \$45 Tier 4: \$45	Up to 100-day supply: Generic: \$10 Brand: \$35	Generic: \$5 preferred pharmacy/\$10 non-preferred pharmacy Brand: \$20 Specialty: 25% coinsurance	Network only: Through OptumRx 20% coinsurance after deductible with important requirements and considerations (refer to Plan Document and one-page summaries)	Network only: Through OptumRx Deductible does not apply Tier 1: 20% coinsurance Tier 2: 25% coinsurance Tier 3: 30% coinsurance
Plan Contact Information	Medical: Humana 1-866-771-1615 your.humana.com/countyoforange Pharmacy: Centerwell (mail delivery) 1-800-379-0092 your.humana.com/countyoforange	1-800-433-0815 7 days/week, 8 a.m. – 8 p.m. (closed holidays) my.kp.org/oc (from top navigation, choose “Plans and services,” then “Early Retirees” or “Retirees”)	Current members: 1-800-559-3500 Prospective members: 1-877-212-7654 scanhealthplan.com/countyoforange	Medical: Blue Shield 1-888-235-1767 blueshieldca.com/oc Pharmacy: OptumRx 1-800-573-3583 welcome.optumrx.com/countyoforange	Medical: Blue Shield 1-888-235-1767 blueshieldca.com/oc Pharmacy: OptumRx 1-800-908-9097 welcome.optumrx.com/countyoforange