



2027 Health Plan Highlights

Below is a high-level comparison of the 2027 plan options. For more details, go to **My OC Benefits** at <http://mybenefits.ocgov.com> or call the health plans directly.

Employees/Retirees Without Medicare

	Cigna Choice HMO	Cigna Select HMO	Kaiser HMO
Annual Deductible (the amount you pay before the plan pays benefits)	None	None	None
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
Office Visits	\$20 per visit	Primary care: \$5 per visit Specialist: \$10 per visit	\$20 per visit
Labs and X-Rays	No charge	No charge	No charge
Chiropractic Care	\$15 per visit (up to 30 visits/year)	\$10 per visit (unlimited visits)	\$15 per visit (up to 30 visits/year; combined limit with acupuncture)
Acupuncture	\$15 per visit (up to 30 visits/year)	\$10 per visit (up to 30 visits/year)	\$15 per visit (up to 30 visits/year; combined limit with chiropractic care)
Inpatient Hospital	\$100 per admission	\$100 per admission	\$100 per admission
Emergency Room (as defined by the plan)	\$50 per visit	\$50 per visit	\$50 per visit
Urgent Care	\$25 per visit	\$25 per visit	\$20 per visit
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
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
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

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Employees/Retirees Without Medicare (cont.)

	Sharewell PPO	Wellwise PPO
Annual Deductible (the amount you pay before the plan pays benefits)	Network/non-network combined: \$5,000 individual and family 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)	Network: \$6,000 individual and family Non-network: \$12,000 individual and 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	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible	
Labs and X-Rays	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible (complex imaging requires prior authorization, except in an emergency)	
Chiropractic Care	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)	
Acupuncture	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	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible (50% if no pre-admission review)	
Emergency Room (as defined by the plan)	Network: 10% coinsurance after deductible Non-network: 10% coinsurance after deductible; member also pays for charges above usual, reasonable, and customary amounts	
Urgent Care	Network: 10% coinsurance after deductible Non-network: 30% coinsurance after deductible	
Mental Health	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)	Network only: Through Optum Rx 20% coinsurance after deductible	Network only: Through Optum Rx Deductible does not apply Tier 1: 20% coinsurance Tier 2: 25% coinsurance Tier 3: 30% coinsurance
Plan Contact Information	Medical: Blue Shield 1-888-235-1767 blueshieldca.com/oc Pharmacy: Optum Rx 1-800-573-3583 welcome.optumrx.com/countyoforange	Medical: Blue Shield 1-888-235-1767 blueshieldca.com/oc Pharmacy: Optum Rx 1-800-573-3583 welcome.optumrx.com/countyoforange

Retirees With Medicare

	Humana Medicare Advantage PPO	Kaiser Senior Advantage HMO	SCAN Medicare Advantage HMO	Wellwise Medicare PPO
Annual Deductible (the amount you pay before the plan pays benefits)	None	None	None	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: \$2,400	Medical: \$1,000 individual Prescription drugs: \$2,400	Medical: \$3,000 Prescription drugs: \$2,400	Network (medical): \$2,500 individual/\$5,000 family Network (prescription drugs): \$2,400 individual Non-network (medical): \$5,000 individual/\$10,000 family Non-network (prescription drugs): \$2,400 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 above 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 Optum Rx 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	1-800-443-0815 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: Optum Rx 1-800-908-9097 welcome.optumrx.com/countyoforange