

Comparison of Benefits

Medicare Supplement Plans

Medicare Advantage

Prescription Drug Plans

Plan Year 2016
Jan. 1 through Dec. 31, 2016



Monthly Premiums for Medicare Eligible Members

Plan Year Jan. 1 – Dec. 31, 2016

MEDICARE SUPPLEMENT PLANS	
HealthChoice SilverScript High Option Medicare Supplement	\$324.18 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	\$253.09 per covered person
BlueSecure High	\$499.90 per covered person
BlueSecure Low	\$337.90 per covered person
MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLANS	
CommunityCare Senior Health Plan	\$267.00 per covered person
Generations Healthcare	\$192.50 per covered person

These rates do not reflect any contribution from your retirement system.

Comparison of Benefits for the High and Low Option Medicare Supplement Plans

Medicare Part A (Hospitalization) Services

All Benefits are Based on Medicare-Approved Amounts

Part A Network Services	BlueSecure	HealthChoice SilverScript
<p>Hospitalization Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies</p> <p>First 60 days</p> <p>Days 61 through 90</p> <p>Days 91 and after while using Medicare's 60 lifetime reserve days</p> <p>The plan's additional lifetime reserve days</p> <p>Beyond the plan's lifetime reserve days</p>	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0 for additional lifetime reserve days Limited to 365 days</p> <p>You pay 100%</p>	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0 for additional lifetime reserve days Limited to 365 days</p> <p>You pay 100%</p>
<p>Skilled Nurse Facility Care Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare-approved facility within 30 days of leaving the hospital; limited to 100 days per calendar year</p> <p>First 20 days</p> <p>Days 21 through 100</p> <p>Days 101 and after</p>	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay 100%</p>	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay 100%</p>
<p>Hospice Care Your doctor and hospice provider must certify you are terminally ill and you elect hospice Includes physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control</p>	<p>You pay Medicare copays and coinsurance</p>	<p>You pay up to \$5 per prescription for palliative drugs or biologicals You also pay 5% of Medicare amounts for inpatient respite care</p>
<p>Blood Limited to the first 3 pints unless you or someone else donates blood to replace what you use</p>	<p>You pay \$0</p>	<p>You pay \$0</p>

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115 percent of the Medicare-approved amount.

Medicare Part B (Medical) Services

All Benefits are Based on Medicare-Approved Amounts

Part B Network Services	BlueSecure	HealthChoice SilverScript
Medical Expenses Medically necessary outpatient services and supplies Includes doctor's visits, out-patient hospital treatment, surgical services, physical and speech therapy and diagnostic tests	You pay \$0	You pay the Part B deductible
Clinical Diagnostic Laboratory Services Includes blood tests, urinalysis and tissue pathology	You pay \$0	You pay \$0
Home Health Care Includes intermittent skilled care and medical supplies	You pay \$0	You pay \$0
Durable Medical Equipment Includes items such as nebulizers, wheelchairs and walkers	You pay \$0	You pay the Part B deductible
Diabetes Monitoring Supplies Includes coverage for glucose monitors, test strips and lancets for those with diabetes Must be requested by your doctor	You pay \$0	You pay the Part B deductible
Ostomy Supplies Includes ostomy bags, wafers and other ostomy supplies for those who have a need based on their condition	You pay \$0	You pay the Part B deductible
Blood Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use	You pay \$0	You pay the Part B deductible
Outpatient Prescriptions Includes infused, oral end-stage renal disease drugs and some cancer and transplant drugs	You pay \$0	You pay the Part B deductible

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115 percent of the Medicare-approved amount.

Medicare Part B (Preventive) Services

All Benefits are Based on Medicare-Approved Amounts

Part B Network Services	BlueSecure	HealthChoice SilverScript
Initial Preventive Physical Exam Includes a one-time “Welcome to Medicare Visit” for Medicare beneficiaries within the first 12 months of initial Part B coverage	You pay \$0	You pay \$0
Annual Wellness Visit Includes one visit every 12 months for Medicare beneficiaries who have been enrolled in Part B for more than 12 months	You pay \$0	You pay \$0
Screening Mammogram Once every 12 months for female Medicare beneficiaries ages 40 and older	You pay \$0	You pay \$0
Cardiovascular Disease Screening Tests Limited to one every five years	You pay \$0	You pay \$0
Pap Test and Pelvic Exam (includes a clinical breast exam) Once every 24 months	You pay \$0	You pay \$0
Once every 12 months if high risk or abnormal Pap test in preceding 36 months	You pay \$0	You pay \$0
Bone Mass Measurements Once every 24 months for all Medicare beneficiaries at risk of losing bone mass	You pay \$0	You pay \$0
Glaucoma Screening Once every 12 months for Medicare beneficiaries at high risk or a family history of glaucoma Must be performed or supervised by an eye doctor who is authorized to provide this service within the scope of their practice	You pay \$0	You pay the Part B deductible

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115 percent of the Medicare-approved amount.

Medicare Part B (Preventive) Services

All Benefits are Based on Medicare-Approved Amounts

Part B Network Services	BlueSecure	HealthChoice SilverScript
<p>Colorectal Cancer Screening For Medicare beneficiaries ages 50 and older</p> <p>Fecal Occult Blood Test Once every 12 months</p>	You pay \$0	You pay \$0
<p>Flexible Sigmoidoscopy Once every 4 years for those at high risk for colorectal cancer If you aren't at high risk, Medicare covers this test once every 4 years, or 119 months after a previous flexible sigmoidoscopy</p>	You pay \$0	You pay \$0
<p>Colonoscopy Once every 2 years for those at high risk for colorectal cancer If you aren't at high risk for colorectal cancer, Medicare covers this test once every 10 years, or 47 months after a previous flexible sigmoidoscopy</p>	You pay \$0	You pay \$0
<p>Barium Enema Doctor can substitute this test for a sigmoidoscopy or colonoscopy Procedure must be performed in an outpatient hospital setting or an ambulatory surgical center</p>	You pay \$0	You pay 25% of the Medicare approved amount
<p>Prostate Cancer Screening For all male Medicare beneficiaries ages 50 and older</p> <p>Digital Rectal Exam Once every 12 months</p>	You pay \$0	You pay \$0
<p>Prostate Specific Antigen Test (PSA) Once every 12 months</p>	You pay \$0	You pay \$0

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115 percent of the Medicare-approved amount.

Preventive Services — Vaccinations

The vaccine and administration are covered at 100% if the provider accepts Medicare assignment.

Vaccinations	BlueSecure	HealthChoice SilverScript
Flu Vaccination One per flu season	You pay \$0	You pay \$0
Pneumonia Vaccination One-time vaccination	You pay \$0	You pay \$0
Hepatitis B Vaccination Medicare beneficiaries at medium to high risk for Hepatitis B	You pay \$0	You pay \$0

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115 percent of the Medicare-approved amount.

Coverage for Additional Medical Services

Service	BlueSecure	HealthChoice SilverScript
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	You pay the first \$250 each calendar year, then 20% and all amounts over the \$50,000 lifetime maximum	You pay the first \$250 each calendar year, then 20% and all amounts over the \$50,000 lifetime maximum

High Option Medicare Supplement Plans

Pharmacy Copay Structure for Network Benefits

General Information	BlueSecure High	HealthChoice SilverScript High Option
<p>These plans use a formulary</p> <p>Mandatory generic and formulary medications you get at a Network Pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Only copays for covered drugs purchased at Network Pharmacies count toward out-of-pocket maximums</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the <i>Medicare Modernization Act of 2003</i></p> <p>You will be notified before any changes are made to your plan's formulary</p>	<p>No annual deductible. Coverage Gap begins at \$3,310 and ends when you reach the annual out-of-pocket maximum of \$4,850.</p> <p>30-Day Supply Generic (Tier 1) Drugs \$5 – \$10 copay Non-Preferred Generics (Tier 2) Drugs \$5 – \$10 copay Preferred Brand (Tier 3) Drugs \$40 – \$45 copay Non-Preferred Brand (Tier 4) Drugs \$70 – \$75 copay Specialty (Tier 5) Drugs \$95 – \$100 copay</p> <p>90-Day Supply Generic (Tier 1) Drugs \$15 – \$30 copay Non-Preferred Generics (Tier 2) Drugs \$15 – \$30 copay Preferred Brand (Tier 3) Drugs \$120 – \$135 copay Non-Preferred Brand (Tier 4) Drugs \$210 – \$225 copay Specialty (Tier 5) Drugs \$285 – \$300 copay</p> <p>Once the out-of-pocket maximum of \$4,850 is reached, for covered prescription drugs purchased at Network Pharmacies, you pay \$2.95 or 5% for drugs in Tiers 1 and 2, whichever is greater. For drugs in Tiers 3, 4 and 5, you pay \$7.40 or 5%, whichever is greater.</p>	<p>No annual deductible and no Coverage Gap. There is an annual out-of-pocket maximum of \$4,850.</p> <p>30-Day Supply Generic (Tier 1) Drugs Up to \$10 copay Preferred (Tier 2) Drugs Up to \$45 copay Non-Preferred (Tier 3) Drugs Up to \$75 copay Specialty (Tier 4) Drugs Up to \$100 copay Preferred Tobacco Cessation (Tier 5) Drugs \$0 copay</p> <p>31- to 90-Day Supply Generic (Tier 1) Drugs Up to \$25 copay Preferred (Tier 2) Drugs Up to a \$90 copay Non-Preferred (Tier 3) Drugs Up to \$150 copay Specialty (Tier 4) Drugs Specialty drugs are available in only a 30-day supply Preferred Tobacco Cessation (Tier 5) Drugs \$0 copay</p> <p>Once the out-of-pocket maximum of \$4,850 is reached, you pay 0% of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year.</p>

Low Option Medicare Supplement Plans

Pharmacy Copay Structure for Network Benefits

General Information	BlueSecure Low	HealthChoice SilverScript Low Option
<p>These plans use a formulary</p> <p>Mandatory generic and formulary medications you get at a Network Pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Only copays for covered drugs purchased at Network Pharmacies count toward the out-of-pocket maximums.</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the <i>Medicare Modernization Act of 2003</i></p> <p>You will be notified before any changes are made to your plan's formulary</p>	<p>Pharmacy Deductible is: \$360.00 You pay \$360.00.</p> <p>Initial Coverage Limit is: \$3,310.00 After the deductible, you and BlueSecure share the costs of the next \$3,310.00 of prescription drug costs. You pay 20 – 25% and BlueSecure pays 75 – 80%.</p> <p>Coverage Gap: During the Coverage Gap, you pay 58% of the cost of generic drugs and 45% of the cost of brand-name drugs.</p> <p>Catastrophic Coverage Begins at: \$4,850.00 After you spend \$4,850.00 out-of-pocket for drugs in Tiers 1 and 2, you pay \$2.95 or 5%, whichever is greater. For drugs in Tiers 3, 4 and 5, you pay \$7.40 or 5%, whichever is greater.</p>	<p>Pharmacy Deductible is: \$360.00 You pay \$360.00.</p> <p>Initial Coverage Limit is: \$2,950.00 After the deductible, you and HealthChoice share the costs of the next \$2,950.00 of prescription drug costs. You pay 25% (\$737.50) and HealthChoice pays 75% (\$2,212.50).</p> <p>Coverage Gap is: \$3,752.50 You pay 100% of the next \$3,752.50 of prescription drug costs. During the Coverage Gap, you pay 58% of the cost of generic drugs and 45% of the cost of brand-name drugs.</p> <p>Catastrophic Coverage Begins at: \$4,850.00 After you spend \$4,850.00 out-of-pocket, HealthChoice pays 100% of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year.</p>

Comparison of Benefits for Medicare Advantage Prescription Drug (MA-PD) Plans

Services or Items	CommunityCare Senior Health Plan	Generations Healthcare
<p>Hospitalization Semiprivate room (private room if medically necessary)</p> <p>Medications</p> <p>Laboratory tests, X-rays and other radiology services</p> <p>Inpatient physician and surgical services, including anesthesia</p> <p>Necessary medical supplies and appliances</p> <p>Blood and its administration</p> <p>Operating room</p>	<p>\$50 copay each day for days 1-5</p> <p>\$0 copay each day for days 6-90 for a Medicare-covered stay in a network hospital</p> <p>Prior authorization is required, except in the case of an emergency</p> <p>You are covered for unlimited days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. You must pay the inpatient hospital copay for each benefit period.</p>	<p>\$250 copay each Medicare-covered stay</p>
<p>Organ Transplants Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas and stem cell</p> <p>Transplants are covered only if performed in a Medicare-approved transplant center</p>	<p>\$50 copay each day for days 1-5</p> <p>\$0 copay each day for days 6-90 for a Medicare-covered stay in an approved transplant center</p>	<p>\$250 copay each Medicare-covered stay in an approved transplant center</p>
<p>Outpatient Hospital Services Including outpatient surgical services and radiation therapy</p>	<p>\$0 copay for each Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility</p> <p>\$0 copay for each Medicare-covered radiation therapy service</p> <p>Prior authorization is required</p>	<p>\$0 copay for covered ambulatory surgical center</p> <p>\$200 copay for covered outpatient hospital facility</p>

Services or Items	CommunityCare Senior Health Plan	Generations Healthcare
In-Area Urgent Care Services	\$10 to \$50 copay for each Medicare-covered visit	\$20 copay for each Medicare-covered visit
Out-of-Area Urgent Care Services	\$10 to \$50 copay for each Medicare-covered visit	\$25 copay for each Medicare-covered visit
Emergency Services Needed Worldwide	\$75 copay for each Medicare-covered visit	\$50 copay for each Medicare-covered visit
Skilled Nurse Facility (Inpatient Services) Semi-private room and regular nursing services Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by the facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	\$0 copay for days 1-20 for a Medicare-covered stay \$50 copay for days 21-100 for each benefit period for a Medicare-covered stay No prior hospital stay is required Prior authorization is required \$20 copay for each Medicare-covered visit; prior authorization is required Covered under the skilled nurse facility copayment \$0 copay for blood services \$0 copay for each Medicare-covered radiation therapy service \$0 to \$50 or 20% copay for each Medicare-covered item Prior authorization is required	\$0 copay per day for days 1-20 for a Medicare-covered stay \$160 copay per day for days 21-100 for a Medicare covered stay
Physical, Occupational and Speech Therapy Services	\$20 copay for each Medicare-covered visit Prior authorization is required	\$20 copay for each Medicare-covered visit
Chiropractic Limited to manual manipulation of the spine	\$15 copay each visit Prior authorization is required	\$20 copay each Medicare-covered visit

Services or Items	CommunityCare Senior Health Plan	Generations Healthcare
Physical Examinations	\$0 copay for a routine physical exam; limited to one exam each year	\$0 copay for a routine physical exam; limited to one each year
X-Ray/Diagnostic Radiology Services Including annual mammography screening, if medically indicated	\$0 copay for Medicare-covered X-rays \$0 copay each Medicare-covered screening mammogram	\$0 copay for Medicare-covered X-rays \$0 copay each Medicare-covered screening mammogram
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	\$10 copay for each Medicare-covered PCP visit \$20 copay for each Medicare-covered specialist visit	\$0 copay for each Medicare-covered PCP visit \$20 copay for each Medicare-covered specialist visit
Hearing Examinations	\$10 copay for routine hearing tests \$20 copay for Medicare-covered diagnostic hearing exams You pay 100% for hearing aids	\$20 copay for each Medicare-covered visit
Immunizations Includes flu, pneumonia, Hepatitis B and all Medicare-approved immunizations	\$0 copay for Medicare-covered immunizations No referral is necessary	\$0 copay for Medicare-covered immunizations

Services or Items	CommunityCare Senior Health Plan	Generations Healthcare
Well Female Exam	\$0 copay for a Medicare-covered Pap smear and pelvic exam; limited to one Pap smear and one pelvic exam each year	\$0 copay; limited to one Pap smear and one pelvic exam each year
Laboratory Services	\$0 copay for each Medicare-covered diagnostic and therapeutic radiology or lab service \$0 to \$100 copay for each Medicare-covered diagnostic procedure or test Prior authorization is required	\$0 copay for Medicare-covered routine services
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care Physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	\$0 copay for Medicare-covered home health visits Prior authorization is required	\$0 copay for Medicare-covered home health visits
Durable Medical Equipment Equipment and supplies, prosthetic devices, therapeutic shoes/inserts for severe diabetes	\$0 to \$50 copay or 20% coinsurance for each Medicare-covered equipment item* \$0 copay for each Medicare-approved prosthetic device* *Prior authorization is required	20% coinsurance for Medicare-covered equipment, prosthetic devices and therapeutic shoes/inserts
Ambulance Services Medically necessary services	\$50 copay for Medicare-covered ambulance services; this amount is waived if you are admitted as an inpatient to a medical facility	\$50 copay for covered ambulance services

Medicare Advantage Prescription Drug Plans

Pharmacy Copay Structure for Network Benefits

General Information	CommunityCare Senior Health Plan	Generations Healthcare
<p>Mandatory generic and formulary medications you get at a Network Pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the <i>Medicare Modernization Act of 2003</i></p> <p>You will be notified before any changes are made to your plan's formulary</p>	<p>This plan uses a formulary</p> <p>Part B: \$0 for Part B covered chemotherapy drugs and other Part B covered drugs</p> <p>Part D Retail – 30-day supply \$0 copay for select generic drugs \$10 copay for Preferred generic drugs \$30 copay for Preferred brand drugs \$60 copay for non-Preferred generic and non-Preferred brand drugs 33% coinsurance for specialty drugs and certain injectables</p> <p>Part D Retail and Mail Order – 90-day supply \$0 copay for select generic drugs \$20 copay for Preferred generic drugs \$60 copay for Preferred brand drugs \$120 copay for non-Preferred generic and non-Preferred brand drugs 33% coinsurance for specialty drugs and certain injectable drugs</p>	<p>This plan uses a formulary</p> <p>Part B: Part B covered chemotherapy drugs and other Part B covered drugs are Tier 1 through Tier 5 depending on the drug</p> <p>Part D Retail – 30-day supply \$0 copay – Tier 1 \$4 copay – Tier 2 \$35 copay – Tier 3 \$65 copay – Tier 4 20% coinsurance – Tier 5</p> <p>Part D Retail – 31- to 90-day supply \$8 copay – Tier 1 \$8 copay – Tier 2 \$70 copay – Tier 3 \$130 copay – Tier 4</p> <p>Part D Mail Order – 30-day supply \$4 copay – Tier 1 \$4 copay – Tier 2 \$35 copay – Tier 3 \$65 copay – Tier 4 20% coinsurance – Tier 5</p> <p>Part D Mail Order – 90-day supply \$4 copay – Tier 1 \$4 copay – Tier 2 \$35 copay – Tier 3 \$65 copay – Tier 4</p>

ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations Healthcare
Adair		74347, 74457, 74931, 74960, 74964, 74965
Alfalfa		73716, 73719, 73722, 73726, 73728, 73739, 73741, 73749
Canadian		73014, 73022, 73036, 73040, 73047, 73064, 73078, 73085, 73090, 73099, 73127, 73128, 73129, 73762
Cherokee		74427, 74434, 74441, 74444, 74451, 74452, 74464, 74465, 74471
Cleveland		73019, 73020, 73026, 73051, 73068, 73069, 73070, 73071, 73072, 73139, 73149, 73150, 73153, 73159, 73160, 73165, 73169, 73170, 73173, 73189, 74851, 74852, 74857, 74878
Craig		74301, 74332, 74333, 74349, 74369
Creek	74010, 74028, 74030, 74033, 74039, 74041, 74044, 74046, 74047, 74052, 74063, 74066, 74067, 74068, 74071, 74079, 74081, 74131, 74132	74010, 74028, 74030, 74038, 74039, 74041, 74044, 74046, 74047, 74052, 74066, 74067, 74068, 74071, 74079, 74081, 74131, 74132
Garvin		73052, 73057, 73074, 73075, 73098, 73433, 73434, 73444, 74872
Grady		73002, 73004, 73010, 73011, 73017, 73018, 73023, 73055, 73059, 73067, 73079, 73082, 73089, 73092
Grant		73758, 73759, 73761, 73766, 73771, 74636, 74640, 74643
Haskell		74440, 74462, 74472, 74552, 74941, 74943, 74944
Kingfisher		73016, 73734, 73742, 73750, 73756, 73762, 73764
Lincoln		74023, 74026, 73045, 73054, 74079, 74824, 74832, 74834, 74851, 74855, 74864, 74869, 74875, 74881
Logan		73007, 73016, 73025, 73027, 73028, 73034, 73044, 73050, 73056, 73058, 73063, 73073, 74881
McClain		73002, 73010, 73011, 73031, 73052, 73057, 73065, 73072, 73074, 73080, 73093, 73095, 74831, 74872

The ZIP codes listed in blue indicate partial participation within the ZIP code.
 The ZIP codes listed in bold indicate new service areas for 2016.

ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations Healthcare
McIntosh		74426, 74428 , 74432, 74438, 74455 , 74459, 74461, 74845
Major		73718 , 73729 , 73737 , 73747 , 73755 , 73760 , 73768 , 73838
Mayes		74016, 74330, 74332 , 74337, 74340, 74349 , 74350, 74352, 74361, 74362, 74364, 74365, 74366, 74367, 74452
Muskogee		74401 , 74402 , 74403 , 74422 , 74423 , 74428 , 74434 , 74436 , 74439 , 74450 , 74455 , 74463 , 74468 , 74769 , 74470
Noble		73061 , 73073 , 73077, 73757 , 74630 , 74644 , 74651
Okfuskee		74829 , 74833 , 74859 , 74860 , 74880
Oklahoma		73003, 73007 , 73008, 73012, 73013, 73020 , 73025 , 73034 , 73045 , 73049, 73054, 73066, 73083, 73084, 73097, 73101, 73102, 73103, 73104, 73105, 73106, 73107, 73108, 73109, 73110, 73111, 73112, 73113, 73114, 73115, 73116, 73117, 73118, 73119, 73120, 73121, 73122, 73123, 73124, 73125, 73126, 73127 , 73128 , 73129, 73130, 73131, 73132, 73134, 73135, 73136, 73137, 73139, 73140, 73141, 73142, 73143, 73144, 73145, 73146, 73147, 73148, 73149 , 73150 , 73151, 73152, 73154, 73155, 73156, 73157, 73159 , 73162, 73163, 73164, 73167, 73169 , 73172, 73173 , 73178, 73179 , 73184, 73185, 73190, 73193, 73194, 73195, 73196, 73197, 73198, 73199, 74857
Osage	74002, 74035, 74054, 74060, 74063, 74070, 74084, 74126, 74127	74001, 74002, 74003, 74035, 74054, 74056, 74060, 74063, 74070 , 74073 , 74084, 74126 , 74127 , 74633, 74637, 74650 , 74652
Pawnee		74020 , 74034 , 74038 , 74045 , 74058 , 74081 , 74650

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ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations Healthcare
Pottawatomie		73045, 74801, 74802, 74804, 74826, 74840, 74849, 74851, 74852, 74854, 74855, 74864, 47866, 74873, 74878
Rogers	74015, 74016, 74017, 74018, 74019, 74021, 74031, 74036, 74053, 74055, 74080, 74116	74015, 74016, 74017, 74018, 74019, 74031, 74036, 74053, 74055, 74080, 74116, 74332
Seminole		74818, 74830, 74837, 74849, 74854, 74867, 74868, 74884
Tulsa	74008, 74011, 74012, 74013, 74014, 74015, 74021, 74033, 74037, 74043, 74047, 74050, 74055, 74063, 74066, 74070, 74073, 74101, 74102, 74103, 74104, 74105, 74106, 74107, 74108, 74110, 74112, 74114, 74115, 74116, 74117, 74119, 74120, 74121, 74126, 74127, 74128, 74129, 74130, 74132, 74133, 74134, 74135, 74136, 74137, 74141, 74145, 74146, 74147, 74148, 74149, 74150, 74152, 74153, 74155, 74156, 74157, 74158, 74159, 74169, 74170, 74171, 74172, 74182, 74183, 74184, 74186, 74187, 74189, 74192, 74193, 74194	74008, 74011, 74012, 74013, 74021, 74033, 74037, 74043, 74047, 74050, 74055, 74063, 74070, 74073, 74101, 74102, 74103, 74104, 74105, 74106, 74107, 74108, 74110, 74112, 74114, 74115, 74116, 74117, 74119, 74120, 74121, 74126, 74127, 74128, 74129, 74130, 74132, 74133, 74134, 74135, 74136, 74137, 74141, 74145, 74146, 74147, 74148, 74149, 74150, 74152, 74153, 74155, 74156, 74157, 74158, 74159, 74169, 74170, 74171, 74172, 74182, 74183, 74184, 74186, 74187, 74189, 74192, 74193, 74194
Wagoner	74008, 74014, 74015, 74108, 74337, 74403, 74429, 74434, 74436, 74446, 74454, 74458, 74467, 74477	74014, 74015, 74108, 74429, 74434, 74436, 74446, 74454, 74458, 74467, 74477
Washington	74003, 74005, 74006, 74029, 74051, 74061, 74070	

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Notes

