Human Resources

Medicare Supplement Plans

2024 Comparison Chart

This chart highlights the health plans offered by MIT in 2024 for eligible retirees and their spouses or domestic partners age 65 and older as well as qualified Medicare recipients on the MIT Long Term Disability Plan. MIT retirees are generally eligible for retiree health benefits if they retire from the Institute on or after age 55 with at least ten years of MIT Retirement Plan membership occurring after the age of 45. The chart briefly indicates how authorized covered services will be paid under each plan at designated participating providers or facilities. To qualify for benefits, services must be considered medically necessary and approved by the plan. This comparison is not a legal document. The plan document for each plan governs all questions.

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		Medex Supplement Plan **Medex 2**	**Medicare HMO Plan** **Tufts Medicare Preferred**	**HMO Supplement Plan** **(no longer available to new enrollees as of 1/01/2012)** **Managed Blue for Seniors**	**HMO Supplement Plan** **Plan closed as of 12/31/2022. Retirees enrolled in this plan will automatically be enrolled in Medex 2, if no action is taken.** **Tufts Medicare Complement**
Plan Provisions	**Deductible**	No deductible; small copayments for some services as noted below.	No deductible; small copayments for some services as noted below.	No deductible; small copayments for some services as noted below.	No deductible; small copayments for some services as noted below.
	Notes	You must continue paying your Medicare Part B premium.	You must continue paying your Medicare Part B premium. Must use plan providers to get your covered services with few exceptions. Must choose a plan provider to be your Primary Care Provider (PCP).	You must continue paying your Medicare Part B premium. All services must be provided or arranged by your Managed Blue for Seniors (MBS) Primary Care Provider. For care not authorized by your MBS Provider, refer to Medicare coverage.	You must continue paying your Medicare Part B premium. You must use plan providers to get your covered services with few exceptions. You must choose a plan provider to be your Primary Care Provider (PCP).
Inpatient Covered Services	**Semi-private room and hospital services**	Full coverage of 1) Medicare deductible and copayment; 2) Lifetime reserve day copayment; 3) Up to 365 additional hospital days in your lifetime when Medicare benefits are used up.	Full coverage of Medicare deductible and coinsurance after you pay one initial deductible of $300 per calendar year for services received at a network hospital.	Full coverage of Medicare deductible and coinsurance.	Full coverage of Medicare deductible and coinsurance.
	Inpatient mental health care	For biologically-based mental health conditions, plan pays Medicare hospital deductible and copayments. Full coverage of lifetime reserve day copayment. **Full coverage up to 365 additional hospital days in your lifetime when your Medicare benefits are used up*.** For non-biologically-based mental conditions, see the Medex 2 Summary of Benefits.	$0 copayment, Medicare deductible and coinsurance covered in full, 190-day lifetime maximum in a psychiatric hospital. This limit does not apply to inpatient mental health care in a general hospital. See the Tufts Medicare Preferred Summary of Benefits.	Plan pays Medicare deductible and coinsurance for biologically-based mental health conditions, there is no inpatient limit in a network general or psychiatric hospital. For non biologically-based mental health conditions, see the Managed Blue for Seniors Summary of Benefits.	$0 copayment, Medicare deductible and coinsurance covered in full, 190-day lifetime maximum in a psychiatric hospital. This limit does not apply to inpatient mental health care in a general hospital. See the Tufts Medicare Complement Benefit Summary.
	Skilled nursing facility (SNF) (for non-custodial care)	Pays in full for days 21-100; then $10 daily for days 101-365 for SNF participating with Medicare. Pays $8 daily for 365 days for SNF not participating with Medicare. Combined maximum of 365 days per benefit period**	Covers Medicare deductible and copayment up to 100 days per benefit period**	Covers Medicare deductible and copayment up to 100 days per benefit period**	Covers Medicare deductible and copayment up to 100 days per benefit period**
Outpatient Covered Services	**Emergency care**	Full coverage of Medicare deductible and coinsurance.	Full coverage of Medicare deductible and coinsurance. You pay a $50 copayment for emergency room. Copayment waived if admitted within 24 hours for the same condition. Worldwide emergency care coverage.	Full coverage of Medicare deductible and coinsurance. You pay $50 copayment for covered services. Copayment is waived if you are admitted. When you are out of the Service Area, you must notify your MBS Provider within 48 hours of a hospital admission and service must be deemed a medical necessity.	Full coverage of Medicare deductible and coinsurance. You pay a $50 copayment for emergency room. Copayment waived if admitted within 24 hours for the same condition. Worldwide emergency care coverage.
	Outpatient surgery	Full coverage of Medicare deductible and coinsurance.	Full coverage of Medicare deductible and coinsurance you pay a $50 copayment per day.	Full coverage of Medicare deductible and coinsurance.	Full coverage of Medicare deductible and coinsurance.
	Skilled nursing facility (SNF) (for non-custodial care)	Medicare pays days 0-20, Plan pays full Medicare deductible and copayments for days 21-100; then $10 daily for days 101-365 for SNF participating with Medicare. Pays $8 daily for 365 days for SNF not participating with Medicare. Combined maximum of 365 days per benefit period**	Medicare covers days 0-20, Plan pays full Medicare deductible and copayments for days 21-100.	Medicare covers days 0-20, Plan pays full Medicare deductible and copayments for days 21-100.	Medicare covers days 0-20, Plan pays full Medicare deductible and copayments for days 21-100.
	Non-custodial home health services	Covered by Medicare	Covered by Medicare	Covered by Medicare	Covered by Medicare
	Limited chiropractic services	Pays Medicare deductible and coinsurance for Medicare-approved charges only.	Pays Medicare deductible and coinsurance for Medicare-approved charges. You pay $15 copayment.	Pays Medicare deductible and coinsurance for Medicare-approved charges. You pay $10 copayment.	Pays Medicare deductible and coinsurance for Medicare-approved charges. You pay $10 copayment.

*** The 365 additional days per lifetime are a combination of days in a general or psychiatric hospital.**

**** A benefit period begins when you first receive inpatient services in a hospital or skilled nursing facility. If you do not receive inpatient care for 60 days after your discharge, that benefit period will end. A new benefit period will begin when you again receive inpatient services.**

		Medex 2	Tufts Medicare Preferred	Managed Blue for Seniors	Tufts Medicare Complement
Outpatient Covered Services *continued*	**Doctor's office visits for specific treatment**	Pays Medicare deductible and coinsurance.	Pays Medicare deductible and coinsurance. You pay $10 copayment per visit to PCP and $15 copayment per visit to a specialist.	Pays Medicare deductible and coinsurance. You pay $10 per visit.	Pays Medicare deductible and coinsurance. You pay $10 copayment per visit to PCP or specialist.
	Immunizations/ Inoculation	$0 copay for all preventive services covered under Medicare. Office copayment may apply if services are required due to an injury or immediate risk of infection and are provided in conjunction with a Provider visit. Otherwise, not covered.	$0 copay for all preventive services covered under Medicare. Office copayment may apply if services are provided in conjunction with a Provider visit.	$0 copay for all preventive services covered under Medicare. Office copayment may apply if services are provided in conjunction with a Provider visit.	$0 copay for all preventive services covered under Medicare. Office copayment may apply if services are provided in conjunction with a Provider visit.
	Routine physicals	Covered by Medicare.	Covered by Medicare.	Covered by Medicare.	Covered by Medicare.
	Routine eye and hearing exams/Eyewear and hearing aids	Not covered.	Eye and hearing exams covered in full after you pay the required copayment. You pay a $15 copayment for each annual routine eye exam. You receive up to $150 allowance in network ($90 out of network) for eyeglasses (prescription lenses and frames) ***or*** contact lenses every calendar year. You pay a $15 copayment for each annual routine hearing test. You receive up to $500 allowance for hearing aids every 3 years.	Covered in full after you pay $10 copayment for each annual routine eye exam. There is no coverage for hearing exams or hearing aids.	Eye and hearing exams are covered in full after you pay the required copayment. $10 copayment for each annual routine eye exam. Discount on lenses, frames and contacts. You pay $10 copayment for each annual routine hearing test. Hearing aids are not covered.
	Diagnostic x-rays and lab tests	Pays Medicare deductible, coinsurance and copayments for approved charges.	Pays Medicare deductible, coinsurance and copayments for approved charges.	Pays Medicare deductible, coinsurance and copayments for approved charges.	Pays Medicare deductible, coinsurance and copayments for approved charges.
Medicare Part D Prescription Drug Plan *(administered by Express Scripts, Inc.)*	**Prescription Drugs**	**Express Scripts Retail Pharmacy:** *NEW for 2024: $50 Annual Deductible* 30-day supply: Tier 1 (generic): $10 copay Tier 2 (preferred brand name): $35 copay Tier 3 (non-preferred brand name): $50 copay **Express Scripts Mail Order Pharmacy:** 90-day supply: Tier 1 (generic): $20 copay Tier 2 (preferred brand name): $50 copay Tier 3 (non-preferred brand name): $80 copay	**Express Scripts Retail Pharmacy:** *NEW for 2024:* $50 Annual Deductible 30-day supply: Tier 1 (generic): $10 copay Tier 2 (preferred brand name): $35 copay Tier 3 (non-preferred brand name): $50 copay **Express Scripts Mail Order Pharmacy:** 90-day supply: Tier 1 (generic): $20 copay Tier 2 (preferred brand name): $50 copay Tier 3 (non-preferred brand name): $80 copay	**Express Scripts Retail Pharmacy:** *NEW for 2024: $50 Annual Deductible* 30-day supply: Tier 1 (generic): $10 copay Tier 2 (preferred brand name): $35 copay Tier 3 (non-preferred brand name): $50 copay **Express Scripts Mail Order Pharmacy:** 90-day supply: Tier 1 (generic): $20 copay Tier 2 (preferred brand name): $50 copay Tier 3 (non-preferred brand name): $80 copay	**Express Scripts Retail Pharmacy:** 30-day supply: Tier 1 (generic) - $8, Tier 2 (preferred brand name) - $35, Tier 3 (non-preferred brand name) - $50. **Express Scripts Mail Order Pharmacy:** 90-day supply: Tier 1 (generic) - $16, Tier 2 (preferred brand name) - $50, Tier 3 (non-preferred brand name) - $80.
	Occupational, physical and speech therapy	Pays Medicare deductible and coinsurance for services approved by Medicare.	Pays Medicare deductible and coinsurance for all equipment approved by Medicare. You pay $15 copayment per visit.	Pays Medicare deductible and coinsurance for all equipment approved by Medicare. You pay $10 copayment per visit.	Pays Medicare deductible and coinsurance for all equipment approved by Medicare. You pay $10 copayment per visit.
	Prosthetic devices and durable medical equipment	Pays Medicare deductible and coinsurance for all equipment approved by Medicare.	Pays Medicare deductible and coinsurance for all equipment approved by Medicare.	Pays Medicare deductible and coinsurance for all equipment approved by Medicare. You pay $10 for Medicare-approved supplies and equipment when prescribed by an MBS Provider and obtained from a participating provider.	Pays Medicare deductible and coinsurance for all equipment approved by Medicare.
	Ambulance service	Pays Medicare deductible and coinsurance for ambulance services approved by Medicare.	Medicare deductible and coinsurance covered in full. You pay $50 copayment per day for Medicare-covered ambulance services.	Medicare deductible and coinsurance covered in full for emergency transport. You pay $40 for each non-emergency transport in certain medically-necessary circumstances.	Pays Medicare deductible and coinsurance for ambulance services approved by Medicare.
	Outpatient mental health care	For biologically-based conditions, when covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum. When visits are not covered by Medicare, Plan provides full coverage. For non-biologically-based mental health conditions, see Medex 2 Summary of Benefits.	Full coverage of Medicare deductible and coinsurance. You pay $15 copayment per visit.	Full coverage of Medicare deductible and coinsurance . You pay $10 per visit. For biologically-based mental health conditions, there is no visit limit. For non-biologically-based mental health conditions, you have a limit of 24 visits. See Summary of Benefits.	Full coverage of Medicare deductible and coinsurance You pay $10 copayment per visit. There is no visit limit for either biologically-based or non-biologically-based mental health conditions.
For medical coverage questions, please contact plans directly:		**Medex** 2: 1-800-932-8323	**Tufts Medicare Preferr**ed: 1-800-701-9000	**Managed Blue for Seniors:** 1-800-325-2583	**Tufts Medicare Complement:** 1-800-462-0224

MIT reserves the right to alter, amend or terminate the provisions of this benefit plan to any extent and in any manner that it may deem advisable.

Note: This comparison chart is not a legal document. It reflects limited plan information as of January 1, 2024. The following are not covered under any plan: custodial confinement, routine foot care, treatment covered by Workers' Compensation, and disabilities related to service in the armed forces. Under Massachusetts state law, Providers and other covered professional providers may not bill you for any balance over the amount approved by Medicare.