



MASSACHUSETTS

# REPRODUCTIVE HEALTH TRAVEL BENEFIT REIMBURSEMENT FORM

We're committed to ensuring that our members have access to the care they need and want. You may be eligible for reimbursement for certain travel expenses related to obtaining abortion services.



## Eligibility

Blue Cross Blue Shield of Massachusetts will reimburse you and, when necessary, one companion for certain expenses related to travel for reproductive health services. Your companion doesn't have to be a Blue Cross member. **To see if you're eligible for this benefit, call Member Service at 1-888-420-4501.**

- To be eligible, your employer must opt in, and you must have the Voluntary Termination of Pregnancy medical or pharmacy benefit
- You must be traveling at least 100 miles from home to obtain either surgical or medication-assisted voluntary termination of pregnancy (abortion) services when access to these services is restricted or not available as a result of state law.



## How to Be Reimbursed

To be reimbursed, submit a form to Blue Cross Blue Shield of Massachusetts. A request form is included with this document.



Save the completed form as a PDF,  
and email it to [TravelBenefits@bcbsma.com](mailto:TravelBenefits@bcbsma.com).  
Include only one form per email.

OR

Mail it to Blue Cross Blue Shield of Massachusetts,  
Local Claims Department, PO Box 986030,  
Boston, MA 02298.



## What This Benefit Covers

**Round trip transportation** including air, train, bus, taxi and ride-sharing service, car rental, tolls, and parking will be reimbursed between your home and the location at which you receive the covered services.

- **Airfare** is limited to commercially scheduled coach-class tickets and will not count toward a daily travel maximum if one has been established by your employer.
- **Mileage** is based on the current Internal Revenue Service (IRS) medical mileage reimbursement, which includes gasoline.

**Lodging** will be reimbursed up to \$50 per person per night (up to \$100 if you travel with a companion).

**Please note:** There may be a limit on the amount you can be reimbursed. To confirm your benefit allowance, call Member Service at 1-888-420-4501.



## What This Benefit Doesn't Cover

- Meals
- Alcohol/tobacco
- Entertainment
- Taxes
- Tips/gratuities
- Lodging other than at a hotel or motel
- Personal care/hygiene items
- Telephone calls
- Childcare expenses
- Lost wages
- Expenses for anyone other than you and your companion

## Questions?

If you have questions, or to confirm your eligibility, call Member Service at 1-888-420-4501, open Monday – Friday, 8:00 a.m. – 9:00 p.m EST.



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Complete this form for reimbursement for certain travel expenses related to obtaining abortion services. To be eligible, your employer must opt in to this benefit.

## SUBSCRIBER INFORMATION (POLICYHOLDER)

ID NUMBER ON SUBSCRIBER ID CARD (including first 3 characters)		SUBSCRIBER'S LAST NAME		FIRST NAME	MIDDLE INITIAL
ADDRESS – NUMBER AND STREET			CITY		
STATE	ZIP CODE	EMPLOYER'S NAME			

## CLAIM INFORMATION

MEMBER'S LAST NAME (Enter the name of the person the claim is for)		FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY
CLAIM IS FOR (CHOOSE ONE AND COLOR THE ENTIRE BOX):				
<input type="checkbox"/> SUBSCRIBER (POLICYHOLDER)		<input type="checkbox"/> SPOUSE (OF POLICYHOLDER)		<input type="checkbox"/> EX-SPOUSE
<input type="checkbox"/> OTHER (SPECIFY): _____				

## TRAVEL INFORMATION

<b>DID YOU TRAVEL WITH A COMPANION?</b> Your companion's travel costs will also be reimbursed if the companion's presence is necessary for you to receive the abortion services. Include their costs in the totals below.	<input type="checkbox"/> YES	DATE OF COVERED SERVICE MM/DD/YYYY	
	<input type="checkbox"/> NO		

SAVE YOUR RECEIPTS, AND FILL OUT THE FOLLOWING AS APPLICABLE:

DATES OF TRAVEL MM/DD/YYYY – MM/DD/YYYY	TOTAL MILES DRIVEN (ROUND TRIP)	COST OF AIRFARE	COST OF ALL OTHER COVERED TRANSPORTATION	LODGING	
to				AVERAGE COST OF LODGING PER NIGHT	\$
				NUMBER OF NIGHTS	
				TOTAL LODGING COST	\$

### Important Information:

- Keep copies of receipts in case we request them from you.
- Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form.
- Reimbursement is sent to the subscriber on the policy and to the subscriber address on file with Blue Cross, unless an alternative address for the member is on file. Please contact Member Services at 1-888-420-4501 to request an alternate address. Reimbursement may be considered taxable income, so you should consult your tax advisor.

### Certification and Authorization (This form must be signed and dated below.)

I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these purchases.

I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about purchases to Blue Cross Blue Shield of Massachusetts.

SUBSCRIBER'S OR MEMBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at 1-888-420-4501.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).