MASSACHUSETTS

Weight-Loss Reimbursement

Your Blue Cross Blue Shield of Massachusetts health plan can save you up to $150[1] annually when you participate in a qualified weight-loss program.

3 Easy Steps to Getting Reimbursed[2]

1. Choose

Start by picking a qualified weight-loss program.

2. Complete

Once you pay for the program, fill out the attached form.

3. Mail

Send the completed form with proof of payment to the address listed.

A qualified weight-loss program is:

- Weight Watchers®, an independent company, with in-person meetings
- Hospital-based weight-loss programs

What is a qualified expense?

- Participation fees

What doesn't qualify?

- Weight Watchers Online
- Fees paid for individual nutrition-counseling sessions, food, books, videos, or scales

Important Information

- You can claim this maximum weight loss reimbursement for fees paid by any combination of members enrolled under the same Blue Cross health plan.
- Keep copies of all your submitted paperwork and proof of payment in case we request it from you. Proof of payment includes the following:
  - » Itemized, dated, paid receipts
  - » Weight Watchers paperwork
- Paperwork and proof of payment should include the name of the family member enrolled in the program and the individual amounts charged with date paid.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement

Be sure to check with your doctor before starting any weight-loss program.

1. Most plans offer a $150 reimbursement, but your employer may have elected a different amount. Please refer to your plan information to confirm.
2. Before starting, check to see if your plan includes the weight-loss reimbursement. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

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Weight-Loss Reimbursement Request[1]

PLEASE PRINT ALL INFORMATION CLEARLY IN BLACK INK

To verify this reimbursement is offered within your plan, please log on to MyBlue® at bluecrossma.com/myblue or call the Member Service number on your ID card. You have until March 31 of the following year to submit this form.

Subscriber Information (Policyholder)

Identification Number on Your 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

Member and Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth: MM/DD/YY

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender (color in the entire box)

☐ Male

☐ Female

Claim is for (choose one and color in the entire box):

☐ Subscriber (policyholder) ☐ Ex-Spouse ☐ Other (specify)_____

☐ Spouse (of policyholder) ☐ Dependent (up to age 26)

Class or Program Information Required

Attach 8.5" x 11" photocopies of paid receipts from your qualified weight-loss program. Receipts must show Blue Cross Blue Shield of Massachusetts member's name, name or logo of program, amount paid per session(s), and date(s) paid. For qualified Weight Watchers programs, a photocopy of your program Membership Book showing this information is required.

Name, Address, and Phone Number of Qualified Weight-Loss Program	Health Plan Year

Total dollars requested: $ _____

My monthly program participation fee is $ _____

1. Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

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

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my qualified weight-loss program. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I certify that I am regularly using the qualified program for which I am requesting reimbursement. I understand that Blue Cross may require additional evidence of program participation and proof of payment before reimbursement is provided.

Subscriber's or Member's Signature: _____ Date: ____/____/____

Questions?

To verify this reimbursement is offered within your plan or for further information, please log onto the **MyBlue** website at bluecrossma.com/myblue or call the Member Service number on the front of your ID card.

Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

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 the number on your ID Card (TTY: 711).

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).

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55-0774 (02/18)