Mass General Brigham Health Plan

Travel Benefit Reimbursement

Form & Instructions

Mass General Brigham Health Plan provides the following travel benefit for members who need to travel in order to obtain services covered under their plan when state law does not allow a provider to administer such coverage in the state that the member resides.

Examples include **medication-assisted termination of pregnancy, surgical procedures for termination of pregnancy, and gender-affirming services.**[1]

Mass General Brigham Health Plan will reimburse the patient for certain travel expenses for you and one companion, if the companion's presence is necessary for you to receive the service (e.g. minor requiring parental consent and/or patient requires sedation for services). Your companion doesn't have to be a member.

Please check your Plan Documents on **Member.MassGeneralBrighamHealthPlan.org** for your maximum benefit amount. If your plan is HSA qualified, reimbursement is after the deductible is met.

Eligibility

- You must be actively enrolled in a plan where your employer opted into this benefit and be eligible for covered services on the date(s) of service(s).
- You must travel[2] more than 100 miles from your home to receive services.
- You must not have access to the covered services in your state of residence, per legal restrictions.
- The covered services must be legal in the state where you travel to.
- You must attest to these conditions and seek reimbursement after services have been rendered.

What this benefit covers

- **Round trip travel** reimbursement between your home and the location you receive the covered services by a qualified covered provider. Includes air, train, taxi/ride sharing services, or car rental.
  - **Airfare** is limited to commercially scheduled, coach class tickets (excludes first class and business class airfare).
  - **Mileage** reimbursement is based on the current IRS medical mileage reimbursement rate.
  - The plan will pay the **car rental fee** but not the mileage.
- **Tolls and parking.**
- **Lodging** at $50 per day or $100 per day if traveling with a companion.[3] The plan will cover lodging expenses from the night before the treatment begins through the night that immediately follows the day the treatment ends.

What this benefit doesn't cover, per IRS guidelines

- Meals, alcohol, tobacco
- Entertainment, souvenirs, telephone calls
- Child care, personal or hygiene items
- Taxes, tips, gratuities, lost wages
- Lodging other than a hotel or motel
- Expenses for people other than you and your companion

[1] Travel for any pharmacy-related services is not covered when the benefit plan does not include prescription drug coverage through Mass General Brigham Health Plan

[2] Travel is defined as "primarily for and essential to…" receiving care, per IRS Code Section 213(d).

[3] Companion reimbursements will be accepted, if a companion is required to accompany you to receive care. (e.g. minor requiring parental consent and/or member requires sedation for services). Companions are limited to 1 under this benefit.

Continued

Mass General Brigham
Health Plan

How to be reimbursed

Fill out the request form on the following page of this document and submit with your receipts for proof of payments to:

Submit by mail or fax

Mass General Brigham Health Plan
Attention: Claims Processing
399 Revolution Drive
Suite 810
Somerville, MA 02145

You may also fax your request form to **617-526-1902**.

Questions?

If you have questions, or to confirm your eligibility, call the customer service number on the back of your member ID card or visit **Member.MassGeneralBrighamHealthPlan.org** to chat with a customer service professional.

Mass General Brigham
Health Plan

Travel Benefit Reimbursement Form

IMPORTANT INFORMATION

1. Complete and submit one reimbursement form per occurrence.
2. submit your receipts with this form and keep copies for your records.
3. You must submit request for reimbursement after service(s) have been rendered.
4. Requests must be submitted within 12 months of the date(s) of service(s).
5. Reimbursement check will be payable to the Patient and be sent to the Patient's address on record with Mass General Brigham Health Plan. Patient's Social Security number must also be on record.

Patient and Subscriber (Policyholder) Information

PATIENT MEMBER ID# (Located on front of ID card) | PATIENT LAST NAME | PATIENT FIRST NAME | PATIENT M.I.

STREET ADDRESS | CITY

STATE | ZIP | PATIENT DATE OF BIRTH (mm/dd/yyyy) / /

RELATIONSHIP TO SUBSCRIBER (Choose one):

☐ SUBSCRIBER (Policyholder) ☐ SPOUSE (Of Policyholder) ☐ CHILD ☐ DEPENDENT

☐ OTHER (Specify) _____

IF PATIENT IS DIFFERENT FROM SUBSCRIBER:

SUBSCRIBER LAST NAME | SUBSCRIBER FIRST NAME | SUBSCRIBER M.I.

Provider or Hospital Information

PROVIDER/HOSPITAL NAME | PROVIDER CITY | STATE

DATE(S) OF COVERED SERVICE(S) (mm/dd/yyyy)

Travel Information (Fill out the following as applicable. Do not include taxes, tips, or gratuities in costs.)

DID YOU TRAVEL WITH A COMPANION? ☐ YES ☐ NO

DATES OF TRAVEL (mm/dd/yyyy – mm/dd/yyyy)	
TOTAL MILES DRIVEN (Round trip, personal vehicle)	
COST OF AIRFARE	$
COST OF AIRFARE FOR COMPANION (If applicable)	$
COST OF OTHER TRANSPORTATION (e.g., car rental, ride share)	$
COST OF TOLLS AND PARKING (If applicable)	$
TOTAL COST OF LODGING	$
TOTAL NUMBER OF NIGHTS LODGING	

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

I hereby apply for benefits and certify that to the best of my knowledge the above information is complete and accurate. I authorize all holders of information relevant to this claim to release that information to the plan for the purpose of evaluating and administering this claim. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which this claim for health benefits has been submitted and that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. I also understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

SUBSCRIBER'S OR PATIENT'S SIGNATURE | DATE