MASSACHUSETTS

FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

$150

Qualified for Reimbursement:

- A full service health club with cardiovascular and strength-training equipment like treadmills, bikes, weight machines, and free weights
- A fitness studio with instructor-led group classes such as yoga, Pilates, Zumba®, kickboxing, indoor cycling/spinning, and other exercise programs
- Online fitness memberships, subscriptions, programs, or classes
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home, such as stationary bikes, weights, exercise bands, treadmills, fitness machines

Not Qualified for Reimbursement:

- One-time initiation or termination fees
- Fees paid for gymnastics, tennis, pool-only facilities, martial arts schools, instructional dance studios, country clubs or social clubs, sports teams or leagues
- Personal trainer sessions
- Fitness clothing

Get Started

To submit your reimbursement, sign in to MyBlue at **bluecrossma.org**.

Your reimbursement is waiting!

MASSACHUSETTS

FITNESS REIMBURSEMENT REQUEST

Please print all information clearly. To verify that this reimbursement is offered within your plan, or for more information, you can sign in to MyBlue at **bluecrossma.org** or call the Member Service number on your ID card.
All fitness reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)

Identification 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	**First Name**	**Middle Initial**	**Date of Birth** ___/___/____

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

- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify): _____

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _____

Calendar year that fees were paid: _____

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 member's address on file with Blue Cross. 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 services. I enrolled in the qualified program with the full intention of using such program. 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 my qualified fitness program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

Complete this form and mail it to:
Blue Cross Blue Shield of Massachusetts,
Local Claims Department,
PO Box 986030, Boston, MA 02298

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MASSACHUSETTS

WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior:
Receive up to $150 annually when you participate in a qualified weight-loss program.[1]

Qualified for Weight-Loss Reimbursement

Participation fees for:

- Hospital-based programs and Weight Watchers® in-person
- Weight Watchers online and other non-hospital programs (in-person or online) that combine healthy eating, exercise, and coaching sessions with certified health professionals such as nutritionists, registered dietitians, or exercise physiologists.

Not Qualified for Weight-Loss Reimbursement

- One-time initiation or termination fees
- Food, supplements, books, scales, or exercise equipment
- Individual nutrition counseling sessions, doctor/nurse visits, lab tests, or other services that are covered benefits under your medical plan

GET REIMBURSED IN THREE EASY STEPS

1

Choose
Start by picking a qualified weight-loss program.

2

Complete
Once you pay for the program, fill out the attached form, or sign in to MyBlue to submit online at **member.bluecrossma.com/login**.

3

Mail
Send the completed form to the address listed.

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

1. To verify this reimbursement is offered for your plan, or for more information, sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. Most plans offer the reimbursement shown, but refer to your plan information for specific details.

Questions?

Contact Member Service by calling the phone number on your member ID card.

WEIGHT-LOSS REIMBURSEMENT REQUEST

Please Print All Information Clearly: To verify this reimbursement is offered within your plan, or for more information, please sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. All weight-loss reimbursement requests must be submitted by March 31 of the following year.

Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department , PO Box 986030, Boston, MA 02298

Subscriber Information (Policyholder)

Identification 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 Last Name	First Name	Middle Initial	Gender (color in the entire box) ❑ Male ❑ Female	Date of Birth ___/___/____

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

❑ Subscriber (policyholder)
❑ Spouse (of policyholder)
❑ Ex-Spouse
❑ Dependent (up to age 26)
❑ Other (specify):

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

Total dollars requested: $ _____

Monthly program participation fee: $ _____

Calendar Year: ___/___/____

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 member's address on file with Blue Cross. Reimbursement may be considered taxable income, so 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 services. 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 my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

Important Information:

- Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Keep copies of proof of payment in case we request it from you. Proof of payment includes:
  - Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.
  - Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.
- Your reimbursement may be considered taxable income, so consult a tax advisor.

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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MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts Formulary: Health Savings Account (HSA) Preventive Medication List

Last Updated: January 1, 2022

The following list includes preventive medications that are covered by HSA-qualified "Saver" plans[1] with the Blue Cross Blue Shield of Massachusetts Formulary. You may not be required to pay the deductible[2] for some of these medications, which are commonly prescribed to help you stay healthy and prevent complications or secondary conditions.

This isn't a complete list of covered medications, and inclusion on this list doesn't guarantee coverage.[3] You must have a valid prescription from a licensed health provider to receive coverage for these medications. Some medications may also be subject to pharmacy management programs, such as Step Therapy, Prior Authorization, or Quality Care Dosing, or have other coverage requirements.

NOTE: Some medications on this list may be considered non-covered, including new medications under review by Blue Cross. Your doctor may request an exception for a non-covered medication when medically necessary.[4]

Learn More About Your Coverage

For more information about these medications, look them up using the **Medication Lookup** tool at **bluecrossma.org/medication**.

1. Blue Cross Blue Shield of Massachusetts plans that are HSA-qualified include the term "Saver" in the plan name. For example: Blue Care Elect Saver or HMO Blue New England Saver $2,000.
2. Some employers may also exempt the copayment or co-insurance. Check your benefit materials for details.
3. Not all medications listed are covered by all prescription plans. Check your benefit materials for details.
4. If approved, you'd pay the highest-tier cost.

HSA Preventive Medications

Drug Class	Medication Name	
ACE Inhibitor	BENAZEPRIL	MOEXIPRIL
	CAPTOPRIL	PERINDOPRIL
	ENALAPRIL	QBRELIS
	ENALAPRILAT	QUINAPRIL
	EPANED	RAMIPRIL
	FOSINOPRIL	TRANDOLAPRIL
	LISINOPRIL	

Drug Class	Medication Name	
ACE Inhibitor (Combination)	AMLODIPINE-BENAZEPRIL	MOEXIPRIL-HCTZ
	BENAZEPRIL-HCTZ	PERINDOPRIL-AMLODIPINE
	CAPTOPRIL-HCTZ	PRESTALIA
	ENALAPRIL-HCTZ	QUINAPRIL-HCTZ
	FOSINOPRIL-HCTZ	TRANDOLAPRIL-VERAPAMIL ER
	LISINOPRIL-HCTZ	
Alpha/Beta-Adrenergic Blocking Agents	CARVEDILOL	LABETALOL
	CARVEDILOL ER	
Anaphylaxis Therapy Agents–Adrenergic Agents	ADRENALIN	EPIPEN
	ADYPHREN	EPISNAP
	AUVI-Q	ISUPREL
	EPINEPHRINE	SYMJEPI
Antidepressants (Selective Serotonin Reuptake Inhibitors–SSRIs)	CELEXA	PAROXETINE HCL
	CITALOPRAM	PAROXETINE HCL ER
	ESCITALOPRAM OXALATE	PAXIL
	FLUOXETINE DR	PAXIL CR
	FLUOXETINE HCL	PEXEVA
	FLUVOXAMINE MALEATE	PROZAC
	FLUVOXAMINE MALEATE ER	PROZAC WEEKLY
	LEXAPRO	RAPIFLUX
	LUVOX	SERTRALINE HCL
	LUVOX CR	ZOLOFT
Antihyperglycemic Agents	ACARBOSE	GLIPIZIDE
	ALOGLIPTIN	GLIPIZIDE ER
	ALOGLIPTIN-METFORMIN	GLIPIZIDE XL
	ALOGLIPTIN-PIOGLITAZONE	GLIPIZIDE-METFORMIN
	BYDUREON	GLYBURIDE
	BYDUREON BCISE	GLYBURIDE-METFORMIN
	BYETTA	GLYBURIDE MICRONIZED
	CYCLOSET	GLYNASE
	DIAZOXIDE	GLYSET
	DM2 KIT	GLYXAMBI
	DUETACT	GVOKE
	FARXIGA	JANUMET
	FORTAMET	JANUMET XR
	GLIMEPIRIDE	JANUVIA

Drug Class	Medication Name	
Antihyperglycemic Agents (Cont.)	JARDIANCE	QTERN
	JENTADUETO	REPAGLINIDE
	JENTADUETO XR	REPAGLINIDE/METFORMIN
	KAZANO	RIOMET
	KOMBIGLYZE XR	RYBELSUS
	METFORMIN	SEGLUROMET
	METFORMIN ER	SOLIQUA
	METFORMIN FILM COATED ER	STEGLUJAN
	METFORMIN XR	STEGLATRO
	MIGLITOL	SYMLINPEN
	NATEGLINIDE	SYNJARDY
	NESINA	SYNJARDY XR
	ONGLYZA	TANZEUM
	OSENI	TOLAZAMIDE
	OZEMPIC	TOLBUTAMIDE
	PIOGLITAZONE HCL	TRADJENTA
	PIOGLITAZONE-GLIMEPIRIDE	TRULICITY
	PIOGLITAZONE-METFORMIN	VICTOZA
	PRANDIN	XIGDUO XR
	PRECOSE	XULTOPHY
Antihyperlipidemic Agents	ALTOPREV	LIVALO
	ATORVASTATIN	LOVASTATIN
	EZALLOR SPRINKLE	PRAVASTATIN
	FLOLIPID	ROSUVASTATIN
	FLUVASTATIN	SIMVASTATIN
	FLUVASTATIN ER	
Antihyperlipidemic Agents (Combination)	ADVICOR	LIPTRUZET
	AMLODIPINE-ATORVASTATIN	SIMCOR
	EZETIMIBE/SIMVASTATIN	
Antihyperlipidemic (Miscellaneous)	ANTARA	FENOFIBRIC ACID
	CHOLESTYRAMINE	FENOGLIDE
	COLESEVELAM	GEMFIBROZIL
	COLESTIPOL	LIPOFEN
	ENDUR-ACIN	LOFIBRA
	EZETIMIBE	LOPID
	FENOFIBRATE	LOVAZA

Drug Class	Medication Name	
Antihyperlipidemic (Miscellaneous) (Cont.)	NIACIN	SLO-NIACIN
	NIACIN ER	TRICOR
	NIACOR	TRIGLIDE
	NIASPAN	TRIKLO
	OMEGA-3 ACID ETHYL ESTERS	TRILIPIX
Antihypertensives	AMIODARONE	MINOXIDIL
	CATAPRES	NITRO-BID
	CLONIDINE	NITROGLYCERIN PATCH
	DOXAZOSIN	PRAZOSIN
	GUANFACINE	PROPAFENONE
	HYDRALAZINE	RESERPINE
	ISOSORBIDE DINITRATE	SOTALOL
	ISOSORBIDE MONONITRATE	SOTALOL AF
	METHYLDOPA	TENEX
	METHYLDOPA-HCTZ	TERAZOSIN
	METHYLDOPATE	
Antihypertensives (Miscellaneous)	ALISKIREN	TEKTURNA
	AMTURNIDE	TEKTURNA HCT
	TEKAMLO	VALTURNA
Antimalarial Agents	ATOVAQUONE-PROGUANIL	MEFLOQUINE
	CHLOROQUINE PHOSPHATE	PRIMAQUINE
	MALARONE	
Antineoplastic	ANASTROZOLE	FEMARA
	ARIMIDEX	LETROZOLE
	AROMASIN	SOLTAMOX
	EXEMESTANE	TAMOXIFEN
	FARESTON	TOREMIFENE
Antiparkinson Drugs	AMANTADINE	OSMOLEX ER
	GOCOVRI	
Antisera	ASCENIV	GAMASTAN S/D
	BIVIGAM	GAMMAGARD LIQUID
	CARIMUNE NF	GAMMAGARD S/D
	CUTAQUIG	GAMMAKED
	CUVITRU	GAMMAPLEX
	CYTOGAM	GAMUNEX
	FLEBOGAMMA DIF	GAMUNEX-C

Drug Class	Medication Name	
Antisera (Cont.)	HIZENTRA	PANZYGA
	HYQVIA	PRIVIGEN
	OCTAGAM	
Antiviral	FLUMADINE	RIMANTADINE
	OSELTAMIVIR	TAMIFLU
	RELENZA	
ARB Blockers	CANDESARTAN	MICARDIS
	EDARBI	OLMESARTAN
	EPROSARTAN	TELMISARTAN
	IRBESARTAN	VALSARTAN
	LOSARTAN	
ARB (Combination)	AMLODIPINE-OLMESARTAN	IRBESARTAN-HCTZ
	AMLODIPINE-VALSARTAN	LOSARTAN-HCTZ
	AMLODIPINE-VALSARTAN-HCTZ	OLMESARTAN-AMLODIPINE-HCTZ
	AZOR	OLMESARTAN-HCTZ
	BYVALSON	TELMISARTAN-AMLODIPINE
	CANDESARTAN-HCTZ	TWYNSTA
	EDARBYCLOR	VALSARTAN-HCTZ
	EXFORGE HCT	
Asthma Agents	ACETYLCYSTEINE	BEVESPI
	ADVAIR DISKUS	BREO ELLIPTA
	ADVAIR HFA	BREZTRI AEROSPHERE
	AEROSPAN	BRONCHIAL MIST
	AIRDUO	BRONKAID DUAL ACTION
	ALBUTEROL	BRONKAID MAX
	ALBUTEROL HFA	BROVANA
	ALVESCO	BUDESONIDE
	AMINOPHYLLINE	BUDESONIDE-FORMOTEROL
	ANORO ELLIPTA	COMBIVENT RESPIMAT
	ARCAPTA NEOHALER	CROMOLYN SODIUM
	ARMONAIR	DALIRESP
	ARNUITY ELLIPTA	DUAKLIR PRESSAIR
	ASMANEX HFA	DULERA
	ASMANEX TWISTHALER	DUONEB
	ASTHMANEFRIN	ELIXOPHYLLIN
	ATROVENT HFA	FASENRA

Drug Class	Medication Name	
Asthma Agents (Cont.)	FLOVENT DISKUS	SEEBRI NEOHALER
	FLOVENT HFA	SEREVENT DISKUS
	FLUTICASONE-SALMETEROL	SPIRIVA
	FORADIL	STIOLTO RESPIMAT
	GASTROCROM	STRIVERDI RESPIMAT
	INCRUSE ELLIPTA	SYMBICORT
	IPRATROPIUM BROMIDE	TERBUTALINE SULFATE
	IPRATROPIUM-ALBUTEROL	THEO-24
	LEVALBUTEROL	THEOCHRON
	LEVALBUTEROL TARTRATE HFA	THEOPHYLLINE
	LONHALA MAGNAIR	TRELEGY ELLIPTA
	METAPROTERENOL	TUDORZA PRESSAIR
	MONTELUKAST	UTIBRON NEOHALER
	PERFOROMIST	WIXELA INHUB
	PROVENTIL HFA	XOPENEX
	PULMICORT	XOPENEX HFA
	PULMICORT FLEXHALER	YUPELRI
	QVAR	ZAFIRLUKAST
	RACEPINEPHRINE	ZILEUTON ER
	S2 RACEPINEPHRINE	
Beta-Blocking Agents	ACEBUTOLOL	LOPRESSOR
	ATENOLOL	METOPROLOL SUCCINATE
	BETAXOLOL	METOPROLOL TARTRATE
	BISOPROLOL	NADOLOL
	BYSTOLIC	PINDOLOL
	ESMOLOL	PROPRANOLOL
	HEMANGEOL	PROPRANOLOL ER
	INNOPRAN XL	TIMOLOL
	KAPSPARGO SPRINKLE	
Beta-Blocking Agents (Combination)	ATENOLOL-CHLORTHALIDONE	NADOLOL-BENDROFLUMETHIAZIDE
	BISOPROLOL-HCT	PROPRANOLOL-HCT
	DUTOPROL	ZIAC
	METOPROLOL-HCT	
Blood Modifiers–Anticoagulants	AGGRENOX	BYVEXXA
	ASPIRIN-DIPYRIDAMOLE ER	CILOSTAZOL
	BRILINTA	CLOPIDOGREL