



MASSACHUSETTS

Fitness Reimbursement



Your Blue Cross Blue Shield of Massachusetts health plan can save you up to \$150¹ annually for participating in a qualified fitness program.

3 Easy Steps to Getting Reimbursed²



1. Choose

Start by picking a qualified fitness program.



2. Complete

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



3. Mail

Send the completed form to the address listed.

A qualified fitness program is:

A full-service health club with a variety of exercise equipment, including:

- Cardiovascular equipment like treadmills and bikes
- Strength-training equipment like free weights and weight machines

What is a qualified expense?

- Membership fees
- Fitness class fees

What doesn't qualify?

You can't receive the fitness reimbursement for expenses for personal training, lessons, coaching, equipment, clothing, or any of the programs below:

- Exercise studios such as martial arts or yoga centers
- Gymnastics, tennis, aerobic, or pool-only facilities
- Country clubs or social clubs
- Sports teams or leagues

Important information:

- You can claim this maximum fitness reimbursement for fees paid by any combination of members enrolled under the same Blue Cross health plan.
- Keep copies of your proof of payment in case we request it from you. Proof of payment includes:
 - » Itemized, dated, paid receipts
 - » Bank or credit card statements
 - » Paycheck stubs, if your payments are automatically deducted from your paycheck
- Proof of payment should include the name of the fitness 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 on your taxes.

Be sure to check with your doctor before starting any exercise program.

1. Most plans offer a \$150 fitness 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 fitness 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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Fitness Reimbursement Request¹

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) | Claim is for (choose one and color in the entire box): | | | |
| <input type="checkbox"/> Male | <input type="checkbox"/> Subscriber (policyholder) | <input type="checkbox"/> Ex-Spouse | <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Female | <input type="checkbox"/> Spouse (of policyholder) | <input type="checkbox"/> Dependent (up to age 26) | | |

Name, Address, and Phone Number of Qualified Fitness Program

| | |
|--|------------------|
| Total dollars requested: \$ _____ for (choose one and color in the entire box): | Health Plan Year |
| <input type="checkbox"/> Membership fees. My monthly membership fee is \$ _____. | |
| <input type="checkbox"/> Fitness class fees. My fee per class 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 fitness 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 regularly use 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 fitness 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).