



Receive up to \$150 annually for participating in a qualified fitness program.¹

Qualified for Fitness Reimbursement:

Membership or fitness class fees at:

- A full service health club with cardiovascular and strength-training equipment like treadmills, bikes, weight machines, and free weights
- **Starting in 2019**—A fitness studio with instructor-led group classes such as yoga, Pilates, Zumba®, kickboxing, indoor cycling/spinning, and other exercise programs

Not Qualified for Fitness 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 equipment or clothing

Get Reimbursed in Three Easy Steps



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.

Important Information:

- Fitness 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 complete 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 membership or class fees clearly documenting your name, the fitness program name, and individual amounts charged with date paid.
 - » Your fitness program membership or participation agreement clearly documenting your name and date signed.
- Reimbursement may be considered taxable income, so consult a tax advisor.

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

1. To verify this reimbursement is offered for your plan, or for more information, log on 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.



MASSACHUSETTS

Fitness Reimbursement Request

PLEASE PRINT ALL INFORMATION CLEARLY

To verify this reimbursement is offered within your plan, or for more information, please log on to MyBlue at bluecrossma.com/myblue 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: MM/DD/YY |
| Gender (color in the entire box): <input type="checkbox"/> Male <input type="checkbox"/> Female | Claim is for (choose one and color in the entire box): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Other (specify) _____ <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): <input type="checkbox"/> Membership fees. Monthly membership fee: \$ _____ <input type="checkbox"/> Fitness class fees. Fee per class: \$ _____ | | | 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 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

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).