FITNESS REIMBURSEMENT

Effective January 1, 2017 through December 31, 2017

Reward Yourself with a Fitness Reimbursement

To encourage you to be fit and stay healthy, Tufts University offers a fitness reimbursement to employees who are enrolled in a Tufts University health plan.

Fitness Reimbursement

Tufts University will give you a reimbursement on your fitness center membership or certain group exercise classes. It’s simple!

The reimbursement is available to members age 18 and older. The subscriber and one other covered dependent qualify for a 3-month reimbursement per year on expenses for fitness center membership or 24 group exercise classes within a 12-week period.

Your fitness expenses must meet the following criteria for the reimbursement:

- For fitness centers, you must be a member of the center for at least three months during 2017 before you qualify for the reimbursement.
- The center must offer cardio and strength-training machines and other programs for improved physical fitness.
- Eligible expenses do not include martial arts centers, gymnastics centers, country clubs, aerobics-only or pool-only centers, sports teams and leagues, social clubs and tennis clubs, personal trainers, sports coaches, or the purchase of personal or at-home exercise machines.
- Group exercise classes must take place in a studio or health club and include aerobics, cycling, yoga, Pilates, Zumba, and kickboxing.
- Eligible expenses do not include dance classes and classes held in a residential setting.

Submitting your request:

- The reimbursement is paid to the subscriber.
- You must submit the request by March 31 in order to be reimbursed for fitness costs for the previous calendar year.
- Submit the Fitness Reimbursement Form on the reverse of this page, along with one of the following:

  1. Proof of fitness center membership and payment

  OR

  2. Proof of charges and payment for group exercise classes
FITNESS REIMBURSEMENT FORM – 2017

You must complete all fields. Please print clearly. Retain a copy of all receipts and documents for your records. Please be sure to sign the form. Tufts University employees who have been a health plan member for at least three months during 2017 are eligible.

You have until March 31, 2018 to submit your request for the fitness reimbursement for 2017. The reimbursement applies to the subscriber and to one dependent age 18 or older per year. The reimbursement is paid to the Tufts Health Plan subscriber. Tufts Health Plan usually process reimbursements within 4 to 6 weeks of receipt.

SUBSCRIBER INFORMATION (If a reimbursement is being requested for the subscriber)

Please continue to the next page if requesting reimbursement for a family member.

Name (Last, First, Middle initial): ____________________________
Date of Birth: ______/______/_________ Sex: ☐ M ☐ F Tufts Health Plan ID#: __________________________
Address: ____________________________ Telephone: ____________________________

FITNESS CENTER INFORMATION
Fitness Club Name: ____________________________
Address: ____________________________ Telephone: ____________________________
Dates of fitness club membership: ____________________________ Amount Paid: ____________________________

GROUP EXERCISE CLASS INFORMATION
Group Exercise Class Name: ____________________________
Address: ____________________________ Telephone: ____________________________
Dates of group exercise class(es): ____________________________ Amount Paid: ____________________________

PAYMENT INFORMATION
Please indicate which one of the following forms of proof of payment you are including with this form:
☐ An itemized receipt from the fitness club and/or group exercise class, showing the dates of membership and dollar amounts paid
☐ A statement from the fitness club’s and/or group exercise class’ letterhead, with an authorized signature, indicating payment was made

FOR INTERNAL USE ONLY
Diagnosis Code: 799 Description: General Procedure code: T4220 Health club membership, annual Procedure code: S9451 Group exercise classes

SIGNATURE REQUIRED
I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Tufts Health Plan may request any additional information it deems necessary to verify that services were received and payment was made. I understand that this reimbursement may be considered taxable income.

Subscriber Signature: ____________________________ Date: ____________________________

Please submit this form and all documentation to:
Tufts Health Plan | Member Reimbursement Claims, PO Box 9191
Watertown, MA 02471-9191
Please do not staple any materials to this form
FITNESS REIMBURSEMENT FORM – 2017

You must complete all fields. Please print clearly. Retain a copy of all receipts and documents for your records. Please be sure to sign the form. Tufts University employees who have been a health plan member for at least three months during 2017 are eligible.

You have until March 31, 2018 to submit your request for the fitness reimbursement for 2017. The reimbursement applies to the subscriber and to one dependent age 18 or older per year. The reimbursement is paid to the Tufts Health Plan subscriber. Tufts Health Plan usually process reimbursements within 4 to 6 weeks of receipt.

DEPENDENT INFORMATION (If reimbursement is being requested for a family member)

Name (Last, First, Middle Initial): ________________________________

Date of Birth: _____/_____/_______ Sex: ☐ M ☐ F Tufts Health Plan ID# ______________ Telephone: ______________

Address: ______________________________ Telephone: __________________

FITNESS CENTER INFORMATION

Fitness Club Name: ______________________________

Address: ______________________________ Telephone: __________________

Dates of fitness club membership: ______________________________ Amount Paid: __________________

GROUP EXERCISE CLASS INFORMATION

Group Exercise Class Name: ______________________________

Address: ______________________________ Telephone: __________________

Dates of group exercise class(es): ______________________________ Amount Paid: __________________

PAYMENT INFORMATION

Please indicate which one of the following forms of proof of payment you are including with this form:

☐ An itemized receipt from the fitness club and/or group exercise class, showing the dates of membership and dollar amounts paid

☐ A statement from the fitness club’s and/or group exercise class’ letterhead, with an authorized signature, indicating payment was made

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Dependent Signature: ______________________________ Date: __________________

Please submit this form and all documentation to:

Tufts Health Plan | Member Reimbursement Claims, PO Box 9191

Watertown, MA 02471-9191

Please do not staple any materials to this form
DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Plan at 800.462.0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)


tuftshealthplan.com | 800.462.0224
For no cost translation in English, call the number on your ID card.

Arabic: للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

Chinese: 若需免费的中文版本，请拨打ID卡上的电话号码。

French: Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German: Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek: Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Haitian Creole: Pou jwen tradiksyon gratis nan lang Kre yol Ayisyen, rele nimewo ki sou kat ID ou.

Italian: Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Japanese: 日本語の無料翻訳についてはIDカードに書いてある番号に電話してください。

Khmer (Cambodian): ចិនគ្នានៅក្នុងការប្រើប្រាស់ការផ្ទុកពាណិជ្ជកម្មកម្ពុជានៃក្រុមជាតិមួយនឹងផ្ទុកពាណិជ្ជកម្មបន្ទាន់។

Korean: 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian: ឬប្រើជាច្រើននៃប្រយោគដែលអាចប្រើប្រាស់បាន។ ឬកៃចត់មួយចំនួននៃការនិយាយទៅ។ ឬមិនអាចអនុវត្តការប្រើប្រាស់បាន។

Navajo: Doo báah ilíní da Diné k’ehjí áhnégho, hodiilnih béezh bée hani’é bée néé ho’dilzingo nantiniígíi bikáá’.

Persian: برای ترجمه رایگان فارسی به شماره تلفن مندرج در کارت شناسانی تان زنگ بزنید.

Polish: Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese: Para tradução grátis para português, ligue para o número no seu cartão de identificação.

Russian: Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish: Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

Tagalog: Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese: Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.