

WELLNESS ALLOWANCE BENEFIT: How To Get Your \$150 Reimbursement

TUFTS  Health Plan
Medicare Preferred

As a Tufts Medicare Preferred HMO plan member, each calendar year you can get up to a total of \$150 toward fees you pay for:

- **Fitness classes led by an instructor for yoga, Pilates, Tai Chi, and/or aerobics.**
- **Membership in a qualified health club or fitness facility.** A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment. Examples include: YMCAs, Tufts Health Plan's network of fitness centers in Massachusetts; Curves®; & Fitness Together
- **Nutritional counseling provided by a registered dietician or licensed nutritional counselor.**
- **Participation in a "Matter of Balance" program led by an instructor, chronic disease self-management program, and wellness programs:** diabetes workshop program, the Healthy Eating for successful Living program, Healthy IDEAs, Powerful Tools for Caregivers, the Arthritis Foundation Exercise program, Enhance Wellness such as memory fitness activities, Fit for your Life, and AAA Senior Driving.

Memory fitness programs eligible for reimbursement must meet the following criteria:

- 1) The program must help you set a goal (e.g. a memory fitness goal)
- 2) The program must track your progress towards your brain fitness goals
- 3) The program must have a publication in a peer-reviewed journal supporting its effectiveness toward improving brain fitness.

Please note, this benefit does not cover membership fees you pay to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers, country clubs, or for sports activities such as golf and tennis.

To Get Your Reimbursement Send Us:

- The completed form on the back of this page (Only one member request per form please).
- Photocopies of one of the following:
 - Dated, paid receipt with the name of the facility, class, or counselor preprinted on the receipt, and the amount paid
 - Front and back of cancelled check written to the facility, class, or counselor
 - Credit card statement or receipt identifying the facility, class, or counselor

Photocopies must be on 8.5" x 11" paper. Multiple receipts can be included on one page.

Mail the form, paid receipts or statements to:

**Tufts Health Plan Medicare Preferred
Wellness Benefit
P.O. Box 9183
Watertown, MA 02471-9183**

Please keep copies of all the paperwork you send us. We are not able to return photocopies of receipts or agreements, even if the request for payment is denied.

Remember to check with your doctor before starting an exercise program!

For more information, call Customer Relations at 1-800-701-9000, (TTY 1-800-208-9562). Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From October 1 – February 14, representatives are available 7 days a week 8:00 a.m. – 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Tufts Health Plan Medicare Preferred is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan Medicare Preferred depends on contract renewal.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan.

Limitations, copayments, and restrictions may apply. Benefits may change on January 1 of each year.

WELLNESS ALLOWANCE BENEFIT REIMBURSEMENT FORM

TUFTS  Health Plan
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Please enter ALL information requested and print clearly. (One form per member.)

Your Information

Tufts Health Plan Medicare Preferred Member # _____ Last Name _____ First Name _____ Middle Initial _____

Address: Number and Street _____ City _____ State _____ Zip _____

Gender: Male _____ Female _____ _____ / _____ / _____
Date of Birth: Month / Day / Year _____ Phone Number _____

Benefit Year (calendar year): _____

Facility, Class, Counselor, or Program Information

Facility/Class/Counselor/Program Name: _____

Facility/Class/Counselor/Program Address: _____

I am requesting reimbursement for (check all boxes that apply):

- Club/Facility Membership fee(s) Nutritional Counseling fee(s) Matter of balance program
 Fitness class fee(s) Chronic disease self-management program Wellness Programs (specify) _____

If you are applying your benefit toward a health club or fitness facility, please confirm you received an orientation to the facility and equipment: Yes, I received an orientation

How to Submit This Form (Please allow 45 days for processing of completed forms)

- You can submit this form with paid receipts once and receive your \$150 Wellness reimbursement in full, OR you may submit this form with paid receipts several times until you have received up to \$150.
- You can receive up to \$150 per calendar year (January 1 – December 31).
- Submit photocopies of:
 - Dated & paid receipts
 - Completed & signed Wellness reimbursement form
- Total reimbursement you are requesting:
 - \$150.00
 - Less than \$150.00
Indicate Amount _____
- Please mail to:
**Tufts Health Plan Medicare Preferred
Wellness Benefit
P.O. Box 9183
Watertown, MA 02471-9183**

Reimbursement requests must be received by Tufts Health Plan Medicare Preferred by March 31st of the following year.

Authorization (This form must be signed and dated below)

I authorize the release of any information to Tufts Health Plan Medicare Preferred about my health club membership. I certify that the information provided is complete and correct and that I have not previously submitted for these services.

Member's Signature: _____ Date: _____