

## Wellness Allowance Benefit:

# How to Get Your Reimbursement

As a Tufts Medicare Preferred HMO plan member, each calendar year you can get up to a total of \$150<sup>1</sup> toward fees you pay for:

- **Fitness classes** led by an instructor for yoga, Pilates, Tai Chi, and/or aerobics.<sup>2</sup>
- **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, and Fitness Together.<sup>2</sup>
- **Nutritional counseling** provided by a registered dietician or licensed nutritional counselor.
- **Visits to a licensed acupuncturist.**
- **Participation in wellness programs,** such as certified instructor-led "Matter of Balance," chronic disease self-management, diabetes workshop, Healthy Eating for Successful Living, Healthy IDEAs, Powerful Tools for Caregivers, Arthritis Foundation Exercise, Fit for Your Life, AAA Senior Driving, and Enhance Wellness, such as memory fitness activities.

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

### 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 8.5×11" paper. Multiple receipts can be included on one page.

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

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 711)**.

<sup>1</sup>Members of Tufts Medicare Preferred HMO Saver Rx plan can get up to a total of \$300 each calendar year.

<sup>2</sup>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.

For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits may change on January 1 of each year. H2256\_2020\_259\_C

# WELLNESS ALLOWANCE BENEFIT REIMBURSEMENT FORM



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

## Your Information

### Relationship to the Subscriber

Self       Authorized Representative

If a Member Reimbursement is being submitted by an Authorized Representative, please complete and include the Tufts Health Plan Appointment of Personal Representative Form (AOR), or any legal documentation verifying personal representation, with your request. We require verification of the authority of a Personal Representative before the request can be processed. You can find the AOR form on our website at [thpmp.org/aor-forms](http://thpmp.org/aor-forms).

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Gender:  Male       Female      Date of Birth: (M M / D D / Y Y Y Y) \_\_\_\_\_ Phone Number: \_\_\_\_\_

Tufts Health Plan Medicare Preferred Member ID #: \_\_\_\_\_ Benefit Year: \_\_\_\_\_ (calendar year)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## 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)     Acupuncture     Fitness class fee(s)  
 Matter of Balance program     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 form)

- You can submit this form with paid receipts once and receive your 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 (up to \$300 for Saver Rx members) per calendar year (Jan 1–Dec 31).
- Submit photocopies of:
  - Dated & paid receipts
  - Completed & signed Wellness reimbursement form
- Total reimbursement you are requesting:
  - \$150.00       \$300.00 (Tufts Medicare Preferred HMO Saver Rx plan members only)
  - 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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 1-800-701-9000 (TTY: 711).

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: 1-888-880-8699 ext. 48000, (TTY number—711 or 1-800-439-2370. Español: 866-930-9252)

Fax: 617-972-9048

Email: [OCRCoordinator@tufts-health.com](mailto: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

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

[thpmp.org](http://thpmp.org) | 1-800-701-9000

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

**Arabic:** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 711).

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-701-9000 (TTY 711)。

**Farsi:** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-701-9000 (TTY: 711) فراهم می باشد. با تماس بگیرید.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

**Greek:** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

**Gujarati:** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

**Haitian Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (TTY: 711).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-701-9000 (TTY: 711) まで、お電話にてご連絡ください。

**Khmer (Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អូល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-701-9000 (TTY: 711)

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

**Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-701-9000 (TTY: 711).

**Navajo:** Díí baa akó nínízin: Díí saad bee yánílt'igo Diné Bizaad, saad bee áká'ánída'áwo'deę, t'áá jiik'eh, éí ná hóló, koji' hódílnih 1800-701-9000 (TTY: 711).

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

**Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-701-9000 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (TTY: 711).

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-701-9000 (TTY: 711).