allways[sm]
HEALTH PARTNERS

Fitness Benefit Coverage

Form & Instructions for My Care Family[SM] Members

How can I get more information about my fitness benefit?

Get details about your fitness benefit, this benefit is available to you and up to five of your covered family members. Each person is eligible for a maximum of $50 per year. Access your plan information and view finalized claims at any time on our member portal at **allwaysmember.org**

How do I request reimbursement for my fitness benefit?

There are two ways to submit your request form:

SUBMIT ON OUR MEMBER PORTAL

The most convenient way to request your reimbursement is on **allwaysmember.org**.

- Complete your form online
- Get confirmation of your submission right away

Please allow 15-30 days for processing

SUBMIT BY MAIL

Complete the form on the back of this flyer, and mail it to:

AllWays Health Partners
Attention: Claims/Fitness
399 Revolution Drive
Suite 810
Somerville MA 02145

You will not get confirmation of your submission.
Please allow 30-45 days for processing

You may also fax your request form to **617-526-1902**.

Please note:

You must be an AllWays Health Partners member and enrolled in a plan with a fitness benefit during the period for which you are requesting reimbursement. You must be covered by AllWays Health Partners for at least three months to be eligible for your fitness benefit.

The deadline to request your fitness benefit for each calendar year is March 31 of the following year. You can only submit one request per calendar year.

Qualifying fitness facilities, programs or activities include, but are not limited to, those that offer cardiovascular, strength-training equipment, aerobic, ClassPass memberships, Pilates, Yoga, Zumba, CrossFit, Barre fitness activities, virtual fitness subscriptions* and more. Visit **allwaysmember.org** to see examples of qualifying fitness facilities, programs and activities.

AllWays Health Partners reserves the right to audit requests for eligibility. If you are chosen for audit, we will contact you and request additional documentation. The audit will take an additional 14 days to process upon receipt of complete documentation.

**Effective immediately*

Continued

My Care Family Fitness Benefit
Coverage Request Form

Member Information

LAST NAME | FIRST NAME | M.I.

STREET ADDRESS | CITY | STATE | ZIP

TELEPHONE NUMBER | MEMBER ID# (located on the front of the ID card)

Fitness Facility, Program/Subscription or Activity Information

NAME OF FACILITY/PROGRAM/SUBSCRIPTION/ACTIVITY | CITY | STATE

Website address of virtual fitness subscriptions: _____

Payment Information

What kind of membership do you have? ☐ Family ☐ Individual

Calendar year reimbursement being requested: _____

Check off months of participation in a qualified fitness facility, program/subscription or activity:

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Total amount paid for months checked off above: _____

Do you pay monthly, annually or per session? _____

Certification/Authorization

The member or the member's guardian must sign and date below. The fitness benefit is subject to approval. AllWays Health Partners reserves the right to request additional information.

Reimbursement requested for: ☐ MEMBER (maximum of $50) ☐ FAMILY MEMBERS ($50 each; $250 family maximum)*

*Please print the full name of each member who is requesting the fitness benefit:

1. _____
2. _____
3. _____
4. _____
5. _____

To the best of my knowledge and belief, my statements in the AllWays Health Partners Fitness Benefit Coverage Request Form are complete and true. I am claiming the coverage amount as indicated on this form.

ALLWAYS HEALTH PARTNERS MEMBER'S SIGNATURE | DATE