DARTMOUTH-HITCHCOCK MEDICAL PLAN
FITNESS BENEFIT

fitness benefit

You are eligible to receive up to $200 per calendar year toward your club's membership fees when you join a qualified health club, and attend at least two sessions a week for 11 out of 13 consecutive weeks during the calendar year.

Save money with your plan's Fitness Benefit!

QUALIFYING HEALTH CLUBS

Qualifying clubs include those with a variety of cardiovascular and strength-training exercise equipment, such as traditional health clubs and YMCAs/YWCAs.

NON-QUALIFYING HEALTH CLUBS

- Martial arts centers
- Gymnastics facilities
- Country or social clubs
- Tennis, aerobic or pool-only facilities
- Sports teams or leagues

Please note:

- Your Fitness Benefit does not cover any aerobic/fitness activity fees — such as those for personal training, lessons, coaching, exercise equipment or clothing — paid to a non-qualified health club.
- Reimbursement under the Fitness Benefit is available to any member (subscriber or dependent aged 14 or older) per calendar year.

How do I receive my benefit?

Submit to Health Plans:

- Your completed Fitness Reimbursement Form (attached);
- Copies of your health club agreement and/or contract that include the name and address of the facility and the membership dates; and
- 8½" x 11" photocopies of your dated, paid receipts. Receipts should include the name of the member and the charges associated with membership. *(Copies of bank or credit card statements are acceptable if your fees are automatically deducted from those accounts.)*

Have questions? Contact HPI Member Services at 866-471-5550 or visit HealthPlansInc.com/D-H

HealthPlans, Inc.

HPI is a Harvard Pilgrim company

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Fitness Reimbursement Form

Did you know that you can submit your claims reimbursement request online? Just log in to My Plan at HealthPlansInc.com/D-H.

Employer Name: Dartmouth-Hitchcock **Group Number:** 1DH

WHAT TYPES OF HEALTH CLUBS QUALIFY UNDER THIS BENEFIT?

- Qualified, full-service health and fitness facilities that provide cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness qualify, such as health clubs and fitness centers, YMCAs and YWCAs, Jewish Community Centers and municipal fitness centers.
- Facilities/programs that DO NOT qualify for reimbursement include: Fees for group classes or personal training outside of a fitness facility/studio; health club initiation fees; costs for instructional dance studios; country clubs, social clubs (*e.g.*, skiing, riding or hiking clubs); spas; gymnastics facilities; martial arts centers; tennis-only, aerobic-only, or pool-only facilities; road race fees; sport camps; ski passes; sports teams/leagues; and school sports athletic user fees.

WHEN TO SUBMIT THIS FORM:

- The fitness benefit is available to plan members age 14 or older who belong to a health club, and attend at least twice per week for 11 out of 13 consecutive weeks in the calendar year. Membership fees must be paid in the current calendar year for membership in that year, and the paid date must be within the member's dates of enrollment in this plan.
- Please refer to your Plan Document or your Summary of Benefits and Coverage for specific details concerning this benefit, including limits and/or restrictions, under your plan.
- Once all sections have been completely filled out and signed by the employee, please mail the completed form with all necessary documentation (copies of receipts and your health club membership agreement form) to Health Plans.

Employee Information

Employee Last Name	*First Name*	*MI*	*Health Plans Member ID#*

Mailing Address	*City*	*ST*	*ZIP Code*

Date of Birth	*Email Address*	*Primary Phone*

Member/Dependent Information

Reimbursement is requested for the following participant *(please check):* ☐ Employee ☐ Spouse ☐ Child/Other Dependent ☐ Ex-Spouse

If reimbursement is requested for a participant *other than the employee*, please provide the dependent information below:

Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship*

Health Club Information

Please provide the following information:

DATES ATTENDED: From: MM/DD/YYYY To: MM/DD/YYYY	**FITNESS CLUB NAME**	**ADDRESS, CITY & STATE**	**PHONE NUMBER** *(incl. Area Code)*	**$ AMOUNT CLAIMED**
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I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Signature: _____ _____

Signature of Employee *Date Signed*

Signature: _____ _____

Signature of Health/Fitness Club Representative *Date Signed*

Submit this completed form and your supporting documentation to:

Health Plans, Inc. — Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575 • 508-792-1188 *(fax)*