CarePartners of Connecticut

CarePartners of Connecticut CareAdvantage Preferred (HMO) Wellness Allowance Benefit:

How to Get Your Reimbursement

As a CareAdvantage Preferred plan member, each calendar year you can get up to a total of $200 toward fees you pay for:

- **Fitness classes** led by an instructor for yoga, Pilates, tai chi, and/or aerobics.
- **Fitness tracker**, such as a Fitbit, covered once every 3 years.
- **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: YMCA, Curves, and Fitness Together.[1]
- **Nutritional counseling** provided by a registered dietitian 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 IDEAs, Powerful Tools for Caregivers, Arthritis Foundation Exercise, AAA Senior Driving, and Enhance Wellness, such as memory fitness activities.

Note: You are eligible for reimbursement for memory fitness classes from companies other than BrainHQ. A zero-cost subscription to BrainHQ is included in your plan.

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 canceled 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.

This benefit is available as of 1/1/2020, to CareAdvantage Preferred members *only*.

Reimbursement requests submitted for dates before 1/1/2020, or for plans other than CareAdvantage Preferred, cannot be accepted by the plan.

Reimbursement requests must be received by CarePartners of Connecticut by 3/31/2021.

Mail the form, paid receipts, or statements to:

CarePartners of Connecticut
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 Service at **1-888-341-1507 (TTY: 711)**.

[1] 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, copays, and restrictions may apply. Benefits may change on January 1 of each year. CarePartners of Connecticut complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CarePartners of Connecticut does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. CarePartners of Connecticut is an HMO plan with a Medicare contract. Enrollment in CarePartners of Connecticut depends on contract renewal. H5273_2020_166_C

CarePartners of Connecticut

CareAdvantage Preferred (HMO) Wellness Allowance Reimbursement Form

If a member reimbursement is being submitted by an Authorized Representative, please complete and include the CarePartners of Connecticut 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 **carepartnersct.com/content/forms**.

☐ **I am completing this form as an Authorized Representative to the subscriber.**

Member Information

First name | M.I. | Last name

Phone number | Date of birth | Member ID number

Benefit calendar year | Street address

City | State | Zip

Program and Reimbursement Information

Name of facility/class/counselor/program

Street address

City | State | Zip

Total reimbursement you are requesting:

◯ $200

◯ Less than $200 (indicate amount below)

$

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

☐ Club/facility membership fee(s)

☐ Nutritional counseling fee(s)

☐ Fitness class fee(s)

☐ Matter of Balance program

☐ Chronic disease self-management program

☐ Memory fitness (other than BrainHQ)

☐ Other wellness program (specify):

Authorization

I authorize the release of any information to CarePartners of Connecticut 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.

Date | Signature