

Fitness Benefit Reimbursement Program

If you belong to a MITRE health plan administered by Aetna, we've got a healthy incentive for you.

As a subscriber, your Fitness Benefit can save you or a family member up to \$200 per calendar year in qualified health and fitness club class and membership fees. To be eligible for the Fitness Benefit reimbursement, you or an eligible dependent must be an active member of the HMO or PPO High Deductible plans administered by Aetna and have belonged to a qualified health club for a full four months (in a calendar year).

What types of health clubs qualify?

A qualified health and fitness club is a facility that offers a variety of cardiovascular (i.e. treadmills, bikes, etc.) and strength-training (i.e. free weights, weight machines, etc.) exercise equipment. These include qualified health and fitness clubs, YMCAs, the MITRE Fitness Center and facilities that offer yoga, Pilates, Zumba, aerobic/group classes, indoor cycling/spinning classes, kickboxing, CrossFit, strength training, tennis, indoor rock climbing, martial arts, and personal training.

Please note that gymnastics facilities; country clubs; tennis, aerobic, or pool-only facilities; social clubs; and sports teams or leagues do not qualify. You cannot receive the Fitness Benefit for any aerobic/fitness activity fees paid to a non-qualified health club (including those paid for personal training, lessons, coaching, exercise equipment, or clothing).

How does a member qualify?

You or an eligible dependent will need to have been a member of a qualified health club and a health plan administered by Aetna for a full four months (in a calendar year).

What do I need to do?

Complete the **Fitness Benefit Form** (Reminder the \$200 is per individual or family membership. Submit only once per calendar year.)

- A copy of your qualified health club agreement or contract that includes the name and address of the qualified health club and the membership or class dates
- Copies of dated, paid receipts, or bank or credit card statements, or paycheck stub if your club fees are automatically deducted from those accounts. Receipts or statements should include the name of the family member enrolled in the club and the individual charges for a full four months of qualified health club membership.

Mail the form and copies of your qualified health club contract and paid receipts or statements to the address at the bottom of the attached claim form by the end of the calendar year.

If you have any questions, please call the Member Service number on your ID card.

Note: Keep copies of all the paperwork you send. Any services denied for payment will be noted on your Claim Summary. Receipts or contract copies, even if denied for payment, are not returned.

Be sure to check with your physician provider before starting an exercise program.

Please be aware that the dollar amount you receive may be taxable income. Consult your tax advisor regarding tax treatment of this reimbursement.

Fitness Benefit Reimbursement Form

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information			
Employee Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Aetna Member ID Number	
Address (Street, City, State, Zip Code)			
Employer Name THE MITRE CORPORATION			
Member Information			
Employee Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Member ID Number	
Address (Street, City, State, Zip Code) (if different from Subscriber)			
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Claimant is (check one): <input type="checkbox"/> Subscriber (coverage holder) <input type="checkbox"/> Dependent Child (age 26 or younger) <input type="checkbox"/> Legal Spouse (of coverage holder) <input type="checkbox"/> Handicapped Dependent (age 26 or older) <input type="checkbox"/> Domestic Partner		
When to Submit this Form: <ul style="list-style-type: none"> After you have been a member of a MITRE health plan administered by Aetna and a qualified health club for four full months in a calendar year. Once per calendar year, filed by March 31st of the following plan year. 			
Qualified Health Club Information Required: <ul style="list-style-type: none"> Attach a copy of a dated paid qualified health club receipt and your qualified health club agreement/contract. 			
Named and Address of Qualified Health Club			Benefit Year

Total Amount Submitted: \$ _____

Certification

I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.	
Subscriber Signature: _____	Date: _____

Failure to complete form in full may cause delay in payment.

Submit Claims To:

Aetna
 PO Box 981106
 El Paso, TX 79998-1106
 FAX: 1-859-455-8650