An added benefit to fit your healthy lifestyle

Blue Healthy Choices includes a lifestyle benefit that can help pay for services and programs you may already be using. And to make it as easy as possible to get and stay healthy, you can use your benefit more places than ever before.

Your benefit

Fit & Healthy Option
$300 annual benefit

Healthy Family Option
$300 annual benefit

What it covers

- **Gym Membership** - Facility must be open to the public and, at a minimum, provide both cardiovascular and strength training equipment.
- **Lasik eye surgery** - Services must be rendered by a licensed Ophthalmologist
- **Teeth whitening** - Services must be provided by a licensed dentist.
- **Toddler gym and swim programs** - Ages 2 - 5 years old
- **Kids fitness activities** - are community based fitness classes, physical activities and organized sports for children ages 5 - 18 years old.

  Examples include but are not limited to soccer, baseball, bowling, sports camps and swim lessons.

You can use your lifestyle benefit at any provider you choose, and **Blue365®** providers also offer discounts so you can save even more. View a full listing at excellusbcbs.com.

What does not qualify?

- Individual exercise programs and personal trainer services
- Merchandise such as attire, fitness equipment, videos, publications, golf clubs, bicycles, and entry fees
- Teeth whitening strips or over the counter whitening products
- Motorcycle classes or courses
- Drivers Education

How to use it

You choose your provider, pay for services, and **submit the reimbursement form on the back of this sheet along with a receipt.** Excellus BlueCross BlueShield will reimburse you directly.

How to submit your reimbursement form

1. Copies of all bills and/or receipts for reimbursement must be enclosed with this completed lifestyle benefit reimbursement form with the following information included:
   - Name of person providing service
   - Dates of service
   - Description of service
   - Amount charged
   - Name of person receiving service

   Balance bills, canceled checks, etc., are not acceptable.
2. Reimbursement forms must be submitted within 12 months of receiving services to be considered for payment by Excellus BlueCross BlueShield.
3. Reimbursement forms must be signed by the member.
4. Mail completed forms with bills and/or receipts to:

   PO Box 21146
   Eagan, MN 55121

If you have any questions, please call our Customer Service Department at the number on the back of your identification card.

Excellus
A nonprofit independent licensee of the BlueCross BlueShield Association

BlueHealthy Choices

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM

Please Note-*If you do not have all of the required information please contact the provider of service for assistance prior to submitting your claim. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of your claim submission.*

If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.

Lifestyle Benefits Reimbursement Form

Mail completed form and all required information to :

P.O. Box 21146
Eagan, MN 55121

SECTION 1
INFORMATION REQUIRED FOR REIMBURSEMENT

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. BALANCE BILL, CANCELLED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING**:

1-FULL NAME AND DATE OF BIRTH OF MEMBER RECEIVING SERVICES

2-NAME AND ADDRESS OF THE INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE(S)

3-DATE FOR **EACH** SERVICE RENDERED

4-DESCRIPTION AND/OR VALID PROCEDURE CODE FOR **EACH** SERVICE RENDERED

5-CHARGE FOR **EACH** SERVICE RENDERED

6-ALL CLAIMS FOR LIFESTYLE BENEFITS REIMBURSEMENT MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE SERVICES WERE RENDERED IN ORDER TO BE CONSIDERED FOR PAYMENT.

SECTION 2
SUBSCRIBER INFORMATION *Please enter all information exactly as shown on your ID card*

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	INITIAL	SUBSCRIBER IDENTIFICATION NUMBER

ADDRESS-NUMBER AND STREET	CITY	STATE	ZIP CODE

SECTION 3
SERVICE INFORMATION *Please complete all sections below for each individual service rendered*

MEMBER'S FULL NAME	MEMBER'S DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	DATE(S) OF SERVICE	SERVICE INFORMATION	AMOUNT
LAST NAME: ☐ FIRST NAME: ☐	___/___/______ mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: ___/___/___ TO: ___/___/___	☐ TEETH WHITENING *D9972/Dx. V509* ☐ LASIK EYE SURGERY *65771/Dx. V410* ☐ TODDLER/PRESCHOOL EXERCISE PROGRAM *S9445/Dx. V6541* ☐ GYM/HEALTH CLUB *S9446/Dx. V6541* ☐ KIDS FITNESS *S9451/Dx. V6541* ☐ DRIVER'S EDUCATION *Available through 12/31/09 99509/Dx. V623* PROVIDED BY: ________	$________
LAST NAME: ☐ FIRST NAME: ☐	___/___/______ mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: ___/___/___ TO: ___/___/___	☐ TEETH WHITENING *D9972/Dx. V509* ☐ LASIK EYE SURGERY *65771/Dx. V410* ☐ TODDLER/PRESCHOOL EXERCISE PROGRAM *S9445/Dx. V6541* ☐ GYM/HEALTH CLUB *S9446/Dx. V6541* ☐ KIDS FITNESS *S9451/Dx. V6541* ☐ DRIVER'S EDUCATION *Available through 12/31/09 99509/Dx. V623* PROVIDED BY: ________	$________
LAST NAME: ☐ FIRST NAME: ☐	___/___/______ mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: ___/___/___ TO: ___/___/___	☐ TEETH WHITENING *D9972/Dx. V509* ☐ LASIK EYE SURGERY *65771/Dx. V410* ☐ TODDLER/PRESCHOOL EXERCISE PROGRAM *S9445/Dx. V6541* ☐ GYM/HEALTH CLUB *S9446/Dx. V6541* ☐ KIDS FITNESS *S9451/Dx. V6541* ☐ DRIVER'S EDUCATION *Available through 12/31/09 99509/Dx. V623* PROVIDED BY: ________	$________

SECTION 4
SIGNATURE AND DATE *Unsigned forms will be returned*

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S), AND THAT THESE EXPENSES ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE.

SUBSCRIBER SIGNATURE: ______________________________ **DATE:** ______________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.