Contra Costa Community College District
Local 1 Co-pay Reimbursement Request Form

Last Name	First Name	Last 4 of SSN and Date of Birth	
Mailing Address	**City**	**State**	**Zip Code**
Work Location	**Phone Number**	**Reimbursement Amount**	

According to Article 20.4.4.5 of the Local 1 contract, the co-payments from a District medical plan that are eligible for reimbursement are 1) office visits, 2) prescription drugs, 3) emergency room visits and 4) hospitalization. The amount of co-payment eligible for reimbursement is the amount that exceeds $5. Reimbursement does not cover out-of-network copayments. Reimbursable copayments are normally in $5, $15, $50 and $100 increments. To request a co-pay reimbursement, you must complete and submit the following: 1) this form and 2) receipts.

Submit to	Navia Benefit Solutions Mail: PO Box 5179, Fresno, CA 93755 Fax: (866) 831-6222 Email: 105@naviabenefits.com **Please keep a copy of your receipts for your records.**
Questions	Phone: (866) 897-1996, Email: 105@naviabenefits.com
Reimbursements	Reimbursements are issued weekly on Friday via direct deposit or check.
HRA Plan Year	The HRA runs on a calendar year January 1st – December 31st. The last day to submit a request for reimbursement is 30 days after the end of the plan year (1/30).

Terms of Eligibility for Out-of-Pocket Medical Cost Reimbursement:

- To be eligible, a Local One represented employee must be covered by a District medical plan.
- $65,000 annually will be set aside to reimburse Local One represented employees.
- These funds will be used on a first-come, first-served basis until the money is exhausted.
- The amount of the co-pay eligible for reimbursement is the amount that exceeds each $5 Co-Pay.
- Employees who are on maintenance prescriptions will be required to participate in the 90-day prescription provisions to receive reimbursement.

To the best of my knowledge my statements on this claim submission are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my health reimbursement arrangement ("HRA") and that unless an expense for which payment or reimbursement is claimed is a qualifying expense under such benefit, I may be liable for the entire amount reimbursed or payment of all related taxes including federal, state, or city income tax on any reimbursement issued hereunder. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. Finally, I understand and have reviewed Navia's website privacy policy, privacy notice, and the website terms and conditions. I consent to the use and disclosure of my information in accordance with Navia's online policies and consistent with applicable law solely for the purposes of administering my benefits as outline in the agreement between my employer and Navia. By providing an email address, I consent to receive all possible communications from Navia, agents, and subcontractors regarding the Plan via email. I may withdraw consent at any time without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my benefits to be reduced by the amount(s) claimed above.

By evidence of my signature, I verify the information submitted is accurate and that I am eligible for this reimbursement under the terms described above.

Employee Name (Print Clearly)	Employee Signature	Date

(Revised 04/24/2025)