Contra Costa Community College District
United Faculty 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**	

Copayments are reimbursable for out-of-pocket costs in excess of $500 for the current fiscal year. Reimbursement does not cover out-of-network PPO percentage copayments. Reimbursable copays are normally in $5, $15, $50 and $100 increments and may ONLY include the following copayments from a District medical plan: Office Visits, Prescription Drugs, Emergency Room Visits and Hospitalization. To request a co-pay reimbursement, you must complete and submit this form.

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 fiscal year July 1st – June 30th. The last day to submit a request for reimbursement is 60 days after the end of the plan year (8/31).

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

- To be eligible, an employee must be covered by a District medical plan and submit receipt showing the employee has spent in excess of $500 in that fiscal year for copayments from a District medical plan. $50,000 per fiscal year will be set aside to reimburse faculty employees with District paid benefits for the copayments mentioned above in excess of $500.
- These funds will be used on a first-come, first-served basis until the money is exhausted.
- Eligible employees who are interested in participating in this program are encouraged to submit a co-pay reimbursement request to Navia including 1) reimbursement request form; and 2) insurance carrier Explanation of Benefits (EOB).
- Employees who are on maintenance prescriptions will be required to participate in the Anthem Blue Cross 90 day prescription mail order program or the Kaiser 100-day prescription supply program.
- Infertility out-of-pocket costs are not reimbursable by the District.

Initial	☐ **Yes**	Yes, I have already exceeded the additional expenses paid beyond $500 for this fiscal year. As a result, all the copayment receipts submitted at this time should be considered for reimbursement.
	☐ **No**	No, I have NOT exceeded the additional expenses paid beyond $500 for this fiscal year OR I will exceed the threshold of $500 at this time. (Reimbursement Total = Copayments - $500).

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)