Contra Costa Community College District
Anthem Medicare PPO Plan
Retiree Co-pay Reimbursement Request Form

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

The Contra Costa Community College District reimburses for office co-payments for those retirees and spouses who are currently on the District sponsored Anthem Medicare PPO plan. Office copayments are $15.00 and the District will reimburse up to $10.00 per office visit, so your co-pay responsibility is $5.00. Reimbursements do not cover out-of-network co-payments or non-office co-payments. To request a co-pay reimbursement, you must complete and submit the following: 1) this form and 2) receipts for each $15.00 co-payment.

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 Anthem Medicare PPO Plan Office Co-Pay Reimbursement:

- To be eligible, retiree and/or spouse must be covered by the District sponsored Anthem Medicare PPO Plan.
- The amount of the co-pay eligible for reimbursement is the amount that exceeds each $5 Co-Pay.
- Receipts must show the name of retiree and/or spouse and the $15.00 office co-payment.

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
Spouse Name (Print Clearly)	Spouse Signature	Date

(Revised 04/24/2025)