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

Last Name	First Name	Social Security Number	
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	PENSION DYNAMICS COMPANY, LLC By Mail: 2300 Contra Costa Boulevard, Suite 400, Pleasant Hill, CA 94523-3955 Or by fax: 844-859-7309 Or by e-mail: benefits@pensiondynamics.com
Questions	Phone: 925-956-0514, any available representative
Checks	Reimbursement checks will be mailed to the employee's home address within 45 days.
Calendar Year	Reimbursements are for a calendar year beginning January 1st and ending December 31st. The last day to submit a request for reimbursement is 30 days after the end of the calendar year.

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.

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 11/6/2019)