

2021 -
2022



BENEFITS FOR NEW HIRES

AND SUMMARY OF MATERIAL MODIFICATIONS



Medical, Dental and Vision

BENEFITS FOR NEW HIRES

AND SUMMARY OF MATERIAL MODIFICATIONS

As a full-time active employee, you are eligible to participate in this competitive benefits program.

2021 – 2022

Welcome to the APEA staff team. The APEA-AFT Health and Welfare Trust is committed to providing a comprehensive Employee Benefit Program that will meet the overall health care needs for you and your family.

Your health care claims are processed by Welfare & Pension Administration Service, Inc. (WPAS), however the money used for claims is funded by the premiums paid by both you and the APEA Office.

This guide provides information about the enrollment process as well as other required notices. Please take a few minutes to review this important information so you can make the best health care coverage decisions for you and your family.



INITIAL AND OPEN ENROLLMENT

Your initial elections will be in place for the remainder of the plan year, which will end on August 30, 2022. Open Enrollment, typically during the summer months, is the time of year to add or remove coverage for any eligible family members. If you do not enroll an eligible spouse or child now because s/he has coverage through another employer, you may only add that person on our plan during next year's Open Enrollment period, unless you experience a qualified family status change.

ELIGIBILITY REQUIREMENTS

Employee	Full-time employees working at least 20 hours per week
Dependents	Your legal spouse who is a resident of the same country in which you reside Dependent children may be covered until age 26
Waiting Period	1 st of the month following date you begin Active Employment

THE AFFORDABLE CARE ACT

PLAN STATUS UNDER HEALTH CARE REFORM

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that our plan does not include all identical requirements found in non-grandfathered plans, for example, the requirement for the provision of preventive health services without any cost sharing. However,

2021/
2022

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grandfathered health plans must comply with certain other requirements in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which requirements apply and which requirements do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-800-732-1121, option 0.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

BENEFITS FOR NEW HIRES

AND SUMMARY OF MATERIAL MODIFICATIONS

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WHAT DO I HAVE TO DO?

- Complete an enrollment form within **31 days of your date of hire**.
- Part-time employees may enroll for coverage, and your monthly employee contributions must be paid on an after-tax basis each month, directly to the Trust Administration Office.
- Full-time employees may elect to waive coverage through the Trust.
- All forms must be completed and returned to the Trust Administration Office and post-market within the 31 days after hire.
- If forms are not postmarked within 31 days of the date of hire, the default election for employees is no coverage.
- Elections will become effective the first of the month following active employment.

All forms must be completed and returned to enrollment@wpas-inc.com or you can mail completed forms to the address below.

CONTACT INFORMATION

For changes and new enrollees, please return completed Enrollment Form, Salary Reduction Agreement Form and required dependent documentation to:

APEA-AFT Health & Welfare Trust
Plan Administrator
PO Box 34203
Seattle, WA 98124-1203
Telephone: (800) 732-1121

Or scan and email to: enrollment@wpas-inc.com

Be sure to include APEA-AFT in the subject line of your email.

DOCUMENTATION IS REQUIRED FOR ALL DEPENDENTS

To enroll your dependent spouse and dependent children, you must provide documentation that they are eligible dependents. If you have already provided this information, you do not have to provide it again. No claims will be paid on your dependents until we receive acceptable documentation.

Examples of dependent documentation are:

- Spouse – copy of marriage certificate
- Natural Child – copy of birth certificate listing the employee as mother or father; or
- Qualified Medical Child Support Order

BENEFITS FOR NEW HIRES

AND SUMMARY OF MATERIAL MODIFICATIONS

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- Adopted Child – proof of legal adoption or placement with you in anticipation of adoption
- Stepchildren - copy of birth certificate listing your spouse as mother or father
- Foster children or Children for whom you have legal responsibility - proof of legal custody or guardianship



HOW MUCH DO I HAVE TO PAY?

The following contributions are effective September 1, 2021.

	Your Contribution
Employee	\$98 per month

Please note that your contributions will be taken out of your paycheck on a pre-tax basis, as allowed by Section 125 of the Internal Revenue Code. IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status. This means you may not drop coverage for a dependent during the year unless there is a qualified change in family status.

MAKING MID-YEAR ELECTION CHANGES

The IRS allows distinct tax advantages to you and to the Trust by not considering the value of your employer's contribution as taxable income. In return, the Trust is subject to strict IRS rules on when it may allow mid-year election changes. Elections made during Open Enrollment must apply for the rest of the Plan Year unless you experience a qualifying event and timely request a change in election because of that qualifying event. Any change you make to your election must also be consistent with the qualifying event. Examples of qualifying events include:

- Marriage, birth or adoption of a child, divorce, death of a dependent
- Dependent ceases to be eligible or gains eligibility
- Loss, gain, or significant change in spouse's coverage
- Changing from full-time to part-time status or vice versa

To change your election, you must submit proof of the qualifying event and a revised enrollment form to the Trust Administration Office within 31 days of the qualifying event.

BENEFITS FOR NEW HIRES

AND SUMMARY OF MATERIAL MODIFICATIONS

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WHAT ARE MY BENEFITS?

The plan utilizes the Aetna preferred provider network. Please review the Summary of Benefits and Coverage for additional information.

Deductible Individual / Family	\$600 / \$1,800
Out of Pocket Maximum Individual / Family	\$1,250 / \$3,750
Preventative Care	Covered at 100%
Coinsurance (most services)	Covered at 80%

APPEALING YOUR ELECTION

You have the right to appeal your plan election to the Board of Trustees. Because your election impacts your payroll, the Trustees have accelerated the timeline for appealing election choices. If you wish to appeal, you must do so within 45 days after your first payroll deduction resulting from the plan election choice. IRS Revenue Regulations limit the circumstances under which election changes can be made, and the Board of Trustees must abide by those regulations when deciding enrollment appeals. You should use great care in making an enrollment election, as the circumstances for changing your election after the close of Open Enrollment is severely limited.

CONTACT INFORMATION:

APEA-AFT Health & Welfare Trust
Plan Administrator
PO Box 34203
Seattle, WA 98124-1203
Telephone (800) 732-1121

APEA-AFT HEALTH & WELFARE TRUST WEBSITE

APEA-AFT Health and Welfare Trust has established a website to provide you with immediate access to your plan information. The site located at www.apea-afttrust.com includes Trust Fund related material such as forms, plan booklets, links to Health Plan Provider Networks and access to paid claims information. We encourage you to visit and use the Trust website.

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HEALTHCARE REFORM

The healthcare reform law (or Affordable Care Act (ACA) or Obamacare) is complicated and you may have questions about how it impacts you, your family and your benefits. There are three items you should know.

First, the individual mandate (the requirement that all individuals have health insurance) remains in place. What has changed is the penalty associated with it. As of January 1, 2019, the ACA tax penalty is repealed and you won't have to pay anything if you don't enroll.

Second, the Health Insurance Marketplace still exists. You can shop for and enroll in insurance plans through the exchange and still apply for income based subsidies.

Third, for most people the plans we offer are considered affordable and neither you nor any family members are eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in APEA's plan.

Please refer to your Notice of Health Insurance Marketplace Coverage for general information. For additional information on Marketplace options in your area and subsidy calculators, go to www.healthcare.gov or call 1-800-318-2596.

ANNUAL REMINDERS

NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact Human Resources for more information.

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HIPAA PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes your rights with regard to your personal health information. You received a copy of the APEA/AFT Health and Welfare Trust Group Health Plan Privacy Notice when you were hired. This notice describes how medical information about you may be used and disclosed, and how you can access that information.

If you have any questions regarding the HIPAA Privacy Notice, or would like another copy, please contact Human Resources.

COBRA

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact our HR Department for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact Human Resources.

IMPORTANT NOTICE FROM APEA/AFT HEALTH AND WELFARE TRUST ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with APEA and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. APEA has determined that the prescription drug coverage offered by the APEA/AFT Health and Welfare Trust Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current APEA coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you or your eligible dependents elects Medicare Part D, you can keep this coverage and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current APEA coverage, be aware that you and your dependents will not be able to get this coverage back until the next Open Enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with APEA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through APEA changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 1, 2021
Name of Entity/Sender:	APEA/AFT Health and Welfare Trust
Contact--Position/Office:	Plan Administrator
Address:	PO Box 34203 Seattle, WA 98124-1203
Phone Number:	(800) 732-1121

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid
Health Insurance Premium Payment (HIPP) Program: Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>

NORTH CAROLINA – Medicaid	TEXAS – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH DAKOTA – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OKLAHOMA – Medicaid and CHIP	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
RHODE ISLAND – Medicaid and CHIP	WEST VIRGINIA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	WYOMING – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

APEA-AFT Health and Welfare Trust Enrollment Form

P60A (APEA Employees)

New Enrollment Open Enrollment Declining Coverage (Complete and return the Waiver of Health Coverage Form)

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER	EMPLOYEE NAME (Last, First, Middle Initial)	<input type="checkbox"/> I AM A FULL TIME EMPLOYEE
		<input type="checkbox"/> I AM A PART TIME EMPLOYEE

MAILING ADDRESS (Street or PO Box, City, State, Zip)

EMPLOYEE DATE OF BIRTH	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PHONE NUMBER	E-MAIL ADDRESS
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DEPENDENT INFORMATION

I WISH TO ENROLL MY DEPENDENTS: <input type="checkbox"/> YES, If yes, list dependents below <input type="checkbox"/> NO, I waive coverage for my dependents	<i>In order to cover a spouse or child, documentation of relationship must be on file at the Trust Administrative Office. Please refer to your open enrollment guide for acceptable forms of documentation.</i>
PLEASE ENROLL ME IN THE FOLLOWING CATEGORY: <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/CHILD(REN) <input type="checkbox"/> EMPLOYEE/SPOUSE/CHILD(REN)	

LIST FAMILY MEMBERS TO BE ENROLLED: Should you require additional lines, please use the reverse side of this form.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	RELATIONSHIP	
SPOUSE				SPOUSE	DATE OF MARRIAGE
CHILD					
CHILD					
CHILD					
CHILD					

OTHER INSURANCE INFORMATION

Are you, your spouse, or other dependents covered by any other group medical insurance plan including Medicare? **Yes** **No**
If "yes," please provide the information requested. If Medicare, copy of Medicare ID card must be on file with the Administrative Office. If separate coverage applies to different dependents, please write additional coverage information on reverse of form.

NAME OF SUBSCRIBER WITH OTHER COVERAGE	SOCIAL SECURITY NUMBER	POLICY OR ID #	Other Insurance covers: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Children
NAME AND ADDRESS OF OTHER INSURANCE COMPANY			Coverage includes: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

ACKNOWLEDGEMENT AND SIGNATURE

I hereby certify that all information on this enrollment form is true and complete, and that I am an eligible participant of the Plan. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF INFORMATION OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND FOR MY DEPENDENTS, AND THAT I WILL BE GUILTY OF INSURANCE FRAUD. I understand that the coverage applied for will not become effective unless and until the required contributions have been paid and the Trust unconditionally approves and accepts the application. I authorize deductions, if any, from any earnings toward the cost of the coverage.

Furthermore, I authorize any licensed physician, medical practitioner, hospital or other medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records of information regarding me or my family or our health, to disclose to WPAS any such information. A copy of this authorization shall be as valid as the original.

DATE OF SIGNATURE	SIGNATURE OF EMPLOYEE X
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RETURN A COPY TO: APEA-AFT Health & Welfare, P.O. BOX 34203, SEATTLE, WA 98124
or Scan and e-mail to: Forms@wpas-inc.com or Fax to: (206) 505-9727
RETAIN A COPY FOR YOUR RECORDS



Flexible Spending Arrangements (FSAs) help you save money on health and day care expenses and allow you to spend it on the things you care about. FSAs will have the whole family cheering!

Taxes 101

The federal government takes about 30% of each dollar you earn in FICA and federal income taxes, and you take home the remaining 70% to use for your living expenses. When you use an FSA, you set aside money before it is taxed, so you spend the entire 100% of your earned income on your day care expenses.

How much could you save?

Let's look at an example: Employees A and B both earn \$55,000 per year. They each have \$2,000 in out of pocket day care expenses.

Employee A and Employee B have the same earnings and tax bracket, but Employee B saves \$600 per year by contributing to an FSA!

Employee A	
Annual gross income	\$55,000
Estimated taxes (30%)	<u>-\$16,500</u>
Annual net income	\$38,500
Out-of-pocket care expenses	<u>-\$2,000</u>
Actual take home pay	\$36,500
Employee B	
Annual gross income	\$55,000
Out-of-pocket care expenses	<u>-\$2,000</u>
Adjusted gross income	\$53,000
Estimated taxes (30%)	<u>-\$15,900</u>
Actual take home pay	\$37,100

How does it work?

- During your open enrollment estimate your expenses for the plan year and enroll in the plan.
- Your annual election amount will be evenly deducted pre-tax from your paycheck throughout the plan year.
- You cannot change your annual election amount after the plan start unless you have a qualified change in status. For example, birth, death, marriage or divorce.
- Check out your Navigate My Benefits and Pre-Tax Solutions pages for more details on how your plan works.

Visit or contact us:

www.naviabenefits.com
customerservice@naviabenefits.com
(800) 669-3539 | (425) 452-3500

Spend less on health and day care expenses and more on the things you love. Enroll now!

How do I access my benefits?

Accessing your benefits couldn't be easier, just swipe your Navia Benefit Card to pay for eligible health care and daycare expenses. Funds come directly out of your FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts! If we need to see it, we will send you an email or notification via our smartphone app.


You can also submit claims online, through our smartphone app for Android and iPhone, email, fax or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Be sure to include documentation that clearly shows the date, type and cost of the service.

Submitting claims is easier than ever using FlexConnect

The FlexConnect feature connects your FSA to your insurance plans and seamlessly creates a claim with proper documentation direct from your insurance carrier! All you have to do is click "reimburse me" and the claim is expedited for payment. Sign up for FlexConnect today!

Get more with the MyNavia mobile app

The MyNavia app is free to download on both iPhone and Android. You can manage your benefits and view important details right from the convenience of your phone.



Benefits made so simple...
anyone can do it!



Show me my pre-tax solutions:

Health Care FSA

The Health Care FSA (HCFSA) allows you to pay for out-of-pocket medical expenses with tax-free dollars. Think of the HCFSA as a tool to pay for all your regular medical expenses throughout the plan year.

- Expenses for you, your spouse and tax-dependents are eligible for reimbursement, regardless of if they are covered on your medical plan.
- The Health Care FSA is a pre-funded benefit. This means you have access to your full annual election amount at any time during the plan year.
- Estimating future expenses is an important step as you prepare to enroll in an FSA. The more accurate you are in estimating your expenses the better the plan will work for you!

Common Eligible Expenses

- Prescription drugs
- Over-the-counter medicines
- Menstrual care products
- Copays and coinsurance
- Deductibles
- Office visits
- Dental work
- Orthodontia
- Glasses
- Contacts
- Chiropractic
- Massage

Expenses that are cosmetic in nature are not eligible. Click [here](#) for a full eligibility list.

Day Care FSA

Child care can be one of the single largest expenses for a family with children. A Day Care FSA (DCFSA) can be used to pay for your qualified day care expenses with pre-tax dollars which can save you up to \$1,700 per year!!

- The DCFSA limit is set by the IRS and is a calendar year limit of \$5,000 per household, \$2,500 if married and filing separately. If your plan year is not on a calendar year, take extra care in calculating your annual election.
- Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be enabling you to work, actively look for work or be a full-time student.

Common Eligible Expenses

- Child Care
- Preschool
- Before and after school care
- Day Camps

Expenses for school tuition and overnight camps are not eligible

Election and Claim Filing Period

Open Enrollment period is a great time to look at your benefits and estimate your out-of-pocket expenses. Be sure to only elect an amount that you know you will use during your plan year. At the end of the plan year you will have a claim filing period to turn in any leftover claims for your benefits. Unused Health Care FSA balances up to \$500.00 will be carried over to the subsequent plan year. Any Health Care FSA funds in excess of \$500.00 is subject to the Use-or-Lose rule and cannot be refunded to you.

Carryover

Your plan offers a carryover feature for your health FSA. This feature allows you to roll over up to \$500.00 of unused health FSA funds to the following plan year. The carryover feature does not apply to unused daycare FSA funds. Carryover amounts will be credited after your claim filing period.

Navia Benefits Card

Rather than filing a claim and waiting for reimbursement, you can use the debit card to pay your provider directly for qualified health care and daycare expenses. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the Master-Card® system. Be sure to hang on to your receipts in case we need to see them to verify the expense eligibility. If we need to see a receipt, you will notice an alert on your mobile app and we will send you an email reminder.

Accessing Your Benefits

Navia wants to make accessing your benefits as simple and efficient as possible.

- Online Account Access: Order additional debit cards, update bank and address information and see up to date details of your benefits.
- Online Claims Submission: Upload your documentation, complete the online wizard, and voila! a reimbursement will be on its way within a few days!
- Mobile App: MyNavia allows you to simply snap a photo and submit for reimbursement direct from your mobile device.
- Flexconnect: Sync your various medical, dental and vision benefits with your FSA plan for a quick and easy reimbursement. No need to submit documentation, we'll get it from the insurance carrier!



Day Care FSA Debit Card

New feature and ease of access



DCFSA funds are now available on the Navia Benefits Card!

Swipe your card instead of requesting for reimbursements!

How to use your Navia Benefits debit card:

- ✓ Check your DCFSA balance on your [portal](#) or mobile app
- ✓ Swipe your card for no more than your balance at your daycare provider. Remaining balance can be paid using a different personal account.

Don't have a Navia Benefits debit card?

Log in to your [participant portal](#) or mobile app to "request a card".

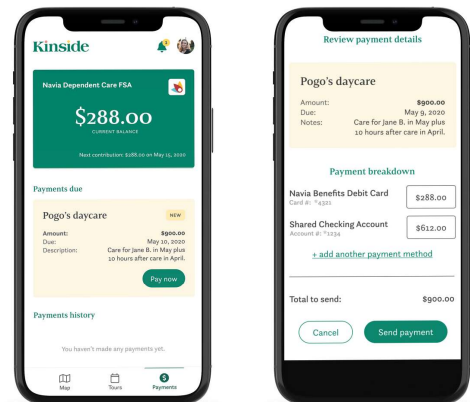


Pair with Kinside

Use your debit card with your Kinside account!

How to use your Navia debit card with Kinside:

- ✓ Create an account with Kinside (if you are not a user)
- ✓ Add your Navia Benefits card to your Kinside account
- ✓ Check your DCFSA balance on your [portal](#) or mobile app
- ✓ Make a payment by entering the amount you want to charge your Navia debit card.



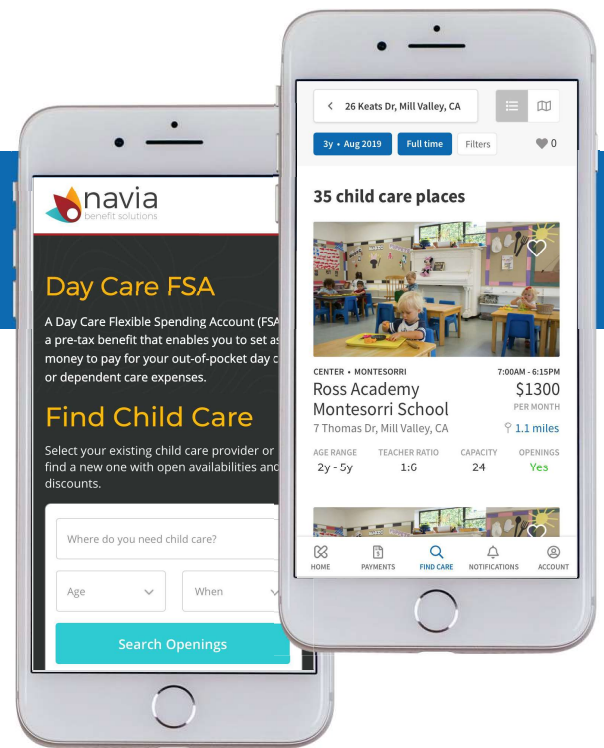
Things to remember when using your debit card

- You cannot make a swipe for an amount more than your available DCFSA fund balance.
- Always check your DCFSA balance before making a payment.
- The Navia Benefit card may be declined at some daycare providers because they are not an approved vendor.

For more information, please visit our [FAQs](#).

Your Child Care Benefit

Save an additional 20 percent on child care when you use Kinside to find openings and discounts at daycares and preschools near you.



Kinside's network provides up-to-date availability, transparent rates and discounts at top rated daycares and preschools

Kinside x Navia Integration

Navia and Kinside have partnered to provide all enrolled employees with a resource for finding affordable child care. Kinside is free for all Navia members and can be accessed both through your Navia account and on Kinside at www.kinside.com/navia — both using your Navia login.

Features



National Database

Kinside's national database can be searched by program type, availability, area code and more.



Savings

Savings can include discounts of 5-20% on tuition, and waived application fees at thousands of centers across the U.S.



Safety & Quality

Access to full licensing and inspection reports for every daycare and preschool for maximum transparency.



Online Tuition Payments

Easy payment portal enables you to pay the entirety of tuition online.

How it Works

- ✓ Employees can login to Kinside with their Navia credentials
- ✓ Search the database for child care providers
- ✓ Filter by criteria like current openings, location, price, education philosophy and more

APEA-AFT Health and Welfare Trust – Flexible Spending Arrangement Enrollment Form

Plan Year: 1/1/2021-12/31/2021

Last Day to Submit Claims: 3/31/2022

**Employee Information** – Please write legibly to ensure proper enrollment

Last Name, First Name		SSN / Employee ID #	
Home Address (Street, City, State, Zip Code)			
Date of Birth	Phone Number	Email Address	Effective Date

Benefit Elections

Section 125 Benefit	Yes/No	Annual Election	# of Paychecks	Paycheck Deduction
Health Care FSA Maximum of \$2,750.00 per plan year	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> 12 <input type="checkbox"/> 24	\$ _____
Day Care FSA Maximum of \$5,000.00 per plan year (or \$2,500 if you're married and filing taxes separately)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> 12 <input type="checkbox"/> 24	\$ _____
Premium Conversion The group insurance premiums you pay through your paycheck are automatically deducted pre-tax. Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.				Automatic

Debit Card & Direct Deposit

Navia Debit Card – You may use the card to pay for expenses directly from the funds in your Health Care FSA. There is no cost for the initial card. The cards are valid for 3 year periods; if you've previously received the card then it will be reloaded with your new election. You must provide a valid email address to use the card. By signing below you are acknowledging that you have read the reverse page and agree to allow your employer to deduct ineligible charges from your wages.	Automatic
Direct Deposit – Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.	<input type="checkbox"/> Yes <input type="checkbox"/> Checking Account #: _____ <input type="checkbox"/> No <input type="checkbox"/> Savings Routing #: _____

Signature

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.	
<input type="checkbox"/> YES , the above benefits have been explained to me and I elect to participate as indicated	
<input type="checkbox"/> NO , the above benefits have been explained to me and I decline participation	
Employee Signature	Date
X	

Completed Enrollment Forms must be returned to Human Resources*Please see the reverse side for important information regarding the above benefits*

Additional Information

Premium Conversion

- If the enrollment status is marked as 'AUTOMATIC', you must notify your employer in writing to decline enrollment in this benefit. Premium Conversion is subject to the change in status rules and is considered an election equal to the amount of your premium deductions.

Health Care Flexible Spending Arrangement ("Health Care FSA")

- Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
- Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA and will be deducted pre-tax through the Premium Conversion Plan. Therefore, do not include the cost of premiums in your FSA annual election amount.

Day Care Flexible Spending Arrangement ("Day Care FSA")

- Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
- Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse is a full-time student, please consult IRS Publication 503.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the \$5,000 calendar year limit mandated by the IRS.

Use-It or Lose-It

- You must claim all elected funds by the end of the run-out period. After the run-out period is complete, unused Day Care FSA balances will be forfeited; this is referred to as the Use-it or Lose-it rule. Unused Health Care FSA balances up to \$500 will be rolled over to the subsequent plan year. Any Health Care FSA funds in excess of \$500 will be forfeited. In order to receive carryover you must re-enroll in the following plan year or have a remaining balance in excess of the plan minimum.

Claim Runout Period

- The claim runout period allows you to submit claims after the end of the plan year. Claims received after this period will be denied.

Lost Checks and Reissues

- Lost or stale dated FSA checks can be reissued 10 business days after the original check date. There is a \$25.00 check reissue fee. The check reissue request will require at least one business day to process.
- Any fees associated with presenting a canceled check will be deducted from your FSA as well as the face value of the check.

Direct Deposit

- All electronic funds transfers (EFT) will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information will be assessed a \$10.00 fee that will be deducted from your FSA balance.

Deductions

- FSA deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form. If you enroll in the plan after open enrollment then please divide your annual election by the remaining deductions in the plan year.

Change in Status

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.
- In the event of a change in status the change in election must be necessitated by and consistent with the change in status and the change must be acceptable under IRS Regulations.

Eligibility

- Independent contractors and self-employed individuals are not eligible to participate in the Plan. Self-employed individuals include: Sole Proprietors of their own business; General Partners in a general partnership and General Partners in a limited partnership; Limited Partners of partnerships with guaranteed payments; more than 2% Shareholders of an S corporation as well as the spouse, children, parents and grandparents of a more than 2% Shareholder; and non-employee Members of an LLC. It is your responsibility to determine your eligibility.
- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

Debit Card

- If you elect to use the card please keep in mind that you may still need to submit supporting documentation to verify that a charge is eligible. You will be notified via email if you have a charge that requires documentation. You can check your account online to view any outstanding charges or contact customer service.
- If you use the card for an ineligible expense or do not substantiate a charge within 120 days of receiving the first request for substantiation your card may be temporarily suspended to prevent further use. The IRS provides the participant with 2 methods for correcting an ineligible or unsubstantiated charge: a) repay the plan for the amount of the expense, or b) request the substitution or offset of future out of pocket expenses. If neither option "a" nor "b" is successful the final option illustrated by the IRS permits the employer to deduct the ineligible expense from the participant's wages or other compensation consistent with federal and state law.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Navia, agents, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at any time at no cost. To withdraw consent, please contact Navia.
- You have a right to receive a paper version of an electronically furnished document at no cost.
- To access documents you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.

Claim Form

(Instructions on next page)



Employee Information

Last Name, First Name		SSN / Employee ID #
Home Address (Street, City, State, Zip Code) <input type="checkbox"/> Please update my address on file		Phone Number
Employer Name		Email Address

**Did you know you can submit paperless claims online or via the MyNavia mobile app?
Just take a picture and submit!**

Day Care FSA Expenses

Service Date(s)	Type of Service	Provider's Name, Tax ID and/or SSN	Services For Whom	Age	Net Cost
Total Reimbursement Request \$ _____					
Day Care Provider Certification: I certify that dependent care services were provided as indicated above. Provider/Facility Name: _____ Provider's Signature X _____ Signer's Name (Printed): _____ Date: _____					

Health Care/Limited FSA/HRA/Wellness Expenses

Service Date(s)	Type of Service	Provider's Name	Services For Whom	Net Cost
Total Reimbursement Request \$ _____				

Signature

To the best of my knowledge my statements on this claim form 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 HRA, Health Care ("HCFSA") or Day Care Flexible Spending Arrangement ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA, HCFSA or DCFSA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse and/or dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. I 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. By providing an email address, I consent to receive all possible communications from Navia Benefit Solutions, 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 Benefit Solutions 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 HRA, HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant's Signature X _____	Date _____
--	------------

Claim Form Instructions

1. Complete employee information section. Be sure to write legibly to ensure proper processing.
2. Itemize your expenses in the table provided and attach copies of your documentation.

Documentation must clearly show the date of service, type of service, and final cost of service. Examples of acceptable documentation include itemized bills/invoices, or the Explanation of Benefits (EOB) from your insurance carrier.

- ❖ If your employer offers an HRA and you are enrolled in a plan that only offers reimbursement for deductible, coinsurance, and/or copays an EOB is required for claim submission.
- ❖ If the expense is a copay amount (multiple of \$5 up to \$500), a payment receipt is acceptable documentation.

Proof of payment is not required in order to reimburse medical/dental/vision services.

Prescriptions

Examples of acceptable documentation include the Rx label, payment receipt, or mail order statement showing the date filled, Rx name or Rx #, and cost. You may also submit an itemized printout from your pharmacy.

OTC Medications & Drugs

Per IRS regulations, OTC medications and drugs with an active ingredient must be accompanied by a prescription in order to be reimbursed from your FSA (ex. pain relievers, cold/allergy medication, ointments, Antacids). Once approved, prescriptions will remain on file with Navia for future claim submissions. Prescriptions are valid for one year after the date written.

Alternative Treatments

Expenses that may be seen as merely beneficial to general health will require a Letter of Medical Necessity (LMN), showing the treatment of a specified medical diagnosis. Examples include vitamins/supplements, herbs, weight loss programs, cosmetic products and procedures. Please have your provider write a letter or complete our [Letter of Medical Necessity template](#).

Dependent Care

Acceptable documentation includes an itemized bill/invoice, showing the date of service, type of service, and cost of service. If the dependent is age 5 or older, the documentation must show the services are "for care," and not educational in nature.

If you are unable to obtain sufficient documentation, you may have the provider sign the front of this claim form to validate the services being claimed.

If you would like to automate your recurring daycare expenses, you may do so by completing our [Recurring Daycare Claim Form](#), logging onto our Participant Portal, and selecting the My Recurring Claims tool tile.

Please **DO NOT** submit the following types of documentation:

- ❖ Statements showing estimated/pending insurance
- ❖ Statements showing the claimed amount as a balance forward/previous balance
- ❖ Statements showing the claimed amount as a prepayment for future services
- ❖ Cancelled checks/copies of cashed checks
- ❖ Personal bank statements

3. Be sure to sign the claim form and submit! Please email or mail a signed claim form using one of the methods below:

General Claims Submittal:

Email: claims@naviabenefits.com
Mail: Navia Benefit Solutions
PO Box 53250 Bellevue, WA 98015
Phone: Local (425) 452-3500 or Toll-free (800) 669-3539

If your employer offers an HRA or Dental plan, submit to:

Email: 105@naviabenefits.com
Mail: Navia Benefit Solutions
PO Box 53250 Bellevue, WA 98015
Phone: Local (425) 452-3421 or Toll-free (866) 897-1996

Claims status is available [online](#). Please allow at least two (2) full business days for Navia to process your claim.