PART-TIME FACULTY BENEFITS

REIMBURSEMENT PROGRAM

As of July 1, 2022, the District will maintain a pool of funds towards reimbursement of medical, dental and vision insurance premiums for eligible part-time faculty. This means reimbursement of **employee-incurred** health benefit premiums (medical, dental and vision) as the primary recipient.

Eligible part-time faculty can request reimbursement for medical, dental and vision premiums incurred during the current fiscal year (July 1 – June 30) up to half of the district contribution (cap) per year. Amounts paid will apply to the semester in which the premiums were paid (fall and spring). Faculty who receive paid benefits from other employers shall only be entitled to the reimbursement for the unpaid portion of their premiums up to the maximum contribution.

Reimbursement request forms must be submitted by the last day of the semester in which reimbursement is being requested. Reimbursement requests for the fall semester will be paid in February and reimbursement requests for the spring semester will be paid in July. Forms submitted early will be paid in accordance with the pay schedule above. Exceptions may apply in the event of separation from the district.

**Reimbursement will be included on payroll check and is taxable income. Reimbursement is not subject to CalSTRS creditable earnings.*

Incomplete forms or forms that lack appropriate supporting documentation will be returned to the part-time faculty member with an explanation as to why the request was incomplete or denied.

ELIGIBILITY

a) Faculty must have taught at least 40%, or equivalent, of a full-time load for the past two semesters, not including the semester in which applying for reimbursement.

Full-time faculty retired from the District who return to Part- time employment **and** are covered by the District paid Retiree Health benefits are not eligible for the Part-time Faculty Benefits Reimbursement program.

REIMBURSEMENT

Reimbursement is only allowed for medical, dental, and vision premiums paid to any HMO, PPO, or indemnity health plan licensed and registered by either the California Department of Insurance or the California Department of Corporations

Item	Reimbursable	Non-Reimbursable
If you have medical/dental/vision insurance	Premium amount not otherwise covered	Co-payments, Deductible, Co-Insurance payment, premiums paid as a dependent (i.e spouse coverage)

DOCUMENTS REQUIRED FOR REIMBURSEMENT

Item	Documents
If you have medical/dental/vision insurance	• Billing statement showing employee as primary recipient of coverage and the premium amount **AND** • Proof of each premium payment

Employees wishing to be reimbursed for medical premiums under the provisions of Article 9 of the BCFA collective bargaining agreement must initiate the request on the Part-Time Faculty Reimbursement Request form available on the Human Resources webpage.

Any questions pertaining to the Part-Time Faculty Medical Reimbursement Program should be directed to the Human Resources Office, HR@Barstow.edu or (760)252-2411 Ext. 7232.

Part-Time Faculty Benefits Reimbursement Request Form

EMPLOYEE NAME: _____ SEMESTER: _____
DIV/DEPT. NAME: _____
PHONE/OFFICE EXTENSION: _____ EMAIL: _____

PART A: PROGRAM ELIGIBILITY (to be completed by employee)

Eligibility: Part-time faculty will have met the criteria listed below:

a) Part-time faculty who have obtained preferred rehire status in accordance with Article 17.
AND
b) have taught or served an average of at least 40% load, or equivalent, of a full-time faculty load for the past two academic semesters (Fall and Spring) for the semester in which they are applying for reimbursement.

District Contribution: Up to one-half (50%) of the maximum District contribution as stated in Article 9.1.1 for the ensuing academic year. The average shall be calculated annually at the start of the Fall semester based upon a look-back at the Fall and Spring of the prior academic year.

I am requesting reimbursement for employee-incurred premium as follows:

Medical	Insurance Premium	**$** _____
Dental	Insurance Premium	**$** _____
Vision	Insurance Premium	**$** _____

TOTAL REQUEST: $ _____

I certify that the premiums submitted for reimbursement have not already been reimbursed from any other source and any indication to the contrary may disqualify my participation in the Part-time Faculty Benefits Reimbursement Program in the future.

Employee Signature: _____ **Date:** _____

PART B: ELIGIBILITY VERIFICATION (to be completed by Human Resources)

Date form was received: _____ **Date adjusted form was received (if applicable):** _____

☐ **YES. Request for reimbursement is approved.** All the required program criteria have been met and verified. Required proof of medical/dental/vision plan enrollment and premium payments are included.

☐ **NO. Request for reimbursement is denied.**
Denial reason: _____

HR Representative Review: _____ Date:_____

Payroll Review: _____ Date:_____

Vice President Review Approved: _____ Date:_____

Total amount approved: $_____ Date submitted to Payroll: _____