Victor Valley Community College District
Office of Human Resources
18422 Bear Valley Road
Victorville, CA 92395
760-245-4271 Ext 2500

Application to Determine Eligibility for Part-Time Faculty Health Insurance Pilot Program

This application is required to determine your eligibility to participate in the Health Insurance Pilot Program. Applications will be processed in the order received. Email your completed application to Benefits@vvc.edu . For questions, send email to the same address or call Human Resources at (760)245-4271 Ext. 2500.

Employee Name: _____ **Date:** _____

1. Do you meet the load requirement of 40% (.40) or more for Health Medical Insurance?
   Yes ☐ **No** ☐
   The load of 40% or the equivalent 224 hours worked can include instructional, non-instructional or combined service. An assignment audit will be conducted by Human Resources in the third week of the semester and periodically during the semester.
   If the above criteria does not continue to be met the part-time Faculty will not continue to be eligible to participate in the program.
2. Are you covered by a spouse, domestic partner, or any other entity? **Yes** ☐ **No** ☐
   A Part time faculty whose health insurance is paid by an employer other than Victor Valley College, is not eligible to participate in the program.
3. Are you a retired full-time faculty with retiree medical coverage or Medicare benefits that has returned to part-time employment? **Yes** ☐ **No** ☐
   Retired Full-Time Faculty with retiree medical or Medicare benefits that have returned to part-time employment are not eligible to participate in program.

If eligible, the part-time faculty has two options for medical benefit coverage and reimbursement under this pilot program:

Option 1: Reimbursement for a non-district plan- Part-time Faculty will be reimbursed for a maximum amount up to 50% of the medical insurance premium they pay or $3500, whichever is greater for the six-month period outlined below. The part- time Faculty will be responsible for obtaining their own medical benefit coverage and will be required to provide proof of payment and coverage with the request for reimbursement form. **Part-Time Faculty Medical Reimbursement Request Form**

Reimbursement for premiums incurred between 9/01/23-2/29/24 shall be paid in April 2024.
Reimbursement for premiums incurred between 3/01/24-8/31/24 shall be paid October 2024.

To receive a reimbursement payment, part-time faculty will need to submit this application to determine eligibility and submit a reimbursement request form.

Option 2: Payroll deduction for District offered plan- The part-time Faculty will have the option to enroll in a District offered plan. The plan elected will be effective the first of the month following their eligibility determination. The part-time faculty will pay 50% of the premium for the selected District offered plan through Payroll deduction(s).

Acknowledgements for District offered plan

- *I acknowledge all premiums paid by me via payroll deductions for the purpose of purchasing health insurance shall be pre-tax to the extent permitted by law. Unless otherwise provided by law, reimbursements are considered taxable income and are not subject to CalSTRS creditable earnings.* ***Initial:***_____
- *I acknowledge if earnings are insufficient to deduct the full amount of my contribution of 50% of the District plan premium, I am responsible for payment of the shortage by the date the premium invoice is due****. Initial:***_____
- *I acknowledge if the eligibility criteria does not continue to be met or my load falls below the mandatory .40 (40%), my District selected medical plan will end on the last date of that month. When the District plan ends, the Part-Time Faculty will receive the mandatory COBRA notice for loss of benefits.* ***Initial:***_____

Chart of Benefit Costs for District offered plans:

Medical Plan	Employee Monthly Payroll Deduction	Employer Monthly Cost	Total Monthly Premium
Blue Shield HMO Access +1C	913.12	913.13	1826.25
Blue Shield HMO Trio 1C	803.59	803.60	1607.19
Blue Shield HMO Access + 9	682.12	682.12	1364.24
Blue Shield HMO Trio 9	600.22	600.22	1200.44
Blue Shield PPO 1	1367.31	1367.31	2734.62
Blue Shield PPO Tandem 1	1285.26	1285.27	2570.53
Kaiser Plan 10, W/Optical	742.61	742.62	1485.23

Instructions to elect a District offered plan Initial here, if you are selecting a District plan

Initial:_____

You will be notified by HR if you meet the criteria and you will be given access to the District Benefit portal via your VVC email.

I have read and understand the terms and conditions as set forth herein. I declare under penalty of perjury under the laws of the State of California that the information provided by me herein is true and correct to the best of my belief and knowledge.

Employee Signature: _____

For HR staff only: Approved _____ Denied _____