Faculty - 12 months

MONTHLY PREMIUMS FOR 2025-2026

***Fringe contribution is based on level of medical enrollment and eligibility**

Faculty Fringe	*$ 756.27*	*$ 1,103.13*	*$ 1,431.70*
Faculty Plan Year 10/1/25- 9/30/26	**Single**	**2-Party**	**Family**
SISC Anthem PPO A- Group # 40303A Deductible $300 individual / $600 family; 80% Office Visits $20 Rx $7 generic / $25 brand	**$958.00**	**$1,868.00**	**$2,618.00**
SISC Anthem PPO B- Group# 40303B Deductible $500 individual / $1000 family; 80% Office Visits $30 Rx $10 generic / $35 Brand Brand name deductible $200 indiv. / $500 family	**$861.00**	**$1,684.00**	**$2,365.00**
SISC Anthem PPO C- Group# 40303C Deductible $2000 individual / $4000 family; 80% Office Visits $30 Rx $10 generic / $35 brand Brand name deductible $200 indiv. / $500 family	**$761.00**	**$1,484.00**	**$2,080.00**
SISC Anthem PPO D- Group# 40303D Deductible $3000 individual / $6000 family; 80% Office Visits $40 Rx $9 generic / $35 brand	**$702.00**	**$1,360.00**	**$1,899.00**
SISC Anthem PPO E- Group# 40303E Deductible $3400 individual / $6800 family; 90% Office Visits- Deductible needs to be met first Health Savings Account compatible Rx $7 generic / $25 brand (subject to deductible)	**$669.00**	**$1,297.00**	**$1,811.00**
SISC Anthem PPO F- Group# 70303B Deductible $5,000 individual / $10,000 family; 70% Office Visits- Deductible needs to be met first Health Savings Account compatible Rx $9 generic / $35 brand (subject to deductible)	**$612.00**	*Employee & child/children ONLY*	**$1,171.00**
SISC Anthem Plan G Proactive Care Platinum- Group# M409 No Deductibles/No Co-Insruance - Copay Only Office Visits $0 Rx $9 generic / $35 brand	**$889.00**	**1,735.00**	**2,433.00**
SISC Plan H Waiver Active Benefit Enrollment (WABE) No Medical Coverage Access to Value Added Plans	**$612.00**	**N/A**	**N/A**
All Staff **Plan Year 1/1/2026 to 12/31/2026** ***Dental Plans -Two year commitment required**	**Single**	**2-Party**	**Family**
DELTA DENTAL- Group #6736-0001 Plan A No Deductible, $1,700/person max - Premier No Deductible, $1,900/person max - PPO $500 adult or child ortho max	**$53.83**	**$95.72**	**$138.25**
DELTA DENTAL- Group #6736-0003 Plan B No Deductible, $2,300/person max - Premier No Deductible, $2,500/person max - PPO $1,000 child ortho max (no adult coverage)	**$60.15**	**$106.93**	**$154.50**
DELTA DENTAL- GROUP #6736-01001 Plan C No Deductible, $2,700/person max - Premier No Deductible, $2,900/person max - PPO This plan has implant coverage $500 adult or child ortho max	**$68.36**	**$121.57**	**$175.03**
DELTA DENTAL- GROUP #6736-01003 Plan D No Deductible, $3,300/person max - Premier No Deductible, $3,500/person max - PPO This plan has implant coverage $1,000 child ortho max (no adult coverage)	**$76.38**	**$135.80**	**$196.18**
VISION- Group #30071230 **Plan Year 1/1/2026 to 12/31/2026** $0 Deductible, $0 co-pay, $300 allowance Yearly exam, Frame/lens/contacts 12 months Light Care Benefit (coverage for non-prescription blue light and sunglasses) Sub-Group # 0001	**$11.37**	**$18.48**	**$29.30**

Faculty - 10 months & Part-Time Faculty

MONTHLY PREMIUMS FOR 2025-2026

***Fringe contribution is based on level of medical enrollment and eligibility.**
****Fringe and premiums are prorated for 12 month coverage paid over 10 months.**

Faculty Fringe	*$ 907.52*	*$ 1,323.76*	*$ 1,718.04*
Faculty Plan Year 10/1/25- 9/30/26	**Single**	**2-Party**	**Family**
SISC Anthem PPO A- Group # 40303A Deductible $300 individual / $600 family; 80% Office Visits $20 Rx $7 generic / $25 brand	**$1,149.60**	**$2,241.60**	**$3,141.60**
SISC Anthem PPO B- Group# 40303B Deductible $500 individual / $1000 family; 80% Office Visits $30 Rx $10 generic / $35 Brand Brand name deductible $200 indiv. / $500 family	**$1,033.20**	**$2,020.80**	**$2,838.00**
SISC Anthem PPO C- Group# 40303C Deductible $2000 individual / $4000 family; 80% Office Visits $30 Rx $10 generic / $35 brand Brand name deductible $200 indiv. / $500 family	**$913.20**	**$1,780.80**	**$2,496.00**
SISC Anthem PPO D- Group# 40303D Deductible $3000 individual / $6000 family; 80% Office Visits $40 Rx $9 generic / $35 brand	**$842.40**	**$1,632.00**	**$2,278.80**
SISC Anthem PPO E- Group# 40303E Deductible $3400 individual / $6800 family; 90% Office Visits- Deductible needs to be met first Health Savings Account compatible Rx $7 generic / $25 brand (subject to deductible)	**$802.80**	**$1,556.40**	**$2,173.20**
SISC Anthem PPO F- Group# 70303B Deductible $5,000 individual / $10,000 family; 70% Office Visits- Deductible needs to be met first Health Savings Account compatible Rx $9 generic / $35 brand (subject to deductible)	**$734.40**	*Employee & child/children ONLY*	**$1,405.20**
SISC Anthem Plan G Proactive Care Platinum- Group# M409 No Deductibles/No Co-Insruance - Copay Only Office Visits $0 Rx $9 generic / $35 brand	**$1,066.80**	**$2,082.00**	**$2,919.60**
SISC Plan H Waiver Active Benefit Enrollment (WABE) No Medical Coverage Access to Value Added Plans	**$734.40**	**N/A**	**N/A**
All Staff **Plan Year 1/1/2026 to 12/31/2026** ***Dental Plans -Two year commitment required**	**Single**	**2-Party**	**Family**
DELTA DENTAL- Group #6736-0001 Plan A No Deductible, $1,700/person max - Premier No Deductible, $1,900/person max - PPO $500 adult or child ortho max	**$64.60**	**$114.86**	**$165.90**
DELTA DENTAL- Group #6736-0003 Plan B No Deductible, $2,300/person max - Premier No Deductible, $2,500/person max - PPO $1,000 child ortho max (no adult coverage)	**$72.18**	**$128.32**	**$185.40**
DELTA DENTAL- GROUP #6736-01001 Plan C No Deductible, $2,700/person max - Premier No Deductible, $2,900/person max - PPO This plan has implant coverage $500 adult or child ortho max	**$82.03**	**$145.88**	**$210.04**
DELTA DENTAL- GROUP #6736-01003 Plan D No Deductible, $3,300/person max - Premier No Deductible, $3,500/person max - PPO This plan has implant coverage $1,000 child ortho max (no adult coverage)	**$91.66**	**$162.96**	**$235.42**
VISION- Group #30071230 **Plan Year 1/1/2025 to 12/31/2025** $0 Deductible, $0 co-pay, $250 allowance Yearly exam, Frame/lens/contacts 12 months Light Care Benefit (coverage for non-prescription blue light and sunglasses) Sub-Group # 0001	**$13.64**	**$22.18**	**$35.16**