

Faculty - 12 months
MONTHLY PREMIUMS FOR 2026-2027

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

Faculty Fringe	\$ 807.77	\$ 1,178.25	\$ 1,529.20
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	\$1,090.00	\$2,127.00	\$2,981.00
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	\$983.00	\$1,923.00	\$2,700.00
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	\$869.00	\$1,694.00	\$2,375.00
SISC Anthem PPO D- Group# 40303D Deductible \$3000 individual / \$6000 family; 80% Office Visits \$40 Rx \$9 generic / \$35 brand	\$798.00	\$1,548.00	\$2,162.00
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)	\$762.00	\$1,477.00	\$2,063.00
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)	\$703.00	\$1,347.00	\$1,347.00
SISC Anthem Plan G Proactive Care Platinum- Group# M409 No Deductibles/No Co-Insurance - Copay Only Office Visits \$0 Rx \$9 generic / \$35 brand	\$1,012.00	1,975.00	2,772.00
SISC Plan H Waiver Active Benefit Enrollment (WABE) No Medical Coverage Access to Value Added Plans	\$703.00	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	\$46.60	\$82.86	\$119.67
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)	\$52.07	\$92.56	\$133.74
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	\$59.17	\$105.23	\$151.51
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)	\$66.11	\$117.55	\$169.81
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	\$10.28	\$16.72	\$26.50

Faculty - 10 months & Part-Time Faculty
MONTHLY PREMIUMS FOR 2026-2027

*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	\$ 969.33	\$ 1,413.90	\$ 1,835.04
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	\$1,308.00	\$2,552.40	\$3,577.20
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	\$1,179.60	\$2,307.60	\$3,240.00
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	\$1,042.80	\$2,032.80	\$2,850.00
SISC Anthem PPO D- Group# 40303D Deductible \$3000 individual / \$6000 family; 80% Office Visits \$40 Rx \$9 generic / \$35 brand	\$957.60	\$1,857.60	\$2,594.40
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)	\$914.40	\$1,772.40	\$2,475.60
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)	\$843.60	\$1,616.40	\$1,616.40
SISC Anthem Plan G Proactive Care Platinum- Group# M409 No Deductibles/No Co-Insurance - Copay Only Office Visits \$0 Rx \$9 generic / \$35 brand	\$1,214.40	\$2,370.00	\$3,326.40
SISC Plan H Waiver Active Benefit Enrollment (WABE) No Medical Coverage Access to Value Added Plans	\$843.60	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	\$55.92	\$99.43	\$143.60
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)	\$62.48	\$111.07	\$160.49
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	\$71.00	\$126.28	\$181.81
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)	\$79.33	\$141.06	\$203.77
VISION- Group #30071230 Plan Year 1/1/2025 to 12/31/2025 \$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	\$12.34	\$20.06	\$31.80