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 $3500 individual / $7000 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** *Employee & child/children ONLY*	**$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 $3500 individual / $7000 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** *Employee & child/children ONLY*	**$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**