Faculty

MONTHLY PREMIUMS FOR 2022-2023

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

Faculty Fringe	***$ 734.24***	***$ 1,071.00***	***$ 1,390.00***

Faculty Plan Year 10/1/22- 9/30/23	**Single**	**2-Party**	**Family**
SISC Anthem PPO A- Group # 40303A Deductible $300 individual / $600 family; 80% Office Visits $20 Rx $7 generic / $25 brand	**$842.00**	**$1,640.00**	**$2,298.00**
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	**$748.00**	**$1,463.00**	**$2,055.00**
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	**$660.00**	**$1,289.00**	**$1,806.00**
SISC Anthem PPO D- Group# 40303D Deductible $3000 individual / $6000 family; 80% Office Visits $40 Rx $9 generic / $35 brand	**$615.00**	**$1,192.00**	**$1,663.00**
SISC Anthem PPO E- Group# 40303E Deductible $3000 individual / $5200 family; 90% Health Savings Account compatible; Office Vists 10% Rx $7 generic / $25 brand (subject to deductible)	**$594.00**	**$1,151.00**	**$1,607.00**
SISC Anthem PPO F- Group#70303B *Employee & child/children ONLY* Deductible $5,000 individual / $10,000 family; 70% Office Visits $60 (first 3 visits only) Rx $9 generic / $35 brand (subject to deductible)	**$533.00**	**$1,020.00**	**$1,020.00**

All Staff **Plan Year 1/1/2024 to 12/31/2024**	**Single**	**2-Party**	**Family**
***Dental Plans -Two year commitment required**			
DELTA DENTAL- Group #6736-0001 Plan A $50/$150 Deductible, $1,200/person max - Premier $50/$150 Deductible, $1,400/person max - PPO $500 adult or child ortho max	**$53.83**	**$95.72**	**$138.25**
DELTA DENTAL- Group #6736-0003 Plan B $50/$150 Deductible, $1,800/person max - Premier $50/$150 Deductible, $2,000/person max - PPO $1,000 child ortho max (no adult coverage)	**$60.15**	**$106.93**	**$154.50**
DELTA DENTAL- GROUP #6736-01001 Plan C $50/$150 Deductible, $2,200/person max - Premier $50/$150 Deductible, $2,400/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 $50/$150 Deductible, $2,800/person max - Premier $50/$150 Deductible, $3,000/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 $0 Deductible, $0 co-pay, $200 allowance Yearly exam, Frame/lens/contacts 12 months Sub-Group # 0001	**$11.37**	**$18.48**	**$29.30**