BALTIMORE-WASHINGTON CONFERENCE

2027 HEALTHFLEX EXCHANGE RATE SHEET FOR CHURCH LAY

THESE ARE MEDICAL PLAN RATES ONLY. RATES DO NOT INCLUDE DENTAL AND/OR VISION. SEE BELOW FOR DENTAL AND VISION RATES.

MEDICAL NETWORK: BLUECROSS BLUESHIELD (BCBS)	2027 MEDICAL PLAN TYPE (BlueCross BlueSheild of Illinois)			
		BWC DEFAULT PLAN		
	PPO	HRA PLAN	HSA PLANS	
Medical Plan Type with Health Account	B1000	C2000 with HRA	H2000 with HSA	H5000 with HSA
Annual Deductibles	$1000/$2000	$2000/$4000	$2000/$4000	$5000/$10,000
Co-Pays / Co-Insurance (after deductible is met)	(Co-Pays) 80%-20%	Co-Ins: 80%/20%	Co-Ins: 80%/20%	Co-Ins: N/A
Annual In-Network Out-of-Pocket Maximum	$5000/$10000	$5000/$10000	$5000/$10000	$5000/$10000
Health Reimbursement Account (HRA) Amount	Not applicable	$500/$1000	Not applicable	Not applicable
Health Savings Account (HSA) Amount	Not applicable	Not applicable	$500-$1000	$0
FLEXIBLE SPENDING ACOUNTS: ***optional - payroll deduction***				
- Medical Reimbursement Account (MRA)	*$300 - TBD*	*$300 - TBD*	*$300 - TBD*	*$300 - TBD*
- Dependent Care Account (DCA)	*$300 - TBD*	*$300 - TBD*	*$300 - TBD*	*$300 - TBD*
HEALTH SAVINGS ACCOUNT (HSA) - *payroll deduction*	***Not applicable***	***Not applicable***	***TBD***	***TBD***
TIER TYPE	**Participant Monthly Premium**	**Participant Monthly Premium**	**Participant Monthly Premium**	**Participant Monthly Premium**
Church Lay Participant Only	$1,327.50	$1,283.70	$1,272.70	$1,176.85
Church Lay Participant + 1	$1,690.90	$1,582.90	$1,573.00	$1,273.45
Church Lay Participant/Family (3 or more)	$1,887.55	$1,750.10	$1,756.70	$1,325.20
GRANDFATHERED TIER TYPE prior to 1/1/2017	**GRANDFATHERED premium - default plan only**			
Church Lay Participant + Child/Children		$1,481.70		

Prior to 1/1/2017, PARTICIPANTS with a Participant/Child or Participant/Children coverage were grandfathered in the DEFAULT plan. If you terminate your dependent coverage and then have to re-enroll a dependent, or if you switch to another plan you will be enrolled in the new tier type.

DENTAL PLANS - 2027 RATES (by CIGNA DENTAL)			
CIGNA DENTAL *(a subsidized benefit) - optional*	**Dental HMO**	**Dental PPO**	**Dental Passive 2000**
Participant	$9.00	$18.00	$32.00
Participant +1	$16.00	$36.00	$64.00
Participant + Family	$28.00	$54.00	$99.00

VISION PLANS - 2027 RATES (by VSP)			
VSP VISION - *optional*	**Exam Core**	**Full Vision**	**Premier Vision**
Participant	$0.00	$9.00	$15.00
Participant +1	$0.00	$14.00	$25.00
Participant + Family	$0.00	$22.00	$40.00

IF SELECTED, THE DENTAL/VISION RATES WILL BE ADDED TO THE MEDICAL RATE FOR THE TOTAL MONTHLY HEALTHFLEX PREMIUM

Acronyms

HRA - Health Reimbursement Account

HSA - Health Savings Account
FSA - Flexible Spending Account
- MRA - Medical Reimbursement Account
- DCA - Dependent Care Account