BALTIMORE-WASHINGTON CONFERENCE

2026 HEALTHFLEX EXCHANGE RATE SHEET FOR CHURCH LAY EMPLOYEES

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)	2026 MEDICAL PLAN TYPE (BlueCross BlueSheild of Illinois)					
		BWC DEFAULT PLAN				
	PPO	HRA PLANS		HSA PLANS		
Medical Plan Type with Health Account	B1000	C2000 with HRA	C3000 with HRA	H2000 with HSA	H2500 with HSA	H5000 with HSA
Annual Deductibles	$1000/$2000	$2000/$4000	$3000/$6000	$2000/$4000	$2500/$5000	$5000/$10,000
Co-Pays / Co-Insurance (after deductible is met)	(Co-Pays)	Co-Ins: 80%	Co-Ins: 50%	Co-Ins: 80%	Co-Ins: 70%	Co-Ins: N/A
Annual In-Network Out-of-Pocket Maximum	$5000/$10,000	$5000/$10,000	$5000/$10,000	$5000/$10,000	$5000/$10,000	$5000/$10,000
Health Reimbursement Account (HRA) Amount	Not applicable	$1000/$2000	$250/$500	Not applicable	Not applicable	Not applicable
Health Savings Account (HSA) Amount	Not applicable	Not applicable	Not applicable	$1000/$2000	$250/$500	$0
FLEXIBLE SPENDING ACOUNTS: *optional - payroll deduction*						
- Medical Reimbursement Account (MRA)	$300 - $TBD	$300 - $TBD	$300 - $TBD	$300 - $TBD	$300 - $TBD	$300 - $TBD
- Dependent Care Account (DCA)	$300 - $5000	$300 - $5000	$300 - $5000	$300 - $5000	$300 - $5000	$300 - $5000
HEALTH SAVINGS ACCOUNT (HSA) - *payroll deduction*	Not applicable	Not applicable	Not applicable	TBD	TBD	TBD

TIER TYPE	Participant Monthly Premium	Participant Monthly Premium	Participant Monthly Premium	Participant Monthly Premium	Participant Monthly Premium	Participant Monthly Premium
Lay Participant Only	$1,200.00	$1,167.00	$1,092.00	$1,157.00	$1,119.00	$1,069.00
Lay Participant + 1	$1,516.00	$1,439.00	$1,270.00	$1,352.00	$1,352.00	$1,153.00
Lay Participant/Family (3 or more)	$1,687.00	$1,591.00	$1,472.00	$1,483.00	$1,483.00	$1,198.00
GRANDFATHERED TIER TYPE prior to 1/1/2017	GRANDFATHERED premium - default plan only					
Lay Participant + Child/Children		$1,347.00				

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 - 2026 RATES (by CIGNA DENTAL)

CIGNA DENTAL *(a subsidized benefit) - optional*	Dental HMO	Dental PPO	Dental Passive 2000
Participant	$9.28	$17.50	$28.50
Participant +1	$16.50	$35.00	$57.00
Participant + Family	$28.88	$52.50	$85.50

VISION PLANS - 2026 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 Accounts
MRA - Medical Reimbursement Account
DCA - Dependent Care Account

HSA Health Savings Account

CHURCH LAY EMPLOYEES: - Medical contribution by both the employer and the employee towards the total premium is based on the policy of each individual church or salary paying unit.