

**2024 Small Group - Blue Cross vs MVP  
( APPROVED RATES)**

STANDARD PLANS	BLUE CROSS BLUE SHIELD				MVP				SAVINGS MVP over BCBS
	Single	Single + Spouse	Single + Child(ren)	Single + Family	Single	Single + Spouse	Single + Child(ren)	Single + Family	
PLATINUM	\$1,132.59	\$2,265.18	\$2,185.90	\$3,182.58	\$1,094.86	\$2,189.72	\$2,113.08	\$3,076.56	3%
GOLD	\$938.54	\$1,877.08	\$1,811.38	\$2,637.30	\$912.32	\$1,824.64	\$1,760.78	\$2,563.62	3%
SILVER REFLECTIVE 3	\$761.82	\$1,523.64	\$1,470.31	\$2,140.71	\$720.03	\$1,440.06	\$1,389.66	\$2,023.28	6%
SILVER REFLECTIVE 4 HDHP	\$791.64	\$1,583.28	\$1,527.87	\$2,224.51	\$733.96	\$1,467.92	\$1,416.54	\$2,062.43	8%
BRONZE 2	\$650.77	\$1,301.54	\$1,255.99	\$1,828.66	\$631.98	\$1,263.96	\$1,219.72	\$1,775.86	3%
BRONZE 3 HDHP	\$680.95	\$1,361.90	\$1,314.23	\$1,913.47	\$641.13	\$1,282.26	\$1,237.38	\$1,801.58	6%
BRONZE 4	\$675.95	\$1,351.90	\$1,304.58	\$1,899.42	\$653.19	\$1,306.38	\$1,260.66	\$1,835.46	3%

NON-STANDARD PLANS	BLUE CROSS BLUE SHIELD				MVP				SAVINGS MVP over BCBS
	Single	Single + Spouse	Single + Child(ren)	Single + Family	Single	Single + Spouse	Single + Child(ren)	Single + Family	
GOLD	\$905.72	\$1,811.44	\$1,748.04	\$2,545.07	\$944.14	\$1,888.28	\$1,822.19	\$2,653.03	-4%
SILVER REFLECTIVE	\$749.21	\$1,498.42	\$1,445.98	\$2,105.28	\$720.03	\$1,440.06	\$1,389.66	\$2,023.28	4%
BRONZE	\$669.06	\$1,338.12	\$1,291.29	\$1,880.06	\$638.01	\$1,276.02	\$1,231.36	\$1,792.81	5%
GOLD HDHP	\$910.92	\$1,821.84	\$1,758.08	\$2,559.69	\$947.82	\$1,895.64	\$1,829.29	\$2,663.37	-4%
SILVER REFLECTIVE HDHP	\$743.58	\$1,487.16	\$1,435.11	\$2,089.46	\$740.27	\$1,480.54	\$1,428.72	\$2,080.16	0%
BRONZE CDHP	\$659.13	\$1,318.26	\$1,272.12	\$1,852.16	\$637.04	\$1,274.08	\$1,229.49	\$1,790.08	3%

# Platinum Level Plan Comparison

Benefits	
<u>Dr. Office or Virtual Visit</u>	
	Primary Care Physician/OBGYN
	Specialists
	Chiropractic Care
	Preventative Care
	Hearing Aid Office Visit/Equipment
	Telemedicine via AmWell / UCM Digital Health
<u>Other Services</u>	
	X-Ray / Lab
	Outpatient Procedures
	Inpatient Care
	Emergency Room
	Ambulance
	Urgent Care
<u>Retail Prescription Drugs</u>	
	Rx Deductible
	Generic
	Preferred Brand
	Non-Preferred Brand
	Rx Out of Pocket Maximum
	Rx OOPM Integrated with Medical OOPM
<u>Annual Deductible</u>	
	Individual
	Family
<u>Out-of-Pocket Maximum</u>	
	Individual
	Family

\*Integrated Deductible

Enrollment	
	Single
	Couple:
	Parent & Child(ren):
	Family:

Percentage Change from 2023

Standard - Platinum	
In-Network Only	
	3 PCP visits per member at \$0, then \$15 copay
	\$40 copay
	\$20 copay
	Covered in full
	<b>\$40 copay/10% after deductible</b>
	MVP: Covered in full / BCBS cost varies
	10% after deductible
	10% after deductible
	10% after deductible
	\$100 copay after deductible
	\$60 copay
	\$50 copay
	No deductible
	\$10 copay
	\$50 copay
	50% coinsurance
	<b>\$1,500 / \$3,000</b>
	No
	<u>Stacked Deductible</u>
	<b>\$450</b>
	<b>\$900</b>
	\$1,500
	\$3,000

Standard Platinum Plan		
	2024 Blue Cross Rates	2024 MVP Rates
	\$1,132.59	\$1,094.86
	\$2,265.18	\$2,189.72
	\$2,185.90	\$2,113.08
	\$3,182.58	\$3,076.56

13.90%

12.80%

# Gold Level Plan Comparison

Benefits	Standard - Gold	Non-Standard - Gold VT Preferred	HSA Compatible Plan Non-Standard - Gold CDHP VT Select
	In-Network Only	In-Network Only	In-Network Only
<u>Dr. Office or Virtual Visit</u>			
Primary Care Physician/OBGYN	3 PCP visits per member at \$0, then \$20 copay	Combined 4-8-12 visits \$0, then \$20 after deductible	0% after deductible
Specialists	\$55 copay	\$40 copay after deductible	0% after deductible
Chiropractic Care	\$35 copay	\$40 copay after deductible	0% after deductible
Preventative Care	Covered in full	Covered in full	Covered in full
Hearing Aid Office Visit/Equipment	\$55 copay/ 30% after deductible		
Telemedicine via AmWell / UCM Digital Health	Covered in full	Cost varies	0% after deductible
<u>Other Services</u>			
X-Ray / Lab	30% after deductible	\$30 copay after deductible	0% after deductible
Outpatient Procedures	30% after deductible	\$750 copay after deductible	0% after deductible
Inpatient Care	30% after deductible	\$750 copay after deductible	0% after deductible
Emergency Room	\$150 copay after deductible	\$250 copay after deductible	0% after deductible
Ambulance	\$75 copay	\$30 copay after deductible	0% after deductible
Urgent Care	\$60 copay	\$30 copay after deductible	0% after deductible
<u>Retail Prescription Drugs</u>			
Rx Deductible (single / family)	\$200/\$400	Medical deductible applies	Medical deductible applies
Generic	\$15 copay, not subject to deductible	\$5/40%/60% after deductible	0% after deductible
Preferred Brand	\$60 copay after deductible	Preventive Rx: \$5/\$50/60%, not subject to deductible	Preventive Rx: \$5/50%/60%, not subject to deductible
Non-Preferred Brand	50% coinsurance after deductible	\$1,600/ \$3,200	\$1,600/ \$3,200
Rx Out of Pocket Maximum	\$1,500/ \$3,000	Yes	Yes
Rx OOPM Integrated with Medical OOPM	No	Collective Deductible*	Collective Deductible*
<u>Annual Deductible</u>	<u>Stacked Deductible</u>		
Individual	\$1,400	\$1,250	\$2,850
Family	\$2,800	\$2,500	\$5,700
<u>Out-of-Pocket Maximum</u>			
Individual	\$5,600	\$5,150	\$2,850
Family	\$11,200	\$10,300 **	\$5,700

\*Integrated Deductible

\*\*Individual within a Family plan OOPM is \$9,450

Enrollment	Standard Gold Plan		Non-Standard - Gold VT Preferred		HSA Compatible Plan Non-Standard - Gold CDHP VT Select	
	2024 Blue Cross Rates	2024 MVP Rates	2024 Blue Cross Rates		2024 Blue Cross Rates	
Single:	\$938.54	\$912.32	\$905.72		\$910.92	
Couple:	\$1,877.08	\$1,824.64	\$1,811.44		\$1,821.84	
Parent & Child(ren):	\$1,811.38	\$1,760.78	\$1,748.04		\$1,758.08	
Family:	\$2,637.30	\$2,563.62	\$2,545.07		\$2,559.69	
<b>Percentage Change from 2023</b>	<b>12.90%</b>	<b>13.80%</b>	<b>14.40%</b>		<b>12.80%</b>	

# Gold Level Plan Comparison

Benefits	
<u>Dr. Office or Virtual Visit</u>	
Primary Care Physician/OBGYN	
Specialists	
Chiropractic Care	
Preventative Care	
Hearing Aid	Office Visit/Equipment
Telemedicine via AmWell / UCM Digital Health	
<u>Other Services</u>	
X-Ray / Lab	
Outpatient Procedures	
Inpatient Care	
Emergency Room	
Ambulance	
Urgent Care	
<u>Retail Prescription Drugs</u>	
Rx Deductible (single / family)	
Generic	
Preferred Brand	
Non-Preferred Brand	
Rx Out of Pocket Maximum	
Rx OOPM Integrated with Medical OOPM	
<u>Annual Deductible</u>	
Individual	
Family	
<u>Out-of-Pocket Maximum</u>	
Individual	
Family	

Standard - Gold	
In-Network Only	
3 PCP visits per member at \$0, then \$20 copay	
\$55 copay	
\$35 copay	
Covered in full	
\$55 copay/30% after deductible	
Covered in full	
30% after deductible	
30% after deductible	
30% after deductible	
\$150 copay after deductible	
\$75 copay	
\$65 copay	
\$200/\$400	
\$15 copay, not subject to deductible	
\$60 copay after deductible	
50% coinsurance after deductible	
\$1,500/ \$3,000	
No	
Stacked Deductible	
\$1,400	
\$2,800	
\$5,600	
\$11,200	

Non-Standard - Gold 2	
In-Network Only	
\$20 copay	
\$45 copay	
\$25 copay	
Covered in full	
\$45 copay/ 20% after deductible	
Covered in full	
\$80 / \$40 copay after deductible	
20% after deductible	
20% after deductible	
\$250 copay after deductible	
\$50 copay	
\$30 copay	
\$350 / \$700	
\$15 copay, not subject to deductible	
\$40 copay after deductible	
50% coinsurance after deductible	
\$1,500/ \$3,000	
No	
Stacked Deductible	
\$850	
\$1,700	
\$6,600	
\$13,200	

HSA Compatible Plan	
Non-Standard - Gold 3	
In-Network Only	
0% after deductible	
0% after deductible	
0% after deductible	
Covered in full	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
Medical deductible applies	
0% after deductible	
Preventive Rx:	
\$10/\$15/5%, not subject to deductible	
\$1,600/ \$3,200	
Yes	
Collective Deductible*	
\$3,000	
\$6,000	
\$3,000	
\$6,000	

\*Integrated Deductible  
**\*\*Individual within a Family plan OOPM is \$9,450**

Enrollment	
Single:	
Couple:	
Parent & Child(ren):	
Family:	

Standard Gold Plan		
	2024 Blue Cross Rates	2024 MVP Rates
Single:	\$938.54	\$912.32
Couple:	\$1,877.08	\$1,824.64
Parent & Child(ren):	\$1,811.38	\$1,760.78
Family:	\$2,637.30	\$2,563.62

Non-Standard - Gold 2	
	2024 MVP Rates
Single:	\$944.14
Couple:	\$1,888.28
Parent & Child(ren):	\$1,822.19
Family:	\$2,653.03

HSA Compatible Plan	
Non-Standard - Gold 3	
	2024 MVP Rates
Single:	\$947.82
Couple:	\$1,895.64
Parent & Child(ren):	\$1,829.29
Family:	\$2,663.37

Percentage Change from 2023

12.90%

13.80%

11.90%

14.20%

# Silver Standard Plan Comparison

Benefits	
<u>Dr. Office or Virtual Visit</u>	
Primary Care Physician/OBGYN	
Specialists	
Chiropractic Care	
Preventative Care	
Hearing Aid	Office Visit/Equipment
Telemedicine via AmWell / UCM Digital Health	
<u>Other Services</u>	
X-Ray / Lab	
Outpatient Procedures	
Inpatient Care	
Emergency Room	
Ambulance	
Urgent Care	
<u>Retail Prescription Drugs</u>	
Rx Deductible (single / family)	
Generic	
Preferred Brand	
Non-Preferred Brand	
Rx Out of Pocket Maximum	
Rx OOPM Integrated with Medical OOPM	
<u>Annual Deductible</u>	
Individual	
Family	
<u>Out-of-Pocket Maximum</u>	
Individual	
Family	

\*Integrated Deductible

\*\*Individual within a Family plan OOPM is \$9,450

Enrollment	
Single:	
Couple:	
Parent & Child(ren):	
Family:	

Percentage Change from 2023

Standard - Silver 3 Reflective	
In-Network Only	
3 PCP visits per member at \$0, then \$40 copay	
\$90 copay	
\$50 copay	
Covered in full	
<b>\$90 copay/ 50% after deductible</b>	
Covered in full	
50% after deductible	
50% after deductible	
50% after deductible	
\$500 copay after deductible	
\$105 copay	
\$100 copay	
\$500 / \$1,000	
\$20 copay, not subject to deductible	
\$70 copay after deductible	
50% after deductible	
<b>\$1,500/ \$3,000</b>	
Yes	
<u>Stacked Deductible</u>	
\$4,000	
\$8,000	
<b>\$9,300</b>	
<b>\$18,600</b>	

Standard - Silver 3 Reflective		
	2024 Blue Cross Rates	2024 MVP Rates
Single:	\$667.15	\$720.03
Couple:	\$1,334.30	\$1,440.06
Parent & Child(ren):	\$1,287.60	\$1,389.66
Family:	\$1,874.69	\$2,023.28

14.20%

7.50%

HSA Compatible Plan	
Standard - Silver 4 Reflective - HDHP	
In-Network Only	
15% after deductible	
35% after deductible	
40% after deductible	
Covered in full	
<b>35% after deductible/35% after deductible</b>	
10% after deductible	
30% after deductible	
30% after deductible	
30% after deductible	
30% after deductible	
35% after deductible	
30% after deductible	
Medical deductible applies - Wellness RX no deductible	
\$10 copay after deductible	
\$40 copay after deductible	
50% after deductible	
<b>\$1,600/ \$3,200</b>	
Yes	
<u>Collective Deductible*</u>	
\$2,100	
\$4,200	
\$7,050	
\$14,100**	

HSA Compatible Plan			
Standard - Silver 4 Reflective - HDHP			
	2024 Blue Cross Rates	2024 MVP Rates	
Single:	\$791.64	\$733.96	
Couple:	\$1,583.28	\$1,467.92	
Parent & Child(ren):	\$1,527.87	\$1,416.54	
Family:	\$2,224.51	\$2,062.43	

12.40%

7.70%

## Silver Non-Standard Plan Comparison

Benefits	Non-Standard - Silver	HSA Compatible Plan Non-Standard - Silver CDHP	Non-Standard - Silver 1- Reflective	HSA Compatible Plan Non-Standard - Silver 2 - Reflective HDHP
	In-Network Only	In-Network Only	In-Network	In-Network Only
<b>Dr. Office or Virtual Visit</b>				
Primary Care Physician/OBGYN	Combined 4-8-12 visits \$0, then \$30 after deductible	0% after deductible	3 PCP visits per member no deductible then \$30 copay	0% after deductible
Specialists	\$50 copay after deductible	0% after deductible	\$60 copay after deductible	0% after deductible
Chiropractic Care	\$30 copay after deductible	0% after deductible	\$45 copay after deductible	0% after deductible
Preventative Care	Covered in full	Covered in full	Covered in full	Covered in full
Hearing Aid Office Visit/Equipment			<b>\$60 copay after deductible/ 50% after deductible</b>	<b>0% after deductible/ 0% after deductible</b>
Telemedicine via AmWell / UCM Digital Health	Cost varies	Cost varies	Covered in full	0% after deductible
Other Services				
X-Ray / Lab	\$50 copay after deductible	0% after deductible	\$150 / \$60 copay after deductible	0% after deductible
Outpatient Procedures	\$1,750 copay after deductible	0% after deductible	\$1,400 copay after deductible	0% after deductible
Inpatient Care	\$1,750 copay after deductible	0% after deductible	50% after deductible	0% after deductible
Emergency Room	\$450 copay after deductible	0% after deductible	\$400 copay after deductible	0% after deductible
Ambulance	\$50 copay after deductible	0% after deductible	\$105 copay after deductible	0% after deductible
Urgent Care	\$50 copay after deductible	0% after deductible	\$60 copay after deductible	0% after deductible
<b>Retail Prescription Drugs</b>				
Rx Deductible (single / family)	Medical deductible applies - Wellness RX no deductible	Medical deductible applies	\$850 / \$1700	Medical deductible applies
Generic	\$5 copay after deductible	0% after deductible	\$5 copay after deductible	0% after deductible
Preferred Brand	40% after deductible	Preventive Rx: \$15/\$50/60%, not subject to deductible	50% after deductible	Preventive Rx: Covered in full
Non-Preferred Brand	60% after deductible		50% after deductible	Covered in full
Rx Out of Pocket Maximum	<b>\$1,600/ \$3,200</b>	<b>\$1,600/ \$3,200</b>	<b>\$1,500/ \$3,000</b>	<b>\$1,600/ \$3,200</b>
Rx OOPM Integrated with Medical OOPM	Yes	Yes	No	Yes
Annual Deductible	Collective Deductible*	Collective Deductible*	Stacked Deductible	Stacked Deductible
Individual	<b>\$3,250</b>	<b>\$5,500</b>	<b>\$2,500</b>	<b>\$5,800</b>
Family	<b>\$6,500</b>	<b>\$11,000</b>	<b>\$5,000</b>	<b>\$11,600</b>
Out-of-Pocket Maximum				
Individual	<b>\$8,750</b>	<b>\$5,500</b>	<b>\$7,500</b>	<b>\$5,800</b>
Family	<b>\$17,500 **</b>	<b>\$11,000 **</b>	<b>\$15,000</b>	<b>\$11,600</b>

\*Integrated Deductible

\*\*Individual within a Family plan OOPM is \$9,450

Enrollment	Non-Standard - Silver VT Preferred	HSA Compatible Plan Non-Standard - Silver CDHP VT Select	Non-Standard - Silver 1 - Reflective	HSA Compatible Plan Non-Standard - Silver 2 - Reflective HDHP
	2024 Blue Cross Rates	2024 Blue Cross Rates	2024 MVP Rates	2024 MVP Rates
Single:	\$749.21	\$743.58	\$720.03	\$740.27
Couple:	\$1,498.42	\$1,487.16	\$1,440.06	\$1,480.54
Parent & Child(ren):	\$1,445.98	\$1,435.11	\$1,389.66	\$1,428.72
Family:	\$2,105.28	\$2,089.46	\$2,023.28	\$2,080.16
<b>Percentage Change from 2023</b>	<b>14.00%</b>	<b>12.70%</b>	<b>8.40%</b>	<b>8.20%</b>

# Bronze Standard Plan Comparison

Benefits	
<u>Dr. Office or Virtual Visit</u>	
Primary Care Physician/OBGYN	
Specialists	
Chiropractic Care	
Preventative Care	
Hearing Aid	Office Visit/Equipment
<u>Telemedicine via AmWell / UCM Digital Health</u>	
<u>Other Services</u>	
X-Ray / Lab	
Outpatient Procedures	
Inpatient Care	
Emergency Room	
Ambulance	
Urgent Care	
<u>Retail Prescription Drugs</u>	
Rx Deductible (single / family)	
Generic	
Preferred Brand	
Non-Preferred Brand	
Rx Out of Pocket Maximum	
Rx OOPM Integrated with Medical OOPM	
<u>Annual Deductible</u>	
Individual	
Family	
<u>Out-of-Pocket Maximum</u>	
Individual	
Family	

Standard - Bronze 2	
In-Network Only	
	\$35 copay after deductible
	\$90 copay after deductible
	\$45 copay after deductible
	Covered in full
	<b>\$90 copay after deductible/50% after deductible</b>
	MVP: Covered in full / BCBS cost varies
	50% after deductible
	50% after deductible
	50% after deductible
	50% after deductible
	\$100 copay after deductible
	\$100 copay after deductible
	\$1,100 / \$2,200
	<b>\$20</b> copay, not subject to deductible
	\$85 copay after deductible
	60% after deductible
	<b>\$1,500/ \$3,000</b>
	MVP: Yes / BCBS: No
	<u>Stacked Deductible</u>
	\$6,450
	\$12,900
	<b>\$9,450</b>
	<b>\$18,900</b>

HSA Compatible Plan	
Standard - Bronze 3- HDHP	
In-Network Only	
	50% after deductible
	50% after deductible
	50% after deductible
	Covered in full
	<b>50% after deductible/50% after deductible</b>
	50% after deductible
	50% after deductible
	50% after deductible
	50% after deductible
	50% after deductible
	50% after deductible
	50% after deductible
	Medical deductible applies
	\$12 copay after deductible
	40% after deductible
	60% after deductible
	<b>\$1,600/ \$3,200</b>
	Yes
	<u>Collective Deductible*</u>
	\$5,800
	\$11,600
	<b>\$7,200</b>
	<b>\$14,400 **</b>

Standard - Bronze 4 Integrated	
In-Network Only	
	3 PCP visits per member at \$0, then \$40 copay
	\$100 copay
	\$50 copay
	Covered in full
	<b>\$100 copay/ 0% after deductible</b>
	MVP: Covered in full / BCBS cost varies
	0% after deductible
	0% after deductible
	0% after deductible
	0% after deductible
	0% after deductible
	0% after deductible
	Medical deductible applies
	\$30 copay, not subject to deductible
	0% after deductible
	0% after deductible
	Medical OOPM applies
	Yes
	<u>Stacked Deductible</u>
	<b>\$9,400</b>
	<b>\$18,800</b>
	<b>\$9,400</b>
	<b>\$18,800</b>

\*Integrated Deductible  
**\*\*Individual within a Family plan OOPM is \$9,450**

Enrollment	
Single:	
Couple:	
Parent & Child(ren):	
Family:	

Standard - Bronze 2		
	2024 Blue Cross Rates	2024 MVP Rates
	\$650.77	\$631.98
	\$1,301.54	\$1,263.96
	\$1,255.99	\$1,219.72
	\$1,828.66	\$1,775.86
	<b>12.7%</b>	<b>9.4%</b>

HSA Compatible Plan		
Standard - Bronze 3 - HDHP		
	2024 Blue Cross Rates	2024 MVP Rates
	\$680.95	\$641.13
	\$1,361.90	\$1,282.26
	\$1,314.23	\$1,237.38
	\$1,913.47	\$1,801.58
	<b>9.7%</b>	<b>8.2%</b>

Standard - Bronze 4 Integrated		
	2024 Blue Cross Rates	2024 MVP Rates
	\$675.95	\$653.19
	\$1,351.90	\$1,306.38
	\$1,304.58	\$1,260.66
	\$1,899.42	\$1,835.46
	<b>13.7%</b>	<b>9.9%</b>

**Percentage Change from 2023**

## Bronze Non-Standard Plan Comparison

Benefits	
Dr. Office or Virtual Visit	
Primary Care Physician/OBGYN	
Specialists	
Chiropractic Care	
Preventative Care	
Hearing Aid Office Visit/Equipment	
Telemedicine via AmWell / UCM Digital Health	
Other Services	
X-Ray / Lab	
Outpatient Procedures	
Inpatient Care	
Emergency Room	
Ambulance	
Urgent Care	
Retail Prescription Drugs	
Rx Deductible (single / family)	
Generic	
Preferred Brand	
Non-Preferred Brand	
Rx Out of Pocket Maximum	
Rx OOPM Integrated with Medical OOPM	
Annual Deductible	
Individual	
Family	
Out-of-Pocket Maximum	
Individual	
Family	

Non-Standard - Bronze VT Preferred	
In-Network Only	
Combined 4-8-12 visits \$0, then \$0 after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
Covered in full	
Covered in full	
Cost varies	
Cost varies	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
Medical deductible applies	
0% after deductible	
Preventive Rx: \$15/\$50/60%, not subject to deductible	
Medical OOPM applies	
Yes	
Collective Deductible*	
\$9,250	
\$18,500	
\$9,250	
\$18,500 **	

HSA Compatible Plan Non-Standard - Bronze CDHP VT Select	
In-Network Only	
0% after deductible	
0% after deductible	
0% after deductible	
Covered in full	
Covered in full	
Cost varies	
Cost varies	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
Medical deductible applies	
0% after deductible	
Preventive Rx: \$25/65%/85%, not subject to deductible	
Medical OOPM applies	
Yes	
Collective Deductible*	
\$7,500	
\$15,000	
\$7,500	
\$15,000 **	

Non-Standard - Bronze 1	
In-Network Only	
\$40 copay after deductible	
\$100 copay after deductible	
\$50 copay after deductible	
Covered in full	
\$100 copay after deductible/ 50% after deductible	
Covered in full	
50% after deductible	
50% after deductible	
50% after deductible	
50% after deductible	
\$100 copay after deductible	
\$100 copay after deductible	
\$700 / \$1,400	
\$25 copay, not subject to deductible	
\$100 copay after deductible	
60% after deductible	
Medical OOPM applies	
Yes	
Stacked Deductible	
\$7,250	
\$14,500	
\$8,400	
\$16,800	

Non-Standard - Bronze 5	
In-Network Only	
3 PCP/MH visits no cost	
0% after deductible	
0% after deductible	
Covered in full	
Covered in full	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
0% after deductible	
Medical deductible applies	
\$35 copay	
0% after deductible	
0% after deductible	
Medical OOPM applies	
Yes	
Stacked Deductible	
\$9,450	
\$18,900	
\$9,450	
\$18,900	

\*Integrated Deductible  
 \*\*Individual within a Family plan OOPM is \$9,450

Non-Standard - Bronze VT Preferred	
2024 Blue Cross Rates	
Single:	\$669.06
Couple:	\$1,338.12
Parent & Child(ren):	\$1,291.29
Family:	\$1,880.06

HSA Compatible Plan Non-Standard - Bronze CDHP VT Select	
2024 Blue Cross Rates	
Single:	\$659.13
Couple:	\$1,318.26
Parent & Child(ren):	\$1,272.12
Family:	\$1,852.16

Non-Standard - Bronze 1	
2024 MVP Rates	
Single:	\$637.04
Couple:	\$1,274.08
Parent & Child(ren):	\$1,229.49
Family:	\$1,790.08

Non-Standard - Bronze 5	
2024 MVP Rates	
Single:	\$638.01
Couple:	\$1,276.02
Parent & Child(ren):	\$1,231.36
Family:	\$1,792.81

Percentage Change from 2023

13.9%

13.4%

9.6%

13.4%