

TranscendAHP PROPOSAL REQUEST FORM

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Agent Name:	Requested Effective date:		
Agent Phone:	Include benefit descriptions?	yes	no
Agent Email:	Is this a requote?	yes	no
Group and Enrollment Information: All new business proposals must include a census. A formatted Excel census can be provided upon request.			
Group Name:	Group is a member of the Transcend Association? yes no		
Group City/Zip:	Total # Eligible (Full Time = 30 hours per week):		
Group County:	Total FTE Count:		
Does the group have more than one location? (If yes, indicate city, state and work location where employees report on census)		yes	no
Does the group have out-of-state EEs, but no out-of-state location or QWDR? (If yes, indicate employees on the census)		yes	no
SIC Code:	Nature of Business:		
Is group a current BCBSM/BCN customer? yes no	Group Number:	Are you the current AOR? yes no	
Does the group offer insurance through another carrier? (If yes, please list current carrier)		yes	no If yes: _____

BCBSM Group Plan Options

All plans include the Elective Abortion Rider and Domestic Partner Rider

Community BlueSM PPO

Plan	Ded.	Coins.	ECM	OOP Max	Employer Contribution	Copay (OV/Spec/UC/ER)	Rx-Includes MOPD3X-\$10 & Contraceptive
CB PPO \$250	\$250	20%	\$1,000	\$6,350	\$0	\$20/\$20/\$20/\$150	\$10/\$40/\$80
CB PPO \$500	\$500	20%	\$1,500	\$6,350	\$0	\$20/\$20/\$20/\$150	\$15/\$50/50%
CB PPO \$5000	\$5,000	0%	N/A	\$6,350	\$0	\$30/\$30/\$30/\$250	\$15/\$50/50%/20%/25%

Simply BlueSM PPO

Plan	Ded.	Coins.	ECM	OOP Max	Employer Contribution	Copay (OV/Spec/UC/ER)	Rx-Includes MOPD3X-\$10 & Contraceptive
SB PPO \$500	\$500	20%	\$2,500	\$6,350	\$0	\$20/\$40/\$60/\$250	\$20/\$60/50%/20%/25%
SB PPO \$1000	\$1,000	20%	\$2,500	\$6,350	\$0	\$30/\$50/\$60/\$250	\$15/\$50/50%/20%/25%
SB PPO \$1500	\$1,500	20%	\$2,500	\$6,350	\$0	\$30/\$50/\$60/\$250	\$15/\$50/50%/20%/25%
SB PPO \$2000	\$2,000	20%	\$2,500	\$6,850	\$0	\$30/\$50/\$60/\$250	\$15/\$50/50%/20%/25%
SB PPO \$2500	\$2,500	20%	\$2,500	\$6,350	\$0	\$40/\$60/\$60/\$250	\$20/\$60/50%/20%/25%
SB PPO \$4000	\$4,000	30%	N/A	\$6,350	\$0	\$40/\$60/\$60/\$250	\$20/\$60/50%/20%/25%

Simply Blue HSASM PPO

Plan	Ded.	Coins.	ECM	OOP Max	Employer Contribution	Copay (OV/Spec/UC/ER)	Rx-Includes MOPD3X-\$10 & Contraceptive
SB HSA \$1,250-20%*	\$1,350	20%	N/A	\$2,250	\$0	Deductible/Coinsurance	\$15/\$50/50%/20%/25%
SB HSA \$2,000-20%*	\$2,000	20%	N/A	\$3,000	\$0	Deductible/Coinsurance	\$15/\$50/50%/20%/25%
SB HSA \$3,000-20%**	\$3,000	20%	N/A	\$6,350	\$0	Deductible/Coinsurance	\$20/\$60/50%/20%/25%
SB HSA \$6,350-0%** Minimum Value Plan	\$6,350	0%	N/A	\$6,350	\$0	Deductible/Coinsurance	Deductible/Coinsurance

*Aggregate deductible and out-of-pocket maximum **Embedded deductible and out-of-pocket maximum

Simply BlueSM Routine Care

Plan	Ded.	Coins.	ECM	OOP Max	Employer Contribution	Copay (OV/Spec/UC/ER)	Rx-Includes MOPD3X-\$10 & Contraceptive
SB Routine Care PPO \$2500	\$2,500	20%	\$2,500	\$6,600	\$0	\$40 OV/\$60 UC/Spec&ER Deductible/Coinsurance	\$10/\$40/\$80

BCN Group Plan Options

All plans include the Elective Abortion Rider and Domestic Partner Rider

BCN HMOSM

Plans	Ded.	Coins.	ECM	OOP Max	Employer Contribution	Copay (OV/Spec/UC/ER)	Rx-Includes MOPD3X-\$10 & Contraceptive
BCN HMO \$500	\$500	20%	\$2,500	\$6,350	\$0	\$20/\$40/\$50/\$250	\$6/\$25/\$50/\$80/20%/20%
BCN HMO \$1000	\$1,000	20%	\$2,500	\$6,600	\$0	\$20/\$40/\$50/\$250	\$6/\$25/\$50/\$80/20%/20%
BCN HMO \$1500	\$1,500	20%	\$2,500	\$6,600	\$0	\$20/\$40/\$50/\$250	\$10/\$30/\$60/\$80/20%/20%
BCN HMO \$2000	\$2,000	20%	\$2,500	\$6,850	\$0	\$30/\$50/\$60/\$250	\$10/\$30/\$60/\$80/20%/20%
BCN HMO \$3000	\$3,000	20%	\$2,500	\$6,850	\$0	\$30/\$50/\$60/\$250	\$10/\$30/\$60/\$80/20%/20%

BCN HSASM HMO

Plan	Ded.	Coins.	ECM	OOP Max	Employer Contribution	Copay (OV/Spec/UC/ER)	Rx-Includes MOPD3X-\$10 & Contraceptive
BCN HSA \$2000/20%*	\$2,000	20%	N/A	\$3,000	\$0	Deductible/Coinsurance	\$6/\$25/\$50/\$80/20%/20%

*Aggregate deductible and out-of-pocket maximum **Embedded deductible and out-of-pocket maximum

Dental and Vision Options *(available with both BCBSM and BCN medical plans).*

Dental Options

Non-Voluntary Plans		Annual Max
PPO Plus 100/80/50; \$50 Deductible		\$1,000
PPO Plus 100/80/50; With Orthodontics; \$50 Deductible		\$1,000
PPO Plus 100/50/50; \$50 Deductible		\$1,000
PPO Plus 50/50/50; \$50 Deductible		\$1,000
PPO 100/80/50 (50/50/50); \$50 Deductible		\$1,000

Vision Options

Non-Voluntary Plans	
12/12/12 Choice Network; \$5/\$10 Copays; \$150 Frames	
24/24/24 Choice Network; \$5/\$10 Copays; \$130 Frames	
12/24/24 Choice Network; \$5/\$10 Copays; \$130 Frames	