Global Insurance

Request for proposal for Connect to U.S. plans

UnitedHealthcare Global supports globally mobile populations through a range of international health benefit plans that leverage our global capabilities and resources to develop comprehensive products and services that enable better outcomes.

Please fill out the requested information in the following form. Upon receipt, we will strive to return a financial proposal within 5–7 business days. Thank you.

Policyholder information

Legal company/entity name:

Country of Non-U.S. headquarters:

U.S. state of incorporation:

U.S. situs address:

Total number of employees, globally:

Company website:

Member-level census provided as a separate Excel document. Please include:

Date of birth, gender, citizenship, country of assignment, relationship to employee/subscriber, enrollment tier, job title/description and salary in USD (required when requesting Financial Protection services)

Plan design details

Plan effective date:

Proposal requested by this date: Policy year ◯ Calendar year ◯ Accumulation credit: Yes ◯ No ◯

Current carrier:

- Does the group have a global carrier in place? Yes ◯ No ◯
- If yes, who is the carrier? Number of years with the current carrier:
- Does the group have a domestic carrier in place? Yes ◯ No ◯
- If yes, who is the carrier?

Historical renewal information:

- Current and renewal rates (attach latest renewal, if available):

Current funding: Fully-insured ◯ Self-insured ◯ Level-funded ◯ Other ◯

continued

United Healthcare Global

Plan design details (cont.)

COBRA administration through UnitedHealthcare ($600 annual fee applies)? Yes ◯ No ◯

Why specifically is the group out to bid?

Employer contribution percentage (minimum 75% single OR 50% of total costs):

Employee:

Dependent:

Plan design request

Custom plan design request: ◯
(Opportunity must be greater than 20 subscribers. Please attach current plan design as a separate document.)

Standard plan design request: ◯
(Proceed to next page to select Standard Plan Design)

Travel Tracking

Gain real-time visibility into your travelers' locations and itineraries with our WorldWatch Monitor™ platform.

☐ Request a quote and complete our **Travel Tracking RFP form.**

Experience-rated groups (100+ subscribers)

- 36 months of claims data (or most available), month-by-month, including subscribers and members by month, broken out by Medical, Pharmacy and Dental
- Large claim information for the same period as the monthly claims data, including diagnosis and prognosis

Producer information

Firm name:

Firm address:

Requested commission percentage:

Day-to-day

Contact:

Email address:

Phone number:

Selling producer/writing agent

Contact:

Email address:

Phone number:

Plan designs

Please choose 1–2 plan options when requesting a quote.

Medical plans

	■ Plan 1	■ Plan 2	■ Plan 3
International benefits			
Deductible (single/family)	$0/$0 (Emb)	$0/$0 (Emb)	$0/$0 (Emb)
Coinsurance	100%	100%	100%
Max out-of-pocket (single/family)	$0/$0	$0/$0	$0/$0
Pharmacy	D&C	D&C	D&C
U.S. in-network benefits			
Deductible (single/family)	$0/$0 (Emb)	$250/$750 (Emb)	$500/$1,500 (Emb)
Coinsurance	100%	80%	80%
Max out-of-pocket	$1,000/$2,000	$2,750/$5,500	$3,000/$6,000
Office copay (PCP/SPC)	PCP $20, SPEC $20	PCP $20, SPEC $20	PCP $25, SPEC $45
Urgent care/emergency room	UC $75, ER $150	UC $75, ER D&C	UC $75, ER $150
Hospital copay	Inpt D&C	Inpt D&C	Inpt D&C
Pharmacy	$15/$40/$60/$150 (3.0x MO)	$15/$40/$60/$150 (3.0x MO)	$15/$40/$60/$150 (3.0x MO)
U.S. out-of-network benefits			
Deductible	$500/$1,500 (Emb)	$500/$1,500 (Emb)	$1,000/$3,000 (Emb)
Coinsurance	70%	60%	60%
Max out-of-pocket	$2,500/$5,000	$5,500/$11,000	$6,000/$12,000
Pharmacy	$15/$40/$60/$150	$15/$40/$60/$150	$15/$40/$60/$150
Evacuation and repatriation			
Medical	Included	Included	Included
Additional benefits*			
Employee Assistance Program (EAP)	Included	Included	Included
Vision materials (per plan year)	Maximum reimbursement of $150	Maximum reimbursement of $150	Maximum reimbursement of $150

*Benefits available upon request

	■ Plan 4	■ Plan 5	■ Plan 6
International benefits			
Deductible (single/family)	$0/$0 (Emb)	$0/$0 (Emb)	$0/$0 (Emb)
Coinsurance	100%	100%	100%
Max out-of-pocket (single/family)	$0/$0	$0/$0	$0/$0
Pharmacy	D&C	D&C	D&C
U.S. in-network benefits			
Deductible (single/family)	$750/$2,250 (Emb)	$1,000/$3,000 (Emb)	$1,500/$4,000 (Emb)
Coinsurance	80%	80%	80%
Max out-of-pocket	$3,500/$7,000	$4,000/$8,000	$5,500/$11,000
Office copay (PCP/SPC)	PCP $25, SPEC $45	PCP $25, SPEC $45	PCP $35, SPEC $50
Urgent care/emergency room	UC $75, ER $150	UC $75, ER $150	UC $75, ER $150
Hospital copay	Inpt D&C	Inpt D&C	Inpt D&C
Pharmacy	$15/$40/$60/$150 (3.0x MO)	$15/$40/$60/$150 (3.0x MO)	$15/$40/$60/$150 (3.0x MO)
U.S. out-of-network benefits			
Deductible	$1,500/$4,500 (Emb)	$2,000/$6,000 (Emb)	$3,000/$9,000 (Emb)
Coinsurance	60%	60%	60%
Max out-of-pocket	$7,500/$15,000	$8,000/$16,000	$11,000/$22,000
Pharmacy	$15/$40/$60/$150	$15/$40/$60/$150	$15/$40/$60/$150
Evacuation and repatriation			
Medical	Included	Included	Included
Additional benefits*			
Employee Assistance Program (EAP)	Included	Included	Included
Vision materials (per plan year)	Maximum reimbursement of $150	Maximum reimbursement of $150	Maximum reimbursement of $150

*Benefits available upon request

International benefits	■ Plan 7	■ Plan 8	■ Plan 9
Deductible (single/family)	$0/$0 (Non Emb)	$0/$0 (Emb)	$0/$0 (Emb)
Coinsurance	100%	100%	100%
Max out-of-pocket (single/family)	$0/$0	$0/$0	$0/$0
Pharmacy	D&C	D&C	D&C
U.S. in-network benefits			
Deductible (single/family)	$2,000/$4,000 (Non Emb)	$3,250/$9,750 (Emb)	$4,000/$8,000 (Emb)
Coinsurance	80%	80%	70%
Max out-of-pocket	$6,550/$8,700	$5,500/$11,000	$9,200/$18,400
Office copay (PCP/SPC)	PCP D&C, SPEC D&C	PCP $35, SPEC $50	PCP $30, SPEC $60
Urgent care/emergency room	UC D&C, ER D&C	UC $75, ER $150	UC $50, ER $250
Hospital copay	Inpt D&C	Inpt D&C	Inpt D&C
Pharmacy	Med Ded, $20/$70/$150 (3.0x MO)	$15/$40/$60//$150 (3.0x MO)	$15/$40/$60/$150 (3.0x MO)
U.S. out-of-network benefits			
Deductible	$6,000/$12,000 (Non Emb)	$5,000/$15,000 (Emb)	$20,000/$40,000 (Emb)
Coinsurance	50%	60%	50%
Max out-of-pocket	$19,650/$39,300	$11,000/$22,000	$30,000/$60,000
Pharmacy	Med Ded, $20/$70/$150	$15/$40/$60/$150	$15/$40/$60/$150
Evacuation and repatriation			
Medical	Included	Included	Included
Additional benefits*			
Employee Assistance Program (EAP)	Included	Included	Included
Vision materials (per plan year)	Maximum reimbursement of $150	Maximum reimbursement of $150	Maximum reimbursement of $150

*Benefits available upon request

Financial protection services

Please choose 1–2 plan options when requesting a quote.

Life/AD&D	■ Option 1	■ Option 2	■ Option 3	■ Option 4	■ Option 5
	Flat $25,000 benefit	Flat $50,000 benefit	1x Salary to $100,000	1x Salary to $200,000	2x Salary to $500,000

Long term disability Yes ○ No ○

Benefit percentage: 60%
Maximum monthly benefit: $6,000

Dental plans

Please choose 1–2 plan options when requesting a quote.

Covered services	■ Plan 1	■ Plan 2	■ Plan 3	■ Plan 4	■ Plan 5	■ Plan 6
Annual individual/family deductible	$0/$0	$50/$150	$50/$150	$50/$150	$50/$150	$50/$150
Annual maximum	$2,000	$2,000	$2,000	$2,000	$1,500	$1,000
Orthodontic maximum – per lifetime (when included) (separate from annual maximum)	$2,000	$2,000	Not covered	$2,000	$1,500	$1,000
Annual deductible applies to preventive and diagnostic?	N/A	No	No	No	No	No
Annual deductible applies to orthodontic services?	N/A	No	N/A	No	N/A	N/A
Diagnostic and preventive services	100%	100%	100%	100%	100%	100%
Basic restorative services	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Major restorative services	80% after deductible	80% after deductible	80% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontic services (when included)	50%	50%	N/A	50%	N/A	N/A

Vision plans

Copays for in-network services	■ Plan 1	■ Plan 2	■ Plan 3
Exam	$0	$10	$15
Materials	$0	$25	$30
Benefit frequency			
Comprehensive exam	Every 12 months	Every 12 months	Every 24 months
Eye glass lenses	Every 12 months	Every 12 months	Every 24 months
Frames	Every 12 months	Every 24 months	Every 24 months
Contact lenses in lieu of eyeglasses	Every 12 months	Every 12 months	Every 24 months
Frame benefit			
Network provider	$130 retail frame allowance	$130 retail frame allowance	$130 retail frame allowance
Lens options			
Standard scratch-resistant coating, tints, ultraviolet coating, polycarbonate, as well as standard and deluxe progressive lenses* *Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	Covered in full	Covered in full (after materials copay)	Covered in full (after materials copay)
Reimbursement	**INN | ONN**	**INN | ONN**	**INN | ONN**
Exam	$40 | Up to $80	$40 | Up to $80	$40 | Up to $80
Frames	$45 | Up to $110	$45 | Up to $110	$45 | Up to $110
Single vision lenses	$40 | Up to $60	$40 | Up to $60	$40 | Up to $60
Bifocal lenses	$60 | Up to $80	$60 | Up to $80	$60 | Up to $80
Trifocal lenses	$80 | Up to $115	$80 | Up to $115	$80 | Up to $115
Lenticular lenses	$105 | Up to $130	$105 | Up to $130	$105 | Up to $130
Elective contacts in lieu of eyeglasses	$105 | Up to $150	$105 | Up to $150	$105 | Up to $150
Necessary in lieu of eyeglasses	$210 | Up to $210	$210 | Up to $210	$210 | Up to $210
Laser Vision Benefit			
	UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call **1-888-563-4497** or visit us at **uhclasik.com.**		

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