Expatriate Insurance

Request for Proposal

UnitedHealthcare Global is dedicated to helping people live healthier lives and to help make the health system work better for everyone. Our mission is to provide global access to quality care, assistance and security for globally mobile populations.

We support globally mobile populations with a comprehensive range of in-house solutions developed using our breadth of capabilities and resources, enabling us to help deliver better outcomes — one person at a time.

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:

Headquarters Address:

State of Incorporation:

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 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:

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

Historical Renewal Information:

- Current & Renewal Rates (attach latest renewal, if available):

Current Funding: Fully-Insured ◯ Self-Insured ◯ Other ◯

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

continued

United Healthcare Global

Plan Design Details (cont.)

Why specifically is the group out to bid?

Employer Contribution Percentage:

Employee (minimum requirement of 50%):

Dependent:

Plan Design Request

Custom Plan Design Request: ◯

(Opportunity must be greater than 10 subscribers. Please attach current plan design as a separate document.)

Standard Plan Design Request: ◯

(Proceed to next page to select Standard Plan Design)

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 & 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			☐ Plan 4		
Annual Deductible	**NON US**	**US INN**	**US OON**	**NON US**	**US INN**	**US OON**	**NON US**	**US INN**	**US OON**	**NON US**	**US INN**	**US OON**
Individual	$0	$0	$0	$0	$500	$1,000	$250	$750	$1,500	$0	$2,000	$4,000
Family	N/A	N/A	N/A	$0	$1,500	$3,000	$750	$2,250	$4,500	$0	$4,000	$8,000
Out of Pocket Maximum*												
Individual	$0	$500	$1,000	$0	$1,000	$2,000	$500	$1,500	$3,000	$2,000	$4,000	$8,000
Family	N/A	$1,500	$3,000	N/A	$3,000	$6,000	$1,500	$4,500	$9,000	$4,000	$8,000	$16,000
Coinsurance												
Ambulance Services (Emerg/Non-Emerg)	100%	100%	100%/80%	100%	100%	100%/80%	90%	90%	90%/70%	80%	80%	80%/60%
Culturally-Based Devices	100%	N/A	N/A	100%	N/A	N/A	90%	N/A	N/A	80%	N/A	N/A
Durable Medical Equipment	100%	100%	80%	100%	100%	80%	90%	90%	70%	80%	80%	60%
Emergency Evacuation	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Emergency Family Reunion	100%	100%	N/A	100%	100%	N/A	100%	100%	N/A	100%	100%	N/A
Emergency Health Svcs	100%	Copay	Copay	100%	Copay	Copay	100%	Copay	Copay	100%	Copay	Copay
Home Health Care Services	100%	100%	80%	100%	100%	80%	90%	90%	70%	80%	80%	60%
Hospice	100%	100%	80%	100%	100%	80%	90%	90%	70%	80%	80%	60%
Inpatient Services	100%	100%	80%	100%	100%	80%	90%	90%	70%	80%	80%	60%
Other Med Services	100%	100%	80%	100%	100%	80%	90%	90%	70%	80%	80%	60%
Physician Office Visits	100%	100%	80%	100%	Copay	80%	100%	Copay	70%	100%	Copay	60%
Prosthetic	100%	100%	80%	100%	100%	80%	90%	90%	70%	80%	80%	60%
Urgent Care Center	100%	Copay	80%	100%	Copay	80%	100%	Copay	70%	100%	Copay	60%
Rehab/OP Therapy	100%	100%	80%	100%	Copay	80%	100%	Copay	70%	100%	Copay	60%
Repatriation of Remains	100%	100%	N/A	100%	100%	N/A	100%	100%	N/A	100%	100%	N/A
Copayments												
Inpatient Admission	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Office Visits	N/A	N/A	N/A	N/A	$15	N/A	N/A	$20	N/A	N/A	$20	N/A
Specialty Phys Visits	N/A	N/A	N/A	N/A	$30	N/A	N/A	$40	N/A	N/A	$40	N/A
Urgent Care Center	N/A	$50	N/A	N/A	$50	N/A	N/A	$50	N/A	N/A	$50	N/A
Rehab/OP Therapy	N/A	N/A	N/A	N/A	$15	N/A	N/A	$20	N/A	N/A	$20	N/A
Emerg Svs. OP	N/A	$200	$200	N/A	$200	$200	N/A	$200	$200	N/A	$300	$300

*Annual out-of-pocket maximum for what members pay for U.S. in-network and out-of-network claims to protect members from excessive costs.

Medical Plans (cont.)

Pharmacy												
Copayments	Covered Under Medical	$0	$0	Covered Under Medical	$10/$25/$60	$10/$25/$60	Covered Under Medical	$10/$25/$60	$10/$25/$60	Covered Under Medical	$10/$25/$60	$10/$25/$60
Coinsurance	Covered Under Medical	100%	80%	Covered Under Medical	100%	100%	Covered Under Medical	100%	80%	Covered Under Medical	100%	100%

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
Annual Individual/Family Deductible	$0 / $0	$50 / $150	$50 / $150
Annual Maximum	$2,000	$2,000	$2,000
Orthodontic Maximum* – Per Lifetime (when included) (Separate from Annual Maximum)	$2,000	$2,000	Not covered
Annual Deductible applies to Preventive and Diagnostic?	N/A	No	No
Annual Deductible applies to Orthodontic Services?	N/A	No	N/A
Diagnostic & Preventive Services	100%	100%	100%
Basic Restorative Services	80%	80% after deductible	80% after deductible
Major Restorative Services	80%	80% after deductible	80% after deductible
Orthodontic Services (when included)	50%	50%	N/A

Vision Plans

Copays for In-Network Services	☐ Plan 1	☐ Plan 2	☐ Plan 3
Exam	$0.00	$10.00	$15.00
Materials	$0.00	$25.00	$30.00
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 Eye Glasses	Every 12 months	Every 12 months	Every 24 months
Frame Benefit			
Network Provider	$130.00 retail frame allowance	$130.00 retail frame allowance	$130.00 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	$40.00 | Up to $80.00	$40.00 | Up to $80.00	$40.00 | Up to $80.00
Frames	$45.00 | Up to $110.00	$45.00 | Up to $110.00	$45.00 | Up to $110.00
Single Vision Lenses	$40.00 | Up to $60.00	$40.00 | Up to $60.00	$40.00 | Up to $60.00
Bifocal Lenses	$60.00 | Up to $80.00	$60.00 | Up to $80.00	$60.00 | Up to $80.00
Trifocal Lenses	$80.00 | Up to $115.00	$80.00 | Up to $115.00	$80.00 | Up to $115.00
Lenticular Lenses	$105.00 | Up to $130.00	$105.00 | Up to $130.00	$105.00 | Up to $130.00
Elective Contacts in Lieu of Eye Glasses	$105.00 | Up to $150.00	$105.00 | Up to $150.00	$105.00 | Up to $150.00
Necessary in Lieu of Eye Glasses	$210.00 | Up to $210.00	$210.00 | Up to $210.00	$210.00 | Up to $210.00
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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United Healthcare Global