Insperity
HR that Makes a Difference™

Insperity Group Health Plan
Deductible Credit Request
United Healthcare Transmittal Form

To Apply for a Deductible Credit to your Insperity Group Health Plan Medical Coverage

If you are the employee of a new Insperity client company, and you were enrolled in your client company's previous group health plan as of the date they joined Insperity, you may be eligible to receive credit for any deductible amounts you have already satisfied under your previous medical coverage.

Any credited amounts will apply to the calendar-year deductible for your Insperity Group Health Plan medical coverage option. Credits do not apply to separate prescription deductibles, or to non-deductible out-of-pocket maximum amounts (such as copays and coinsurance) satisfied under your previous coverage.

To be eligible for a deductible credit:

- You must be eligible to enroll in the Insperity Group Health Plan as of your client company's Insperity Benefits Effective Date;
- You must enroll in a UnitedHealthcare or Point32Health (Tufts) coverage option during your initial enrollment period (within 30 days of your client company's Insperity Benefits Effective Date); and
- You must complete and submit this form within 60 days of the Insperity Benefits Effective Date.

Please note that deductible credit will not apply, and you should NOT complete this form, if:

- You were not enrolled in your client company's previous group health plan as of that plan's term date.
- You were enrolled in an HMO coverage option without a deductible under your previous group health plan.
- You are enrolling in an HMO coverage option without a deductible under the Insperity Group Health Plan.
- You are enrolling in a Point32Health (Tufts) HDHP coverage option and your previous coverage option was NOT an HDHP.

To apply for a deductible credit to your Insperity Group Health Plan medical coverage:

1. Obtain copies of the most recent Explanations of Benefits (EOBs) or other carrier documentation reflecting any deductible amounts met during the current coverage period for your previous group health plan.
2. Complete sections 2, 3 and 4 of your UnitedHealthcare or Point32Health (Tufts) Transmittal Form (depending on your selected coverage option). Include deductible amounts met for yourself and any enrolled dependents.
3. Submit your completed form, along with your carrier documentation for all deductible amounts met under your previous group health plan, to UnitedHealthcare or Point32Health (Tufts) according to the form instructions.
4. Keep a copy of the transmittal form and any submitted EOBs for future reference.

Please note that it may take up to six weeks for deductible credits to appear on your UnitedHealthcare or Point32Health (Tufts) account.

To Apply for a Deductible Credit to your Insperity Group Health Plan Dental Coverage

No form is necessary. Obtain copies of your final dental Explanations of Benefits (EOB) reflecting any deductible amounts met for the current calendar year from your previous coverage provider, and submit it to the address below:

UnitedHealthcare Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, Utah 84130-0567

1. Information About Your Client Company's Previous Group Health Plan

This section is completed by Insperity. If any information is missing when you receive this form, please notify your supervisor.

Client Company Name ACTIVSTYLE LLC	**Client Company ID** 6257400
Insperity Benefits Effective Date Deductible credit courtesy is only available to employees who were enrolled in the client's previous group health plan as of that plan's term date, and who are eligible for Insperity Group Health coverage as of the client's Insperity Benefits Effective Date and enroll during their initial enrollment period at client onboarding. It is not available to employees in wait periods as of the client's Insperity Benefits Effective Date, or to new employees hired after client onboarding. **Effective Date (mm/dd/yyyy):** 05/01/2025	**Previous Group Health Plan Termination Date** For employees to be eligible for deductible credit, coverage must be consecutive; **there cannot be a gap** between previous group health plan coverage and Insperity Group Health Plan coverage. This means the term date of the client's previous group health plan *must be no more than one day before the Insperity Benefits Effective Date.* **Mergers and Acquisitions:** In the event that employees are losing coverage under a previous group health plan due to a client company merger or acquisition, a termination date for coverage under their previous group health plan is required for those employees to complete and submit a deductible credit request, and all other eligibility and continuous coverage requirements must be met. Please indicate Merger/Acquisition and enter the coverage termination date below. **Termination Date (mm/dd/yyyy):** 04/30/2025
Previous Group Health Plan Coverage Period If the client's previous plan year was from Jan. 1 to Dec. 31, select "calendar year." If the plan's 12-month coverage period did not start on Jan. 1 each year, please select "off-calendar plan year" and enter the start and end dates of the plan year. × **Calendar Year** ☐ **Off-Calendar Plan Year:** If an off-calendar plan year, when did the policy terminate? ☐ **At Policy Renewal** ☐ **Mid-Year**	**Previous Group Health Plan Administrator** If the client was the sponsor of their previous group health plan, please select "client." If the client did not administer the previous group health plan, please select "other." If the previous plan administrator was another PEO, please supply name of PEO. ☐ **Client** × **Other Administrator:**
Previous Group Health Plan Carrier(s) Please list all carriers providing medical coverage options under the client's previous group health plan: Blue Cross Blue Shield of North Carolina	**Previous Group Health Plan Coverage Types** Please select/list all medical coverage option types available through the client's previous group health plan: × **PPO** × **HMO** ☐ **Deductible HMO** × **HDHP (PPO)** × **HDHP (HMO)** × **Other:** Prime- HPN

2. Information About Your Previous Group Health Plan Coverage

Please complete this section about your previous coverage and the Insperity Group Health Plan coverage you are electing.

Employee Name	**Last Four Digits of Employee Social Security Number**
Insperity Group Health Plan Coverage Tier Who are you enrolling for coverage? Select "employee" if you are only enrolling yourself; select "family" if you are covering yourself, plus a spouse/domestic partner *and* children. **Employee** **Employee + Spouse or Domestic Partner** **Employee + Child(ren)** **Family**	**Insperity Group Health Plan Coverage Option** Which UnitedHealthcare coverage option are you enrolling in?
Insperity Benefits Eligibility Date Date you became eligible to enroll in the Insperity Group Health Plan	**Previous Group Health Plan Carrier** What is the name of the insurance carrier on your previous ID card?
Previous Group Health Plan Coverage Type What kind of previous medical coverage were you enrolled in? **PPO** **HMO** **Deductible HMO** **HDHP** **Other (please specify):**	**Carrier Documentation for Deductible Amounts Met** You will need to submit documentation from your previous group health plan carrier that displays total deductible amounts met for the current coverage period for each family member you are enrolling. **Explanation of Benefits (EOB)** **Other (please specify):**

3. Information About Deductible Amounts Met Under Your Previous Group Health Plan Coverage

Please provide the eligible deductible amounts met for each enrolled family member under your previous coverage.

For each enrolled family member, you must provide an Explanations of Benefits (EOB) or other carrier documentation reflecting any deductible amounts met under your previous coverage. Contact the carrier for your previous coverage if you need assistance with obtaining the appropriate documentation.

Name of Employee or Dependent	Date of Birth	Last 4 digits of SSN or UHC Member ID	In-Network Deductible Amount Met Under Previous Coverage	Out-of-Network Deductible Amount Met Under Previous Coverage

4. Sign And Date Form		
Employee Name (Print Clearly)	Last 4 Digits of Social Security No. **OR**	Insperity Employee ID No.
Employee Signature	Date Signed (mm/dd/yyyy)	

Submit all pages of this form, along with supporting documentation, directly to UnitedHealthcare at:

Email: insperitydedcredits@uhc.com

Fax: 844.762.1420

Mail: UnitedHealthcare
Attn: Insperity Holdings New Client Deductible Request
4316 Rice Lake Road
Duluth, MN 55811

Retain a copy of this form and all attached documentation for your records. Please note that Insperity does not conduct or participate in the review or approval process for the deductible credit. UnitedHealthcare will make the determination to approve or deny a deductible credit request.