THE OHIO STATE UNIVERSITY
HEALTH PLAN

2026 Prime Care Connect

Before filling out your Prime Care Connect application, please make sure that these four statements are true:

1. I am not an employee of an affiliated group (Central Ohio Technical College, OSU Physicians) or a graduate associate.

2. I am a full-time university employee (75-100% FTE) in a regular, term or seasonal appointment.

3. I am applying during Open Enrollment or because of a qualifying event.

4. My adjusted gross household income[1] does not exceed the maximum amount in the table below for the number of people in my household[2].

Persons in Household[2]	Maximum Household Income[1]
1	$35,213
2	$47,588
3	$59,963
4	$72,338
5	$84,713
6	$97,088
7	$109,463
8	$121,838
For households[2] with more than 8 persons, add $12,375 for each additional person.	

[1]Income is determined by previous year's adjusted gross income.

[2]Your household includes all persons residing in your home, even those who are not enrolled. Note: the adjusted gross income of every person residing in your home will be added to your total household income, even if that person is not an eligible dependent. Your household also includes any dependent who is going to be enrolled and lives outside of your home.

If you need help completing the application, or have any questions, please call OSU Health Plan at **614-292-4700 or 800-678-6269 or email OSUHealthPlanCS@osumc.edu.**

For translation services please visit osuhealthplan.com/translations or call 800-264-1552, access code #80014189.

THE OHIO STATE UNIVERSITY
HEALTH PLAN

Prime Care Connect 2026 Application

You will need the following items to complete this application. Check the box once you have gathered this information:

- ☐ Your **Employee ID Number**
- ☐ Your **most recent tax return** (see the last page of this application for an example of a tax return)
- ☐ Your **spouse's most recent tax return** if filed separately
- ☐ **Most recent tax returns of everyone over 18 years old** living in your home, and any dependent(s) to be enrolled in the medical plan not living in the home
- ☐ **Social Security Numbers of everyone** to be enrolled

SPECIAL NOTE: If you are applying for Prime Care Connect, please also enroll in one of the other Ohio State medical coverage options while waiting to hear if you are approved for Prime Care Connect.

If your application for Prime Care Connect is approved, you will automatically be enrolled as of your date of hire or date of Qualifying Event. If your application for Prime Care Connect is denied, you will be enrolled in the Ohio State medical plan you selected as a backup for Prime Care Connect.

What is a Qualifying Event? A qualifying event includes major life events such as the birth or adoption of a child, marriage, loss of other coverage and open enrollment.

What is a dependent? A child or other individual who you claim as a personal exemption tax deduction on your tax return, and/or intend to enroll in your medical plan.

Your application will not be processed if all information is not provided on the form. If you would like an example to check your work, see the last three pages of this document.

If you need help completing the application, please call OSU Health Plan at **614-292-4700 or 800-678-6269 or email OSUHealthPlanCS@osumc.edu.**

INSTRUCTIONS

EMPLOYEE INFORMATION
1. Enter your employee information on lines 1–10 of the application.

INCOME INFORMATION
2. Enter your most recent adjusted gross income on line 4 of the application.

FAMILY INFORMATION

3. As applicable, enter the name of your spouse, all household members and any dependent(s) who do not live with you that you would like to enroll in your medical plan. **Be sure to include date of birth, gender, and social security number of all household members and any dependent(s) who do not live with you that you would like to be enrolled in Prime Care Connect.**

4. Include the most recent adjusted gross income amount from the tax return of all household members, and dependent(s) not living in the home that you would like to enroll in the medical plan, over the age of 18.

5. Tell us whether each person is living with you and if you want them enrolled in the Prime Care Connect medical plan, if approved, by circling “yes” or “no.”

6. Include copies of your most recent tax return as well as your spouse’s, any other adult person living in your home, and any adult dependent not living in your home that you would like to enroll in the medical plan (see attached for example of a tax return), including copies of the forms, schedules, and any other supporting documentation that make up your total adjusted gross income.

If you do not have a copy of your most recent tax return, you can request a tax return transcript free of charge at www.irs.gov/individuals/get-transcript.

Do not send ANY original documents, please keep the originals for your records, and ONLY send copies. No documents will be returned to you.

7. If you, your spouse, adult dependents living outside of the home that you wish to enroll in the medical plan, or other adults living in your home did not file a tax return in the most recent tax year, you can instead provide their most recent W-2.For Ohio State employees, you can access your previous year's W-2 by logging into www.myworkday.com/osu, choose Benefits and Pay Hub, under Pay, choose Tax.

If you do not have internet access, you can request a copy of your Ohio State W-2 by calling 800-996-7566 between 8 a.m. and 9 p.m. For non-Ohio State employees, contact your most recent employer.

8. The OSU Health Plan may contact you if you have not provided all information needed to process your application.

9. Notification of approval or denial of your eligibility for Prime Care Connect will be mailed to the address listed on the application within approximately10 business days from the date your completed application and needed documentation is received.

10. Approvals will be sent to the Office of Human Resources for appropriate processing of enrollment; however, no income information from your application will be shared with the Office of Human Resources.

11. Your eligibility is valid only for the plan year, and you must reapply annually to keep your eligibility.

12. Make sure your application is complete, then print and sign your name and today’s date on page 5, to verify that the information is valid and accurate.

13. Mail the completed application and requested documents to: The OSU Health Plan, 700 Ackerman Road, Suite 1007, Columbus, OH 43202, email to OSUHealthPlanCS@osumc.edu, or fax the materials to 614-292-2667.

OSU Prime Care Connect Medical Plan – Application

Submit this completed application along with the applicable documents.

If you filed for a tax return in the last year, you must submit:

☐Copy of your most recent income tax return, and

☐Copy of the most recent tax return from your spouse (if filed separately), dependent(s) not living in your home who are going to be enrolled, and all household member(s) over the age of 18.

If a tax return was not filed in the last year, you must submit:

☐Copy of your most recent W-2, and/or

☐Copy of the most recent W-2(s) for your spouse, dependent(s) not living in your home who are going to be enrolled, and all household member(s) over the age of 18.

EMPLOYEE INFORMATION

1._____ 2. _____

Last Name First Name Middle Initial Employee ID

3._____ 4._____ 5. _____

Date of Hire (mm/dd/yyyy) Employee Income Date of Birth (mm/dd/yyyy)

6._____

Home Address

7._____ 8._____ 9._(____)_____-_____

City ZIP Code Preferred Phone Number

10. Write in best time to call: _____or check one:

☐ 8 a.m. – 12 p.m. ☐ 12 p.m. – 4 p.m. ☐ 4 p.m. – 6 p.m.

11. **REASON FOR COMPLETING APPLICATION**

Date of event: _____/ _____/ _____

Application and required documentation must be returned within 30 days of the event date.

Qualifying status change (please specify):

☐ Open Enrollment
☐ Marriage[1]
☐ Loss of other coverage[1]
☐ Birth/ Adoption/ Legal guardianship/ Legal custody[1]

[1]Documentation required

FAMILY/ HOUSEHOLD[1] MEMBERS

Enter the name, relationship, date of birth, gender, and social security number of all household[1] members and any dependent(s) who do not live with you but who you would like to enroll in medical coverage. For each person, indicate whether they currently live with you in your home and if you wish to enroll them in medical coverage. Include the adjusted gross income for everyone listed aged 18 or older.

EACH COLUMN MUST BE COMPLETED

Name	Relationship Code[2]	Date of Birth (mm/dd/yyyy)	Gender[3]	Social Security Number[4]	Yearly Income[5] (spouse or adult 18+)	Currently Live in Your Home	Enroll in OSU Medical Coverage
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No

[1]Your household includes all persons residing in your home, even those who are not enrolled. Note: the adjusted gross income of every person residing in your home will be added to your total household income, even if that person is not an eligible dependent. Your household also includes any dependent who is going to be enrolled and lives outside of your home.

[2]Use the following codes to show your relationship with the person you are enrolling in medical coverage.

Code	Relationship
SP	Spouse
C	Child

[3]Use the following codes for gender for each person you are enrolling in medical coverage.

Code	Relationship
F	Female
M	Male

[4]Social security number required only for household members to enroll in Prime Care Connect

[5]Income is determined by previous year's adjusted gross income.

I certify that the information on this application is complete and accurate and that all the supporting documents I have provided are valid and accurately show my current financial status. **I also understand it is my responsibility to notify the OSU Health Plan within 30 days if I have a change in financial status during the year that makes me no longer eligible for Prime Care Connect.** I understand that including false information or leaving out information on this application, or failure to inform the OSU Health Plan if I am no longer eligible for Prime Care Connect within 30 days of the change, is considered fraud. It may result in disciplinary action of an employee up to and including termination of benefits and/or employment. I also agree that the university may recover damages for all losses and reasonable attorneys' fees incurred to recover such damages.

I have read and understand the materials describing the terms and conditions of the OSU Health Plan and agree to such terms and conditions. I declare that any individual for whom I am requesting health coverage as my dependent meets the definition of an eligible dependent, according to the Dependent Eligibility Guidelines, available online at hr.osu.edu/benefits/dependent-eligibility-guidelines. I understand that the university can rescind (i.e., retroactively terminate) coverage if it was gained due to fraud. This includes an individual (or person seeking coverage on behalf of an individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact. I understand that any person who applies for coverage or files a claim containing any materially false information may be subject to disciplinary action, up to and including termination of benefits and/or employment. I understand that my elections may not be changed or voluntarily canceled at any time during the plan year (ending December 31) unless a qualifying status change occurs, as defined by the applicable plan, and the Office of Human Resources receives timely notification of such change as provided under the applicable plan. I authorize the university to deduct from my pay, on a pre-tax basis, the applicable employee contribution described in the benefit rates online at hr.osu.edu/benefits/rates. I understand that this authorization to deduct employee contributions directly from my pay (i.e., a salary redirection arrangement) will remain in effect during the period of coverage and it cannot be revoked, except as described in the applicable plan. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for the benefits that I elect, or if I go on an unpaid leave of absence, I will be billed directly for these employee contributions. In such case, I agree to pay those employee contributions promptly and in full. I understand that, if employee contributions are not paid in full, the benefits will be terminated for lack of payment, and I will be responsible for employee contributions missed prior to my coverage termination date. I certify that all information provided on this form is true and correct to the best of my knowledge.

_____

Employee Name (print)

_____ _____

Employee Signature **Date**

***Note*: Eligibility determination is valid only for the plan year, you must reapply annually to maintain eligibility.**

OSU Prime Care Connect Medical Plan – SAMPLE APPLICATION

Submit this completed application along with the applicable documents.

If you filed for a tax return in the last year, you must submit:

☐ Copy of your most recent income tax return, and

☐ Copy of the most recent tax return from your spouse (if filed separately), dependent(s) not living in your home who are going to be enrolled, and all household member(s) over the age of 18.

If a tax return was not filed in the last year, you must submit:

☒ Copy of your most recent W-2, and/or

☒ Copy of the most recent W-2(s) for your spouse, dependent(s) not living in your home who are going to be enrolled, and all household member(s) over the age of 18.

EMPLOYEE INFORMATION

1. **Buckeye** (Last Name) **Brutus** (First Name) **T.** (Middle Initial)

2. **12345678** (Employee ID)

3. **05/17/2017** (Date of Hire (mm/dd/yyyy))

4. **42,596** (Employee Income)

5. **04/30/1980** (Date of Birth (mm/dd/yyyy))

6. **281 West Lane Avenue** (Home Address)

7. **Columbus** (City)

8. **43201** (ZIP Code)

9. (**614**) **292** - **6446** (Preferred Phone Number)

10. Write in best time to call: _____ or check one:

☐ 8 a.m. – 12 p.m. ☐ 12 p.m. – 4 p.m. ☒ 4 p.m. – 6 p.m.

11. **REASON FOR COMPLETING APPLICATION**

Date of event: **01** / **01** / **2026**

Application and required documentation must be returned within 30 days of the event date.

Qualifying status change (please specify):

☒ Open Enrollment
☐ Marriage[1]
☐ Loss of other coverage[1]
☐ Birth/ Adoption/ Legal guardianship/ Legal custody[1]

[1]Documentation required

FAMILY/ HOUSEHOLD[1] MEMBERS

Enter the name, relationship, date of birth, gender, and social security number of all household[1] members and any dependent(s) who do not live with you but who you would like to enroll in medical coverage. For each person, indicate whether they currently live with you in your home and if you wish to enroll them in medical coverage. Include the adjusted gross income for everyone listed aged 18 or older.

EACH COLUMN MUST BE COMPLETED

Name	Relationship Code[2]	Date of Birth (mm/dd/yyyy)	Gender[3]	Social Security Number[4]	Yearly Income[5] (spouse or adult 18+)	Currently Live in Your Home	Enroll in OSU Medical Coverage
William Buckeye	**C**	**04/29/2005**	**M**	**111-22-3333**	**12,962**	Yes / (No)	(Yes) / No
Grayson Buckeye	**C**	**02/07/2015**	**M**	**444-55-6666**	**N/A**	(Yes) / No	(Yes) / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No
						Yes / No	Yes / No

[1]Your household includes all persons residing in your home, even those who are not enrolled. Note: the adjusted gross income of every person residing in your home will be added to your total household income, even if that person is not an eligible dependent. Your household also includes any dependent who is going to be enrolled and lives outside of your home.

[2]Use the following codes to show your relationship with the person you are enrolling in medical coverage.

Code	Relationship
SP	Spouse
C	Child

[3]Use the following codes for gender for each person you are enrolling in medical coverage.

Code	Relationship
F	Female
M	Male

[4]Social security number required only for household members to enroll in Prime Care Connect

[5]Income is determined by previous year's adjusted gross income.

I certify that the information on this application is complete and accurate and that all the supporting documents I have provided are valid and accurately show my current financial status. **I also understand it is my responsibility to notify the OSU Health Plan within 30 days if I have a change in financial status during the year that makes me no longer eligible for Prime Care Connect.** I understand that including false information or leaving out information on this application, or failure to inform the OSU Health Plan if I am no longer eligible for Prime Care Connect within 30 days of the change, is considered fraud. It may result in disciplinary action of an employee up to and including termination of benefits and/or employment. I also agree that the university may recover damages for all losses and reasonable attorneys' fees incurred to recover such damages.

I have read and understand the materials describing the terms and conditions of the OSU Health Plan and agree to such terms and conditions. I declare that any individual for whom I am requesting health coverage as my dependent meets the definition of an eligible dependent, according to the Dependent Eligibility Guidelines, available online at hr.osu.edu/benefits/dependent-eligibility-guidelines. I understand that the university can rescind (i.e., retroactively terminate) coverage if it was gained due to fraud. This includes an individual (or person seeking coverage on behalf of an individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact. I understand that any person who applies for coverage or files a claim containing any materially false information may be subject to disciplinary action, up to and including termination of benefits and/or employment. I understand that my elections may not be changed or voluntarily canceled at any time during the plan year (ending December 31) unless a qualifying status change occurs, as defined by the applicable plan, and the Office of Human Resources receives timely notification of such change as provided under the applicable plan. I authorize the university to deduct from my pay, on a pre-tax basis, the applicable employee contribution described in the benefit rates online at hr.osu.edu/benefits/rates. I understand that this authorization to deduct employee contributions directly from my pay (i.e., a salary redirection arrangement) will remain in effect during the period of coverage and it cannot be revoked, except as described in the applicable plan. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for the benefits that I elect, or if I go on an unpaid leave of absence, I will be billed directly for these employee contributions. In such case, I agree to pay those employee contributions promptly and in full. I understand that, if employee contributions are not paid in full, the benefits will be terminated for lack of payment, and I will be responsible for employee contributions missed prior to my coverage termination date. I certify that all information provided on this form is true and correct to the best of my knowledge.

Brutus Buckeye

Employee Name (print)

Brutus Buckeye

Employee Signature

11/11/2025

Date

***Note*: eligibility determination is valid only for the plan year, you must reapply annually to maintain eligibility**

Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** **2024** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2024, or other tax year beginning _____, 2024, ending _____, 20_____ See separate instructions.

Your first name and middle initial	Last name	Your social security number
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. Apt. no.

City, town, or post office. If you have a foreign address, also complete spaces below. State ZIP code

Foreign country name Foreign province/state/county Foreign postal code

Presidential Election Campaign Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse

Filing Status Check only one box.

☐ Single ☐ Head of household (HOH)
☐ Married filing jointly (even if only one had income)
☐ Married filing separately (MFS) ☐ Qualifying surviving spouse (QSS)

If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QSS box, enter the child's name if the qualifying person is a child but not your dependent: _____

☐ If treating a nonresident alien or dual-status alien spouse as a U.S. resident for the entire tax year, check the box and enter their name (see instructions and attach statement if required): _____

Digital Assets At any time during 2024, did you: (a) receive (as a reward, award, or payment for property or services); or (b) sell, exchange, or otherwise dispose of a digital asset (or a financial interest in a digital asset)? (See instructions.) ☐ Yes ☐ No

Standard Deduction **Someone can claim:** ☐ You as a dependent ☐ Your spouse as a dependent
☐ Spouse itemizes on a separate return or you were a dual-status alien

Age/Blindness **You:** ☐ Were born before January 2, 1960 ☐ Are blind **Spouse:** ☐ Was born before January 2, 1960 ☐ Is blind

Dependents (see instructions): If more than four dependents, see instructions and check here . . ☐

(1) First name Last name	(2) Social security number	(3) Relationship to you	(4) Check the box if qualifies for (see instructions): Child tax credit	Credit for other dependents
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a Form W-2, see instructions.

1a	Total amount from Form(s) W-2, box 1 (see instructions)				1a	
b	Household employee wages not reported on Form(s) W-2				1b	
c	Tip income not reported on line 1a (see instructions)				1c	
d	Medicaid waiver payments not reported on Form(s) W-2 (see instructions)				1d	
e	Taxable dependent care benefits from Form 2441, line 26				1e	
f	Employer-provided adoption benefits from Form 8839, line 29				1f	
g	Wages from Form 8919, line 6				1g	
h	Other earned income (see instructions)				1h	
i	Nontaxable combat pay election (see instructions)	1i				
z	Add lines 1a through 1h				1z	
2a	Tax-exempt interest	2a		b Taxable interest	2b	
3a	Qualified dividends	3a		b Ordinary dividends	3b	
4a	IRA distributions	4a		b Taxable amount	4b	
5a	Pensions and annuities	5a		b Taxable amount	5b	
6a	Social security benefits	6a		b Taxable amount	6b	
c	If you elect to use the lump-sum election method, check here (see instructions) ☐					
7	Capital gain or (loss). Attach Schedule D if required. If not required, check here ☐				7	
8	Additional income from Schedule 1, line 10				8	
9	Add lines 1z, 2b, 3b, 4b, 5b, 6b, 7, and 8. This is your **total income**				9	
10	Adjustments to income from Schedule 1, line 26				10	
11	Subtract line 10 from line 9. This is your **adjusted gross income**				11	
12	**Standard deduction or itemized deductions** (from Schedule A)				12	
13	Qualified business income deduction from Form 8995 or Form 8995-A				13	
14	Add lines 12 and 13				14	
15	Subtract line 14 from line 11. If zero or less, enter -0-. This is your **taxable income**				15	

Attach Sch. B if required.

Standard Deduction for—
- Single or Married filing separately, $14,600
- Married filing jointly or Qualifying surviving spouse, $29,200
- Head of household, $21,900
- If you checked any box under *Standard Deduction*, see instructions.