THE OHIO STATE UNIVERSITY
HEALTH PLAN

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 or Term appointment.

3. I am applying for Open Enrollment or because of a qualifying event. See below (#11) regarding eligibility.

4. My household income is not more than the maximum amount listing in the chart for the number of people in my household.

Members in Household	Maximum Household Income
1	$28,980
2	$39,195
3	$49,410
4	$59,625
5	$69,840
6	$80,055
7	$90,270
8	$100,485
9 and up	add $10,215 per additional person

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.**

THE OHIO STATE UNIVERSITY
HEALTH PLAN

Prime Care Connect 2021 Application

You will need these **numbers** and **tax returns** to complete this application. Check the box once you have gathered this information:

- ☐ Your **Employee ID Number**
- ☐ Your **most recent tax return (1040, 1040A, or 1040EZ)** (see the last page of this application for an example of a tax return)
- ☐ Your **spouse's most recent tax return (1040, 1040A, or 1040EZ)** if you filed separately
- ☐ **Most recent tax returns (1040, 1040A, or 1040EZ) of everyone over 18 years old** living in your home
- ☐ **Social Security Numbers of all family members** who live with you in your home

SPECIAL NOTE: If you are applying as a new hire or qualifying event, newly eligible or have a qualifying event please also enroll in one of the other Ohio State medical coverage options during Open Enrollment period, while waiting to hear if you are approved for Prime Care Connect. That way, you know you will have coverage if you are not approved.

Note: You are not eligible for this coverage if you are an employee of an affiliated group (COTC, OSUP), or a graduate associate. To be eligible you must hold a full-time university appointment (75-100% FTE) in a Regular or Term appointment.

If you are approved for Prime Care Connect, you will automatically be enrolled effective from your date of hire or the date for your Qualifying Event. You will receive a letter from the OSU Health Plan advising whether or not you have been approved.

What is a Qualifying Event? Major life events such as birth or adoption of a child, marriage, or open enrollment.

What is a dependent? A child or other individual who you claim as a personal exemption tax deduction on your tax return.

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 packet.

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. Write your employee information on lines 1–10 of the application.

INCOME INFORMATION

2. Write your most recent adjusted gross income on line 4 of the application. If your household income has changed significantly since your most recent tax return, you will have to provide more information (see instruction number 6).

FAMILY INFORMATOIN

3. Write the name of your spouse, all of the people who live with you and any dependents who do not live with you. **Be sure to include the birthdate and the social security number of all of the household members to be enrolled in Prime Care Connect.**

4. Include the most recent income amount from the tax return of all household members 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—1040, 1040A, or 1040EZ—as well as your spouse’s, and any other adult person living in your home (see attached for example of a tax return), including copies of the forms, schedules, and any other supporting documentation that make up your total taxable wages.

   If you do not have a copy of your most recent tax return, you can request a tax return transcript free of charge by calling the IRS toll free at 800-829-0922 Monday through Friday, 7 a.m. to 10 p.m. For faster delivery, if you have access to a fax machine, you can fax your transcript instead of mailing it.

   When the transcript(s) arrive(s), include a copy along with the completed application and other necessary documents we have asked for. **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, or other adults living in your home did not file a tax return in latest tax season, provide the most recent W-2 from everyone’s employers. For Ohio State employees, you can request a copy of your most recent W-2 by visiting Employee Self Service, choosing “W-2 Forms” and clicking on “Year End Form” for the year 2019.

   Print your most recent W-2 and include it in the return envelope with your application. 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 given us all of the information we need 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 10 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 any of the needed documents, and check the box beside those items that you include.

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

☐ Copy or transcript of your most recent income tax return (1040, 1040A, or 1040 EZ), and
☐ Copy or transcript of the most recent income tax return(s) (1040, 1040A, or 1040 EZ) from your spouse, and/or other adult household member(s) if filed separately.

If you did not file for a tax return in the last year, you must submit:

☐ Copy of your most recent W-2, and
☐ Copy of the most recent W-2(s) for your spouse, and/or other adult household member(s).

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 FORM**

Date of event: _____/ _____ / ____ (return form within 30 days of event date)

Qualifying status change (please specify):

☐ Open Enrollment (To ensure medical coverage, be sure you enroll in one of Ohio State's other medical coverage options during Open Enrollment while waiting to hear if you have been approved for this coverage.)
☐ Marriage[1]
☐ Loss of Other Coverage[1]
☐ Birth/Adoption/Legal Guardianship/Legal Custody

[1]Documentation required

TURN OVER TO COMPLETE APPLICATION

FAMILY/HOUSEHOLD MEMBERS

List the names and relationships of all household members that contribute to household income. List any dependents who do not live with you but who you would also like to enroll in medical coverage. For each person, indicate whether they currently live with you in your home and whether you wish to enroll them in medical coverage. Include the income for all household residents age 18 or older.

EACH COLUMN MUST BE COMPLETED

Name	Relationship Code*	Date of Birth (mm/dd/yyyy)	Social Security Number[1]	Yearly Income (of spouse or adult household residents 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

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

Code	Relationship
SP	Spouse
C	Child

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

I certify that the information on this application is complete and accurate and that all of the supporting documents I have provided are valid and an 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 Ohio State University Faculty and Staff 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 has the ability to stop (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 cancelled 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 or after tax basis, as the case may be, the applicable employee contributions 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 any of the needed documents, and check the box beside those items that you include.

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

☐ Copy or transcript of your most recent income tax return (1040, 1040A, or 1040 EZ), and
☐ Copy or transcript of the most recent income tax return(s) (1040, 1040A, or 1040 EZ) from your spouse, and/or other adult household member(s) if filed separately.

If you did not file for a tax return in the last year, you must submit:

☐ Copy of your most recent W-2, and
☐ Copy of the most recent W-2(s) for your spouse, and/or other adult household member(s).

EMPLOYEE INFORMATION

1. Buckeye (Last Name) Brutus (First Name) O. (Middle Initial) 2. 12345678 (Employee ID)

3. 05/21/2007 (Date of Hire (mm/dd/yyyy)) 4. $15,000 (Employee Income) 5. 06/07/1984 (Date of Birth (mm/dd/yyyy))

6. 1234 Buckeye Way (Home Address)

7. Columbus (City) 8. 43210 (ZIP Code) 9. (614) 123-4567 (Preferred Phone Number)

10. Write in best time to call: 8am-10am 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 FORM**

Date of event: _____/ ____ / ___ (return form within 30 days of event date)

Qualifying status change (please specify):

☒ Open Enrollment (To ensure medical coverage, be sure you enroll in one of Ohio State's other medical coverage options during Open Enrollment while waiting to hear if you have been approved for this plan.)
☐ Marriage[1]
☐ Loss of Other Coverage[1]
☐ Birth/Adoption/Legal Guardianship/Legal Custody[1]

[1]Documentation required

FAMILY/HOUSEHOLD MEMBERS

List the names and relationships of all family members who reside in your household. List any dependents who do not reside in your household but who you would also like to enroll in the medical coverage. For each person, indicate whether they currently reside in the household and whether you wish to enroll them in the medical coverage. Include the income for all household residents age 18 or older.

EACH COLUMN MUST BE COMPLETED

Name	Relationship Code*	Date of Birth (mm/dd/yyyy)	Social Security Number	Yearly Income (of spouse or adult household residents 18+)	Currently Live in Your Home	Enroll in OSU Medical coverage?
Buckeye, Betty	SP	06/07/1984	123456789	$15,000	(Yes) / No	(Yes) / No
Buckeye, Grayson	C	02/07/2015	123456908	$0	(Yes) / No	(Yes) / No
Buckeye, Brooke	C	09/15/2008	901234567	$0	(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

*Use the following codes to show your relationship with the person you are enrolling.

Code	Relationship
SP	Spouse – Must be the legal spouse of the employee
C	Child – Must be a dependent child of the employee or the employee's legal spouse who is under age 26, unless fully disabled and approved for continued coverage.

I certify that the information on this application is complete and accurate and that all of the supporting documents I have provided are valid and an 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 Ohio State University Faculty and Staff 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 has the ability to stop (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 cancelled 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 or after tax basis, as the case may be, the applicable employee contributions described in the benefit plan 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):

Brutus Buckeye

Employee Signature **Date**

Brutus Buckeye 11/01/2021

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