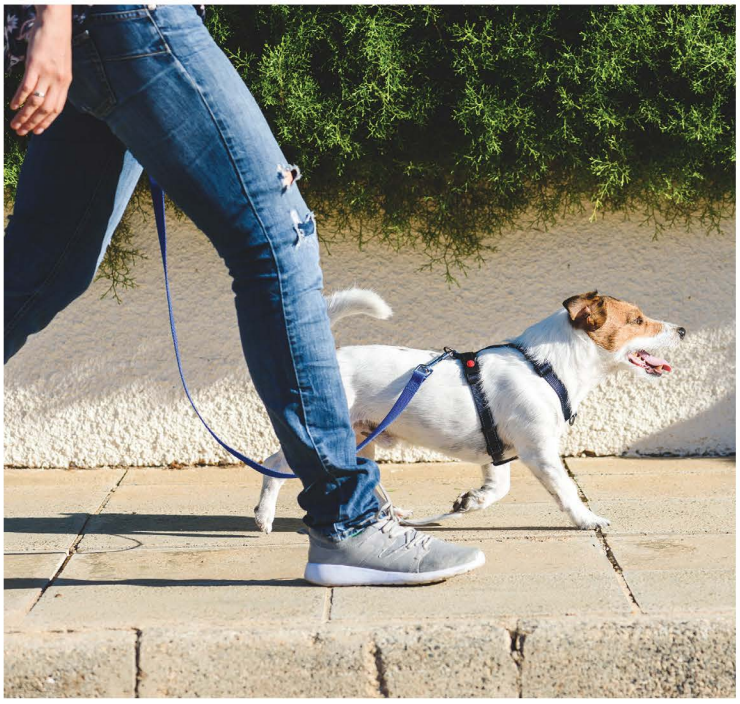
AON ACTIVE HEALTH EXCHANGE™

Make It Yours To Go



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Eligibility

It's up to you to understand who you can cover under your medical, dental, vision, and other benefits. Be sure to review the information below *before* you enroll in coverage.

You are eligible to participate in OnePlus if you are a:

- Regular full-time employee scheduled to work at least 30 hours a week, or
- Regular part-time employee scheduled to work at least 20 hours, but less than 30 hours, each week.*

Part-time employees are eligible for the same OnePlus benefits that are available to full-time employees.

Eligible Dependents

Dependents who are eligible for OnePlus medical, dental, vision, and spouse and/or dependent life insurance benefits coverage include your:

- Spouse or domestic partner**;
- Biological children, stepchildren, legally adopted children, children to whom you are a legal guardian up to age 26***†;
- Handicapped children of any age who are unmarried, disabled, and rely on you for support; and
- Domestic partner's eligible children up to age 26***†.

Please note, when you are enrolling your dependents, Ricoh expects you to provide accurate information. It is important to ensure that only eligible dependents are enrolled in Ricoh coverage. Dependents who are not eligible for coverage or for whom you are unable to provide documentation will be dropped from coverage.

Ricoh has implemented Plan Guard to verify the eligibility of dependents covered under the OnePlus plans. Dependents who are not eligible for coverage or for whom you are unable to provide documentation will be dropped from coverage.

*Other state mandates may apply.

**There is an additional amount you may pay for medical coverage each pay period if you enroll a spouse or domestic partner who has access to medical coverage from his or her employer.

***Not eligible for spouse or dependent life insurance if also employed by Ricoh.

† Coverage ends the last day of the month after dependent's 26th birthday.

Medical Coverage Level

In a hurry? Get the highlights the easy way—just watch the video! (Closed captioning is available.)

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want. If you're enrolling again, consider what changes you may be facing. Change is constant, so make sure you **do your homework** before sticking with what you had in the past.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Medical Coverage Level Options

You have several coverage levels to choose from. Each coverage level is available from different **insurance carriers** at different costs.

When you enroll, you'll find plenty of tools and resources to help you choose a coverage level.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO	PPO that offers limited benefits for out-of-network care**
Paycheck contributions	$	$	$$	$$$	$$$$
			Annual Deductible		
In-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900	$1,000 / $2,000	$800 / $1,600	$250 / $500
Out-of-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900	$2,000 / $4,000	$1,600 / $3,200	$5,000 / $10,000
Traditional or true family?	Traditional	True family	Traditional	Traditional	Traditional
			Annual-Out-of-Pocket-Maximum		
In-network (individual / family)	$6,400 / $12,800	$3,900 / $7,800	$5,300 / $10,600	$3,600 / $7,200	$2,300 / $4,600

Out-of-network (individual / family)	$12,800 / $25,600	$11,500 / $23,000	$10,600 / $21,200	$7,200 / $14,400	$11,500 / $23,000
Traditional or true family?	Traditional	True family	Traditional	Traditional	Traditional
		In-Network Benefits			
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible
Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay 25% after deductible	You pay 15% after deductible
Urgent care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 15% after deductible
Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 15% after deductible
Outpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	If not an office visit, you pay 25% after deductible	You pay 15% after deductible

**For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
		30-Day Retail Supply			
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10	You pay $8
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60	You pay $50
		90-Day Mail Order Supply			

Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100	You pay $75
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to Your Benefits Resources at **https://digital.alight.com/rus/**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on Your Benefits Resources at **https://digital.alight.com/rus/**.

California Residents: Your options will be different, depending on the insurance carrier you choose. See **what's different**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier.

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how the insurance carrier will cover any medications you and your covered family members need. **Get the details**.

Questions?

It's easy to find answers! Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

California Medical Coverage Level

Live In California?

Your options will be different, depending on the insurance carrier you choose.

For starters, each **insurance carrier** in California has the option to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) **or** an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer **either the standard Gold option or a Gold II option—not both**. The Gold II option offers **only** in-network benefits.

Review the table below to see which insurance carriers offer out-of-network benefits for the coverage levels you're considering.

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Aetna	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Cigna	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In-network only	In-network only
Health Net	**Northern California** In-network only **Southern California** In- and out-of-network	**Northern California** In-network only **Southern California** In- and out-of-network	**Northern California** In-network only **Southern California** In- and out-of-network	N/A	In-network only	**Northern California** In-network only **Southern California** In- and out-of-network
Independence Blue Cross	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Kaiser Permanente	In-network only	In-network only	In-network only	N/A	In-network only	In-network only
United Healthcare	In- and out-of-network	In- and out-of-network	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network

Medical Coverage Level

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Option type	High-deductible option with HSA	High-deductible option with HSA	PPO	PPO	HMO	PPO that offers limited benefits for out-of-network care**
Paycheck contributions	$	$	$$	$$$	$$$	$$$$
			Annual Deductible			
In-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900†	$1,000 / $2,000	$800 / $1,600	N / A	$250 / $500
Out-of-network (individual / family)	$3,300 / $6,600	$2,450 / $4,900†	$2,000 / $4,000	$1,600 / $3,200	N / A	$5,000 / $10,000
Traditional or true family?	Traditional	True family	Traditional	Traditional	N / A	Traditional
			Annual Out-of-Pocket Maximum			
In-network (individual / family)	$6,400 / $12,800	$3,900 / $7,800‡	$5,300 / $10,600	$3,600 / $7,200	$5,400 / $10,800	$2,300 / $4,600
Out-of-network (individual / family)	$12,800 / $25,600	$11,500 / $23,000‡	$10,600 / $21,200	$7,200 / $14,400	N / A	$11,500 / $23,000
Traditional or true family?	Traditional	True family	Traditional	Traditional	Traditional	Traditional
			In-Network Benefits			
Preventive care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%	Covered 100%, no deductible

Doctor's office visit	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency room	You pay 25% after deductible	You pay 25% after deductible	You pay $150, then 30% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
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Inpatient care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
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**For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.

†Under Health Net and Kaiser Permanente, if you cover dependents, no covered member pays more than $2,800 toward the family deductible. Also, these options feature a traditional annual deductible.

‡Under Health Net and Kaiser Permanente, these options feature a traditional annual out-of-pocket maximum.

Prescription Drug Coverage

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive drugs	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**	You pay $0**
			30-Day Retail Supply			
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10	You pay $10	You pay $8

Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40	You pay $40	You pay $30
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60	You pay $60	You pay $50
90-Day Mail Order Supply						
Tier 1 (generally lowest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25	You pay $25	You pay $20
Tier 2 (generally medium cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100	You pay $100	You pay $75
Tier 3 (generally highest cost options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150	You pay $150	You pay $125

**Preventive drugs are determined by the insurance carrier. You must have a doctor's prescription for the medication—even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service.

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For a more detailed look at these and additional coverages, go to Your Benefits Resources at **https://digital.alight.com/rus/**. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on Your Benefits Resources at **https://digital.alight.com/rus/**.

Out-of-Area: Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier.

Choosing a Primary Care Physician: Certain options require you to choose a primary care physician. You may need to designate a primary care physician to coordinate your care if you choose Kaiser Permanente or Health Net as your insurance carrier.

Do You Take Any Prescription Drugs?

This is really important! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

While your coverage level will determine your coverage for prescription drugs, each pharmacy benefit manager has its own rules. You need to make sure you're comfortable with how the insurance carrier will cover any medications you and your covered family members need. **Get the details**.

Questions?

It's easy to find answers! Check out the **Frequently Asked Questions** (PDF) and the **Glossary**.

How Deductibles Work

The deductible is what you pay out of your own pocket before your insurance begins to pay a share of your costs.

For example, let's say you break your wrist. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you reach the deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept for a particular service from the **insurance carrier**.

It Depends On Your Medical Coverage Level

Bronze, Silver, Gold, and Platinum have a traditional deductible.

Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Bronze Plus has a "true family deductible". This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members.

There is no "individual deductible" in the Bronze Plus coverage level when you have family coverage. So even if one person in your family has a lot of expenses, you'll have to pay for it on your own until the full family deductible is met.

The annual deductible doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?

Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do **not** cover out-of-network benefits at all.

How Out-of-Pocket Maximums Work

The out-of-pocket maximum is the most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance.

Here’s how the out-of-pocket maximum works if you have family coverage:

It Depends On Your Medical Coverage Level

Bronze, Silver, Gold, and Platinum have a traditional out-of-pocket-maximum.

Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

It doesn't include amounts taken out of your paycheck for health coverage. Also, if you choose coverage under Kaiser Permanente, copays for certain medical benefits may not apply towards the annual out-of-pocket maximum under the Silver, Gold, and Platinum options.

Bronze Plus has a "true family out-of-pocket-maximum". This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

There is no "individual out-of-pocket maximum" in the Bronze Plus coverage level when you have family coverage.

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage.

Do You Use Out-of-Network Providers?
Out-of-network charges will **not** count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges—they will **not** count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Medical Price

In a hurry? Get the highlights the easy way—just watch the video! (Closed captioning is available.)

When you make a purchase, you decide how you want to pay. Would you rather pay cash now, or use credit and pay later?

It's the same idea with the exchange. You get to decide if you'd rather **pay now or pay later**.

How much you pay out of your paycheck is one thing. You also have to consider what you'll pay throughout the year when you need care.

How much you'll pay for medical coverage depends on:

The Amount Of Your Subsidy Credit From Ricoh

All eligible team members will receive a subsidy credit to use toward the cost of coverage.

You'll see the subsidy credit amount from Ricoh and your price options for coverage when you **enroll**.

The Coverage Level You Choose

The Bronze and Bronze Plus coverage levels cost less per paycheck, but you will pay a higher deductible before your coverage kicks in.

The Silver, Gold, and Platinum coverage levels cost more per paycheck, but you'll probably pay less out of pocket for services throughout the year.

Learn more about coverage levels.

The Insurance Carrier You Choose

You can see which insurance carrier offers the lowest paycheck amount for each coverage level. For example, if you know you want a Silver option, you can look to see how much each insurance carrier would charge you for it. **Learn more about insurance carriers.**

Important: Choose an insurance carrier whose network includes providers critical to your care. If you see an out-of-network provider, your medical insurance carrier could pay a much lower benefit—leaving you to pay the rest.

Your Dependents

You can enroll any combination of you, your **eligible** spouse/domestic partner, and your children in the option you choose.

Pay Now or Later?

It's a trade-off. It's up to you to choose which option gives you the best deal on your total health care costs.

Would you rather pay **less** now and **more** when you need care? Or pay **more** now and **less** when you need care?

Pay Less *Now*

The Bronze and Bronze Plus coverage levels cost less per paycheck, but your deductible is higher. That means you'll pay more out of your pocket when you need care.

Make sure you know **how the deductible works**. Also, make sure the deductible amount is something you could afford in the event you need a lot of health care.

TIP: You can save money by enrolling in an **HSA** when you enroll in a Bronze or Bronze Plus coverage level.

Pay Less *Later*

The Silver, Gold, and Platinum coverage levels cost more per paycheck, but your deductible is lower. If you don't expect to have a lot of health care needs, you could be spending money for benefits you don't use.

How to Get the Right Medical Option

Now that you understand the basics, it's time to put it all together. Get confident in your choices—before you enroll—by finding answers to some really important questions. And breathe easy knowing online tools will make it easy to make it yours.

Don't wait. **Get ready** now so when it's time to enroll, you'll have answers to the following questions.

Which Providers Are In The Carrier's Network?

Why It Matters
Seeing out-of-network providers will cost you more—sometimes a lot more. For example, you will have to pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount.

What to Do
Choose an insurance carrier whose network includes providers (e.g., doctors, specialists, hospitals) critical to your care.

Do **not** rely on your provider's office to know the carriers' network(s). To search for providers:

- Check out the **insurance carrier** preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on Your Benefits Resources at **https://digital.alight.com/rus/**. For the best results:
    - Search for your provider by name—not medical practice.
    - Check only the office location(s) you are willing to visit.
    - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! Do **not** rely on your provider's office to know the carriers' network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you can keep your current insurance carrier, the provider network could be different and can change, so always check the provider networks on the carrier preview sites before making a decision.

How Will My Prescription Drugs Be Covered?

Why It Matters
Each medical insurance carrier's pharmacy benefit manager has its own rules about how prescription drugs are covered. To avoid potentially costly surprises, you need to do your homework.

What to Do
If you or a covered family member regularly takes medication, make sure you're comfortable with the carrier's coverage for drugs you and your covered family members need:

- Call the medical **insurance carrier** before you enroll. Get a list of **prescription drug questions** to ask the insurance carriers.

- If you're currently taking a more expensive brand name prescription drug, ask your doctor (or pharmacist) if a generic is available to you.
- When it's time to enroll, you can use the prescription drug search tool to look up your medication, see how it will be classified (Tier 1, Tier 2, Tier 3), and more.

Which Medical Coverage Level Is Best For Me?

Why It Matters
You want to get the right amount of coverage for your needs at the best price. Get help choosing the right level of coverage.

What to Do
If you need help deciding, there are tools to help you:

- Get an overview of your medical **coverage levels**.
- Compare your options side by side when you enroll on Your Benefits Resources at **https://digital.alight.com/rus/**. Just check the boxes next to medical options you want to review and click **Compare**. You can quickly see which options cost more out of your paycheck and which options cost more when you get care. (You may also find Summaries of Benefits and Coverage for comparison on Your Benefits Resources at **https://digital.alight.com/rus/**.)

Which Medical Insurance Carrier Is Best For Me?

Why It Matters
All insurance carriers are different. Each carrier will offer its own price for each coverage level, and you'll be able to see all of the prices in one place on Your Benefits Resources at **https://digital.alight.com/rus/**. (**Note:** The benefits provided under a coverage level will be very similar across carriers, but there could be some differences.)

What to Do
If you need help deciding:

- See how other people rate their health carriers on Your Benefits Resources at **https://digital.alight.com/rus/** anytime.
- Compare the details, when you enroll online, by checking the boxes next to medical options you want to review and clicking **Compare**. That makes it easy to see which carrier is offering you the best deal. (You may also find Summaries of Benefits and Coverage for comparison on Your Benefits Resources at **https://digital.alight.com/rus/**.)
- Browse the carrier preview sites to learn about programs, tools, and other considerations that could influence your decision.

Ready to enroll? **Find out how.**

HSA Basics

An HSA—or Health Savings Account—is a special bank account that you can use when you enroll in a Bronze or Bronze Plus coverage level. If you also have coverage under a second medical plan, it must also be a high-deductible option for you to use an HSA.

It's a great way to save for the future. Just set aside a few dollars from each paycheck now, and then you'll have funds to help cover health care expenses that come up. Plus, it's tax-free, so you're actually getting a better deal.

You can decide if you want to enroll in an HSA when you enroll for benefits. That's a great time to **decide how much to save**.

You can change the amount you save at any time throughout the year.

Why Consider An HSA?

You'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or Bronze Plus coverage level. An HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Let's say you injure your knee playing basketball. With a high deductible, you might worry about how you're going to afford the medical bills.

Now imagine if you had already set aside money for expenses like these. That's where an HSA comes in handy! You could already have the money you need saved up.

An HSA allows you to set aside tax-free money to pay for qualified health care expenses. This includes your medical, dental, and vision copays, deductibles, and coinsurance.

If you want, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit.

It's Tax-Free—And Yours To Keep!

While no one likes taking money out of their paycheck, there are a number of advantages to setting aside a little money in an HSA.

It's tax-free when it goes in. You can put money into your HSA on a before-tax basis through convenient payroll contributions. You'll save money on qualified health care expenses and lower your taxable income.

It's tax-free as it grows. You earn tax-free interest on your money.

It's tax-free when you spend it. When you spend your HSA on qualified health care expenses, you don't pay any taxes. That means you're saving money on your qualified medical, dental, and vision expenses.

It's always your money. You can carry over your unused HSA balance from year to year. Just like a bank account, you own your HSA, so it's yours to keep and use even if you change medical options, leave the company, or retire.

Important! Make sure you use money in your HSA only for qualified health care expenses. Otherwise, you'll pay income taxes on that distribution. You'll also pay an additional 20% penalty tax if you're under age 65.

Wondering what the difference is between an HSA and a Health Care Flexible Spending Account (FSA)? **Find out.**

Questions?

Get answers to your questions, including eligibility rules and what happens if you already have an HSA or FSA.

If you enroll in a Bronze or Bronze Plus coverage level, learn how the HSA works in the **HSA User's Guide** (PDF).

HSA vs FSA

Wondering how an HSA is different from a Health Care Flexible Spending account (FSA)? Here's how:

	HEALTH SAVINGS ACCOUNT	FLEXIBLE SPENDING ACCOUNT
When to Use	You can use the HSA to pay for eligible medical, dental, and vision expenses under the Bronze or Bronze Plus coverage levels.	You can use the Health Care FSA to pay for eligible medical, dental, and vision expenses under any coverage level.
Contributions	You can contribute to your account before taxes. For 2022, the annual limits set by the IRS are $3,650 for individual coverage, and $7,300 for family coverage. If you're age 55 or older (or will turn age 55 during the plan year), you can also contribute an additional $1,000 catch-up contribution.	You can contribute to your account before taxes, up to the $2,850 annual limit.
Fund Availability	You can use up to the total amount you have contributed to your HSA.	The total amount of your annual election is available at the beginning of the plan year.
Rollovers	Unused dollars roll over from year to year. The funds are always yours to keep, even if you leave the company or retire.	Unused dollars **don't** roll over from year to year.
Earning Interest	The money in your HSA earns interest.	The money in your FSA does **not** earn interest.
Debit Cards	Yes, a debit card is available.	Yes, a debit card is available.
Investment Option	You can open an investment account when your balance reaches $1,000.	You cannot invest your FSA balance.

Which Account Should I Use

If you enroll in the Bronze or Bronze Plus coverage level, you can use an HSA, a Health Care FSA, or both an HSA and Health Care FSA. If you contribute to an:

- HSA **or** Health Care FSA, you can use your account to pay for qualified medical, dental, and vision expenses.
- HSA **and** Health Care FSA, your Health Care FSA will be "limited use" and can only be used to pay for qualified dental and vision expenses. However, once you meet the medical plan deductible, then it can be used toward qualified medical expenses as well. Your HSA can be used for qualified medical, dental, and vision expenses.

If you enroll in the Silver, Gold, or Platinum coverage level, you can use the Health Care FSA to pay for qualified medical, dental, and vision expenses.

How Much to Save?

You decide how much money you want to save in your HSA, and you can change it at any time. It's a smart idea to save enough to cover your annual deductible.

For 2022, you can save up to $3,650 if you're covering just yourself, or $7,300 if you're covering yourself and your family. If you're age 55 or older (or will turn age 55 during the plan year), you can also make additional "catch-up" contributions to your HSA up to $1,000.

And if you don't need that much health care, your money stays in your account and earns tax-free interest. It's a great way to save for future expenses.

Note: If you want to, you can elect to contribute after-tax dollars to your HSA through the bank. Your before-tax and after-tax contributions apply to the same annual limit.

Prescription Drugs

This is a really big deal! Your prescription drug coverage will be provided through your insurance carrier's pharmacy benefit manager.

That means your prescription drug coverage depends on the medical coverage level you choose **and** your medical **insurance carrier.**

Your Coverage Level Matters

You pay nothing for preventive drugs, as determined by your insurance carrier. You need a doctor's prescription, and you must use an in-network retail pharmacy or mail-order service.

Bronze or Bronze Plus
You pay the full cost for prescription drugs until you reach the annual medical deductible. Then you pay coinsurance. Once you reach the out-of-pocket maximum, you pay nothing.

Silver, Gold, or Platinum
You pay a copay for all prescription drugs. Once you reach the out-of-pocket maximum, you pay nothing.

Your specific prescription coverage is based on the medical coverage level you select. **Get the details**.

Your Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. So you need to do your homework to find out how your medications will be covered—**before** choosing an insurance carrier.

Get a list of **prescription drug questions** to ask the insurance carriers.

Prescription Drug Questions

Do you or a family member take medications? This could be a big deal for you!

Your prescription drug coverage will be provided through your **insurance carrier's** pharmacy benefit manager. Your prescription drug coverage depends on the **medical coverage level** you choose.

However, each pharmacy benefit manager has its own rules about how prescription drugs are covered. So **you need to do your homework** to find out how your medications will be covered—**before** you choose an insurance carrier.

What To Ask

Here's a list of questions to ask each carrier you're considering.

Tip: You can also print out the **Prescription Drug Transition Worksheet** (PDF) and use it to take notes.

Is my drug on the formulary?
A formulary is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. If your drug isn't listed on the formulary, you'll pay more for it.

How much will my drug cost?
It depends on how your medication is classified by your insurance carrier—Tier 1, Tier 2, or Tier 3. Typically, the higher the tier, the more you'll pay.

While generics typically cost less than brand name drugs, insurance carriers can classify higher-cost generics as Tier 2 or Tier 3 drugs. This means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can find this information on the carrier preview sites. Or you can use the prescription drug search tool when you enroll.

Will I have to pay a penalty if I choose a brand name drug?
Because many brand name drugs are so expensive, some medical insurance carriers will require you to pay the copay or coinsurance of a higher tier—**plus** the cost difference between brand and generic drugs—if you choose a brand when a generic is available.

Is my drug considered "preventive" (covered 100%)?
The Affordable Care Act requires that certain preventive care drugs are covered at 100% when you fill them in-network. But each insurance carrier determines which drugs it considers "preventive." If a drug isn't on the preventive drug list, you'll have to pay your portion of the cost.

Will my doctor have to provide more information before my prescription drug can be approved?
Many insurance carriers require approval of certain medications before covering them. This may apply for costly medications that aren't considered medically necessary.

Will I have a step therapy program?
If this applies to one of your medications, you'll need to try using the most cost-effective version first—usually the generic. A more expensive version will be covered only if the first drug isn't effective in treating your condition.

Are there any quantity limits for my medication?
Certain drugs have quantity limits—for example, a 30-day supply—to reduce costs and encourage proper use.

How do I take advantage of mail-order service?
You'll likely need a new 90-day prescription from your doctor. Mail order can take a few weeks to establish. So it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

We'll Help You Through The Transition

After you enroll, check out things to know **before your benefits start**.

Medicare Basics

Medicare is a federal medical insurance program, which includes Original Medicare. Original Medicare is a low-cost government insurance program that guarantees access to health insurance for Americans age 65 and older and younger people with certain medical disabilities. It pays for many health care expenses, but not all.

How It Works

Medicare covers its share of an approved amount and you pay the rest through deductibles and coinsurance. Original Medicare is made up of two parts:

- **Part A is hospital insurance.** It covers inpatient hospital care, skilled nursing facilities, hospice, lab tests, surgery, and home health care.
- **Part B is medical insurance.** It covers things like clinical research, ambulance services, durable medical equipment, mental health services, limited outpatient prescription drugs, and more.

You are automatically eligible for Medicare Parts A and B when you become Medicare-eligible. If you are receiving Social Security benefits, you may be enrolled in Medicare automatically.

If you have to sign up to get coverage, you can enroll starting three months before the month you turn age 65. The deadline to enroll is three months after the month you turn age 65. (Note: You can wait to enroll in Part B; however, you may have to pay a late enrollment penalty. However, in general, you can wait to enroll in Medicare Part B without facing a late enrollment penalty until your active employment ends or the date your coverage under your employer's plan ends, whichever occurs first. Consult your Medicare advisor for more details.)

Part D is optional prescription drug coverage. You can enroll in Part D if you want coverage to help pay for your prescription drug costs.

How Medicare Works With Company Coverage

If you are actively employed, your company's health plan will be your primary medical coverage, and, if you choose to enroll in Medicare, Medicare will be your secondary coverage. Please note, once you are enrolled in any part of Medicare (Parts A or B), you can no longer make contributions to an HSA, even if you are also covered by an HSA-eligible medical plan.

If you are retired and have coverage through your previous employer, Medicare will be your primary medical coverage, and your company's health plan will be your secondary coverage.

As you prepare to transition to Medicare, you will want to understand if your dependents under age 65 will be eligible for coverage under your company's health plan. To understand your options, contact Benefits Express at **1.800.953.2526** from 8:00 a.m. to 4:00 p.m. CT, Monday through Friday.

How Medicare Works With COBRA

If you are eligible for Medicare Parts A and B but you choose to not enroll in Medicare Parts A and B, you may face potentially significant out-of-pocket expenses. COBRA coverage pays secondary to Medicare Parts A and B. Therefore, the plan will pay as if Medicare has already made a payment, even if the Medicare-eligible individual did not actually enroll in Medicare.

If your Medicare benefits (Parts A or B) become effective on or before the day you elect COBRA coverage, you can have COBRA and Medicare coverage. This is true even if your Part A benefits begin before you elect COBRA coverage but you don't sign up for Part B until later.

If you become entitled to Medicare after you've signed up for COBRA coverage, your COBRA coverage may be terminated by your plan as of the day you enroll in Medicare. (But if COBRA covers your spouse and/or dependent children, their coverage may continue.)

To Learn More

Start **here** (PDF) to better understand Medicare, your options, impacts to your current coverage, and more. Below are resources where you can find additional information and help:

- Visit **Alight Retiree Health Solutions** or call **1.833.791.0780**
- Visit the **Social Security website** or call **1.800.772.1213** (TTY **1.800.325.0778**) between 8:00 a.m. and 7:00 p.m. Monday through Friday
- Review the **Medicare & You** handbook from the Centers for Medicare & Medicaid Services

Accident Insurance

Accidents can slam your wallet too.

Even with medical coverage, your costs related to an accident can be hefty. Depending on the injury, you may be faced with copays, deductibles, hospital charges, transportation fees, and lodging expenses.

Accident insurance pays a benefit in the event you or a family member covered under this plan is in an accident. Accident insurance is not a replacement for medical coverage.

You can learn more about this coverage **here**.

Things To Consider

When deciding whether to enroll in accident insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through Your Benefits Resources at **https://digital.alight.com/rus/**.

Your and Your Family's Needs
Does your family lead an active lifestyle? Have you or an eligible family member suffered financial loss resulting from an accident? If you answered "yes" to either question, having accident insurance could give you peace of mind.

Other Coverage
Consider how accident insurance could fit in with other coverage for which you might enroll.

Critical Illness Insurance

When illness strikes, you can strike back. If you experience a serious health condition in the future, critical illness coverage can help lighten the load.

Even with medical insurance, a serious health condition could cost you. Critical illness insurance can provide you with extra cash when you need it most—if you or a family member once covered under this plan is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage renal disease).

You can learn more about this coverage **here**. Critical illness coverage has limitations and exclusions.

Choose Your Coverage Level

If you decide you want critical illness coverage, you may choose $10,000, $20,000, $30,000 or $40,000 of coverage.

Things To Consider

When deciding whether to enroll in critical illness insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover, age, tobacco status, and the level of coverage you elect. You'll be able to see the cost per paycheck for all your options when you enroll through Your Benefits Resources at **https://digital.alight.com/rus/**.

Your and Your Family's Needs
Does a serious health condition run in your family? Would you need financial help to offset the cost of a serious health situation? If you answered "yes" to either question, having critical illness insurance could give you peace of mind.

Hospital Indemnity Insurance

Even with medical insurance, hospital stays can be costly. You may have copays, deductibles, and other incidental hospital charges that add up. That's why you can buy extra insurance through hospital indemnity coverage.

Hospital indemnity insurance pays you a single lump-sum benefit in the event you or a family member covered under this plan is hospitalized. The benefit is based on the type of hospital stay.

You can learn more about this coverage **here**.

Things To Consider

When deciding whether to enroll in hospital indemnity insurance, be sure to consider the following:

Cost per Paycheck
The cost of coverage is based on who you cover. You'll be able to see the cost per paycheck when you enroll through Your Benefits Resources at **https://digital.alight.com/rus/**.

Your and Your Family's Needs
Does a serious health condition run in your family? Are you or an eligible family member frequently hospitalized? If you answered "yes" to either question, having hospital indemnity insurance could give you peace of mind.

Vision Coverage Level

Which Coverage Level Is Best?

You get to choose how much coverage you need and how you want to pay for it. It's up to you! When you choose your coverage level, you get to pick the one with the features you want.

Your coverage level determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care. Make sure to take your **total** costs into consideration when choosing a coverage level.

Don't let the names of the coverage levels fool you. One option isn't better than another. The coverage levels are designed to give you choices. It's up to you to find the one that makes sense for your situation.

Vision Coverage Level Options

	BRONZE	SILVER	GOLD
		In-Network Benefits	
Routine vision exam (once per plan year)	Covered 100%	You pay $20	You pay $10
Frames (once per plan year)	Discount may apply	$130 allowance[1]	$200 allowance[1]
		Lenses (once per plan year; premium lenses may cost more)	
Single vision	Discount may apply	You pay $20	You pay $10
Bifocal	Discount may apply	You pay $20	You pay $10
Trifocal	Discount may apply	You pay $20	You pay $10
Standard Progressive[2]	Discount may apply	You pay $20	You pay $10
Lenticular	Discount may apply	You pay $20	You pay $10
		Lens Enhancements	
UV treatment	Discount may apply	You pay $15	You pay $15

Tint (solid and gradient)	Discount may apply	You pay $15	You pay $15
Standard plastic scratch-resistant coating	Discount may apply	You pay $15	You pay $15
Standard anti-reflective coating	Discount may apply	You pay $45	You pay $45
Standard polycarbonate (adults)	Discount may apply	You pay $40	You pay $15
Standard polycarbonate (children)	Discount may apply	You pay nothing	You pay nothing
Other add-ons	Discount may apply	Discount only	Discount only
Contact Lenses			
Medically necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$130 allowance[1]	$200 allowance[1]
Fit and evaluation	Discount may apply	You pay $20	You pay $10
Laser Surgery			
Elective	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

[1]Allowance can be used for frames or elective contact lenses, but not both.

[2]Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.

These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this site and the official plan documents, the official plan documents will control.

These charts are a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. They are intended to provide you with a snapshot of benefits provided across coverage levels. In general, carriers have agreed to the majority of standardized plan benefits recommended by the exchange.

For a more detailed look at these and additional coverages, go to Your Benefits Resources at https://digital.alight.com/rus/. It does account for any carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the options you want to review and click **Compare**. In order to get the most comprehensive information about any specific coverage, you will need to call the carrier directly.

Note: For additional comparison, you may find Summaries of Benefits and Coverage on Your Benefits Resources at https://digital.alight.com/rus/.

Vision Price

Find the right balance between what you pay out of your paycheck and what you pay when you get care.

When you make a purchase, you decide how you want to pay. Would you rather pay cash now or use credit and pay later? It's the same idea with the exchange.

Just like your medical coverage, your vision coverage costs will depend on a few factors:

The Coverage Level You Choose

The Bronze option will generally be less expensive per paycheck. That's because it covers only exams with some in-network discounts available. The Silver and Gold options will cost more per paycheck and provide coverage for exams as well as frames and lenses.

The Insurance Carrier You Choose

Certain insurance carriers may be able to provide a more competitive price per paycheck.

Your Dependents

You can enroll any combination of you, your **eligible** spouse/domestic partner, and your children in the option you choose.

Dental Coverage

Both PPO and DMO options are available. Make sure you understand the differences so that you can choose the type that's best for you and your family.

Cigna Dental PPO Options

Cigna will be the dental plan administrator for the dental PPO options. You'll pay the cost of dental coverage with before-tax dollars. In an effort to provide team members with both choice and flexibility, Ricoh will offer two dental PPO options—the Dental PPO Plus and the Dental PPO preventive option—both of which are administered by Cigna. By taking advantage of discounted rates through Cigna network dentists, the dental PPO allows Ricoh and team members to more effectively manage dental costs. Under these "active" PPO dental options, receiving care from a Cigna dentist results in lower out-of-pocket costs for you due to higher coinsurance percentages paid by the insurance carrier and in-network discounted rates. Although you may still choose to receive dental care from any dentist, if you receive care from an out-of-network dentist, you will pay higher out-of-pocket costs. Like your medical coverage, choosing dental coverage is a personal decision. As you make this decision, take a look at the highlights and the different deductibles and coinsurance amounts of the dental PPO options.

	CIGNA DENTAL PPO	
	In-Network (Total Cigna DPPO)	**Out-of-Network**
Individual deductible	You pay $50	You pay $100
Family deductible	You pay $150	You pay $300
Calendar Year Benefits Maximum*	Year 1: $1,000 Year 2: $1,125 Year 3: $1,250 Year 4: $1,375	Year 1: $1,000 Year 2: $1,125 Year 3: $1,250 Year 4: $1,375
Preventive & Diagnostic services	You pay 0%	You pay 10% after deductible
Basic Restorative	You pay 20% after deductible	You pay 30% after deductible
Major Restorative	You pay 70% after deductible	You pay 75% after deductible
Orthodontia	Not covered	
Orthodontia deductible	Not applicable	
Orthodontia lifetime maximum the plan will pay	Not applicable	

*Progressive Benefit Year 2: Increase contingent upon receiving Preventive Services in Plan Year 1.
*Progressive Benefit Year 3: Increase contingent upon receiving Preventive Services in Plan Years 1 & 2.
*Progressive Benefit Year 4: Increase contingent upon receiving Preventive Services in Plan Years 1, 2 & 3.

	CIGNA DENTAL PPO PLUS	
	In-Network (Total Cigna DPPO)	**Out-of-Network**

Individual deductible	You pay $50	You pay $100
Family deductible	You pay $150	You pay $300
Calendar Year Benefits Maximum*	Year 1: $1,500 Year 2: $1,625 Year 3: $1,750 Year 4: $1,875	Year 1: $1,500 Year 2: $1,625 Year 3: $1,750 Year 4: $1,875
Preventive & Diagnostic services	You pay 0%	You pay 10% after deductible
Basic Restorative	You pay 20% after deductible	You pay 30% after deductible
Major Restorative	You pay 50% after deductible	You pay 60% after deductible
Orthodontia	You pay 50% after deductible	You pay 60% after deductible
Orthodontia deductible	Refer to individual/Family deductible	
Orthodontia lifetime maximum the plan will pay	$1,500	

*Progressive Benefit Year 2: Increase contingent upon receiving Preventive Services in Plan Year 1.
*Progressive Benefit Year 3: Increase contingent upon receiving Preventive Services in Plan Years 1 & 2.
*Progressive Benefit Year 4: Increase contingent upon receiving Preventive Services in Plan Years 1, 2 & 3.

Preventive & Diagnostic Services

- Oral Evaluations
- Prophylaxis: routine cleanings
- X-rays: routine
- X-rays: non-routine
- Fluoride Application
- Sealants: per tooth
- Space Maintainers: non-orthodontic
- Emergency Care to Relieve Pain

Basic Services

- Restorative: fillings
- Endodontics: minor and major
- Periodontics: minor and major
- Oral Surgery: minor and major
- Anesthesia: general and IV sedation
- Repairs: Bridges, Crowns and Inlays
- Inlays and Onlays

Major Services

- Prosthesis Over Implant
- Crowns: prefabricated stainless steel / resin
- Crowns: permanent cast and porcelain
- Bridges and Dentures
- Repairs: Dentures
- Denture Relines, Rebases and Adjustments

Orthodontia

- Orthodontia, up to lifetime maximum

For Children

- One fluoride treatment annually; sealants

You are encouraged to submit a pre-treatment estimate if you expect to have dental work for which charges are anticipated to exceed $250.

Both dental PPO options allow you to take advantage of network discounts and get more benefit for theannual maximum by using a Cigna network dentist. You are not required to use a Cigna network dentist; however, if you do not, you will pay more in out-of-pocket expenses under either of the dental PPO options.

The Cigna network of dentists is extensive and includes over 72,000 dentists across the country. Detailed access studies indicate that over 90% of Ricoh's team members live within 10 miles of at least two dentists in the Cigna network. To locate a Cigna dentist in your area, you can access the Cigna website at **www.cigna.com**. Click on "Find a Doctor" and be sure to search under "Dental: Total Cigna DPPO Network". You can also find providers using Provider Direct on the Your Benefits Resources website.

ID Cards will not be provided to members of the Cigna dental plans. When visiting your dentist, provide them with a Cigna dental claim form, which includes Ricoh's Cigna plan number. This Cigna claim form is available on RWorld and on **http://mycigna.com**.

Aetna Dental DMO Option

Aetna will be the carrier for the Dental DMO option. The Aetna Dental DMO option provides benefits for the same services that are covered under the Dental PPO options, but at a significantly lower out-of-pocket cost as long as you use a dentist that participates in the Aetna Dental DMO network.

FEATURE	IN-NETWORK	OUT-OF-NETWORK
Deductible	$0	Not Covered
Annual maximum	$0	Not Covered
Preventive services	Covered 100%	Not Covered
Basic services	Covered 100%	Not Covered
Major services	You pay 40%	Not Covered
Orthodontia	You pay 50%	Not Covered

The Aetna Dental DMO may be available to you depending on where you live. When you log in to Your Benefits Resources (YBR), you will see if the Aetna Dental DMO is available to you in your area. To locate an Aetna dentist in your area, you can access the Aetna website at **https://www.aetna.com/** or call them at **1.855.496.6289**.

Like a medical HMO option, if you elect coverage under the Aetna Dental DMO option you must seek dental care only from a dentist that participates in the Aetna Dental DMO network. In addition, you must elect a Primary Care Dentist (PCD) for each covered member of your family in order to access dental care. Failure to elect a PCD may result in claims being denied. Before you choose the Aetna Dental DMO option, you should check Aetna's online dental provider directory for a list of local participating dentists.

When you enroll in the Aetna Dental DMO, you must select a primary dentist. If you do not, you will not receive an ID card and claims may be denied.

If you select a dentist when you enroll, you will receive an ID card in the mail within the first few weeks of January.

No out-of-network benefits are paid through the Aetna Dental DMO.

The summary above describes only the Aetna Dental DMO option. A few other non-Aetna dental DMOs with slightly different plan designs are available in different locations across the U.S. For information on these other DMO options, please refer to the specific information listed on the Your Benefits Resources website.

This overview serves as a summary on various Ricoh 2021 benefit plans. It is intended to provide an overview of information about some of the benefits you may be eligible for through Ricoh. If there is a discrepancy between the information displayed and the official plan documents, the official plan documents will govern.

Flexible Spending Accounts (FSAs)

By using the Flexible Spending Accounts (FSAs), you can save on health care or dependent day care expenses by setting aside pre-tax dollars. You can contribute from $60 to $2,850 to the Health Care FSA and from $60 to $5,000 to the Dependent Day Care FSA ($2,500 if you are married and you and your spouse file separate income tax returns).

If you wish to contribute to a Health Care Flexible Spending Account and/or the Dependent Day Care Flexible Spending Account, you must make an active election every year. Elections **DO NOT** automatically roll over from year to year.

You can only use your FSA funds for eligible expenses incurred during the plan year. If you do not use all of the money in your FSAs for expenses that you incur before the end of the plan year, you lose it. Please be sure to anticipate your costs and FSA contributions carefully!

No Mid-Year Changes

If you elect to contribute to one or both of the FSAs, you will be allowed to stop contributing only if you experience a qualifying life event during the year. You'll have **31 days** from the date of your life event to stop contributions to your FSAs. Although you can't restart your contributions once you stop them, you can continue to receive reimbursements for eligible expenses incurred up to the point you stopped contributions.

Health Care FSA

The Health Care FSA allows you to reduce your taxable income and reimburse yourself for out-of-pocket medical, dental and vision costs for you and all your eligible dependents. You can elect to contribute from **$60 to $2,850** a year to the account.

NOTE: If you live in the U.S. mainland, enroll in the Bronze or Bronze Plus medical option, and elect to contribute to a Health Savings Account (HSA), money contributed to the Health Care FSA cannot be used for medical expenses until you meet your combined medical and prescription drug deductible. FSA money may only be used for dental and vision expenses, and for unreimbursed medical and prescription expenses after your deductible is met. (If you live in Hawaii, this note does not apply to you.)

A list of eligible expenses can be found on the Your Benefits Resources website at https://digital.alight.com/rus.

Call **1.800.953.2526** if you have questions regarding eligible Health Care FSA expenses. The Alight Smart-Choice Accounts section of the Your Benefits Resources website will provide you with additional information regarding FSAs.

Dependent Day Care FSA

The Dependent Day Care FSA reimburses you for certain dependent day care expenses, provided that you (and your spouse, if you're married) work full-time.

The Dependent Day Care FSA helps you pay for dependent day care expenses—for your child or a disabled spouse or parent—with tax-free dollars. You can elect to contribute from $60 to $5,000 to the Dependent Day Care FSA ($2,500 if you are married and you and your spouse file separate income tax returns).

Eligible dependents for the Dependent Day Care FSA include:

- Children under age 13; or
- Dependents of any age that depend on you for more than half of their support and cannot care for themselves

Please note, if you are considered a highly compensated employee (HCE) in 2021, your Dependent Day Care FSA will be limited to $2,100. For 2022, you are considered "highly compensated" if you had gross earnings of $130,000 or more in 2021.

Using the Dependent Day Care FSA to fund expenses for the care of your family during the workday can also save you money in taxes, because your contribution dollars are deducted from your pay on a before-tax basis. Reimbursements for Dependent Day Care FSA expenses are made based on contributions made to date.

The types of expenses that can be reimbursed through the Dependent Day Care FSA include:

- Charges for dependent day care services at home or in a day care facility;
- Housekeeping expenses if a portion of these services is directly related to caring for the dependent; and
- Education expenses for children in nursery school.

For a complete listing of eligible expenses, please visit the Alight Smart-Choice Accounts section of the Your Benefits Resources website.

About the Dependent Day Care Federal Tax Credit

The Dependent Day Care FSA is an alternative to the dependent day care federal tax credit on your federal income tax return. As a result, federal law precludes you from using the same expenses for both purposes. Instead, federal law requires that the money you set aside in your Dependent Day Care FSA lowers—dollar for dollar—the amount you can apply toward the dependent care tax credit. The Dependent Day Care FSA is usually more advantageous to you if your household income is more than $24,000. Because every individual tax situation is different, you may want to consult a financial advisor to determine the best approach for you.

What You Can't Use a Dependent Day Care FSA for:

- Babysitting during non-working hours;
- Care by providers who don't supply a taxpayer identification number (Social Security number or employer identification number);
- Care by a family member who is under age 19 or someone you claim as a dependent on your tax return;
- Education costs for children in kindergarten or higher convalescent nursing home expenses; and
- Dependent health care expenses.

FSA Administrator

Benefits Express, through its **Alight Smart-Choice Accounts** website, is Ricoh's FSA administrator.

The Alight Smart-Choice Accounts Website

You'll find useful information and tools to help you manage your FSA account(s) through the Alight Smart-Choice Accounts website. Among the features of this website, you'll be able to:

- Submit your FSA claims and review FSA claim status;
- Learn about eligible FSA expenses;
- Check your current FSA balance(s); and
- Get information about the new Health Care FSA debit card program.

The Alight Smart-Choice Accounts website is available 24 hours a day, seven days a week from any computer with Internet access. You can access the site via a link from the Your Benefits Resources website.

The Health Care FSA Debit Card Program

If you enroll in the Health Care FSA for the first time for at least $100, you will receive an Alight Smart-Choice Accounts debit card, which is a special Mastercard debit card that you can use to pay for eligible health care expenses. Using the debit card is easy and more convenient than submitting claim forms because your eligible health care expenses will be deducted automatically from your Health Care FSA. Be sure to retain all receipts for your health care spending account purchases as supporting documentation may be required.

More Information

After you complete your OnePlus enrollment elections and elect to contribute to a Health Care FSA for the first time, detailed information regarding the Health Care FSA debit card program will be mailed to your home address. Please note that the debit card program is only available for the Health Care FSA; it is not available for use with the Dependent Day Care FSA. You must elect at least $100 into your Health Care FSA to be issued a debit card.

Keep in mind that you are not permitted to transfer dollars between flexible spending accounts. Once designated for the Health Care FSA or Dependent Day Care FSA it must remain in that account.

Life Insurance

Life insurance is available for yourself, your spouse, and your children.

Employee Life and Supplemental AD&D coverage

OnePlus offers basic life and basic Accidental Death and Dismemberment (AD&D) insurance and supplemental life and AD&D coverage designed to provide you with different levels of financial protection and security. It's up to you to choose the level of life insurance/AD&D coverage that suits your specific needs. As you make your choice, you should consider any life insurance/AD&D coverage you have outside of Ricoh.

Ricoh pays for your basic employee life and AD&D insurance coverage in an amount equal to one times your Annualized Benefits Salary (ABS) to a maximum of $100,000. If you desire a higher level of life insurance/AD&D coverage, you can elect supplemental coverage of up to seven times your Annualized Benefits Salary, to a maximum of $1 million of coverage. Please note that for voluntary coverage amounts of $600,000 or more, you'll need to provide proof of good health by completing an Evidence of Insurability form.

MetLife will be Ricoh's employee life and AD&D carrier.

Annualized Benefits Salary

Annualized Benefits Salary (ABS) is the pay that is used to determine your employee life and AD&D insurance coverage, disability coverage, and medical subsidy credit each year. For 2022, the ABS is calculated by adding your base salary and commissions from October 1, 2020 through September 30, 2021. For new hires, Annualized Benefits Salary is based on the base salary plus commissions at hire date, rounded to the next $1,000.

Bonuses are not included in the calculation of ABS.

Once your ABS and the salary band is determined in September, it becomes effective as of January 1 and remains in effect throughout the year.

Reductions to Employee Life Coverage

	WHEN YOU REACH AGE:	YOUR COVERAGE IS REDUCED BY:
Employee life and AD&D insurance coverage is automatically reduced over time beginning at age 65 according to the chart:	65	25%
	70	50%
	75	75%

Each year, reductions are based on your Annualized Benefits Salary and your elected coverage level and rounded to the next $1,000. For example, if you reach age 65 in 2022, your 2022 elected coverage amount will be reduced by 25%. The premium you pay for any supplemental employee life and AD&D coverage will be based on the coverage amount after the applicable age reduction.

Evidence of Insurability

If your supplemental employee life/AD&D coverage election equals $600,000 or more, you will need to complete an Evidence of Insurability form. This form will be sent to you by MetLife shortly after you enroll. If your Evidence of Insurability form is approved by MetLife, the coverage you've elected will take effect on the first of the month following the date of approval. Until then, you will receive the next multiple level you elected under $600,000. You must be actively employed as of January 1 to receive employee life and AD&D insurance coverage in 2022. If you enroll, but are not actively employed as of January 1, 2022—you are on a leave of absence, for example—any benefits payable to you or your beneficiary will be based on the coverage amount in effect in 2021. Once you return to active employment in 2022, your 2022 coverage amounts will take effect provided you made all required premium payments during your leave.

Spouse and Dependent Life Options

The spouse and dependent life insurance options are designed to help you meet the expenses associated with a family member's death. If you elect either of these insurance coverages, you are automatically the beneficiary.

Spouse Life Options

- No Coverage
- $25,000 option
- $50,000 option
- $75,000 option*
- $100,000 option*

Dependent Life Options

- No Coverage
- $10,000 per child

If your spouse and/or dependent is employed by Ricoh, they are not eligible to be covered under spouse and dependent life insurance options.

A Word About Taxes

The IRS requires that the value of life insurance over $50,000 and spouse and dependent life coverage be added to your taxable income as imputed income. If you elect either of these options, imputed income applies to the difference, if any, between IRS rates and the amount you pay for the coverage. You will see this listed on your paycheck as "Imputed Income."

* Spouse life insurance over $50,000 will be subject to approval with an Evidence of Insurability (EOI) form. In such a case, spouse life insurance will take effect as of the first of the month after the EOI form is received and approved. Until the coverage is approved, you will receive the highest coverage available or $50,000.

This overview serves as a summary on various Ricoh 2022 benefit plans. It is intended to provide an overview of information about some of the benefits you may be eligible for through Ricoh. If there is a discrepancy between the information displayed and the official plan documents, the official plan documents will govern.

Disability

Recuperating from surgery? Having a baby? From short-term absences to serious illnesses or injuries that prevent you from working for years, coverage is available.

Short-Term Disability (STD)

If you are going to be absent from work for more than seven days because of maternity or a non-occupational injury or sickness, you may be entitled to STD benefits. However, your disability must be certified by a qualified physician and approved by Ricoh's disability insurance carrier before STD benefits are paid.

MetLife will be Ricoh's short-term disability carrier. Ricoh pays the full cost of basic STD benefit coverage. Basic STD coverage is equal to **50%** of your Annualized Benefits Salary (ABS) and payable for 26 weeks while you are disabled. You may also choose to increase your income protection and elect to purchase, at your cost, supplemental STD coverage (Buy-Up coverage) for the higher monthly maximums, as summarized below:

STD Options

STD Basic Benefit Option (50% ABS): Maximum weekly benefit of $1,500 for up to 26 weeks
STD "Buy-Up" Option (66.67% ABS): Maximum weekly benefit of $4,000 for up to 26 weeks

Any STD benefits you receive under OnePlus will be reduced by Social Security disability benefits and other similar benefits, such as worker's compensation, that you may be eligible to receive while you are disabled.

The STD Plan contains a pre-existing condition exclusion that limits the eligibility of certain team members to receive STD benefits.

For newly hired team members, this pre-existing exclusion period includes the 30 days prior to employment by Ricoh. If a team member suffers a disability during the first 12 months after STD coverage becomes effective that is determined to be a pre-existing condition, this disability will not be covered under the STD Plan. For current team members, the pre-existing condition exclusion applies to any team member who elects STD Buy-Up coverage, **but it applies only to the additional STD Buy-Up coverage**. For example, a team member with a pre-existing condition based on treatment received anytime during the three months just prior to January 1 will not be eligible for any STD Buy-Up coverage for that disability related to the pre-existing condition, but rather will receive STD benefits at the basic coverage level for that disability.

Long-Term Disability (LTD)

If you become disabled, you may be eligible to receive LTD benefits after the first 180 days of the disabling condition. Your disability will need a qualified physician's certification and approval by Ricoh's disability insurance carrier, before LTD benefits are paid. Ricoh pays the full cost of basic LTD benefit coverage. Basic LTD coverage is equal to 50% of your Annualized Benefits Salary to certain maximum monthly benefits, depending on your length of service with Ricoh. You may elect to purchase, at your cost, supplemental LTD coverage (Buy-Up coverage) equal to 66.67% of Annualized Benefits Salary to a higher maximum monthly benefit. Any LTD benefits you receive under OnePlus will be reduced by Social Security disability benefits and other similar benefits, such as worker's compensation, that you may be eligible to receive while disabled. MetLife will be Ricoh's long-term disability carrier.

A Summary of LTD Benefits

The LTD plan also contains a pre-existing condition exclusion that limits the eligibility of certain team members to receive LTD benefits.

For newly hired team members who become eligible for LTD benefits, pre-existing condition exclusion is also in place under the LTD plan. For current team members, the pre-existing condition exclusion applies to any team member who elects LTD Buy-Up coverage, but it applies only to the additional LTD Buy-Up coverage. Team members who receive any treatment just prior to January 1 will not be covered for any LTD Buy-Up coverage for that disability related to the pre-existing condition, but rather will receive LTD benefits at the basic coverage level for that disability.

You must be actively employed as of January 1, 2022 to receive STD and LTD coverage in 2022. If you enroll for 2022, but are not actively employed as of January 1, 2022—you are on a leave of absence, for example—any benefits payable to you or your beneficiary will be based on the coverage amount in effect in 2021. Once you return to active employment in 2022, your 2022 coverage amounts will take effect provided you made all required premium payments during your leave.

LTD Options

LTD Basic Benefit Option: 50% of ABS with a maximum monthly benefit of $5,000
LTD "Buy-Up" Option: 66.67% of ABS with a maximum monthly benefit of $11,000

Imputed Income for Disability

The IRS requires that the value of STD and LTD benefits be added to your taxable income as imputed income. This allows you to receive this benefit tax free if you ever need to use it. You will see this listed on your paycheck as "Imputed Income."

Pre-Existing Conditions and Disability

For the STD and LTD plans, a pre-existing condition is any medical condition for which you have received medical treatment, medical advice, care or services, including diagnostic measures, or for which you took prescribed drugs or medicines in the three months immediately prior to the effective date of coverage.

This overview serves as a summary on various Ricoh 2022 benefit plans. It is intended to provide an overview of information about some of the benefits you may be eligible for through Ricoh. If there is a discrepancy between the information displayed and the official plan documents, the official plan documents will govern.

Legal Services

Group legal coverage does not roll over from year to year. If you want coverage under the MetLife Legal Plan, you will need to elect coverage during enrollment. If you elect to join the MetLife Legal Plan, coverage will begin January 1 and remain in effect through December 31. If you choose to join the MetLife Legal Plan, you must participate for the full year.

Group Legal Plan

The MetLife group legal plan is available to all OnePlus eligible team members during annual enrollment this year.

Most people don't have an attorney, fear the high cost of legal fees and don't know how to find an attorney if they have a legal issue. The MetLife Legal Plan provides you with easy access to pre-qualified attorneys and covers most personal legal matters. The MetLife Legal Plan provides legal assistance in connection with:

- Preparation of estate planning documents, including simple and complex wills, trusts, living wills and powers of attorney;
- Real estate matters, including the purchase or sale of a home, refinancing a home, tenant negotiations and property tax assessments;
- Financial matters, including personal bankruptcy, debt collection and identity theft;
- Traffic violations, excluding DUI;
- Family law matters, including adoption assistance and premarital agreements; and
- Consumer protection matters, including small claims assistance.

Note: Please be advised that no employment-related matters are covered by the MetLife Legal Plan.

Under the MetLife Legal Plan, participating team members and their eligible OnePlus dependents are provided with telephone and office consultations for an unlimited number of covered legal matters, and all covered matters are 100% paid for by the plan. MetLife has an extensive network of pre-qualified attorneys, allowing participants in the MetLife Legal Plan to choose from over 9,000 attorneys across the country.

The cost of the MetLife Legal Plan is fully paid for by you, if you elect to participate. The cost is $7.62 per bi-weekly pay period ($16.50 per month) and is automatically deducted from your paycheck on an after-tax basis.

Even if you don't anticipate needing legal assistance, you should still consider whether the MetLife Legal Plan is right for you in the event of an unexpected situation.

Identity Theft Protection

Victims of identity theft spend countless hours trying to sort out the damage.

Identity theft protection could help you catch fraud in its early stages through 24/7 monitoring of your personal and financial information. It can also help you act quickly to limit damage if your personal or financial information is stolen.

For more information, you can visit **www.myaip.com/exchangepap** or call **1.800.789.2720**.

Identity theft protection is a voluntary benefit administered by Allstate Identity Protection. The plan covers all eligible family members. And you can drop coverage at any time during the year.

Things To Consider

When deciding whether to enroll in identity theft protection, be sure to consider the following:

Cost per Paycheck
You'll be able to see the cost per paycheck when you enroll.

Your Risk Factors
While everyone has risk, some people are at greater risk than others. Have you used credit cards on unsecure websites? Do you make online purchases regularly? If you answered "yes" to either question, having identity theft protection could give you peace of mind.

Vacation Purchase Program

Ricoh will continue to offer a Vacation Purchase Program (VPP) during benefits open enrollment to all team members except those residing in the state of California. The VPP will allow team members to purchase from one to five additional vacation days on a before-tax basis during annual enrollment. Purchased days will be available for use on January 1, 2022 and must be used by December 31, 2022 or will be forfeited.

The cost for purchased days will be determined by dividing your annual base pay as of September 30, 2021 by 260 working days, with the cost to you being deducted from your pay over the course of 2022. Additional vacation days purchased through the VPP will be tracked as Vacation Purchase Program days through the applicable payroll recordkeeping system. Managers of team members who elect to purchase additional vacation days will be informed of the number of days purchased for each direct report and will be expected to track these days appropriately.

If the team member under the Sample Calculation below elected to purchase an additional five vacation days through the VPP, $28.85 would be deducted on a before-tax basis from each bi-weekly paycheck in 2022.

If you are a part-time team member, your calculation will be based on the number of hours you are scheduled to work in a year.

The VPP is a completely voluntary benefit that can be used at your discretion and is a “use it or lose it” program. **Any days not used at the end of the year or upon termination will not be paid out and will be forfeited.** As always, team members who elect additional vacation days are required to work with their Manager in scheduling when any additional vacation days are to be used before December 31, 2022.

Sample Calculation

Below is a sample calculation of the cost of purchasing additional vacation days based on an annual base pay as of September 30, 2021 of $39,000:

= Annual base pay ÷ 260

= $39,000 ÷ 260

= $150 for 1 day of vacation

Total cost for five additional vacation days through the VPP:

= $150 x 5 days

= $750 Total

Important Considerations

- If you wish to purchase VPP days, you must make an active election to do so. Elections you made for the current year will NOT be automatically rolled over.
- Team members with a vacation excess bank of eight hours or more are NOT eligible to participate in the Vacation Purchase Program.

How to Enroll

Log on to Your Benefits Resources at **https://digital.alight.com/rus/** to enroll in your benefits for 2022.

Logging on for the first time? From Your Benefits Resources, register as a new user and follow the prompts to provide requested information and set up your username and password.

Following your enrollment, you may still need to take action. If you do, the required follow-ups will appear on a confirmation page.

There are also things you should do to set yourself up for success **after you enroll**.

Questions?

Start with the **Frequently Asked Questions** (PDF). If you still have questions, you can reach a customer service representative through Your Benefits Resources at **https://digital.alight.com/rus/**. You can also call Benefits Express at **1.800.953.2526** from 8:00 a.m. to 4:00 p.m. CT Monday through Friday. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

Actions After You Enroll

Now that you've enrolled, it's time to focus on the road ahead. And there are things you need to do **now** to use your benefits successfully when they take effect.

Here's your to-do list:

Know How Your Prescription Drug Plan Works

Your prescription drug coverage is provided through your medical insurance carrier's pharmacy benefit manager, who sets the rules for how medications are covered. Don't be caught by surprise! Visit your carrier's website for information about your medications. And, check out the **Prescription Drug Transition Worksheet** (PDF) for tips and questions you may need to ask your carrier.

Check the Formulary

A **formulary** is a list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. **Check with your carrier** to make sure your drug is listed on the formulary **before** you fill it. If it isn't, you'll pay more.

Go Generic

Generic drugs meet the same standards as brand name drugs, but they **typically** cost less. And, because brand name drugs can be expensive, some carriers don't cover them **at all** if a generic is available. Ask your doctor if a generic drug is available for you.

Mail-Order Setup

Mail-order service can save you a trip to the pharmacy and may reduce your costs. To set up mail order with a new medical insurance carrier, you'll likely need a new 90-day prescription from your doctor. Because mail-order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime.

Track your to-dos and get organized! Print the **Prescription Drug Transition Worksheet** (PDF).

"Transition Of Care" Setup

Are you or a covered family member pregnant? Will you or your covered family member continue needing treatment for an ongoing medical condition?

If you will have a new medical insurance carrier and you answered "yes" to either question, you may be able to temporarily continue that care with your current provider once your **new** medical coverage begins. This is true even if your provider isn't in the new insurance carrier's network.

If you think this applies to you, **call customer service** at your **new** medical insurance carrier as soon as possible to ask for help with "transition of care."

Give your new insurance carrier information about your treatment and the providers you use today.

Track your to-dos and get organized! Print the **Transition of Care Worksheet** (PDF).

Avoid Unexpected Out-Of-Network Costs

It's very important to know whether your doctor participates in your medical insurance carrier's network.

You Could Pay a Lot More for Out-of-Network Care

Your medical insurance carrier could pay a much lower benefit if you see an out-of-network doctor—leaving you to pay the rest.

For instance, you will pay more through a higher out-of-network deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum.

Each medical insurance carrier can determine its maximum allowed amounts for out-of-network providers. For example, among other ways, carriers may use what's considered "reasonable and customary" and/or a Medicare-based calculation to determine the maximum allowed amount.

Example
For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 45% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 45% of $2,000 and 100% of the remaining $3,000, for a total of $3,900.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 45% of $3,000 and 100% of the remaining $2,000, for a total of $3,350.

Take These Steps to Protect Yourself

If you *didn't* check your doctor's status before you enrolled or you want to look up a different doctor, do it *now*—before making an appointment with that doctor.

You can check the provider directory through Your Benefits Resources at **https://digital.alight.com/rus/** or your medical insurance carrier's website.

Important! Do not rely on your provider's office to know the carriers' network(s). If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

Even if you're keeping the same insurance carrier, the provider network could be different. **Always** check the provider directories on the carrier preview sites before making a decision.

If your doctor is out-of-network and you still want to see him or her, check the cost with your doctor *before* you get care. Then ask your doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you'll be responsible. That way you'll be prepared for any potentially significant costs.

When To Expect New Cards

You'll receive a new ID card when you enroll for the first time or change insurance carriers or coverage levels. You'll use your ID card for medical and prescription drug needs.

For questions about ID cards, **contact the insurance carrier**. If you need an ID card immediately, go to your insurance carrier's website, register online, and print a temporary ID card.

Contributing To An HSA?

If you enrolled in the Bronze or Bronze Plus coverage levels, you had the option to elect to contribute to an HSA.

If you decided to put money in an HSA for the first time, you'll receive a welcome letter and HSA debit card in the mail. If you decided to put money in your HSA and you've previously contributed to the HSA, you'll continue to use your existing debit card. New money added to your account will be accessible through your current debit card.

HSA vs. FSA: Which One Should You Use?

Heads up: If you enrolled in an HSA **and** a Health Care Flexible Spending Account (FSA), you will use the same debit card for **both** accounts. And Alight Smart-Choice Accounts will automatically follow IRS guidelines on how to use each account. So when you use the debit card to pay for medical, dental, or vision expenses, the expense will automatically be deducted from the correct account.

Transfer Existing HSA Balances

If you enrolled in the Bronze or Bronze Plus coverage levels, you'll have access to an HSA.

If you already have an HSA with an account balance, you can continue to use it for qualified health care expenses at any time in the future. Or, you can transfer unspent money into your new HSA so you don't have to manage two separate accounts. During the plan year, you can find a "transfers form" and directions through Your Benefits Resources at **https://digital.alight.com/rus/**. There are no tax penalties for transferring money from one HSA to another.

How to Get Care

When you get care, it helps to know what you can expect:

Getting Care At The Doctor's Office

Present your medical ID card at your doctor's office to get discounted rates. If you're enrolled in the Bronze or Bronze Plus coverage levels, you can wait to pay until your insurance carrier processes the claim and you get your doctor's bill.

When it's time to pay, you can **pay with your HSA**, FSA, or pay another way—it's your choice!

Filling Prescription Drugs At A Retail Pharmacy

Present your medical ID card each time you drop off a prescription. If payment is due, you pay out of pocket. Or you can **pay with your HSA** or FSA if you have one.

Know When You'll Owe

If your doctor bills services as preventive care or your medication is listed as preventive on the formulary, you'll owe nothing. For other types of covered services or non-preventive prescription drugs, you could owe a deductible, copay, and/or coinsurance.

Remember: You'll Pay Less With In-Network Providers

You can check the provider directory on Your Benefits Resources at **https://digital.alight.com/rus/** or refer to your **insurance carrier's website**.

If a doctor is out-of-network and you still want to see him or her, check the cost with the doctor before you get care.

Then, ask the doctor to confirm the portion that will be covered by your medical insurance carrier and the portion for which you will be responsible.

That way, you'll be prepared for any potentially significant costs.

Remember: Not all options cover out-of-network care.

Paying for Care

When you receive medical care, you choose how to pay your share of the cost. Follow these easy steps when it's time to get care:

Step 1: Meet With Your Provider

Don't forget, you'll probably pay **a lot** less when you see in-network providers. You can check the provider directory on Your Benefits Resources at **https://digital.alight.com/rus/** or refer to your **insurance carrier's website**.

Remember: Not all options cover out-of-network care.

Step 2: Present Your Medical ID Card

When you visit your doctor, hospital, or other health care provider, remember to show them your ID card so they know how to bill for the services they are providing you.

Step 3: Review The Explanation Of Benefits (EOB)

An EOB is **not** a bill. It's simply a statement from your insurance carrier that shows when you got care and how much it cost.

It will show your provider's charges, the negotiated amount your insurance carrier agreed to pay, how much is covered (if any), and your payment responsibility.

Remember, if you haven't met your deductible, you could owe the entire negotiated amount. Keep the EOB for your records because you'll need it for the next step.

Step 4: Review Your Provider's Bill

A provider's bill typically arrives in your mailbox after the EOB arrives. The amount you owe on your provider's bill should match what's on the EOB.

Step 5: Pay Your Provider

You can pay your provider out of pocket. Or, you can **pay with your HSA** or FSA for eligible health care expenses.

Paying With Your HSA

You can open an HSA if you enrolled in a Bronze or Bronze Plus coverage level. When it's time for you to pay for care or prescription drugs, your HSA gives you options:

Use Your HSA Debit Card

Just use it when you're ready to pay for qualified medical expenses. The funds will be taken directly from your account.

Make sure you only use the card for eligible expenses, and that you have enough money in your HSA to cover it.

Log on to Your Benefits Resources at **https://digital.alight.com/rus/** to check your balance beforehand.

Pay Out Of Pocket

If you prefer, you can pay for your expenses up front and pay yourself back through your HSA later. You'll log on to Your Benefits Resources at **https://digital.alight.com/rus/** to transfer money from your HSA to your regular bank account. If you need help with this, contact Alight Smart-Choice Accounts at **1.800.953.2526**.

Set Up Direct Payments

Another option is to have Alight Smart-Choice Accounts make direct payments to your provider from your HSA. Log on to Your Benefits Resources at **https://digital.alight.com/rus/** to set up direct payments.

Eligible Expenses

You can find a complete list of eligible expenses at **https://www.irs.gov/publications/p502**.

Don't forget! If you use money from your HSA to pay for nonqualified expenses, you'll pay taxes on that money. You'll also pay an additional 20% penalty tax if you're under age 65. This applies to expenses such as child care, cosmetic surgery, health club fees, teeth whitening products, and vitamins.

Keep Your Receipts!

Always remember to save your receipts when you make payments from your HSA, in case you need to provide proof of your eligible expenses to the IRS.

Your Carrier Connection

Check out your health care insurance carrier choices—and see all the unique features and services they have to offer YOU. Discover what each provides, see the doctors included in their network—then decide for yourself.

Medical

Carrier Name: Aetna

Areas We Serve: Offered in all states except AK, ID, MT, WY, MO and SD. Availability in some states may be limited.

Before you're a member (preview site): https://www.aetna.com/aon/fi/2022

Once you're a member (website): https://www.aetna.com

Customer Service Hours: Monday - Friday: 8:00 am - 6:00 pm local time

Phone Number: 1.855.496.6289

Who We Are: At Aetna, we're not just a health insurance company. We're a health company that understands that your health is about more than just coverage and costs.

Learn More

Carrier Name: Cigna

Areas We Serve: Generally offered in most states, except MN, ND. Limited availability in MI.

Before you're a member (preview site): https://connections.cigna.com/aonactivehealth-2022/

Once you're a member (website): https://my.cigna.com

Customer Service Hours: Cigna One Guide® personal guides are available Monday - Friday: 8:00 a.m. - 9:00 p.m. EST.

Outside of the standard hours, customer service advocates are available 24 hours a day, 7 days a week.

Phone Number: 1.855.694.9638, For Cigna company names and product disclosures, visit Cigna.com/product-disclosure

Who We Are: For over 225 years, Cigna has made it our mission to improve the health, well-being, and peace of mind for our customers - delivering quality care at an affordable price. Especially in times of uncertainty, you can count on us to work hard and help you safeguard your health and financial stability.

Learn More

Carrier Name: Dean/Prevea360

Areas We Serve: South Central and Northeastern Wisconsin

Before you're a member (preview site): http://aon.deanhealthplan.com/

Once you're a member (website): http://aon.deanhealthplan.com/

Customer Service Hours: Mon - Thurs: 7:30 a.m. - 5:00 p.m. CST
Friday: 8:00 a.m. - 4:30 p.m. CST

Phone Number: 1.877.232.9375

Who We Are: With access to more than 4,000 practitioners and close to 200 primary care sites and 28 hospitals, Dean Health Plan connects a strong network of health care providers, innovative hospitals, and comprehensive insurance coverage into one integrated health care system working for you.

Learn More

Carrier Name: Geisinger Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://geisinger.org/aon

Once you're a member (website): https://www.geisinger.org/member-portal

Customer Service Hours: Monday - Friday: 7:00 a.m. - 7:00 p.m. EST
Saturday: 8:00 a.m. - 2:00 p.m EST

Phone Number: 1.844.390.8332

Who We Are: Choosing a good health insurance plan is more important than ever. With Geisinger Health Plan, we cover the services you need and help you stay healthy by better managing your healthcare needs.

Learn More

Carrier Name: Health Net

Areas We Serve: Oregon and select markets in California

Before you're a member (preview site): https://www.healthnet.com/myaon

Once you're a member (website): https://www.healthnet.com/myaon

Customer Service Hours: Monday - Friday: 8:00 a.m. - 6:00 p.m. PT

Phone Number: 1.888.926.1692

Who We Are: Health Net.... Coverage for every stage of life™

Learn More

Carrier Name: Independence Blue Cross

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.ibx.com/aon

Once you're a member (website): https://www.ibx.com/login

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. ET

Phone Number: 1-855-438-2583 , (1-855-GET-BLUE) before you are a member; 1-800-275-2583 (1-800-ASK-Blue) once you are a member

Who We Are: You want health care that's effective, affordable, and simple. So do we. That's why at Independence Blue Cross we are offering solutions to make health care work better for you and your family. Every decision we make revolves around our members and helping them live happier, healthier lives.

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in CA, CO, DC, GA, MD, VA, OR, and southwest WA

Before you're a member (preview site): http://kp.org/aon

Once you're a member (website): https://www.kp.org

Customer Service Hours:
CA: 24/7 except major holidays
CO: Mon - Fri: 8:00 a.m. - 6:00 p.m. MST
GA: Mon - Fri: 7:00 a.m. - 7:00 p.m. EST
DC, MD, VA: Mon - Fri: 7:30 a.m. - 9:00 p.m. EST
OR and WA (Vancouver/Longview area): Mon - Fri: 8:00 a.m. - 6:00 p.m. PST

Phone Number:
1.877.580.6125, CA Post-enrollment: 1.800.464.4000
CO Post-enrollment: 1.303.338.3800
GA Post-enrollment: 1.404.504.5712
DC, MD, VA Post-enrollment: 1.800.777.7902
OR and southwest WA Post-enrollment: 1.800.813.2000

Pre-enrollment Phone Number: 1.877.580.6125

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Kaiser Permanente

Areas We Serve: Generally available in WA

Before you're a member (preview site): https://kp.org/wa/aonactivehealth

Once you're a member (website): https://wa-member.kaiserpermanente.org

Customer Service Hours: Monday - Friday: 8:00 a.m. - 5:00 p.m. PST

Phone Number: 1.855.407.0900

Who We Are: Experience the Kaiser Permanente difference. To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together — so you get everything you need to stay on top of your health in one easy-to-use package.

Learn More

Carrier Name: Medical Mutual

Areas We Serve: Generally available in OH

Before you're a member (preview site): http://www.medmutual.com/aon

Once you're a member (website): https://member.medmutual.com

Customer Service Hours: Monday- Thursday: 7:30 a.m. - 7:30 p.m. EST Friday: 7:30 a.m. - 6:00 p.m. EST
Saturday: 9:00 a.m. - 1:00 p.m. EST

Phone Number: 1.800.541.2770

Pre-enrollment Phone Number: 1.800.677.8028

Who We Are: We care about the health and wellbeing of Ohioans. That's why we offer high-quality health insurance plans with access to the doctors and hospitals you know and trust. Plus, prescription drug coverage, personalized wellness programs and more.

Learn More

Carrier Name: Priority Health

Areas We Serve: Available in the lower peninsula of MI

Before you're a member (preview site): https://www.priorityhealth.com/aon

Once you're a member (website): https://member.priorityhealth.com/

Customer Service Hours: Monday -Thursday 7:30 a.m. -7:00 p.m. EST
Friday 9:00 a.m. - 5:00 p.m. EST
Saturday 8:30 a.m. - noon EST

Phone Number: 1.833.207.3211

Who We Are: Looking for a health plan that fits with your lifestyle? We work hard to create health insurance plans that work for you, your family, your health status and your budget. From cost cutting tools to nationally-recognized customer service, Priority Health delivers a better experience.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://eims.uhc.com/aon7

Once you're a member (website): http://myuhc.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. all time zones

Phone Number: 1.888.297.0878

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Carrier Name: UPMC Health Plan

Areas We Serve: Generally available in PA

Before you're a member (preview site): https://www.upmchealthplan.com/aon/

Once you're a member (website): https://www.upmchealthplan.com/members/

Customer Service Hours: Monday-Friday: 7:00 a.m. - 7:00 p.m. EST Saturday: 8:00 a.m. - 3:00 p.m. EST

Phone Number: 1.844.252.0690

Phone Number: 1.844.252.0690

Who We Are: Here's the plan for getting the high-quality care you and your family deserve: Choose UPMC Health Plan. When you do, you can expect the best.

Learn More

Vision

Carrier Name: EyeMed

Areas We Serve: Available nationally

Before you're a member (preview site): https://www.eyemedexchange.com/aon/

Once you're a member (website): https://eyemed.com/en-us

Customer Service Hours: Monday - Friday: 7:30 a.m. - 11:00 p.m. EST
Saturday: 8:00 a.m. - 11:00 p.m. EST
Sunday: 11:00 a.m. - 8:00 p.m. EST

Phone Number: 1.844.739.9837

Who We Are: Driven to become the nation's first choice for vision benefits, EyeMed seeks to give you choice and to make using your benefits easy. We're focused on developing innovative benefit solutions and the networks you want. Visit eyemed.com.

Learn More

Carrier Name: MetLife

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://www.metlife.com/aon-exchange

Once you're a member (website): https://www.metlife.com/mybenefits

Customer Service Hours: Monday - Friday 8:00 a.m. - 11:00 p.m., ET
Saturday 10:00 a.m. - 11:00 p.m., ET
Sunday 10:00 a.m. - 11:00 p.m., ET

Phone Number: 1.888.309.5526

Who We Are: MetLife is among the largest global providers of insurance, annuities, and employee benefit programs, with 90 million customers in over 60 countries. We are also the largest commercial dental insurance carrier in the U.S. and offer both dental and vision benefits on the Aon Active Health Exchange.

Learn More

Carrier Name: UnitedHealthcare

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): https://eims.uhc.com/aon7

Once you're a member (website): https://www.myuhcvision.com

Customer Service Hours: Monday - Friday: 8:00 a.m. - 8:00 p.m. all time zones

Phone Number: 1.888.571.5218

Who We Are: UnitedHealthcare provides health plans and services to help our members live healthier lives. We are dedicated to simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

Learn More

Carrier Name: VSP Vision Care

Areas We Serve: Generally offered in all states, but availability in some states may be limited.

Before you're a member (preview site): http://aon.vspexchange.com

Once you're a member (website): https://www.vsp.com/login

Customer Service Hours: Monday - Friday: 5:00 a.m. - 6:00 p.m. PT
Saturday: 7:00 a.m. - 5:00 p.m. PT
Sunday: 7:00 a.m. - 5:00 p.m. PT

Phone Number: 1.877.478.7559

Who We Are: Your well-being is at the heart of everything we do. VSP® Vision Care gives you access to quality eye care from VSP network doctors with low out-of-pocket costs. Get the most out of your vision plan with up to 100K provider access points including independent doctors, popular retailers, and online.

Learn More

Get Carrier Ratings

See how others have rated their health carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and specific comments are available at **https://digital.alight.com/rus/** during enrollment and throughout the year.

Your specific medical options are based on where you live. You'll be able to see the options available to you when you enroll. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver coverage level. Aetna will be the insurance carrier. (Note: Coverage may be slightly different than the Silver option on this site. Refer to **https://digital.alight.com/rus/** for details.).

Contacts

You can reach a customer service representative through Your Benefits Resources at **https://digital.alight.com/rus/**. You can also call Benefits Express at **1.800.953.2526** from 8:00 a.m. to 4:00 p.m. CT Monday through Friday. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.

Health Pros are also available to assist with tough issues like claims and billing disputes.

Questions About Coverage?
Start by contacting the **insurance carrier** directly. They know their coverage rules best.

If you enrolled in a Bronze or Bronze Plus medical coverage level, check out the **HSA User's Guide** (PDF) for additional contacts during the year.

Contact a Health Pro

Have questions about your claims or coverage? Start by contacting your **insurance carrier** directly. They know their coverage rules best and have the final say on all claims and billing questions.

Sometimes you need more help than your insurance carrier can provide. If you have a billing issue, such as your provider charging you more than the amount your Explanation of Benefits (EOB) says you owe, or you believe your plan covers more than what your EOB shows, Alight Advocacy Services is available. Alight Health Pros are experts in handling and resolving your claims and billing issues. Find more information about Health Pros **here**.

If you aren't satisfied with the resolution, you can file an appeal through your insurance carrier, who will be able to direct you through that process. Ricoh doesn't have any influence on the outcome. The insurance carrier—not Ricoh—is responsible for the cost of claims.

Questions?

Don't worry. You have backups. When you face a billing issue:

1. Start with your insurance carrier.
2. Email a Health Pro at **AlightHealthPro@alight.com** or call **1.866.300.6530** if you need help.
3. File an appeal if you're unhappy with the final outcome.

Get the Answers

Have a question? We've got you covered.

Start with the **Frequently Asked Questions** (PDF).

Wondering what something means? Check out the **Glossary**.

Just want to talk to a real person? No sweat! Here's who to **contact**.

Glossary

Wondering what a term means? Find it here!

Brand Name
A more expensive prescription drug for which there is an active patent. (A patent is a time-sensitive right to market a drug under a certain name.)

Coinsurance
The percentage of costs you pay for eligible expenses after you meet the deductible.

Coverage Level
A benefit level that determines how services are covered.

Deductible
What you pay out of your own pocket before your insurance begins to pay a share of your costs. **How the deductible works** depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual deductible. They only count toward your out-of-network deductible.

EOB
Also known as an Explanation of Benefits. An EOB shows the claim filed by your health care professional, what was paid, and what your portion of the payment was or will be. Your insurance carrier provides the EOB. It's not a bill.

Formulary
A list of generic and brand name drugs that are approved by the Food and Drug Administration (FDA) and are covered under your prescription drug plan. You should make sure your medication is on the formulary of the medical insurance carrier you choose.

Generic
Medications that have been approved by the FDA as safe and effective. These medications contain the same active ingredients in the same amounts as brand name products. Generics may be different in color, shape, or size from their brand name counterparts. Your physician may substitute a generic for a brand name drug to save you money.

Health Savings Account (HSA)
A special bank account that allows you to set aside tax-free money to pay for qualified health care expenses. These include your medical, dental, and vision copays, deductibles, and coinsurance.

HMO
Health Maintenance Organization (HMO) options offer care through a network of doctors and hospitals. All of your care generally must be provided through the HMO network and coordinated through the HMO primary care physician (PCP) you select when you enroll. Except in emergencies, your care is usually covered only if it's coordinated by your PCP. There's no coverage for out-of-network care.

Network
A group of health care providers that offer services to participants in a health plan at a negotiated, discounted cost. You'll save money if you use doctors inside your carrier's network.

Out-of-Pocket Maximum
The most you have to pay for covered medical services in a year. Generally, it includes any applicable deductible, copayments, and/or coinsurance. **How the out-of-pocket maximum works** depends on your coverage level. Out-of-network charges do **not** count toward your in-network annual out-of-pocket maximum. They only count toward your out-of-network out-of-pocket maximum.

Payroll Contribution
The amount deducted from your paycheck on a pre-tax basis to cover your share of health care benefit costs.

Pharmacy Benefit Manager
The insurance carrier or third-party administrator who manages your retail and mail-order prescription drug benefit.

PPO
A Preferred Provider Organization, or PPO, is a type of medical plan that uses a network of physicians, hospitals, and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

Preventive Care
Annual physicals, wellness screenings, immunizations, well-woman exams, well-baby exams, and more. In-network preventive care is 100% covered without having to pay your deductible.

Reasonable and Customary
The normal charge made by a licensed practitioner in a specific area for a specific service. It doesn't exceed the normal charge made by most providers in the area where the service is provided.

Traditional Deductible
Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Traditional Out-of-Pocket Maximum
Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

True Family Deductible
The entire family deductible must be met before your insurance will pay benefits for any covered family member.

True Family Out-of-Pocket Maximum
The entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

Newly Eligible for Benefits?

Welcome!

Being new to the company, you have a lot on your plate. Enrolling in Ricoh benefits is one of those really important “to dos”—and shouldn’t take all that long.

For your 2022 benefits, you can start here:

- Quick Guide
- Enrollment Checklist
- Compare Costs (use the access code provided in recent communications)
- Medical
- Vision

Make It Yours

Once you’ve done your homework, if you want coverage through Ricoh, you must enroll by your deadline. Otherwise, you won’t have medical and prescription drug, dental, or vision coverage through Ricoh for you and your family.

Enroll now

Questions?

Check out the Frequently Asked Questions (PDF) for more details.

Helpful Documents

Compare Costs

Use this interactive pricing tool before you enroll to compare the costs of your health care options based on your situation.

- **Compare Costs** (Use the access code from the postcard that was mailed to your home.)

Annual Enrollment Preparation

Refer to "AE Preparation and Reminders" for important tips for this year's Annual Enrollment.

- **AE Preparation and Reminders** (PDF)

COBRA Coverage Options

If you leave the company or lose coverage due to a status change, your COBRA enrollment notice has details regarding your options.

If you choose not to enroll by your COBRA enrollment deadline, you will not be able to enroll in COBRA coverage in the future. Also, once enrolled, you can make changes to your elections only during enrollment or following a qualified change in status.

You will receive additional information—including prices—once you lose access to health benefits through the company.

Your COBRA Coverage Options

You can start by reviewing your **medical** and **vision** coverage level options.

You'll also want to review your **insurance carrier** options.

How To Enroll

To enroll in COBRA coverage when eligible, follow the instructions on the COBRA enrollment notice mailed to you.

Want more? Find the details about all your coverage options in the **COBRA Reference Guide (PDF)**.