2024 COBRA GUIDE

Eligibility & What you need to do

Eligible Dependents

Dependents who are eligible for OnePlus medical, dental, and vision 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.

Domestic Partner Coverage and Taxes

The IRS requires that the value of any medical, dental, and vision coverage that you purchase for your domestic partner and your domestic partner's child(ren) be added to your taxable income, as imputed income. If you elect any of these options and cover a domestic partner and his or her child(ren), imputed income applies to the difference, if any, between IRS rates and the amount you pay for the coverage.

What you need to do

You should enroll to make sure you get the coverage you want next year!

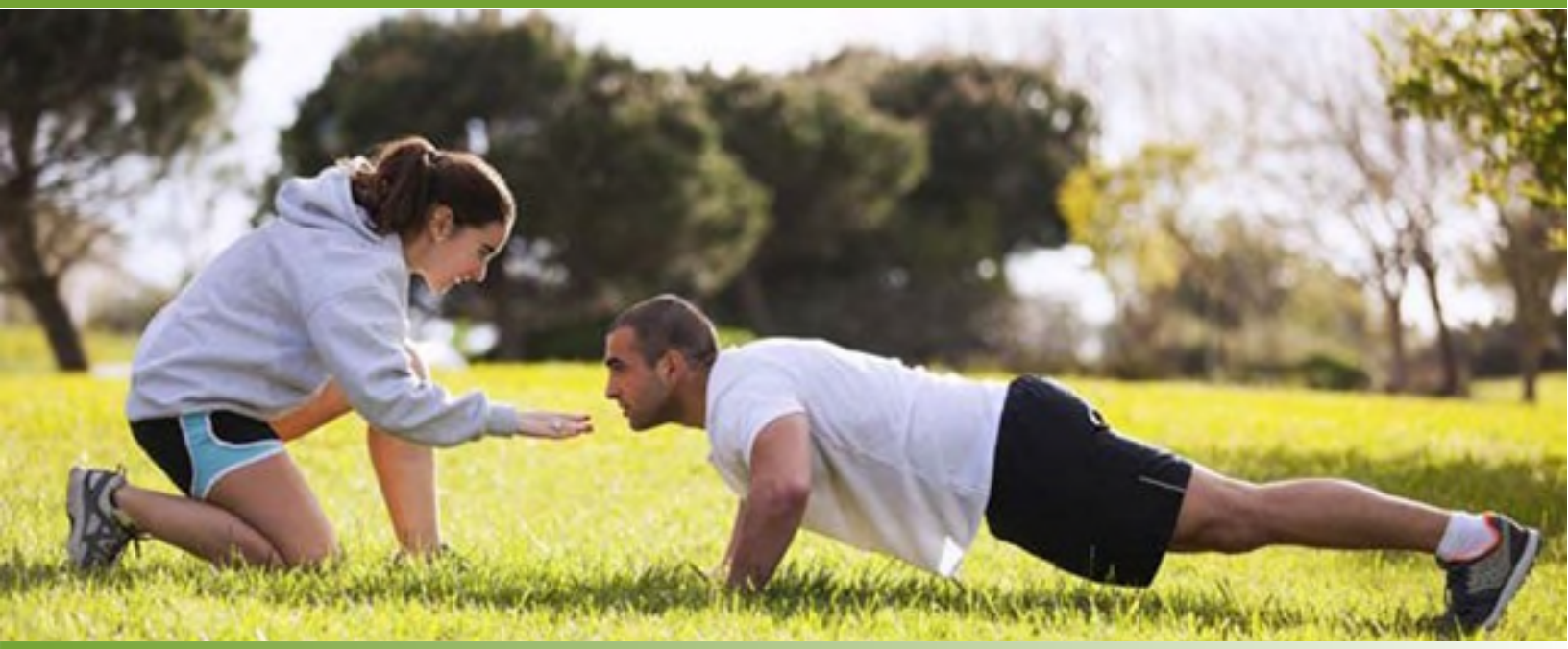
Not only could your needs have changed, but other things could have changed too—including your options, plan designs and prices, the network of doctors, and how your drugs are covered.

Enroll in 2024 coverage between November 13 – 29 through the *Your Benefits Resources (YBR)* website at https://digital.alight.com/rus/ or by calling Benefits Express at 800-953-2526 (M-F, 8AM-4PM CST).

If you don't enroll:
• Your current medical, dental, and vision coverage will continue at 2024 prices unless it is no longer available to you. If you currently do not have coverage through Ricoh, you will not have coverage through Ricoh in 2024.

Changes to your OnePlus benefit options must be made during the Annual Enrollment period—**November 13 through November 29, 2023**.

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



Medical & Prescription Drug

You have control when you enroll through the exchange—you get to choose the medical coverage level, cost, and insurance carrier that are right for your situation. Make sure to take action so you don't miss out!

Medical Coverage

Don't let the names of the coverage levels fool you.

One option isn't better than another. The best coverage level for you depends on your tastes and your needs.

Choose Your Coverage Level

You have several coverage levels to choose from, including:

- Bronze & Bronze Plus: A high-deductible option with an HSA and prescription drug coinsurance
- Silver: A preferred provider organization (PPO) option with prescription drug copays
- Gold: A PPO option with prescription drug copays
- Platinum: A PPO option with prescription drug copays that covers in-network care and offers limited benefits for out-of-network care (or, for some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, an HMO option with prescription drug copays that covers in-network care only)

Each coverage level is available from different insurance carriers at different costs.

Do You Live in California?

Your options will be different, depending on the insurance carrier you choose. See page 7 for details.

Do You Live Outside the Service 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.

Is a Primary Care Physician Required?

You must designate a primary care physician to coordinate your care if you:

- Choose Kaiser Permanente as your insurance carrier;
- Live in Northern California and choose Health Net as your insurance carrier; or
- Live in Southern California and choose Health Net as your insurance carrier and Gold II as your coverage level.

The Importance of Checking Networks

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. And certain Platinum options won't cover out-of-network services at all.

Even if you can keep your current insurance carrier, the provider network could be different and can change from year to year, so *always* check the provider networks before making a decision. See pages 13-14 for more information.

Annual Deductible

The deductible is what you pay out of pocket before your insurance starts paying its share of your costs. It doesn't include monthly contributions for health coverage. Here's how the deductible works if you have family coverage:

The Bronze Plus coverage level 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 member. There is no "individual deductible" in this coverage level when you have family coverage.

The Bronze, Silver, Gold, and Platinum coverage levels 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 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.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Annual Deductible (individual/family)	In-network: $3,300 / $6,600	In-network: $2,450 / $4,900	In-network: $1,000 / $2,000	In-network: $800 / $1,600	In-network: $250 / $500
	Out-of-network: $3,300 / $6,600	Out-of-network: $2,450 / $4,900	Out-of-network: $2,000 / $4,000	Out-of-network: $1,600 / $3,200	Out-of-network: $5,000 / $10,000

The charts within this guide 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.

Going Out of Network?

Keep in mind:

- Out-of-network charges will not count toward your in-network annual deductible or out-of-pocket maximum. The same goes for in-network charges—they will not count toward your out-of-network annual deductible or out-of-pocket maximum.
- Some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs.

The Bronze Plus coverage level 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 this coverage level when you have family coverage.

The Bronze, Silver, Gold, and Platinum coverage levels 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.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Annual Out-of-Pocket Maximum (individual/family)	In-network: $6,400 / $12,800	In-network: $3,900 / $7,800	In-network: $5,300 / $10,600	In-network: $3,600 / $7,200	In-network: $2,300 / $4,600
	Out-of-network: $12,800 / $25,600	Out-of-network: $11,500 / $23,000	Out-of-network: $10,600 / $21,200	Out-of-network: $7,200 / $14,400	Out-of-network: $11,500 / $23,000

The charts within this guide 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.

What's Included?

The annual out-of-pocket maximum includes amounts paid toward your deductible under the Bronze, Bronze Plus, Silver, Gold, and Platinum options. It doesn't include monthly contributions for health coverage. Also, copays for certain medical benefits do not apply toward the annual out-of-pocket maximum under the Silver, Gold, and Platinum coverage levels.

In-Network Benefits

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
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 30% after deductible	You pay $150, then 25% after deductible	You pay $150, then 15% after deductible
Urgent Care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay $40	You pay $25
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	If not an office visit, you pay 15% after deductible

The chart(s) above is a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. This chart is 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. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here.

Your Benefits Resources™ gives a more detailed look at these and additional coverages—and does account for some 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.

Just for Californians!

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

For starters, each insurance carrier in California can choose 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).

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	N/A	In- and out-of-network
Cigna	In- and out-of-network	In- and out-of-network	N/A	In-network only
Health Net	In- and out-of-network	N/A	In-network only	In- and out-of-network
Independence Blue Cross	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network
Kaiser Permanente	In-network only	N/A	In-network only	In-network only
UnitedHealthcare	In- and out-of-network	In- and out-of-network	N/A	In- and out-of-network

Gold or Gold II?

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

Annual Deductible and Out-of-Pocket Maximum (California Residents)

	BRONZE	BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM**
Annual Deductible (individual/family)	In-network: $3,300 / $6,600 Out-of-network: $3,300 / $6,600	In-network: $2,450 / $4,900†◆ Out-of-network: $2,450 / $4,900†◆	In-network: $1,000 / $2,000 Out-of-network: $2,000 / $4,000	In-network: $800 / $1,600 Out-of-network: $1,600 / $3,200	In-network: N/A Out-of-network: N/A	In-network: $250 / $500 Out-of-network: $5,000 / $10,000
Annual Out-of-Pocket Maximum (individual/family)	In-network: $6,400 / $12,800 Out-of-network: $12,800 / $25,600	In-network: $3,900 / $7,800‡ Out-of-network: $11,500 / $23,000‡	In-network: $5,300 / $10,600 Out-of-network: $10,600 / $21,200	In-network: $3,600 / $7,200 Out-of-network: $7,200 / $14,400	In-network: $5,400 / $10,800 Out-of-network: N/A	In-network: $2,300 / $4,600 Out-of-network: $11,500 /$23,000

**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, the Bronze Plus coverage level features a traditional annual deductible. If you cover dependents under the Bronze Plus coverage level, no covered member pays more than $3,200 toward the family deductible.
‡Under Health Net and Kaiser Permanente, these options feature a traditional annual out-of-pocket maximum.
◆Under Health Net, if you cover dependents under the Bronze Plus coverage level, the family deductible is $4,800.

Going Out of Network?

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

In-Network Benefits (California Residents)

	BRONZE & BRONZE PLUS	SILVER	GOLD	GOLD II	PLATINUM
Preventive Care	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 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 30% after deductible	You pay $150, then 25% after deductible	You pay $150, then pay 30% after copay	You pay $150, then pay 15% after deductible
Urgent Care	You pay 25% after deductible	You pay 30% after deductible	You pay $40	You pay $40	You pay $25
Inpatient Care	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30%	You pay 15% after deductible
Outpatient Care	You pay 25% after deductible	You pay 30% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, you pay 30%	You pay 15% after deductible

The chart(s) above is a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. This chart is 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. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here.

Your Benefits Resources gives a more detailed look at these and additional coverages—and does account for some 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.

Prescription Drug Coverage

Do you or a family member take medications?
Listen up! 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 *and* your medical insurance carrier. Below is an overview of the in-network coverage for each coverage level. See pages 13-14 to find out why your carrier matters too.

	BRONZE & BRONZE PLUS	SILVER	GOLD**	PLATINUM
Preventive drugs*	You pay $0 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.			
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 $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 $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 $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 $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 $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 $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.

**If you live in California and you're eligible for coverage under Gold II, note that prescription drug coverage is the same as for the Gold coverage level shown above.

Prescription Drug Coverage: Your Medical Insurance Carrier Matters

Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That's why you need to do your homework to determine how your medications will be covered before choosing a medical insurance carrier.

Things to Consider

If you or a covered family member regularly takes medication, it is strongly recommended that you call the medical insurance carrier before you enroll. Just tell the carrier you're considering medical coverage offered through the Aon Active Health Exchange and ask the following questions.

☑ 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 on a carrier's formulary, you'll pay more for it.

☑ How much will my drug cost?

The cost of your prescription depends on how your medication is classified by your insurance carrier—either Tier 1, Tier 2, or Tier 3. 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, which means you'll pay the Tier 2 or Tier 3 price for certain generic drugs. You can also find this information on the carrier preview sites or 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.

What's a Pharmacy Benefit Manager?

In the exchange, each medical carrier uses a pharmacy benefit manager to handle its prescription drug coverage. It's like how car manufacturers rely on other companies to build certain parts of the car, like the radio or tires.

Heads up: Your prescription drug coverage *could* change if:

- You stay with the same medical carrier as you have today and the carrier changes its pharmacy benefit manager or how it covers your drugs.
- You change your medical carrier.

So, you still need to do your homework and make sure you're comfortable with how your prescription drugs will be covered *before* choosing your medical carrier.

Will my doctor have to provide more information before my prescription can be approved?

Many carriers require approval, or prior authorization, of certain medications before covering them. This may apply for costly medications that have lower-cost alternatives or aren't considered medically necessary.

Will I have a step therapy program?

If you switch insurance carriers and 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 only be covered 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. And, 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.

Choose Your Insurance Carrier

This is how the exchange saves you money—by making insurance companies compete for your business. Instead of Ricoh choosing one or two carriers to do business with, you have several carriers to choose from.

No matter which coverage level you select, you may be able to choose from the following carriers:*

- **Aetna**
  Before you're a member (preview site):
  https://www.aetna.com/microsites/aonfi/index.html
  Once you're a member (website): https://www.aetna.com
  Phone number: 1.855.496.6289

- **Cigna**
  Before you're a member (preview site):
  https://connections.cigna.com/aonactivehealth-2024/
  Once you're a member (website): https://my.cigna.com
  Phone number: 1.855.694.9638

- **Dean / Prevea360 (generally available in WI)**
  Before you're a member (preview site): http://aon.deanhealthplan.com
  Once you're a member (website): http://aon.deanhealthplan.com
  Phone number: 1.877.232.9375

- **Geisinger (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
  Phone number: 1.844.390.8332

- **Health Net (Oregon & select markets in CA)**
  Before you're a member (preview site): https://myaon.healthnet.com/
  Once you're a member (website): https://myaon.healthnet.com/
  Phone number: 1.888.926.1692

- **Independence Blue Cross**
  Before you're a member (preview site):
  https://www.ibx.com/htdocs/custom/exchange/index.html
  Once you're a member (website): https://www.ibx.com/login
  Phone number: 1.855.438.2583

*If you live outside the service areas of all the insurance carriers, an out-of-area option through Aetna at the Silver coverage level will be your only choice.

Which Carriers Are Available to Me?

Your specific options are based on where you live (so it's important to make sure your address on record is correct before you enroll). You'll be able to see the options available to you when you enroll.

- **Kaiser Permanente (generally available in CA, CO, DC, GA, MD, VA, OR, WA)**
  Before you're a member (preview site): http://www.kp.org/aon
  Once you're a member (website): http://www.kp.org
  Pre-enrollment phone number: 1.877.580.6125
  CA Post-enrollment phone number: 1.800.464.4000
  CO Post-enrollment phone number: 1.800.632.9700
  DC, MD, VA Post-enrollment phone number: 1.800.777.7902
  GA Post-enrollment phone number: 1.404.261.2590
  OR and southwest WA Post-enrollment phone number: 1.800.813.2000

- **Medical Mutual (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
  Post-enrollment phone number: 1.800.541.2770
  Pre-enrollment phone number: 1.800.677.8028

- **Priority Health (generally available in 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/
  Phone number: 1.833.207.3211

- **UnitedHealthcare**
  Before you're a member (preview site): https://www.whyuhc.com/aon9
  Once you're a member (website): http://myuhc.com
  Phone number: 1.888.297.0878

- **UPMC Health Plan (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
  Phone number: 1.844.252.0690

Before you're a member, you can visit specially designed carrier sites to get a "preview" of their services, networks, and more. You should check out the carrier preview sites to get a closer look at the carriers you're considering. Once you're a member, you'll be able to register and log on to the carrier's main website for personalized information.

Do You Live in California?

Remember, the insurance carrier you choose may also affect your coverage level choices. See page 7 for details.

What Are People Saying About Their Experiences With Health Carriers?

Sometimes it really helps to see what other people think about consumer products and services. 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 Your Benefits Resources at http://digital.alight.com/rus during enrollment and throughout the year. Taking a look may help you.

Why Stay With the "In" Crowd?

Seeing out-of-network providers may cost you substantially more than seeing in-network providers. For example, 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.

If you use out-of-network providers, call the insurance carriers beforehand to confirm the maximum allowed amounts for the type of services you need. It could make a big difference. For example, let's say you will have an out-of-network surgery that costs $5,000 and you will pay 40% coinsurance. The maximum allowed amounts could be different across carriers:

- If one carrier has a maximum allowed amount of $2,000, you would owe 40% of $2,000 *and* 100% of the remaining $3,000, for a total of $3,800.
- If a second carrier has a maximum allowed amount of $3,000, you would owe 40% of $3,000 *and* 100% of the remaining $2,000, for a total of $3,200.

Dental

Make sure to take action so you don't miss out!

Dental Coverage

Dental benefits to meet your needs.

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 continue to be the dental plan administrator for the dental PPO options in 2024. Ricoh will offer two dental PPO options for 2024—the Dental PPO Plus and the Dental PPO option—both of which are administered by Cigna. By taking advantage of discounted rates through Cigna network dentists, the dental PPO allows participants 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.

	CIGNA DENTAL PPO		**CIGNA DENTAL PPO PLUS**	
	In-Network Total Cigna DPPO Network	Out-of-Network	In-Network Total Cigna DPPO Network	Out-of-Network
Individual deductible	You pay $50	You pay $100	You pay $50	You pay $100
Family deductible	You pay $150	You pay $300	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	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 services	You pay 0%	You pay 10% after deductible	You pay 0%	You pay 10% after deductible
Basic services	You pay 20% after deductible	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible
Major services	You pay 70% after deductible	You pay 75% after deductible	You pay 50% after deductible	You pay 60% after deductible
Orthodontia	Not covered		You pay 50% after deductible	You pay 60% after deductible
Orthodontia deductible	Not applicable		Refer to individual/family deductible	
Orthodontia lifetime maximum the plan will pay	Not applicable		$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 SERVICES	BASIC SERVICES	MAJOR SERVICES
• Oral evaluations	• Oral surgery	• Dentures
• Routine cleanings	• Fillings	• Bridgework
• X-rays	• Repairs	• Crowns
	• Periodontics	
	• Endodontics	
	• Inlays, onlays	

ORTHODONTIA	FOR CHILDREN
• Orthodontia, up to lifetime maximum	• One fluoride treatment annually

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 the annual 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.

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.

Cigna ID Cards

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 http://mycigna.com.

Aetna Dental DMO Option

Aetna will remain the carrier for the Dental DMO option for 2024. 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.

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.

Aetna ID Cards

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 2024.

Vision

Just like your medical coverage, you get to choose the vision coverage level, cost, and insurance carrier that are right for your situation. Make sure to take action so you don't miss out!

Vision Coverage

See how you can benefit from vision coverage.

You have several vision options available that offer a range of coverage—from exams only to coverage for lenses, frames, and contacts.

Choose Your Coverage Level

You have several coverage levels to choose from, including:

- Bronze: Exam-only option that provides in-network discounts for certain materials
- Silver: A PPO option that covers in- and out-of-network care
- Gold: An enhanced PPO option that covers in- and out-of-network care

Paying for Coverage

Just like your medical coverage, you get to decide how much you want to pay for coverage through the exchange. You can choose the coverage level you want from the insurance carrier offering it at the best price. How much you pay is based on the dependents you cover. You can enroll any combination of you, your spouse, and your children in the option you choose.

The Importance of Checking Networks

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. Even if you can keep your current insurance carrier, the provider network could be different and can change from year to year, so *always* check the provider networks before making a decision.

In-Network Benefits

	BRONZE	SILVER	GOLD
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			
Trifocal			
Standard Progressive[2]			
Lenticular			
Lens Enhancements			
UV Treatment	Discount may apply	Varies by carrier	Varies by carrier
Tint (solid and gradient)		Varies by carrier	Varies by carrier
Standard Plastic Scratch-Resistant Coating		Varies by carrier	Varies by carrier
Standard Anti-Reflective Coating		Varies by carrier	Varies by carrier
Standard Polycarbonate—Adults		Varies by carrier	Varies by carrier
Standard Polycarbonate—Children		You pay nothing	You pay nothing
Other Add-Ons		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			
	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.

The chart(s) above is a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. This chart is 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. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here.

Your Benefits Resources gives a more detailed look at these and additional coverages—and does account for some 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 Benefit Summaries on Your Benefits Resources.

Choose Your Insurance Carrier

No matter which coverage level you select, you'll be able to choose from the following insurance carriers:

- **EyeMed**
  Before you're a member (preview site): https://eyemed.com/en-us/exchange-aon/
  Once you're a member (website):
  https://www.eyemedvisioncare.com/member/public/login.emvc
  Phone number: 1.844.739.9837

- **MetLife**
  Before you're a member (preview site): https://www.metlife.com/aon-exchange/
  Once you're a member (website): https://www.metlife.com/mybenefits
  Phone number: 1.888.309.5526

- **UnitedHealthcare**
  Before you're a member (preview site): https://eims.uhc.com/aon7
  Once you're a member (website): https://www.myuhcvision.com
  Phone number: 1.888.571.5218

- **VSP**
  Before you're a member (preview site): https://www.vsp.com/vision-insurance-plans/aon-vsp-exchange
  Once you're a member (website): https://www.vsp.com/signon.html
  Phone number: 1.877.478.7559

Before you're a member, you can visit specially designed carrier sites to get a "preview" of their services, networks, and more. You should check out the carrier preview sites to get a closer look at the carriers you're considering. Once you're a member, you'll be able to register and log on to the carrier's main website for personalized information.

This overview serves as a summary on various Ricoh 2024 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.