2022 OnePlus Benefits
Frequently Asked Questions

FAQs

If you have a specific question, see if it's here in the list below and click on the link to be taken directly to the answer you're looking for. Otherwise, feel free to browse and scan the FAQs at your own pace.

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The Aon Active Health Exchange™

1. What is an exchange?

An exchange is a way for you to get medical and vision coverage. It is an online insurance marketplace where buyers like you can shop for coverage from multiple insurance carriers who are competing for your business. An exchange merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free market competition.

The Aon Active Health Exchange is America's first national large employer multi-insurance carrier exchange. Its website is easy to navigate and, just like other online stores, you'll be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you've selected the right coverage options for your circumstances and budget.

2. Is Aon's exchange sponsored by the government?

No. The Aon Active Health Exchange is a private exchange. It is unrelated to the government-run state and federal health insurance exchanges, or marketplaces. It does, however, provide benefits consistent with the law and guarantees coverage for those eligible, regardless of pre-existing conditions.

3. What are the advantages of the exchange?

The medical and prescription drug and vision benefits available through the exchange offer you:

- **More choices.** In the past, you got to choose from the traditional health plan options offered by Ricoh. Through the exchange, you're able to choose from several coverage levels, a variety of insurance carriers, and a range of costs.
- **Competitive pricing.** The insurance carriers are competing for your business. So it's in their best interest to offer their best prices. Plus, Ricoh offers you an opportunity to receive a subsidy credit to use toward the cost of your medical coverage. If you complete the steps to receive your subsidy credit, you'll be able to see the subsidy credit amount from Ricoh and your price options for coverage on the Your Benefits Resources™ (YBR) website when you enroll. This subsidy credit is for medical coverage only and doesn't apply to vision coverage.

You also have help when you need it. There are great tools and resources to help you every step of the way. See question #4 for details about tools and resources.

4. Where can I get more information?

There are lots of resources available to help before, during, and after enrollment.

<table>
<tr><th></th><th>Before you enroll</th><th>When you enroll</th><th>After you enroll</th></tr>
<tr><td>Make It Yours website</td><td colspan="2">https://ricoh.makeityoursource.com

Learn how the exchange works and what coverage options you may have—and get tips for choosing the right coverage for you. You can also watch videos and access the insurance carrier preview sites here.</td><td>Visit year-round for practical tips that help you to get the most out of your benefits. Get “The Inside Scoop” on how to work the health care system, be a savvy shopper, and even save some money.</td></tr>
<tr><td>Your Carrier Connection
(available through the Make It Yours website https://ricoh.makeityoursource.com/your-carrier-connection)</td><td colspan="2">Carrier preview sites: Get up to speed on provider networks, prescription drug information, and other carrier resources.

And you can contact insurance carriers directly with specific questions.</td><td>Once you’re a member: Take advantage of all the tools, resources, and information offered through your insurance carrier. For questions about your coverage, always start with your carrier. They know their plans best and have the final authority on all claims, billing disputes, etc. (contact information is available on the Make It Yours website).</td></tr>
<tr><td>Changes for 2022</td><td colspan="2">There is a listing of changes for 2022 Annual Enrollment posted on the Make It Yours website at https://ricoh.makeityoursource.com/documents/whats-changing.pdf.
.</td><td>Visit Make It Yours for practical tips that help you to get the most out of your benefits.</td></tr>
<tr><td>Your Benefits Resources (YBR)</td><td>Access your current, personalized coverage details and manage your benefits.</td><td>Log on to YBR at https://digital.alight.com/rus/, where you can compare your options, get helpful decision support, and enroll. You’ll also see the subsidy credit amount from Ricoh and prices by option.

If you still have questions, you can reach a customer service representative by scheduling an appointment through YBR. You can also call Benefits Express at 1.800.953.2526, Monday through Friday, from 8:00 a.m. to 4:00 p.m. CT. 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.</td><td>Once coverage begins: Access your personalized coverage details and manage your benefits throughout the year.

If you need help with more complex coverage issues, call Benefits Express at 1.800.953.2526 and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve issues.</td></tr>
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Enrollment

5. When is OnePlus enrollment?

The enrollment period for your 2022 benefits will take place from November 1 through November 17, 2021.

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6. What will I need to do?

Between November 1 and November 17, 2021, 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 and prices, the network of doctors, and how your prescription drugs are covered. It's very important to double-check even if you choose exactly what you have today.

To enroll, log on to YBR at **https://digital.alight.com/rus/** during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2022.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your OnePlus benefits.
- When you're finished, carefully review your choices and be sure to finalize your enrollment as instructed. Save the confirmation email you will receive.

7. What happens if I don't enroll?

If you don't enroll:

- Your current medical, dental, and vision coverage will continue at 2022 prices unless it is no longer available.
- You may pay an additional amount each pay period if you are currently covering a spouse who has access to medical coverage from his or her employer.
- To contribute to a Health Savings Account (HSA) (if eligible) or to a flexible spending account, you must make an active election.
- Your elections for life and disability coverages will carry over into 2022.
- To participate in the Vacation Purchase Plan and Group Legal Plan, you must make an election.

8. Who's eligible for OnePlus benefits?

Full-time and regular part-time employees are eligible for Ricoh's medical and vision benefits.

- Full-time means that you work between 30 and 40 hours per week.
- Regular part-time employment means that you work 20 or more hours but less than 30 hours per week.[1]

Eligible dependents include:

- Spouse or domestic partner[2], subject to receipt of required documentation supporting domestic partner status;
- Biological children, stepchildren, legally adopted children, children for whom you are a legal guardian up to age 26[3, 4];
- 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[3, 4], subject to receipt of required documentation supporting domestic partner status.

[1]Other state mandates may apply.
[2]There is an additional amount you may pay for medical coverage each pay period if you enroll a spouse who has access to medical coverage from his or her employer.
[3]Not eligible for spouse or dependent life insurance if also employed by Ricoh.
[4]Coverage ends the last day of the month after dependent's 26th birthday.

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9. If I am a new hire, what do I need to do to enroll in my benefits for the remainder of 2021 and for 2022?

If you were hired before December 1, 2021, you need to make your 2021 benefit elections first. Log on to the YBR website at https://digital.alight.com/rus/ and click on **Enroll in Your Benefits** to start the 2021 enrollment process. Your user name and password will be required.

You will then need to enroll in your 2022 benefits, which you can do as soon as you've completed the 2021 enrollment process. You won't even need to log out—just navigate back to the home page to enroll. In order to make your 2022 elections, you must take action by the deadline provided on YBR at https://digital.alight.com/rus/. Your user name and password will be required.

Please note, if you want to participate in the Health Care Flexible Spending Account, Dependent Day Care Flexible Spending Account, HSA, Vacation Purchase Program, or Group Legal Plan, you must enroll each year. Coverage in these plans does not carry over from year to year.

If you do not complete your enrollment by the deadline provided, you will receive default coverages for the 2022 plan year. If you have any questions, please call Benefits Express at **1.800.953.2526**, Monday through Friday, from 8:00 a.m. to 4:00 p.m. CT.

My Options

10. What are my options for OnePlus medical and prescription drug coverage?

You have several coverage levels to choose from, including Bronze, Bronze Plus, Silver, Gold, and Platinum. Each coverage level is available from multiple insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your medical options. To review details, visit the Make It Yours website at https://ricoh.makeityoursource.com.

11. What happens if I enroll in a Bronze or Bronze Plus medical option and have expenses early in the plan year?

If you enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible—in case you have significant medical expenses shortly after the plan year begins. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early in the year. One option is to pay for those early qualified expenses out of pocket and then, when your account balance grows enough to cover the expense, reimburse yourself from your HSA. This is a good reason to make sure you're saving enough in an HSA.

12. I live in California. How are my medical options different?

Your options will be different depending on the 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** as 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 **only** offers in-network benefits.

Learn more about your California coverage options and insurance carriers on the Make It Yours website at https://ricoh.makeityoursource.com/medical/california-medical-coverage-level.

13. I live outside the carriers' service areas. How are my medical options different?

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.

14. Am I required to designate a primary care physician?

You must designate a primary care physician to coordinate your medical 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.

15. Is one coverage level better than another?

No. Don't let the names of the coverage levels fool you—one option isn't necessarily better than another. They're designed to give you choices so that you can find the option that makes sense for your situation. Remember to take your total costs into consideration, which includes what you pay out of your paycheck (before-tax premiums) and what you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

For example, the Silver, Gold, and Platinum coverage levels will cost you more each paycheck, but less when you receive care. These coverage levels have copays for some services and lower deductibles compared to the Bronze Plus coverage level.

The Bronze and Bronze Plus coverage levels come with lower paycheck deductions (before-tax premiums) and higher deductibles. If you don't need a lot of health care services, you'll spend less on your total health care costs because you're not paying premiums for coverage you don't need.

16. What's the difference between a traditional PPO and a high-deductible PPO?

A PPO is a type of medical option 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.

When you enroll in a traditional PPO, like a Gold option, you have to meet a lower deductible before the insurance carrier starts paying a percentage of the costs. For example, the Gold option deductible is $800 for Employee Only coverage and $1,600 for Family coverage. In exchange for that lower deductible, you will have higher paycheck deductions.

A high-deductible PPO operates the same, but as the name suggests, you have a significantly higher deductible before your medical and prescription drug coverage kicks in. To balance the cost of the high deductible, your paycheck deductions will be lower. You can use an HSA to pay qualified health care expenses tax-free. Once you meet your deductible, you get the protection of a traditional PPO and pay a percentage of your ongoing expenses, up to the out-of-pocket maximum.

17. Can each family member choose a different medical coverage level or insurance carrier?

No. All family members must be enrolled in the same coverage level with the same insurance carrier.

18. From which medical insurance carriers will I be able to choose?

Most of the largest insurance carriers are participating in the exchange. Keep in mind that carriers may vary by region.

Your specific options are based on where you live. You'll be able to see the options available to you when you enroll.

Before you're a member, you can visit specially designed sites to get a "preview" of their services, networks, and more. You should check out the carrier preview sites before enrollment to get a closer look at the carriers you're considering. You can get to the carrier preview sites beginning October 13 through the Make It Yours website at **https://ricoh.makeityoursource.com**. Once you enroll and become a member of a carrier, you'll be able to register and log on to the carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through YBR at **https://digital.alight.com/rus/**.

19. Will I be able to use the same providers as I do today?

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care.

Even if you can keep your current insurance carrier through the exchange, the provider network could be different and can change, so *always* check the provider directories before making a decision.

Do **not** rely on your provider's office to know the carriers' network(s). To see whether your doctor is in network:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on YBR. 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! If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, you need to call the insurance carrier. You can find insurance carrier contact information on the Make It Yours website at **https://ricoh.makeityoursource.com/your-carrier-connection**.

20. Why should I use in-network providers?

Seeing out-of-network providers will very likely cost you substantially more than seeing in-network providers. For example, you will 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 after you've reached your annual out-of-network out-of-pocket maximum. And certain Platinum options won't cover out-of-network services at all.

21. How should I choose an insurance carrier if my dependents and I live in different states?

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offers national provider networks, so that your dependents have access to in-network providers in most locations. (Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. You can contact the insurance carrier for details.)

Do **not** rely on your provider's office to know the carriers' network(s). You need to call the insurance carrier to confirm whether an out-of-area provider participates in a carrier's network.

22. How do I decide which OnePlus medical option is right for me?

You'll have access to a number of resources to help you make smart decisions. You should start by visiting the Make It Yours website at **https://ricoh.makeityoursource.com** to access videos, details about your options, comparison charts, and more.

Then, when you enroll, you'll be able to see the subsidy credit amount from Ricoh and your price options on YBR at **https://digital.alight.com/rus/**. You'll also be able to access tools that give you a personalized suggestion, help compare the details of your options, let you see insurance carrier ratings, and more.

If you still have questions, you can reach a customer service representative by scheduling an appointment through YBR. You can also call Benefits Express at **1.800.953.2526,** Monday through Friday, from 8:00 a.m. to 4:00 p.m. CT. 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. You can also call the insurance carriers with specific questions about the options they offer.

23. Will pre-existing conditions be covered?

Yes. When you enroll in medical coverage through the exchange, coverage is guaranteed, regardless of whether you and your eligible dependents have pre-existing conditions.

24. What's included in the preventive care that's covered at 100% by all medical plans?

Recommendations from the U.S. Preventive Services Task Force are used to determine which services are considered preventive services. In general, the following outpatient preventive care services are 100% paid by the insurance carrier when you see an in-network provider, without needing to meet the deductible. Limitations vary by carrier, so check with your insurance carrier if you have any questions.

Examples of preventive care that could be covered at 100% include:

- Annual physical exam
- Pediatric exam
- Well-woman exam (includes Pap test)
- Mammogram
- Bone density screening
- Cancer screenings
- Cardiovascular screenings
- Colorectal screening
- Prostate screening
- Digital rectal exam
- High blood pressure screening (adult)

- Depression screening (adolescent)
- Depression screening (adult)
- Diabetes screening
- Immunizations (child)
- Immunizations (adult)
- Influenza, shingles, and pneumonia vaccinations (adult)

25. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your medical insurance carrier's pharmacy benefit manager, which could be a separate prescription drug company. 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 an insurance carrier.

If you or a covered family member regularly takes medication, it is strongly recommended that you call the medical insurance carrier before you enroll to better understand how your particular prescription drug(s) will be covered. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. Visit the Make It Yours website for a list of questions to ask.

26. What is "prior review" and when is it required?

Before getting certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting "prior review" (also referred to as prior authorization or precertification) allows the carrier to make sure you're eligible for the services, ensure you're getting care that makes sense for your condition, and confirm how the bill is going to be paid.

Who completes the process depends on where you get care:

- When you stay in network, your doctor usually completes the process on your behalf when it's required. But you should always confirm with your doctor to be sure he or she is handling it.
- If you go out of network, you are usually responsible for completing the process. You may have to work with your doctor or directly with your insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior review is required and you don't get preapproved, you could get stuck paying most or **all** of the bill or a penalty. For that reason, it's always in your best interest to ask your doctor if you need to do anything in advance and confirm that services you need will be covered by your insurance carrier.

27. What are my options for vision coverage?

You have three 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-network and, for certain services, out-of-network care.
- **Gold:** An enhanced PPO option that covers in-network and, for certain services, out-of-network care.

Each coverage level is available from different insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your vision options.

28. From which vision insurance carriers will I be able to choose?

You'll be able to choose from EyeMed, MetLife, UnitedHealthcare, and VSP.

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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. You can get to the carrier preview sites through the Make It Yours website at **https://ricoh.makeityoursource.com**. Once you're a member, you'll be able to register and log on to the carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through YBR at **https://digital.alight.com/rus/**.

29. What do I need to know about vision networks?

Each vision insurance carrier has its own provider network. If it's important that you continue using the same eye doctor or retail store, you should check to see whether your eye doctor or retail store is in the network before you choose a carrier.

Do **not** rely on your provider's office to know the carriers' networks. To see whether your eye doctor or retail store is in-network:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on YBR.

30. What other benefit options are available to me through the exchange?

You can also choose to enroll in:

- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud. Allstate Identity Protection will be your new benefits provider next year.
- **Critical illness insurance:** Pays a benefit if you or a covered family member 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 kidney disease).
- **Hospital indemnity insurance:** Pays a benefit in the event you or a family member covered under this plan is hospitalized.
- **Accident insurance:** Pays a benefit in the event you or a family member covered under this plan is in an accident.

You can get more details on the Make It Yours website at **https://ricoh.makeityoursource.com**.

31. What other benefits can I enroll in?

In addition to the benefits available through the exchange, you continue to have access to the following plans through Ricoh:

- Dental coverage;
- Life and disability insurance coverage;
- Health Care and Dependent Care Flexible Spending Accounts;
- Legal services through MetLife Legal (formerly through Hyatt); and
- Aflac coverage.

Paying for Coverage

32. Do I get to keep the Ricoh subsidy credit if I don't enroll in coverage?

No. The subsidy credit you get from Ricoh is for the medical/prescription drug coverage you purchase through the exchange. A cash refund is not available.

33. What will I have to pay when I need medical care?

Other than in-network preventive care, which is paid 100%, how much you have to pay when you need medical care primarily depends on your coverage level. Find the details for all coverage levels on the Make It Yours website at **https://ricoh.makeityoursource.com**.

34. What's a deductible and how does it work?

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your costs. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you meet your deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept from the insurance carrier for providing a particular service.

How the medical deductible works depends on your coverage level:

- **The Bronze, Silver, Gold, and Platinum medical 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 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 Bronze Plus medical coverage level has a "true family deductible."[5]** 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 these coverage levels when you have family coverage.

  To clarify, if you choose a Bronze Plus coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, though, you must satisfy the family deductible before coinsurance will kick in, even if only one family member has expenses.

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

Do you use out-of-network providers? Out-of-network charges do **not** count toward your in-network annual deductible; they only count toward your out-of-network deductible.

[5]**Exception:** If you live in California, cover dependents, and enroll under Health Net or Kaiser Permanente at the Bronze Plus coverage level, you will have a *traditional* annual deductible. No member in the family will pay more than $2,800 toward the family deductible.

35. What's an out-of-pocket maximum and how does it work?

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

The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage or certain copays under the Silver, Gold, and Platinum coverage levels. How the medical out-of-pocket maximum works depends on your coverage level:

- **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.

- **The Bronze Plus coverage level has a "true family out-of-pocket maximum."**[6] 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 these options when you have family coverage.

Do you use out-of-network providers? 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.

[6]**Exception:** If you live in California, cover dependents, and enroll under Health Net or Kaiser Permanente at the Bronze Plus coverage level, you will have a *traditional* annual out-of-pocket maximum.

36. What is a Health Savings Account (HSA)?

An HSA is a special bank account that you can use when you enroll in a Bronze or Bronze Plus coverage level. It allows you to set aside tax-free money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. Because 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 levels, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Just make sure you use money in your HSA only for qualified health care expenses. Otherwise, you'll pay income taxes on that distribution and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and the corresponding withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute when you enroll. And if you don't have a lot of health care expenses, your money can stay in your account year to year and earn tax-free interest. If you have questions about the use and appropriateness of an HSA as it applies to your specific situation, you should consult a tax professional.

Although you can enroll your children up to age 26 in your medical coverage, you can't use money from your HSA to pay their health care expenses unless you claim them as dependents on your federal income taxes (generally children under age 19, or under age 24 if they are full-time students).

37. How is an HSA different from a Health Care Flexible Spending Account (Health Care FSA)?

While both accounts offer a tax-free benefit when you pay for eligible medical, dental, and vision expenses, they differ in several key ways. Compare their differences on the Make It Yours website.

38. Can I enroll in both the HSA and Health Care FSA?

Yes. 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** a Health Care FSA. If you have an HSA and a Health Care FSA, in order to contribute to an HSA, your Health Care FSA must be "limited purpose" and can only be used to pay for eligible dental and vision expenses. However, once you meet the medical deductible, then it can be used toward eligible medical and prescription drug expenses as well, with proof the deductible has been met. Your HSA can be used for qualified medical and prescription drug, dental, and vision expenses.

39. Why would I want to use both an HSA and an FSA?

Both accounts allow you to pay for eligible expenses with tax-free dollars. The biggest difference between the accounts is that your HSA balance rolls over from year to year, even if you change medical plans, leave the company, or retire. With the Health Care FSA (whether limited purpose or not), any unused balance is forfeited at the end of the year.

It may not be advantageous to enroll in both, except in unique situations. For example, if you expect to have higher expenses than your HSA balance can cover (based on the maximum you can contribute each year), you may also want to contribute to the limited purpose Health Care FSA to pay for those expenses with tax-free money, once the medical deductible is reached.

40. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified health care expenses, like your medical and vision copays, deductibles, and coinsurance. You decide how much money you want to save, and you can change it at any time.

The HSA has the following tax advantages:

- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out.
- Interest earnings on your HSA balance are not taxed.
- You are not taxed on the HSA dollars when you use them to pay eligible expenses.

41. Can I contribute to an HSA if I am covered under my spouse's general-purpose Health Care FSA?

No. If your spouse's general-purpose Health Care FSA covers your medical expenses, it would be considered other health coverage and you would not be eligible to contribute to an HSA.

42. Can I contribute to an HSA?

In order to contribute to an HSA, you need to meet the following criteria:

- You must be enrolled in a high-deductible option at the Bronze or Bronze Plus coverage level;
- You cannot be enrolled in Medicare or a veteran's medical plan (TRICARE);
- You cannot be claimed as a dependent on someone else's tax return;
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option; and
- You cannot be enrolled in a general-purpose Health Care FSA, but you may be enrolled only in a limited purpose Health Care FSA.

You can use money from your HSA to pay your dependents' health care expenses as long as you claim them as dependents on your federal income taxes (generally children up to age 19 or under age 24 if they are full-time students).

43. What happens to my current HSA if I elect a Silver, Gold, or Platinum medical plan for 2022?

If you are no longer enrolled in a medical plan that offers the HSA, your HSA will become orphaned, which means that your account will be maintained directly at UMB rather than Smart-Choice Accounts™. Within six weeks of your account end date, you will receive a letter from UMB with information on how to access your account and a new HSA card supported by UMB. There will be a monthly fee of $2.50 for your account.

44. Do I need to consider COVID-19 coverage when making my 2022 elections?

Please note that any COVID-19 federal laws that are passed—such as 100% coverage for testing—are applicable and administered by all carriers. As a result, you don't need to consider these laws when choosing a carrier for coverage in 2022.

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