Our benefits are all about YOU.

2017 Healthcare Benefits Enrollment Guide
Welcome To Ryder

We are glad you have joined the Ryder team and hope you truly benefit from the programs available to you and your family. Ryder recognizes that employees are our most valuable resource. The Ryder benefits program provides you with a choice of benefit options to help protect your health and finances today, and in the future.

Ryder offers the opportunity to enroll in Medical, Prescription, Dental, Vision, Flexible Spending Accounts, Additional Life Insurance, AD&D Insurance, Additional Disability and Legal Plans. While these plans do require employee payroll deductions, Ryder pays a significant portion of the aggregate cost for Medical, Prescription, Dental and Vision. As health plan premiums continue to rise, the participation in these plans, especially if adding dependents, can get expensive. It’s critical that you take the time to learn about the benefit programs offered, weigh the costs and features of each plan, and then choose the plans that will provide the most appropriate coverage for you and your family.

This brochure is designed to outline the general features of each of your benefit choices. Your Summary Plan Description (SPD) is available online and fully details the coverage and provisions of the benefit programs. To review the SPD, log on to Ryder.BenefitsNow.com and select the Health & Welfare tab. If you are an hourly employee, the SPD will be mailed to your home address.

Summary of Benefits and Coverage (SBC)
The purpose of the Summary of Benefits and Coverage is to provide employees with standard information so they can compare medical plans as they make decisions about which plan to choose. All SBCs are available on the Ryder BenefitsNow Portal. You can access the SBCs by logging on to Ryder.BenefitsNow.com > Health & Welfare. To request a paper copy, please contact the Ryder BenefitsNow Service Center at 1-800-280-2999.

What’s Inside

Welcome to Ryder
How And When To Enroll 2
Benefit Videos 2

Review the Rules
Dependent Eligibility Rules 3
Working Spouse Rule 3-4
Tobacco Usage Plan Rules 5

Understand the Plans
Medical Plans 6-15
Medical Plans Overview 16-17
Prescription Coverage 18
Dental Coverage 19
Vision 20

Real Appeal Weight Loss Plan 21
Virtual Visits 22
Flexible Spending Accounts 23
Disability 24
Life Insurance 25

Tools And Resources
Health Advocate 26
Other Benefits 27-28
COBRA Rights 29-31
Contact Information 32

Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc. has the right to amend or terminate any premiums, or other employee payments charged or benefits provided.

Note: Employees who work under the provisions of certain collective bargaining agreements or customer contracts may be covered under different benefit provisions than those described in this brochure.
How and When to Enroll

Your benefits will become effective the first day of the month following 60 days (not to exceed 90 days) of continuous, regular, active, full-time employment. *However, you must enroll within 45 days from your hire date.*

* If you were hired due to a new business contract or acquisition or you are a rehired employee, your benefit effective date could be different. Refer to the enclosed Personalized Enrollment Worksheet for your benefits effective date.

Your enrollment deadline is indicated on your Personalized Enrollment Worksheet included in this kit. Please be sure to enroll by the deadline date stated on your Personalized Enrollment Worksheet. You must complete the audit process on all dependents you enroll.

You will automatically be enrolled in the Company-provided Short-Term Disability, Long-Term Disability and Employee Basic Life Insurance programs at no cost to you.

You must make a beneficiary election for your Company-provided Basic Life Insurance and any Additional Employee Life Insurance or Accidental Death & Dismemberment Insurance you elect. You can elect your Beneficiary Designation online through Ryder.BenefitsNow.com or call the Ryder BenefitsNow Service Center.

ID cards are provided for your Medical and Prescription elections and will be mailed to you directly from the carrier within 30 days of your enrollment. A Dental or Vision ID card is not required to access coverage, but can be printed from the websites. See page 32 for Contact Information.

Getting it done with BenefitsNow

Log on to access your personal benefits information. You have 45 days from your hire date to enroll.

2. View the Benefit Videos to understand what Ryder offers!
3. Review the Benefits Enrollment Guide.
4. Select the “Enroll Now” button to enroll in your benefits.

After you make your enrollment elections, make sure to hit the “Complete” button at the bottom of the page and print your Confirmation Statement for your records.

No computer? Enrollment can also be done by calling the Ryder BenefitsNow Service Center at 1-800-280-2999.

Benefit Videos

We want you to understand your benefit plans! To help you with that go to Ryder.BenefitsNow.com to view different videos that explain our benefits in detail. You can also view them by scanning the QR Code above to access them on your mobile device or you can go directly to the web at: https://ryder.a.guidespark.com/.
Ryder Dependent Eligibility Rules

Definition of Eligible Dependents

1. Your legal spouse, of the same or opposite sex, to whom you are married under state law. Common law spouses are treated as domestic partners, subject to the requirements outlined below. Ex-spouses are not eligible, even if a divorce decree requires medical coverage.

2. Your domestic partner, of the same or opposite sex, if he/she has met all of the following criteria for the 12 months prior to the coverage effective date:
   - The individual is your sole domestic partner and intends to remain so indefinitely.
   - The individual is not married or legally separated from yourself or from anyone else.
   - The individual is not related by blood or adoption to a degree of closeness that would prohibit legal marriage in the state in which he/she resides.
   - The individual is at least 18 years of age and mentally competent to consent to a contract.
   - You and the individual are living together in the same residence and intend to do so indefinitely.
   - You and the individual are living together in a committed relationship of mutual caring and support, and are jointly responsible for each other’s common welfare and living expenses.

To be eligible for Domestic Partner benefits, the employee must agree to all of the above criteria verbally with a Ryder BenefitsNow Service Center phone representative. A signed affidavit will be required as part of the audit process.

3. Your natural or adopted children, those of your spouse/domestic partner and children for whom you have legal custody or guardianship, to age 26.

4. Your natural or adopted children, those of your spouse/domestic partner and children of whom you have legal custody or guardianship, age 26 and older, if due to a physical or mental disability, they are unable to support and maintain themselves financially.

The Medical plan carrier you elect solely determines eligibility for coverage. You may apply when you first become eligible to enroll for coverage, or if already enrolled, you must request continued coverage before the dependent’s coverage would otherwise end.

Dependent Audit Documentation

You will be asked to provide proper legal documentation for each dependent (spouse, domestic partner, child) that you enroll in coverage. Examples of documentation are birth certificates for children (must indicate birth parents’ names), marriage certificates, federal income tax return forms, court-issued documents of legal guardianship and domestic partner/common law spouse affidavit. Failure to provide documentation will result in termination of dependents’ coverage.

Working Spouse/Domestic Partner Coverage Rule

Working spouses/domestic partners who are eligible for comprehensive coverage under another group plan through their employer are not eligible for coverage under Ryder’s group Medical, Prescription or Dental plans.

Comprehensive Medical plan includes:
- physician services;
- major medical including hospitalization and surgery; and
- prescription drug coverage.

Comprehensive Dental plan includes:
- preventive (oral exams, cleanings, X-rays);
- basic restorative (fillings, root canals, extractions); and
- major restorative (crowns, dentures, bridges).

Your spouse/domestic partner will not be eligible for coverage under Ryder’s health care plans if his/her employer’s health care plans meet the above criteria, regardless of cost, network providers or plan designs (co-pays, deductible, co-insurance).

Note: Employees who knowingly or unknowingly enroll ineligible dependents in any company benefit plan will be subject to immediate and appropriate disciplinary action, up to and including termination of coverage and termination of employment.
Coverage Rule for Working Spouses/Domestic Partners

Ryder expects all employees to comply with the Working Spouse Policy summarized as follows:

<table>
<thead>
<tr>
<th>If your working spouse/domestic partner...</th>
<th>then your spouse/domestic partner CAN be covered under Ryder’s...</th>
</tr>
</thead>
<tbody>
<tr>
<td>is not eligible for medical, prescription or dental coverage through his/her employer</td>
<td>Medical, Prescription and Dental plans</td>
</tr>
<tr>
<td>is eligible for a non-comprehensive medical and prescription plan (i.e., does not cover hospitalization)</td>
<td>Medical and Prescription plans</td>
</tr>
<tr>
<td>is eligible for a medical plan through his/her employer, but is not eligible for a dental plan</td>
<td>Dental plan (but not under Ryder’s Medical plan)</td>
</tr>
<tr>
<td>is eligible for a comprehensive medical plan, but there is no prescription coverage</td>
<td>Medical and Prescription plans</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your working spouse/domestic partner...</th>
<th>then your spouse/domestic partner CANNOT be covered under Ryder’s...</th>
</tr>
</thead>
<tbody>
<tr>
<td>is eligible for comprehensive medical and prescription coverage through his/her employer</td>
<td>Medical and Prescription plans</td>
</tr>
<tr>
<td>is eligible for a comprehensive medical plan, but has a restricted provider network</td>
<td>Medical and Prescription plans</td>
</tr>
<tr>
<td>is eligible for a comprehensive medical plan with a higher deductible for physician services, hospitalization or surgery</td>
<td>Medical and Prescription plans</td>
</tr>
<tr>
<td>is eligible for a comprehensive medical plan, but his/her doctor is not in the plan’s network</td>
<td>Medical and Prescription plans</td>
</tr>
<tr>
<td>is eligible for comprehensive medical, prescription and dental coverage, but the cost of coverage is more expensive</td>
<td>Medical, Prescription or Dental plans</td>
</tr>
<tr>
<td>is eligible for comprehensive dental coverage through his/her employer</td>
<td>Dental plan</td>
</tr>
<tr>
<td>is eligible for comprehensive dental coverage through his/her employer, but does not offer orthodontia</td>
<td>Dental plan</td>
</tr>
</tbody>
</table>

Q&A

If my spouse/domestic partner is not eligible due to the working spouse rule, can I still cover my children under Ryder’s plans?
Yes. You can still cover your children or those of your spouse/domestic partner under Ryder’s Medical, Prescription and Dental plans, even if your spouse/domestic partner has coverage through his/her employer.

If my spouse/domestic partner is self-employed and does not have any insurance, can I cover him/her under Ryder’s Medical, Prescription and Dental plans?
Yes. If your spouse/domestic partner is self-employed, and without insurance you can enroll him/her under Ryder’s plans.

If my spouse/domestic partner starts to work and has access to coverage, do I need to make a change?
Yes. If your spouse/domestic partner becomes eligible for coverage through their new employer, the spouse/domestic partner must be removed from Ryder coverage.

If my spouse/domestic partner is not employed, can I cover him/her under Ryder’s Medical, Prescription and Dental plans?
Yes. You can enroll your spouse/domestic partner under Ryder’s Medical, Prescription and Dental plans if he/she is unemployed.
Tobacco Usage Plan Rules

To maintain a healthy workforce, we are encouraging tobacco users to improve their health and rewarding tobacco-free employees with a credit toward monthly medical premium costs. Medical research data confirms that tobacco use is one of the leading causes of heart-related conditions and premature death in the country.

What is A Tobacco User?

Ryder defines a tobacco user as someone who smokes cigarettes, cigars, pipes or uses chewing tobacco. You must select either the Tobacco User or Non-Tobacco User option when enrolling in a Ryder Medical plan. The Tobacco User option must be selected if you are covering a spouse/domestic partner who uses tobacco products even if you do not use tobacco products. Please review your Personalized Enrollment Worksheet to see if you are eligible for this credit.

How the Plan Works

With the Tobacco Usage plan, you must identify whether you and/or your covered spouse/domestic partner are tobacco users. If you elect the Non-Tobacco User option, you will receive a $25 credit each month toward your Medical plan contributions.

By selecting the Non-Tobacco User option, you and your covered spouse/domestic partner certify that you will not use tobacco products during the current plan year. You are considered a tobacco user if you use any tobacco products, regardless of how often you use them. If you and/or your covered spouse/domestic partner are tobacco users, you are not eligible for the Non-Tobacco User Credit.

How to Enroll

To receive the $25 monthly premium credit, you must select the Non-Tobacco User option when you enroll in a Medical plan as a newly eligible employee.

Your enrollment in the Tobacco Usage plan must be accurate and truthful. Any intentional misrepresentation will subject you to immediate and appropriate disciplinary action, up to and including termination of medical coverage and termination of employment. Your plan election is binding for the entire calendar plan year, and may not be adjusted until next year’s benefits Annual Enrollment, unless you successfully complete the UHC QuitPower® tobacco cessation program.

Q&A

Q. I do not smoke everyday, but I sometimes smoke when I go out on weekends. Do I have to select the Tobacco User option?
A. Yes. A tobacco user is defined as someone who uses tobacco products, even occasionally.

Q. I don’t smoke, but my spouse smokes, and I am covering him on my Medical plan. Do I have to select the Tobacco User option?
A. Yes. If you are covering your spouse/domestic partner under a Ryder Medical plan and he/she uses tobacco, you must select the Tobacco User option.

Q. I am trying to quit smoking, but have not stopped completely. If I stop smoking during the middle of the year, can I get the Non-Tobacco User credit at that time?
A. Yes. If you successfully complete the UHC QuitPower tobacco cessation program during the plan year, you may elect the Non-Tobacco at that time provided that your enrolled spouse/domestic partner is also tobacco free. Please see page 28 of this guide for more information on QuitPower.
UnitedHealthcare (UHC) Medical Plans

UHC Option 1 Plan

How the UHC Option 1 Plan works.
The UHC Option 1 Medical Plan is a traditional PPO type plan with deductibles and co-insurance.

First, you are responsible for paying the deductible amount for eligible medical expenses.

Then, once you meet your annual deductible, Ryder pays 80% for eligible in-network medical expenses and you pay 20%.

Last, if you reach your out-of-pocket maximum, Ryder will pay eligible in-network expenses at 100% for the rest of the calendar year. Out-of-pocket maximum includes deductibles and your 20% co-insurance.

Note: Eligible non-network medical claims will be paid based on 110% of Medicare-linked reimbursement rate, which may be less than what you are billed, up to 60% (compared to 80% in-network) and after the non-network annual deductible is met. Charges over this reimbursement rate are not covered by the plan.

For In-Network Expenses

**Plan Pays 100% of Preventive Care (Deductible does not apply)**

** Preventive care is covered according to the guidelines of the U.S. Preventive Task Force (USPSTF) and the requirements of the Affordable Care Act.
Meeting the Deductible and How Expenses are Paid.
The deductible is the part you pay before co-insurance begins. Once you meet the deductible, Ryder pays 80% of eligible in-network expenses, and you pay the other 20%. Here’s how meeting the deductible would work for each of the levels of coverage.

In-Network Expenses

Employee Only
Alex has a $900 Claim

- Deductible $650
- Co-insurance 80%/20%

Balance
$900 ➞ Alex pays $650 ➞ $250 ➞ Ryder pays (80%): $200
Alex pays (20%): $50

Employee +1
John has a $700 Claim, John’s dependent has no claims.

- Deductible $1,300
  (individual deductible of $650 each)
- Co-insurance 80%/20%

Balance
$700 + $0 ➞ John pays $650 ➞ $50 ➞ Ryder pays (80%): $40
John pays (20%): $10

Family
Marsha and family all have claims: Marsha’s husband needed surgery and a hospital stay for an appendectomy.

- Deductible $1,950
  (Any combination of family members can meet the $1,950 deductible, but no one person will exceed $650)
- Co-insurance 80%/20%

Balance
$700 + $25,000 + $675 + $950 ➞ Marsha pays $650 ➞ $50 ➞ Ryder pays: $40 Marsha pays $10
Spouse pays $650 ➞ $24,350 ➞ Ryder pays: $19,480 Spouse pays $4,870
Child #1 pays $650 ➞ $25 ➞ Ryder pays: $20 Child #1 pays $5
Child #2 pays $0 ➞ $950 ➞ Ryder pays: $760 Child #2 pays $190

This plan does NOT include prescriptions. You must enroll in the Caremark Rx Plan if you want Prescription Coverage.
**UHC Health Savings Account (HSA) Medical Plan**

How the UHC HSA Plan works.
The HSA combines a high-deductible medical plan with a tax favored Health Savings Account (HSA) that covers a wide range of health care expenses. You can pay for current medical expenses from the account or save the money in your HSA for future medical expenses. HSA dollars are always yours, even if you leave Ryder.

**First,** you are responsible for paying the deductible amount for eligible medical expenses. The deductible includes eligible medical expenses and the full cost of many prescriptions.*

**Ryder contributes money into your HSA** and you can contribute money as well. Ryder’s contributions are intended to offset the higher deductible. (For more information on Ryder’s contribution, refer to page 11).

**Then,** once you meet your annual deductible, Ryder pays 80% for eligible in-network medical expenses and you pay 20% up to the out-of-pocket maximum. Once you meet the deductible, your prescriptions are covered based on the prescription plan described on page 18.

**Last,** if you reach your out-of-pocket maximum, Ryder will pay eligible in-network expenses at 100% for the rest of the calendar year. Out-of-pocket maximum includes deductibles and your 20% co-insurance.

**In-Network Expenses**

<table>
<thead>
<tr>
<th>FIRST, You Pay</th>
<th>Your HSA Account</th>
<th>THEN, Plan Pays</th>
<th>LAST, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Ryder contributes up to:</td>
<td>Ryder pays 80%</td>
<td>Ryder pays 100% after reaching Out-Of-Pocket Maximum of</td>
</tr>
<tr>
<td>$1,300</td>
<td>$250 Single coverage</td>
<td>$6,550 Employee</td>
<td>$6,550 Employee</td>
</tr>
<tr>
<td>Employee</td>
<td>$500 Employee +1 and Family coverage</td>
<td></td>
<td>$13,100 Employee +1 &amp; Family</td>
</tr>
<tr>
<td>$2,600</td>
<td>You may contribute on a pretax basis up to:**</td>
<td>You pay 20% up to Out-Of-Pocket Maximum</td>
<td></td>
</tr>
<tr>
<td>Employee +1</td>
<td>$3,400 Single coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3,900</td>
<td>$6,750 Employee +1 and Family coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$1,000 Additional if age 55 or older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you choose to contribute to your HSA account, the minimum yearly amount is $100. When choosing your annual amount, you must deduct any Ryder contributions and incentives to make sure you don’t go over the annual maximum allowed by the I.R.S.**

**Plan Pays 100% of Preventive Care (Deductible does not apply)***

To help with funding your Health Savings Account, you (and your enrolled spouse/domestic partner) can each earn $100 that will be deposited into your Health Savings Account if you complete an annual preventive care physical exam. Preventive Care services are covered at 100% with no deductible when you use an in-network physician. Annual exams can identify certain medical problems early, before they become serious, and make you more aware of your health and what you need to do to live a healthy lifestyle.

* Approved preventive drugs are covered at 100% without having to meet the deductible. Approved preventive therapy medications bypass the deductible.

** See page 10 for details on how much you can contribute.

*** Preventive care is covered according to the guidelines of the U.S. Preventive Task Force (USPSTF) and the requirements of the Affordable Care Act.
Meeting the Deductible

The deductible is the amount you pay before co-insurance begins. The deductible includes eligible medical expenses and the full cost of many prescriptions. Once you meet the deductible, the plan pays 80% of eligible in-network medical expenses, and you pay the other 20%. Once you meet the deductible, prescriptions are covered based on the prescription plan described on page 18. Here’s how meeting the deductible would work for individual coverage and family coverage:

These examples illustrate the UHC HSA Medical Plan

1. **UHC HSA**

2. **Deductible**
   - **You Decide**
     - Pay with dollars from your HSA Account
     - Pay with after-tax dollars from your pocket

3. **Co-insurance**
   - **Employee Only**
     - Alex has a $1,300 Deductible
     - Eligible Expenses Total $1,300
     - Ryder Pays 80% of subsequent eligible in-network expenses
     - Member pays the other 20% of subsequent eligible medical expenses, plus prescription drug co-pays and co-insurance

   - **Employee +1**
     - John and One Dependent have a $2,600 deductible
     - Eligible Expenses Total $2,600
     - John meets the $2,600 deductible
     - One member or a combination of two must meet the $2,600 deductible

   - **Family**
     - Marsha and Family have a $3,900 Family deductible
     - Eligible Expenses Total $2,300 + $600 + $1,000
     - Marsha and family meet the family deductible of $3,900
     - Any combination of family member needs to meet $3,900, however, no one person can exceed $2,600. Once one person hits $2,600 – that person goes to co-insurance of 80%/20%.
Ryder makes it easy to enroll in the Health Savings Account. When you enroll in the UHC HSA Medical Plan online or via phone, you are automatically agreeing to the terms of opening the savings account (no different than a typical savings account).

After you enroll in the UHC HSA Medical Plan, you will receive a Welcome Kit and your HSA debit card from Optum Bank. At times, it may be necessary to verify your information if you have recently made a change to your home address, last name or any other similar change. Please make sure to respond so that you can receive your debit card as quickly as possible.

If you choose to contribute to your HSA account (in addition to Ryder’s contribution), you can make convenient pre-tax contributions through payroll deductions. You have the option to change your contribution amount throughout the calendar year. You can contribute up to $3,400 per year for single coverage or $6,750 per year for employee +1 or family coverage. If you are 55 years of age or older you can contribute an additional $1,000. This maximum amount includes Ryder contributions and any earned reward money as a result of completing an annual preventive care physical exam.

Optum Bank will open up an eAccess account. Ryder will pay the monthly maintenance fee of $1.00 per month. You have the option to invest your HSA dollars in Mutual Funds once you have a balance of $2,000 or more. There may be additional investment fees. You may contact Optum Bank directly for more information.

**Limits on HSA Contributions**

As a new hire there are rules around how much you can contribute into the HSA. Please note you are responsible to manage contribution maximums allowed into the HSA.

- If you are a new hire with a prior High Deductible Health Plan/HSA Enrollment, and you have continual 12-month enrollment, you may elect up to the maximum amount ($3,400 single/$6,750 employee + one or family) regardless of the benefit effective date.
- If you are a new hire with NO prior High Deductible Health Plan/HSA Enrollment, below is a guide of amounts you may elect through payroll deduction for the rest of the calendar year.

It is possible to contribute up to the maximum annual limit for that year – even if you did not have eligibility for the full calendar year. However, the IRS requires that you maintain HSA eligibility through December 31 of the following year (this is referred to as the "testing period"). If you do not remain HSA-eligible through the testing period, income taxes plus a penalty likely apply. For more information, consult your tax advisor.

### Table: HSA Contribution Limits

<table>
<thead>
<tr>
<th>Benefit Effective Date</th>
<th>Maximum Employee Annual Pre-Tax HSA Contribution Single*</th>
<th>Maximum Employee Annual Pre-Tax HSA Contribution Family*</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>$ 3,400</td>
<td>$ 6,750</td>
</tr>
<tr>
<td>February 1</td>
<td>$ 3,113</td>
<td>$ 6,182</td>
</tr>
<tr>
<td>March 1</td>
<td>$ 2,830</td>
<td>$ 5,620</td>
</tr>
<tr>
<td>April 1</td>
<td>$ 2,547</td>
<td>$ 5,058</td>
</tr>
<tr>
<td>May 1</td>
<td>$ 2,264</td>
<td>$ 4,496</td>
</tr>
<tr>
<td>June 1</td>
<td>$ 1,981</td>
<td>$ 3,934</td>
</tr>
<tr>
<td>July 1</td>
<td>$ 1,698</td>
<td>$ 3,372</td>
</tr>
<tr>
<td>August 1</td>
<td>$ 1,415</td>
<td>$ 2,810</td>
</tr>
<tr>
<td>September 1</td>
<td>$ 1,132</td>
<td>$ 2,248</td>
</tr>
<tr>
<td>October 1</td>
<td>$ 849</td>
<td>$ 1,686</td>
</tr>
<tr>
<td>November 1</td>
<td>$ 566</td>
<td>$ 1,124</td>
</tr>
<tr>
<td>December 1</td>
<td>$ 283</td>
<td>$ 562</td>
</tr>
</tbody>
</table>

*Less any contributions made to the HSA by Ryder or any earned incentives.*
How HSA Funds Grow

The HSA is a true savings account. Ryder contributes to it, and so can you; and the contributions can earn interest and other investment returns. Take a look at how this works:

Family Example:

Ryder contributes up to $500 annually.

<table>
<thead>
<tr>
<th>Benefit Effective Date</th>
<th>Total Ryder Contributions:</th>
<th>Contribution Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1 - June 1</td>
<td>$250 Single $500 Employee +1 /Family</td>
<td>Within 1-2 months of Benefit Effective Date</td>
</tr>
<tr>
<td>July 1 - Nov 1</td>
<td>$125 Single $250 Employee +1 /Family</td>
<td>Within 1-2 months of Benefit Effective Date</td>
</tr>
<tr>
<td>Dec 1</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

You have the option of contributing up to $6,750* (family maximum) of your own money to your HSA tax-free. If you are age 55 or older and not eligible for Medicare, you can make additional catch-up contributions of up to $1,000.

On balances of $2,000 and up, you can choose to invest your savings in mutual funds for greater potential long-term growth (fees apply).

Your HSA grows tax-free. You can use your HSA dollars for current or future health care expenses – you decide.

Triple-tax advantage

1. As dollars go in (pre-tax)
2. As account grows (no tax on investment returns)
3. As dollars come out for eligible expenses (no tax upon withdrawal)

Ryder makes no representations about future contributions.

* Less any contributions made to the HSA by Ryder or any earned reward.
Health Savings Account (HSA) Notice

By enrolling in the HSA Medical Plan and agreeing to appoint Ryder System, Inc. as your agent for purposes of opening and administering an OptumHealth Bank Health Savings Account (HSA) on your behalf, you authorize Ryder to send and receive information to and from OptumHealth Bank in order to administer your Health Savings Account.

You are certifying that you are eligible to contribute to an HSA under Internal Revenue Code Section 223.

You understand that you may access the Custodial and Deposit Agreement governing your HSA at optumhealthbank.com or by calling 1-866-234-8913, and that a copy of said agreement will be sent to you in a “Welcome Kit” after your HSA is opened.

You agree that Ryder will remain your agent unless:

1. You submit written notice to Ryder that you intend to terminate this appointment, and Ryder has a reasonable period of time to act on such notice;
2. You inform Ryder that you are no longer an HSA eligible individual; or
3. You receive a notice from OptumHealth Bank that your application for an HSA has been declined. By enrolling in the UHC HSA Medical Plan you also authorize OptumHealth Bank to make any inquiries that it considers appropriate to determine if it should open and maintain your HSA. This may include ordering your credit report, or other report (e.g., information from any motor vehicle department or other state agency).

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT – To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means for you: When you open an account, Optum Bank will ask for your name, address, date of birth and other information that will allow them to identify you. Optum Bank may also ask to see your driver’s license or other identifying documents.

HSA Q&A

Can dependent children who are no longer full-time students and/or are no longer tax dependent on their parents taxes still enroll in Ryder’s HSA plan?

Yes, the dependent child can still enroll in the Ryder HSA plan and utilize the High Deductible Health Plan (HDHP) portion of the benefit. However, the employee cannot utilize pre-tax HSA dollars to reimburse expenses for a child that is not a tax dependent.

Can someone enrolled in Medicare or Medicaid use any HSA funds they had contributed prior to their enrollment in Medicare/Medicaid?

Yes, those funds can be used to reimburse for any qualified expenses, but you cannot contribute any additional pre-tax funds. Note, if you are eligible for Medicare, but have not yet enrolled, you can still contribute to the HSA.

How do HSA contributions work if you are married, but enrolled in separate plans?

Sometimes, an employee and their spouse will both enroll separately in employer provided coverage. If that is the case, then:

- If you each enroll in “self-only” coverage, you can each contribute up to the self-only limit in your respective HSA.
- If either or both of you enroll in any type of “family” coverage (employee + spouse, family, etc.) then you are able to contribute up to the family limit – on a combined basis. You will want to be careful that both of your combined HSA contributions do NOT exceed the maximum allowed under family coverage.

Can I enroll my Domestic Partner in the HSA Plan?

Yes, the domestic partner can enroll in the Ryder HSA plan and utilize the High Deductible Health Plan portion of the benefit. However, the employee cannot utilize pre-tax dollars to reimburse expenses for a domestic partner that is not a tax dependent. The domestic partner can open up their own HSA with any bank of their choice and contribute to their own HSA.

Who is eligible to make “Catch-Up” contributions?

If you are age 55 and older you can contribute an additional $1,000 to your HSA. You can do this each year that you are eligible for an HSA. Once you enroll in Medicare, you are no longer permitted to make these contributions.

If you have family HDHP that covers your spouse, and your spouse is age 55 or older – he or she can make a catch-up contribution, but they would need to open their own HSA. Only one person can “own” an HSA and a spouse can’t contribute his/her catch-up contribution to your HSA.

What happens if my Spouse enrolls in Medicare?

If your spouse enrolls in Medicare, but you are still enrolled in Family HDHP, you may contribute up to the family limit. Your spouse would not be able to contribute to an HSA.
How the UHC Standard Medical Plan works.
The UHC Standard Medical Plan is a PPO type plan with a high deductible, copays and co-insurance. This plan only has in-network benefits. If you choose doctors, facilities, hospitals or services outside of the network, there is NO reimbursement under the plan.

First, you are responsible for either the copay of an in-network Primary Care Physician (PCP) visit or in-network Urgent Care visit, or you pay for all other medical expenses and the full cost of non-generic prescription drugs until you meet the deductible.

Then, once you meet your annual deductible, Ryder pays 80% for eligible in-network medical expenses and non-generic prescription drugs and you pay 20%.

Last, if you reach your out-of-pocket maximum, Ryder will pay eligible in-network expenses at 100% for the rest of the calendar year. Out-of-pocket maximum includes copays, deductibles and your 20% co-insurance. Copays for PCP and Urgent Care do not count towards your deductible, however, they do count towards the medical out-of-pocket maximum.

For In-Network Expenses Only

<table>
<thead>
<tr>
<th>FIRST, You Pay</th>
<th>THEN, Plan Pays</th>
<th>LAST, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays*</td>
<td>Deductible</td>
<td>Ryder pays 100% after reaching Out-Of-Pocket Maximum of</td>
</tr>
<tr>
<td>$25**</td>
<td>$2,500</td>
<td>$6,550 Employee</td>
</tr>
<tr>
<td>PCP</td>
<td>Employee</td>
<td>$13,100 Employee +1 &amp; Family</td>
</tr>
<tr>
<td>$75**</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Employee +1</td>
<td></td>
</tr>
<tr>
<td>$15</td>
<td>$7,500</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brand named drug prescriptions subject to deductible then co-insurance.

* Copays not subject to deductibles.
** Additional costs for lab, xray, etc. may apply.

Plan Pays 100% of Preventive Care (Deductible does not apply)
Copays, meeting the Deductible and How Expenses are Paid.

A copay is a fixed amount you pay when you visit your PCP or Urgent Care. The deductible is the amount you pay before co-insurance begins. Once you meet the deductible, Ryder pays 80% of eligible in-network expenses, and you pay the other 20%. There is no out-of-network benefit in this plan. Here's how meeting the deductible would work for each of the levels of coverage.

**In-Network Expenses Only**

**Employee Only**
Alex has a $3,000 Claim visiting a specialist

- **Deductible $2,500**
- **Co-insurance 80%/20%**

<table>
<thead>
<tr>
<th>Balance</th>
<th>Ryder pays (80%): $400</th>
<th>Alex pays (20%): $100</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000</td>
<td>$500</td>
<td></td>
</tr>
</tbody>
</table>

**Employee +1**
John has a $6,000 in-network hospital bill, John’s dependent has no claims

- **Deductible $5,000**
  (individual deductible of $2,500 each)
- **Co-insurance 80%/20%**

<table>
<thead>
<tr>
<th>Balance</th>
<th>Ryder pays (80%): $2,800</th>
<th>John pays (20%): $700</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,000 + $0</td>
<td>$3,500</td>
<td></td>
</tr>
</tbody>
</table>

**Family**
Marsha and family all have claims:

- **Copays + Deductible $7,500**
  (Any combination of family members can meet the $7,500 deductible, but no one person will exceed $2,500)
- **Co-insurance 80%/20%**

<table>
<thead>
<tr>
<th>Cost of Visit/Member Pays</th>
<th>Balance</th>
<th>Ryder pays:</th>
<th>Marsha pays</th>
<th>Spouse pays</th>
<th>Child #1 pays</th>
<th>Child #2 pays</th>
<th>Family Deductible is met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marsha visits PCP for the flu</td>
<td>$100/$25</td>
<td>$75</td>
<td>$75</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Spouse sprains ankle and goes to urgent care</td>
<td>$250/$75</td>
<td>$175</td>
<td>$175</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Child #1 goes to specialist for tests</td>
<td>$2,800/$2,500</td>
<td>$300</td>
<td>$300</td>
<td>$240</td>
<td>Child #1 pays</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Child #2 breaks leg and goes to hospital</td>
<td>$4,000/$2,500</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,200</td>
<td>Child #2 pays</td>
<td>$300</td>
<td></td>
</tr>
<tr>
<td>Spouse goes into hospital for surgery</td>
<td>$7,000/$2,500</td>
<td>$4,500</td>
<td>$4,500</td>
<td>$3,600</td>
<td>Spouse pays</td>
<td>$900</td>
<td></td>
</tr>
<tr>
<td>Marsha goes to dermatologist</td>
<td>$350/20% of bill</td>
<td>$350</td>
<td>$350</td>
<td>$280</td>
<td>Marsha pays</td>
<td>$70</td>
<td></td>
</tr>
</tbody>
</table>
Want to know more about the UHC Standard Medical Plan? Read on:

Does the UHC Standard Medical Plan have out-of-network benefits? No, it does not. Any services performed by an out-of-network provider or facility will not be covered under the plan. You will be responsible for the full cost of those claims.

Does the UHC Standard Medical Plan include prescription coverage? Yes, it includes prescription in the following format: PPACA drugs are covered at 100%; generic drugs have a $15 copay; all other drugs are subject to the deductible and coinsurance. You will receive a separate Caremark Rx Card that is used when purchasing your prescription.

Is there an out-of-pocket maximum for prescriptions? Yes. All generic prescriptions have a copay of $15 and any brand named drugs (known as non-generic drugs) that are covered under the prescription plan are subject to the deductible and coinsurance of 80%/20% under the medical plan. Once you meet your out-of-pocket maximum, prescriptions are paid at 100% for the rest of the calendar year.

Does the $15 copay for generic drugs count towards the deductible? No, it does not. Only the covered brand named drugs count towards the deductible.

How much would a 90 day supply of generic drugs cost? Generally, the cost for a 90 day supply under the plan would be a maximum of $30.00.

If I go to my Primary Care Physician (PCP) for a doctor visit how much would I pay? If you visit your doctor due to an illness, you would pay a $25 copay for the visit. Additional charges for tests and lab work may apply and are paid 80/20 after deductible. If the visit to your PCP is for your annual wellness, it is paid at 100%.

What if my PCP refers me to a specialist for tests? If your PCP refers you to a specialist for any tests, then those claims count toward your deductible as long as you remain in-network.

If I visit the Urgent Care, how much is my copay? Your copay for urgent care is $75 as long as you remain in-network. Additional charges for tests or lab work may apply and subject to deductible and coinsurance.

How do I make sure I remain in-network? You can call UHC directly at 1-888-899-4734 or you can go online to www.myuhc.com to look for in-network providers.

Can I enroll in a Health Care Spending Account (HCSA) with this plan? Yes you can. Just make sure you budget carefully since there is a “use it or lose it” rule with the HCSA. Refer to page 23 for more details about setting aside pre-tax dollars for eligible expenses.

If I get sick while traveling and have to visit the emergency room, will claims get paid? Whether the hospital is in-network or out-of-network, if you have a life threatening situation, then the claims will be paid as in-network.
# UHC Medical Plans Overview

The Medical Plan options outlined below may not be available in all areas. Please refer to your Personalized Enrollment Worksheet or contact your Supervisor or local Human Resources Representative for more information about the medical plans available in your area.

<table>
<thead>
<tr>
<th></th>
<th>UHC OPTION 1</th>
<th>UHC HSA</th>
<th>UHC Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network*</td>
<td>In-Network</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$650</td>
<td>$1,300</td>
<td>$1,300</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$1,300</td>
<td>$2,600</td>
<td>$2,600</td>
</tr>
<tr>
<td>Family</td>
<td>$1,950</td>
<td>$3,900</td>
<td>$3,900</td>
</tr>
</tbody>
</table>

| Prescription         | Not Included** | Included as part of Medical Plan you pay the full cost of the prescription until you meet the deductible*** | Included as part of Medical Plan $15 copay for generics. All other drugs you pay full cost until the deductible is met. Then coinsurance applies at 80%/20%*** |
|                      |               |           |              |

| Co-Insurance         | Plan pays 80% Medicare Reimbursement Rate (MRR)* | Plan pays 80% Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible |
|                      |          |          |              |
| Annual Out-of-Pocket Maximum | $5,100 | $10,000 | $6,550 | $6,550 |
| Per Person           | $10,200  | $20,000  | $13,100     | $13,100     |
| Family               | $10,200  | $20,000  | $13,100     | $13,100     |

| Physician Office Visit | Plan pays 80% after annual deductible | Plan pays 80% after annual deductible | Plan pays 80% after annual deductible |
| Primary Care Specialist | Medicare Reimbursement Rate (MRR)* | Medicare Reimbursement Rate (MRR)* | Medicare Reimbursement Rate (MRR)* |
|                        | POC: $25 no deductible | Specialist: plan pays 80% after deductible |              |

| Virtual Visits        | $40         | $40       | $25          |

| Preventive Care       | Plan pays 100% no deductible Medicare Reimbursement Rate (MRR)* | Plan pays 100% no deductible Medicare Reimbursement Rate (MRR)* | Plan pays 100% no deductible |
| (Includes colonoscopies) |              |          |              |

| Laboratory & X-Ray    | Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible |
| (Free-standing or hospital-based) | In-Office | In Specialist’s Office | |

| Inpatient Hospital Care/ Outpatient Hospital or Facility | Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible |
|                                                          | Medicare Reimbursement Rate (MRR)* | Medicare Reimbursement Rate (MRR)* |              |

| Emergency Room       | $300 co-pay after annual deductible | Plan pays 80% after in-network annual deductible | Plan pays 80% after annual deductible |

| Urgent Care          | Plan pays 80% after annual deductible | Plan pays 80% after annual deductible | $75 copay no deductible |
|                      |                                      |                                      |

| Mental Health/Substance Abuse EAP (through FEI Behavioral Health) | Up to 5 office visits no cost | Up to 5 office visits no cost | Up to 5 office visits no cost |

| Mental Health Inpatient Hospital or Facility/Outpatient Office Visits | Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)* | Plan pays 80% after annual deductible |
|                                                                      | Medicare Reimbursement Rate (MRR)* | Medicare Reimbursement Rate (MRR)* |              |

| Substance Abuse Inpatient Hospital or Facility/Outpatient Office Visits | Medicare Reimbursement Rate (MRR)* | Medicare Reimbursement Rate (MRR)* |              |

---

* The plan pays benefits based on 110% of Medicare-linked reimbursement up to 60% for UHC Option 1 & UHC HSA after annual deductible is met. Charges over this reimbursement rate are not covered by the plan. This does not apply to the UHC Option 1 Passive PPO (not listed).

** You must elect the Caremark Rx Plan in order to receive prescription benefits.

*** PPACA drugs covered at 100% for all plans; under the HSA Plan only, approved chronic medications bypass the deductible.

Employees that live in a particular geographical area without access to the UHC Option 1 network will be eligible for UHC Option 1 Passive PPO Plan. The Passive PPO plan design mirrors the regular UHC Option 1 plan option, however, out-of-network claims are treated as in-network and are not subject to the Medicare Reimbursement Rate (MRR).

**Note:** During the calendar year, you can add or drop coverage or any dependents within 30 days if you experience a life changing event, you cannot change plans in the middle of the year.
# Kaiser CA Plan Overview

The Kaiser Plan may not be available to you. Please refer to your Personalized Enrollment Worksheet for more information about the Medical Plans you are eligible for.

<table>
<thead>
<tr>
<th>Kaiser CA*</th>
<th>All services from providers in network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$500</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>25% coinsurance ($100 max)</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>covered at preferred cost share when medically necessary</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after annual deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$3,425</td>
</tr>
<tr>
<td>Family</td>
<td>$6,850</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>(Includes colonoscopies)</td>
<td>Plan pays 100% no deductible</td>
</tr>
<tr>
<td><strong>Laboratory &amp; X-Ray</strong></td>
<td></td>
</tr>
<tr>
<td>(Free-standing or hospital-based)</td>
<td>$10 copay after annual deductible is met</td>
</tr>
<tr>
<td>In Office</td>
<td></td>
</tr>
<tr>
<td>In Specialists Office</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care/Outpatient Hospital or Facility</strong></td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td></td>
</tr>
<tr>
<td>Convenience Care</td>
<td>$30 copay per visit</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td>Up to 5 office visits no cost</td>
</tr>
<tr>
<td>EAP (through FEI Behavioral Health)</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital or Facility/Outpatient Office Visits</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Facility/Outpatient Office Visits</td>
<td>$30 co-pay for individual visit; $5 co-pay for group visit</td>
</tr>
</tbody>
</table>

* Kaiser plan designs vary by state. The Kaiser plan design offered in California varies slightly from the plans in other states. Refer to the Summary of Benefit Coverage (SBC) details available online at Ryder.BenefitsNow.com under the Health & Welfare tab.

**Note:** During the calendar year, you can add or drop coverage or any dependents within 30 days if you experience a life changing event, you cannot change plans in the middle of the year.
Prescription Drug Coverage

Prescription drug coverage is managed by CVS Caremark if you elect the Caremark Rx plan or enroll in the UHC Standard Medical Plan or the UHC HSA Medical Plan. Getting your prescription filled is easy: just present your prescription and Prescription Drug ID Card at a local participating pharmacy. Your Prescription ID Card is accepted at all CVS Caremark pharmacies or at any of the approximately 65,000 nationwide network participating retail pharmacies. For a complete list of participating pharmacies near you, go to www.caremark.com, Group Code: Ryder, or call 1-800-421-5501.

**Required 90-day Supply for Maintenance Medications**

It saves you time and money to fill a 90-day supply for your maintenance medications. You can get your 90-day supply at CVS/Caremark retail pharmacy or through the mail, whichever you prefer.

Please note, for maintenance medications, you can only pick up two 30-day supplies at any retail pharmacy before transitioning to the 90 day supply requirement. Otherwise, you will be charged almost the full cost of the prescription. All 90-day supply prescriptions can be filled through mail order or at a CVS retail pharmacy.

If you choose to use mail order, ask your doctor for a 30-day and a 90-day prescription so that you'll be able to pick up an immediate 30-day supply at a retail pharmacy while you wait for your 90-day mail order prescription to be processed.

---

### Caremark Rx Plan

<table>
<thead>
<tr>
<th></th>
<th>Retail</th>
<th>Mail Service Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Must use network pharmacy Limited to a 30-day supply</td>
<td>or CVS Retail Store Limited to a 90-day supply</td>
</tr>
<tr>
<td><strong>Generic Co-pay</strong></td>
<td>$100 - does not apply to generics or to the HSA</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td><strong>Preferred Drug List - Brand Name</strong> Co-insurance</td>
<td>You pay 25% after annual deductible ($25 min. $100 max. co-pay)</td>
<td>You pay 25% after annual deductible ($62.50 min. $250 max. co-pay)</td>
</tr>
<tr>
<td><strong>Non-Preferred Drug List - Brand Name</strong> Co-insurance</td>
<td>You pay 45% after annual deductible ($50 min. - $150 max. co-pay)</td>
<td>You pay 45% after annual deductible ($125 min. - $375 max. co-pay)</td>
</tr>
<tr>
<td><strong>Biotech Medication</strong></td>
<td>$125 co-pay 30-day supply, subject to pre-authorization</td>
<td></td>
</tr>
</tbody>
</table>

**If you are enrolled in the UHC Option 1** Medical Plan, you have an Out-of-Pocket Maximum for prescriptions. **$1,750 single/$3,500 family**

*If a generic medication is available and you elect to fill the prescription with a brand name medication, you will pay the brand name co-insurance plus the cost difference between the brand name and generic medications even if Dispensed as Written is indicated on the prescription.

---

**If you enroll in the UHC Option 1** Medical Plan

1. You need to be enrolled separately in the Caremark Rx plan to receive any prescription coverage.
2. Generic co-pay is $10 for a 30 day supply or $25 co-pay for a 90 day supply.
3. If you fund the Health Care Spending Account, you can use your YSA card to pay for your prescriptions.

**If you enroll in the UHC HSA Medical Plan**

1. **The prescription coverage is through Caremark and it is included in the Medical Plan.** You pay the full cost of your prescription until you meet the medical plan deductible. When you use a network pharmacy, you pay a discounted rate for prescriptions.
2. **Once you meet the UHC HSA medical plan deductible ($1,300/$2,600/$3,900), you will have prescription drug coverage according to the prescription plan design summarized on the chart above, except the out-of-pocket maximum for the UHC HSA Medical Plan applies.**
3. You have the option to use your HSA dollars to pay for prescriptions.

**If you enroll in the UHC Standard Medical Plan**

1. **The prescription plan design above does NOT apply with this plan.** The prescription coverage is through Caremark, however, it is included in the Medical Plan. Generics have a $15 copay. For all other drugs, you pay the full cost of your prescription until you meet the Medical Plan deductible. The coinsurance then kicks in at 80%/20% and the out-of-pocket maximum for the UHC Standard Medical Plan applies.
2. If you fund the Health Care Spending Account, you can use your YSA card to pay for your prescriptions.

---

**Important Note:**

If you are enrolled in the UHC Option 1 Medical Plan or the UHC Option 1 Passive PPO Plan, the prescription coverage is provided by Caremark. However, this plan design does not apply. See page 13 for details on how prescriptions are covered under the UHC Standard Plan.

---

* * *

**Prescription Drug Coverage**

Prescription drug coverage is managed by CVS Caremark if you elect the Caremark Rx plan or enroll in the UHC Standard Medical Plan or the UHC HSA Medical Plan. Getting your prescription filled is easy: just present your prescription and Prescription Drug ID Card at a local participating pharmacy. Your Prescription ID Card is accepted at all CVS Caremark pharmacies or at any of the approximately 65,000 nationwide network participating retail pharmacies. For a complete list of participating pharmacies near you, go to www.caremark.com, Group Code: Ryder, or call 1-800-421-5501.

**Required 90-day Supply for Maintenance Medications**

It saves you time and money to fill a 90-day supply for your maintenance medications. You can get your 90-day supply at CVS/Caremark retail pharmacy or through the mail, whichever you prefer.

Please note, for maintenance medications, you can only pick up two 30-day supplies at any retail pharmacy before transitioning to the 90 day supply requirement. Otherwise, you will be charged almost the full cost of the prescription. All 90-day supply prescriptions can be filled through mail order or at a CVS retail pharmacy.

If you choose to use mail order, ask your doctor for a 30-day and a 90-day prescription so that you’ll be able to pick up an immediate 30-day supply at a retail pharmacy while you wait for your 90-day mail order prescription to be processed.

---

**If you enroll in the UHC Option 1** Medical Plan

1. You need to be enrolled separately in the Caremark Rx plan to receive any prescription coverage.
2. Generic co-pay is $10 for a 30 day supply or $25 co-pay for a 90 day supply.
3. If you fund the Health Care Spending Account, you can use your YSA card to pay for your prescriptions.

**If you enroll in the UHC HSA Medical Plan**

1. **The prescription coverage is through Caremark and it is included in the Medical Plan.** You pay the full cost of your prescription until you meet the medical plan deductible. When you use a network pharmacy, you pay a discounted rate for prescriptions.
2. **Once you meet the UHC HSA medical plan deductible ($1,300/$2,600/$3,900), you will have prescription drug coverage according to the prescription plan design summarized on the chart above, except the out-of-pocket maximum for the UHC HSA Medical Plan applies.**
3. You have the option to use your HSA dollars to pay for prescriptions.

**If you enroll in the UHC Standard Medical Plan**

1. **The prescription plan design above does NOT apply with this plan.** The prescription coverage is through Caremark, however, it is included in the Medical Plan. Generics have a $15 copay. For all other drugs, you pay the full cost of your prescription until you meet the Medical Plan deductible. The coinsurance then kicks in at 80%/20% and the out-of-pocket maximum for the UHC Standard Medical Plan applies.
2. If you fund the Health Care Spending Account, you can use your YSA card to pay for your prescriptions.

---

* * *
**Dental Coverage**

Ryder offers two (2) dental plans: the Cigna Dental Care HMO and the Cigna Dental PPO. Both Dental Plans cover preventive dental services, basic/major dental services, and orthodontia services. However, the Cigna Dental Care HMO is not available in all areas.

**Cigna Dental Care HMO:**

If you elect the Cigna Dental Care HMO plan, you must select an in-network provider. There are no deductibles and no dollar maximums. You can view a detailed patient fee schedule online at Ryder.BenefitsNow.com under the Health & Welfare tab or you can call Cigna directly at 1-800-244-6224. To locate a provider, log onto the Cigna Website (www.cigna.com) and search under Find a Doctor/Dentist, select Dentist, select the plan Cigna Dental Care HMO.

**Cigna Dental PPO Plan:***

If you elect the Cigna PPO Plan, you have the option to select an in-network Dentist under Cigna Advantage Network or an out-of-network Dentist under the DPPO Network. When you use an in-network provider (Cigna Advantage Network), you receive the deepest discounts and your claims will always be processed at the in-network level as seen in the chart below.

If you choose to use an out-of-network provider under Cigna PPO network, you will still receive discounts for services, your dentist cannot balance bill you and your claims will be processed at the out-of-network level as seen in the chart below. If you choose to use a provider not on the Cigna list there are no discounts and claims will be paid according to the chart below up to the usual and prevailing charges.

To locate a provider in the Cigna Dental PPO network, log onto Cigna.com, click on “Find a Doctor,” choose the directory by clicking on the “If Your Insurance Plan is Offered Through Work or School,” select Dentist, enter search location – city, state, zip code, select a plan by clicking drop down arrow and click on the Cigna Dental PPO or EPO, click on Choose, then click on Search. Once you enroll and become a Cigna member, you can locate in-network dentists by logging onto the Cigna Website (www.mycigna.com) and search under Find a Doctor or Service. Cigna does not mail member ID cards, however, you can print an ID card directly from the website’s home page.

<table>
<thead>
<tr>
<th></th>
<th>Cigna Dental Care HMO</th>
<th>Cigna Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CIGNA DPPO ADVANTAGE</td>
</tr>
<tr>
<td>Features</td>
<td>All care must be received from network</td>
<td>All services from Cigna DPPO Advantage Providers and approved by the plan</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>N/A</td>
<td>$25 Individual/$75 Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 Individual/$150 Family</td>
</tr>
<tr>
<td>Maximum Annual Benefit Payment</td>
<td>N/A</td>
<td>$1,500 Includes Orthodontia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,250 Includes Orthodontia</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Most services 100%(1)</td>
<td>Plan pays 100% no annual deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Basic Services</td>
<td>Most services 100%(1)</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 70% after annual deductible</td>
</tr>
<tr>
<td>Major Services</td>
<td>Co-pay varies(1)</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Co-pay varies (1)</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays 40% after annual deductible</td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum</td>
<td>N/A</td>
<td>$1,250</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,000</td>
</tr>
</tbody>
</table>

Employees that live in a particular geographical area without access to Cigna PPO network will be eligible for the Cigna Indemnity Plan. The Cigna Indemnity Plan mirrors the Cigna PPO plan design, however, out-of-network claims are treated as in-network.

* Dentists listed on Cigna.com that are not noted as DPPO Advantage providers, have agreed to discount their fees, however, claims are paid at the out-of-network coverage level seen in the chart.

** Dentists that have no affiliation with Cigna. These claims are reimbursed based on usual and prevailing (U & P) charges. Any charges in excess of U & P are the responsibility of the patient.

(1) See Fee schedule located on the benefits website Ryder.Benefitsnow.com
**EyeMed Vision Plan**

Your eyes need protection from the sun! Quality sunglasses can block out at least 99% of both UVA and UVB rays. In fact, extended sun exposure has been linked to damage of the lens, retina and the eye’s surface. All enrolled members of the EyeMed vision plan can receive $20 off any purchase up to $199 or $50 off a purchase of $200 or more toward premium non-prescription sunglasses at Sunglass Hut. All you have to do is sign up at eyemed-visioncare.com/sunperks. You will automatically receive an email with a savings code. Use your savings code at Sunglass Hut locations or at sunglasshut.com.

<table>
<thead>
<tr>
<th>Vision Service</th>
<th>Member Cost: In-Network</th>
<th>Member Allowance: Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAM WITH DILATION, AS NECESSARY</td>
<td>NO CHARGE</td>
<td>$35</td>
</tr>
<tr>
<td>EXAM OPTIONS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Contact Lens Fit*</td>
<td>up to $55</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Contact Lens Fit**</td>
<td>10% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>RETINAL IMAGING</td>
<td>up to $39 co-pay</td>
<td>N/A</td>
</tr>
<tr>
<td>FRAMES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any available frame at a provider location</td>
<td>$0 co-pay up to $130 allowance  20% off balance over $130</td>
<td>$65</td>
</tr>
<tr>
<td>STANDARD PLASTIC LENSES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$5 co-pay</td>
<td>$25</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$5 co-pay</td>
<td>$40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$5 co-pay</td>
<td>$55</td>
</tr>
<tr>
<td>LENS OPTIONS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard scratch-resistance</td>
<td>$0 co-pay</td>
<td>up to $11</td>
</tr>
<tr>
<td>UV Coating</td>
<td>$15 co-pay</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint (solid and gradient)</td>
<td>$15 co-pay</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard polycarbonate</td>
<td>$40 co-pay</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard anti-reflective coating</td>
<td>$45 co-pay</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard progressive (bifocal)</td>
<td>$70 co-pay</td>
<td>up to $40</td>
</tr>
<tr>
<td>Premium progressive</td>
<td>$70, 80% of charge less $120 allowance</td>
<td>up to $40</td>
</tr>
<tr>
<td>Other add-ons &amp; services</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>CONTACT LENSES: Materials only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 co-pay up to $130 and 15% off balance over $130</td>
<td>$104</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 co-pay up to $130</td>
<td>$104</td>
</tr>
<tr>
<td>Medically Necessary ***</td>
<td>$0 co-pay, paid in full</td>
<td>$200</td>
</tr>
<tr>
<td>ADDITIONAL PAIRS BENEFITS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>FREQUENCY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Lenses or Contact Lenses</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Frame</td>
<td>Once every 24 months</td>
<td>Once every 24 months</td>
</tr>
</tbody>
</table>

* Standard contact lenses are spherical clear contacts in conventional wear and planned replacements, such as disposable lenses.

** Premium contact lenses are all lens designs, materials and specialty fittings other than standard contact lenses, such as toric, multifocal, etc.

*** Contact lenses are considered medically necessary when standard eyeglass lenses will not correct a member’s vision.

**Eye Wear Discount Program**

If you do not elect to enroll in the Vision Plan, you are still eligible for eyewear discounts through EyeMed. The Vision Discount Plan does not require enrollment and has no cost. It offers discounts of 20% to 60% off the retail cost of eyewear, including eyeglass frames, lenses and conventional contact lenses. The plan also provides discounts of 15% on the usual and prevailing fee for LASIK and PRK surgery when services are provided by U.S. Laser Network. (You can find your Discount Program Card on the benefits portal by logging into Ryder.BenefitsNow.com. Go to the Health & Welfare Tab > Vision Plan.)
Real Appeal

Real Appeal is an online weight loss program that can help you take small steps that lead to big results. If you’ve been struggling to lose weight, Real Appeal’s personalized approach can help you look great and feel your best without turning your life upside-down. By implementing small changes over time, you’ll gradually shift to a healthier, happier lifestyle and begin to see results that last. If you or your spouse/domestic partner are enrolled in one of the UnitedHealthcare Medical Plans and you meet the requirement of a body mass index (BMI) of 25 or higher you may be eligible to join Real Appeal at no cost, not even a co-pay or deductible! You can sign up at ryder.realappeal.com.

Once you enroll, you will meet with a Transformation Coach - right from your smart phone, tablet or personal computer - who customizes a program that suits your lifestyle and targets your desired weight loss goals. **NOTE:** It will not be possible to participate in the program using a Ryder issued computer, as the security firewall and bandwidth space will limit or deny user access. Accordingly, you must use your smart phone, tablet, or home computer to take part in the program. You will receive 52 weeks of access to this coach who will offer continual support and help you stay on track. After your goals are set and your coaching support network is intact, you’ll need all the right tools and resources to kick start your weight loss. The Real Appeal Success Kit is delivered right to your door at no cost. The kit comes complete with nutrition and activity guides, workout DVDs, a pedometer, a blender for making healthy shakes and snacks on the go, and more!

![Real Appeal Kit](image)

In addition to all of this, Real Appeal offers a complete online experience to keep you motivated and inspired. You’ll receive unlimited access to digital content like streaming workout videos and the Real Appeal All Star Show featuring tips and tricks from celebrities, athletes and health experts. You’ll also have access to online tools to track diet, activity and weight loss progress and a Real Appeal Success Group to connect with other people in the program. There’s even a Real Appeal mobile app so you can access these tools anytime, anywhere.
Virtual Visits – Your access to care online, any time.

When you don’t feel well or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. After registering and requesting a visit you will pay your portion of the service costs according to your medical plan, and then you will enter a virtual waiting room. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. And, it’s part of your health benefits with UnitedHealthcare.

Access Virtual Visits
You have access to a network of virtual visit provider groups. To learn more about virtual visits and our network please log into myuhc.com® or the UnitedHealthcare Health4Me® app.

Once you choose a virtual visit provider group you will be directed to their website from myuhc.com or their app from Health4Me. You also have the option of going directly to their website or app to access care. You can download their app directly from Google Play™ or the Apple® App Store®.

Virtual visits are covered under your health plan benefits either way you decide to access care.

Frequently Asked Questions
Q: What type of conditions are commonly treated through a virtual visit?
A: Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:
- Cold/flu
- Bronchitis
- Sore throat
- Bladder infection/
  Urinary tract infection
- Diarrhea
- Fever
- Pink eye
- Minor rashes
- Sinus problems
- Stomach ache
- Migraine/
  headaches

Q: How safe is the information being shared during a virtual visit appointment?
A: UnitedHealthcare requires all network providers, including virtual visit providers, to comply with all applicable laws, including laws relating to the security and confidentiality of patient information. Virtual visit providers are covered entities under HIPAA and its regulations. Therefore, these providers have direct legal requirements to protect and secure confidential patient information. Virtual visit providers determine the manner and means by which they meet these privacy and security requirements. Additional information regarding security and privacy is available at each virtual visit provider group’s website.

Q: Can my child or underage dependent use virtual visits?
A: Yes. In general a parent or legal guardian must be present when the virtual visit is conducted with a minor dependent who is covered under your plan.
Ryder Offers Two Flexible Spending Accounts (FSA)

1. Health Care Spending Account (HCSA) *(not available if you enroll in the UHC HSA Medical Plan)*
2. Dependent Care Spending Account (DCSA)

These accounts cover eligible health care and/or dependent care expenses. You contribute money to your spending account(s) from your paycheck before taxes. The amount you choose will be deducted in equal amounts from your pay for the remainder of the calendar year. Any eligible expenses are reimbursed with the money in your account. This means you actually end up paying less taxes at the end of the year. You cannot change or stop your contributions unless you experience a Qualified Life Event and request a change to your spending account elections within 30 days. Make sure you budget carefully for the year. You need to estimate what your expenses may be and only set aside enough money to cover those costs. You don’t want to overestimate your health care or dependent care expenses because any dollars not used must be forfeited due to IRS rules – it’s called the “use it or lose it” rule. Ryder has adopted the allowable 2.5 month grace period to help minimize forfeitures.

By planning ahead, you’ll be able to contribute enough to cover the expenses you are sure of, and maximize your health care and/or dependent care dollars. Under the HCSA you have until March 15th of the following year to incur eligible expenses. All expenses must be submitted for reimbursement by April 30, 2018. You also have the flexibility to decide whether services incurred during the “grace period” between January 1st and March 15th, 2018 are applied to your 2017 or 2018 account.

If you enroll in the HCSA, you will receive a Debit VISA Card (Your Spending Account [YSA] Card).

**Here’s how it works:**
- You will receive your YSA Card loaded with the annual amount you elected to contribute into your Health Care Spending Account.
- Present your YSA Card for eligible health care expenses to select providers and merchants that accept debit cards and make sure to choose “CREDIT” when you swipe your card.
- **You will be asked to submit additional documentation so save your itemized receipts.** If you don’t provide additional documentation when it’s requested, your YSA card may be suspended until the documentation is received. The documentation can be provided online, via fax or mailed. You will receive notification through the mail with a due date, however, for faster processing you should consider the online process. By going online, you can see the status of the claim, when your documentation is due and you can attach the documentation and submit it right then and there! (Tip: the only time you may not need to submit documentation would be when you use your card for prescriptions, as long as it is used in an approved pharmacy).

### Health Care Spending Account (HCSA):
- You can contribute from $250 up to $2,550 annually.
- HCSA reimbursements cannot be made for your domestic partners nor his/her children unless they are claimed as a tax dependent on your federal tax form.
- Eligible expenses include, but are not limited to: medical co-pays and deductibles, dental work including orthodontia, prescriptions, prescription glasses, contacts and LASIK surgery.
- For a full list of eligible expenses, go to www.irs.gov and search under Publication 502.

### Dependent Care Spending Account (DCSA):
- You can contribute from $100 up to $5,000 annually.
- A dependent care spending account is used to pay for eligible, work-related expenses that are necessary for you and your spouse or domestic partner to work or attend school.
- Your dependent care expenses must be for qualified individuals including your dependent child under the age of 13 who lives with you for more than half the year, or your spouse or other tax dependent who is physically or mentally incapable of self-care and lives with you more than half the year.
- Eligible expenses include, but are not limited to certified day care or day camp, before and after-school programs, baby-sitting services by qualified individuals and elder care services.
Disability Benefits

Disability plans provide financial protection if you become disabled. Several types of coverage are available. Did you know, between the ages of 35 and 65, you have a 30% chance of becoming disabled – and unable to work – for 90 days or longer? That’s why protecting your income is important at every stage of your life.

**Basic Short-Term Disability (STD):** Company-provided benefit offering financial protection against the unexpected loss of income should you be unable to work due to a non-occupational illness or injury.

**Basic Long-Term Disability (LTD):** Company-provided benefit offering income replacement for up to 24 months of a covered disability.

**Additional Short-Term Disability (STD):** Optional employee-paid STD benefit to supplement basic coverage.

**Additional Long-Term Disability (LTD):** Optional employee-paid LTD benefit to supplement basic coverage and provide a continuing source of income during extended periods of disability. If you wish to increase your LTD at a later time, you will be required to complete a medical questionnaire providing information about your medical history and current health. Coverage is subject to carrier approval. All LTD payments are subject to reduction in benefits from other sources of disability income such as Worker’s Compensation or Social Security disability payments.

<table>
<thead>
<tr>
<th>Company Provided</th>
<th>Optional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Short-Term Disability (STD)*</td>
<td>Basic Long-Term Disability (LTD)</td>
</tr>
<tr>
<td>Portion of Pay</td>
<td>Payment Maximum</td>
</tr>
<tr>
<td>$325 per week</td>
<td>$8,000 per month</td>
</tr>
<tr>
<td>Benefit Payment Period</td>
<td>Subject to Withholding</td>
</tr>
<tr>
<td>Up to 25 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Subject to Withholding</td>
<td>Yes</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>Why Choose This Plan?</td>
</tr>
<tr>
<td>7 consecutive calendar days</td>
<td>Company provides this at no cost to you.</td>
</tr>
<tr>
<td>Why Choose This Plan?</td>
<td>If you earn more than $465 per week, Additional STD provides a benefit with no weekly maximum.</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation</td>
<td>If 40% of your earnings is not enough to meet your needs, purchasing Additional LTD provides extra income for up to 5 years.</td>
</tr>
</tbody>
</table>

**STD** coverage as described here does not apply to salaried employees, instead a salary continuation plan is offered. See your Summary Plan Description (SPD) for details.

**LTD** coverage for salaried employees allows for disability coverage up to age 65.

**Pre-Existing Condition Limitation**
A medical condition that has been diagnosed, treated or prescribed for within three months prior to your effective date of coverage is considered a pre-existing condition. A pre-existing condition is not eligible for coverage under the Short-Term and Long-Term Disability plans until twelve months following the effective date of coverage.
Life Insurance

Life insurance is designed to provide your beneficiary with financial assistance in the event of your death while the policy is in effect. Ryder offers several types of life insurance to provide security for you and your family.

<table>
<thead>
<tr>
<th>Employee Life Insurance</th>
<th>Company Pays</th>
<th>Optional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic Life Insurance</td>
<td>1x pay</td>
</tr>
<tr>
<td></td>
<td>Seat Belt Insurance</td>
<td>1x pay</td>
</tr>
<tr>
<td>Benefit</td>
<td>$200,000 up to $25,000</td>
<td>No</td>
</tr>
<tr>
<td>Benefit Maximum</td>
<td>$1,500,000 combined Basic and Additional</td>
<td>Only required for more than 5x pay or $500,000</td>
</tr>
<tr>
<td>Subject to insurance carrier approval</td>
<td>No</td>
<td>To supplement the Basic Company-provided coverage in the event of your death.</td>
</tr>
<tr>
<td>Why Choose Coverage?</td>
<td>Company provides this at no cost to you.</td>
<td></td>
</tr>
</tbody>
</table>

Note: Employees covered under a collective bargaining agreement may be covered by other provisions for these coverages.

<table>
<thead>
<tr>
<th>Family Life Insurance</th>
<th>Optional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spouse Life Insurance</td>
</tr>
<tr>
<td></td>
<td>$10,000 increments of $10,000</td>
</tr>
<tr>
<td>Benefit</td>
<td>$200,000</td>
</tr>
<tr>
<td>Benefit Maximum</td>
<td>No</td>
</tr>
<tr>
<td>Subject to insurance carrier approval</td>
<td>No</td>
</tr>
<tr>
<td>Why Choose Coverage?</td>
<td>Provides life insurance for your spouse/domestic partner.</td>
</tr>
</tbody>
</table>

* Family Accidental Death & Dismemberment (AD&D) is a percentage of the employee’s AD&D coverage.

Submitting a Medical Questionnaire

If you decide to enroll in more than 5 times pay of additional employee life insurance or over $500,000, you will be required to complete a medical questionnaire providing information about your medical history and current health. If you want to enroll in more than $30,000 of spouse life insurance, your spouse will be required to complete a medical questionnaire. Coverage will be subject to insurance company approval. Approved coverage will become effective soon after the insurance company’s approval.

- **Basic Employee Life Insurance**: Company-provided benefit in the event of a death due to illness or injury.
- **Seat Belt Benefit**: Additional Company-provided benefit in the event that death occurs due to a motor vehicle accident in which the insured was wearing a seat belt.
- **Additional Life Insurance**: Optional life insurance to supplement the basic benefit.
- **Spouse Life Insurance**: Optional life insurance for your spouse/domestic partner.
- **Child Life Insurance**: Optional life insurance for your eligible dependent children to age 26.
- **Employee Accidental Death & Dismemberment Insurance (AD&D)**: Optional benefit for loss of limb, sight, hearing or death due to an accidental injury.
- **Family Accidental Death & Dismemberment Insurance (AD&D)**: Optional benefit for you, your spouse/domestic partner and children. Family AD&D coverage is a percentage of your AD&D coverage. Dependent children are covered to age 26.
Health Advocate

Health Advocate is a company-provided benefit for employees enrolled in a Ryder Medical plan. Health Advocate helps you and your entire family navigate the health care system and maximize your benefits.

Who Is Eligible? You, your spouse or domestic partner, dependent children, parents, and parents-in-law are covered at no cost. Health Advocate will assist with clinical and administrative issues involving medical, hospital, vision, dental, pharmacy and other health care needs.

How Do I Use It? It's simple to use. If you need help with a health care or insurance issue, just call Health Advocate at 1-866-695-8622. The first time you call, you will speak with a Personal Health Advocate (PHA) who will ask you to complete a short authorization form.

What Services Does Health Advocate Provide?
Typically you will speak with the same PHA every time you call. Your PHA will help you to:
- Understand your benefit plan provisions and features
- Untangle insurance claims
- Find qualified doctors and hospitals
- Locate and research treatments for a medical condition, including “best-in-class” medical facilities
- Secure appointments with hard-to-reach specialists
- Assist with eldercare issues
- Prepare for health care appointments

How Often May I Call Health Advocate? You or a covered family member may call as often as needed.

Does Health Advocate Replace My Health Care Coverage?
No. This program is not a substitute for health insurance. Rather, it complements basic health coverage by providing a range of services as outlined above.

What Are Health Advocate’s Hours Of Operation? Health Advocate can be accessed 24/7. Normal business hours are Monday - Friday between 8 a.m. and 9 p.m. Eastern Time. A message service is also available after hours and during weekends.

Health Advocate MedChoice SupportTM
Health Advocate MedChoice SupportTM is a valuable feature of your Health Advocate benefit provided at no cost to you. If you or your eligible family member are facing a tough health decision, you have a convenient, online MedChoice Support tool to help you. You’ll learn the facts, risks and potential outcomes – and your feelings about – tests, procedures, treatments and medications to make the best choice.

Here’s how the MedChoice Support tool can help:
- Step-by-step guidance for healthcare decisions, using evidence-based information on topics from surgery to alternative treatments
- Personal assessments that gauges how you feel about your decisions
- Downloadable summary to share with your healthcare team
- You, your spouse, dependent children, parents and parents-in-law can all use this service

Health Advocate can help you feel more confident about your health decisions, by helping you answer questions like...

...should I get a CT scan or an X-ray for lower back pain?

...what happens if I wait – or don’t have – the cancer treatment?

...do I really need a medication for my mild blood pressure?

...should my child get a flu shot?

Your Health Advocate benefit offers personal help with a full range of health care and insurance related problems. You can reach Health Advocate MedChoice SupportTM by calling 1-866-695-8622.
Other Benefit Programs

Ryder 401(k) Savings Plan
The 401(k) Savings Plan provides the tools you need to help you build a solid retirement future. Ryder new hires/re-hires are eligible to make before-tax contributions to the plan through payroll deductions after six (6 months) of employment.

Once eligible, you can contribute on either a pre-tax or post-tax basis, a combined maximum of 50% of your annual earnings. The maximum the IRS allows you to contribute on a pre-tax basis is $18,000. If you are age 50 or over, you can contribute up to an additional $6,000 in pre-tax dollars after your contributions have reached the allowable maximum of $18,000.

You are eligible to receive a matching Company contribution on the first of the month after you reach age 21 and complete one year of service in which you worked 1,000 hours.

Employee Assistance Plan (EAP)
The EAP program makes professional counseling available for you and your family on a voluntary basis. The program is designed to assist you and your family with personal or family problems before they become overwhelming. This includes (but is not limited to):

- family or marital conflicts
- financial budgeting
- parent-child relationships
- crisis and substance abuse problems.

Ryder pays the full cost of the initial assessment and up to four additional counseling sessions.

Power Financial Credit Union
Power Financial Credit Union is a $615 million financial institution that is dedicated to providing financial solutions and services to Ryder employees. Services include savings and checking accounts; investments; ATM/Debit cards; credit cards; Online Banking; Mobile App; eStatements; direct deposit; financial counseling; mortgages and home equity loans; lines of credit; auto loans; boat loans; motorcycle loans; business loans; personal loans and much more. Visit the website at: www.powerfi.org or call us at 800.548.5465.

Hyatt Legal Plan
The Hyatt Legal Plan offers you and your family value, convenience and peace of mind, providing easy and low-cost access to a wide variety of personal legal services. Covered services include:

- Wills
- Trusts
- Adoption
- Real Estate transactions
- Contested and uncontested divorce
- Identity theft
- Contested guardianship

You can choose:

- Services from attorneys who are a part of the Hyatt Legal Plan and have all covered services paid in full; or
- Services from a non-plan attorney and be reimbursed according to a set fee schedule.

Tuition Reimbursement
You are eligible for reimbursement of tuition expenses for pre-approved, qualified courses that are work-related or part of a work-related degree program. You pay the full cost of the course(s) up front and may request reimbursement within 90 days after satisfactory completion of the course(s). You will be reimbursed 75% of the tuition cost up to $5,250 per calendar year, for approved courses in which a grade of C-minus (or its equivalent) or better is received. You must be actively employed by Ryder at the time you start and finish the course(s).

Adoption Assistance
If you are enrolled in a Ryder Medical plan, you are eligible to receive up to $2,000 toward the cost of documented adoption related expenses. You must be enrolled in a Ryder Medical Plan for the entire duration of the adoption process. This benefit is limited to two adoptions per family and provides reimbursement for legal, medical and foster care expenses related to the adoption.

To be eligible, the adoptive child may not be related to either adopting parent. Log on to Ryder.BenefitsNow.com or call the Ryder BenefitsNow Service Center at 1-800-280-2999 for reimbursement applications.
**RyderShares**

When you become a shareholder, you share in the growth and success of Ryder. RyderShares gives you the opportunity to purchase Ryder Common Stock at 85 percent of fair market value – a 15 percent discount – through payroll deductions. You pay no commissions or fees when you purchase shares and pay reduced commissions anytime shares are sold from the plan. There is a three-month waiting period after the end of each quarter before your shares can be sold.

All dividends from shares owned are automatically reinvested, purchasing additional shares of stock. You are eligible to enroll the first quarter after you have worked 90 days. Your contributions begin the first payroll period each January, April, July or October. If you have any questions or would like to enroll, call Morgan Stanley directly at 1-888-301-0681, or go to www.stockplanconnect.com.

**QuitPower®. You can break free from tobacco.**

*Are you ready to quit?*

If you’re thinking of breaking free from your nicotine addiction, QuitPower® can help. QuitPower® is a comprehensive tobacco cessation program that can help you live a healthier life. As a member of a UHC medical plan, you have access to:

- A personal coach for ongoing information and support;
- A quit plan that’s customized for your needs; and
- Nicotine patches or gum, delivered to your home at no cost to you.

To fit your busy schedule, QuitPower® is available over the telephone, online and through the mail. Using coaching and nicotine replacement therapy can increase your chance of kicking the habit. Could QuitPower® be the key to your success?

QuitPower® Coaches work with you one-on-one, on your schedule, to help you create a personalized plan to quit tobacco. Your coach will continue to work with you for six months to help keep you motivated and on track. You’ll get all this, plus nicotine replacement therapy products that can help you quit successfully, at no additional cost.

Once you enroll, the quitting process looks like this:

**Step 1:** Meet your coach. You’ll connect with your own personal QuitPower® Coach over the phone.

**Step 2:** Tailor a quit plan. Work with your coach to make a personalized, confidential plan.

**Step 3:** Get healthy stuff. QuitPower® will send you resources and nicotine replacement therapy that can help you quit.

**Step 4:** Make healthy changes. Have regular calls with your QuitPower® coach to stay on track.

**Step 5:** Celebrate.

You’ll feel great. And you will be encouraged to stay tobacco-free. Once you have completed the QuitPower® Program you can enroll in Ryder’s Non-Tobacco User Credit for a $25 savings on your monthly medical premiums, provided that your enrolled spouse/domestic partner is also tobacco free.

To enroll for QuitPower®, simply register on myuhc.com and click on the Health & Wellness tab, then Take Health Assessment to get started. For questions, please call **1-877-QUIT-PWR (1-877-784-8797).**
Group Health Continuation Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires Ryder System, Inc. to offer employees and their families the opportunity to temporarily continue their group health coverage under the Ryder Health Plan(s) in certain instances where coverage under the Plan would otherwise end.

This notice contains important information about your right to COBRA continuation coverage. It generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

This is only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and federal law, you should review the Summary Plan Description (SPD) or contact the Plan Administrator.

COBRA Qualifying Events

Employee
If you are an employee covered by the Plan, you will become a qualified beneficiary and have the right to elect COBRA continuation coverage if you lose your group health coverage due to any of the following qualifying events:

- Termination of your employment for any reason other than your gross misconduct; or
- A reduction in your hours of employment.

Spouse
If you are the spouse of an employee and are covered by the Plan you will become a qualified beneficiary and have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage due to any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse’s employment for any reason other than gross misconduct;
- A reduction in your spouse’s hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare (Part A, Part B or both).

Dependent
If a dependent child is covered by the Plan, he or she will become a qualified beneficiary and have the right to elect COBRA continuation coverage if group health coverage under the Plan is lost due to any of the following qualifying events:

- The death of the parent-employee;
- The termination of the parent-employee’s employment for any reason other than gross misconduct;
- A reduction in the parent-employee’s hours of employment;
- Parent’s divorce or legal separation;
- The parent-employee becomes entitled to Medicare (Part A, Part B or both); or
- The dependent child ceases to be a “dependent child” under the terms of the Plan.

A child born to, adopted by or placed for adoption with the parent-employee during the period of COBRA continuation coverage would also be a qualified beneficiary and has the right to COBRA continuation coverage.

Retirees and spouses, surviving spouses and dependent children of retirees will become qualified beneficiaries and have the right to elect COBRA continuation coverage if their group health coverage is lost or substantially eliminated due to Ryder filing a proceeding in bankruptcy under Title 11 of the United States Code.

Responsibilities Regarding COBRA Continuation Coverage

To be entitled to COBRA continuation coverage, you, your spouse or your dependents must notify the Ryder BenefitsNow Service Center within 60 days of the date on which any of the following qualifying events occur:

- Divorce;
- Legal separation;
- Child ceasing to be a dependent child under the terms of the Plan; or
- Medicare entitlement (Part A, Part B or both)

To notify the Ryder BenefitsNow Service Center, call 1-800-280-2999 Monday through Friday between 8:00 a.m. and 8:00 p.m. Eastern time.
Ryder must notify the Ryder BenefitsNow Service Center of the following qualifying events:

- Reduction in hours of employment;
- Termination of employment;
- Death of the employee; or
- Commencement of a proceeding in bankruptcy with respect to the employer.

E lecting COBRA Continuation Coverage

Once the Ryder BenefitsNow Service Center is notified that a qualifying event has occurred, they will notify you of your right to elect COBRA continuation coverage. You have 60 days from the later of the date your coverage ends or the date that you are notified of your right to COBRA continuation coverage, to notify the Ryder BenefitsNow Service Center that you want to elect COBRA continuation coverage.

You do not have to show that you are insurable to elect COBRA continuation coverage.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If you elect COBRA continuation coverage, Ryder is required to allow you to purchase coverage that is identical to the coverage being provided under the Plan to similarly situated active employees or family members. If coverage under the Plan is modified for such similarly situated individuals, your coverage will also be modified.

If you do not elect COBRA continuation coverage within the timeframe stated above, your Ryder group health coverage will end.

Length of the COBRA Continuation Period

You, your covered spouse and any dependent children will be entitled to COBRA continuation coverage for up to a maximum of:

- 18 months when the qualifying event is termination of employment (other than for gross misconduct) or reduction in hours of employment; or
- 36 months when the qualifying event is the death of the employee, divorce or legal separation, the employee’s entitlement to Medicare (Part A, Part B or both) or a dependent child ceasing to be a dependent under the Plan.

If the employee becomes entitled to Medicare before the date of his/her qualifying event, the employee’s spouse and any dependent children are entitled to elect COBRA continuation coverage for up to the greater of 36 months from the date of Medicare entitlement or 18 months from the date of the employee’s qualifying event.

Second Qualifying Event Extension

The 18-month COBRA continuation period may be extended to 36 months for your spouse and dependent children who are qualified beneficiaries if a second qualifying event (death, divorce, legal separation) or a dependent child ceasing to be a dependent under the terms of the Plan) occurs during the 18-month COBRA continuation period. However, this extension will only be allowed if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

To be granted an extension, the qualified beneficiary must notify the Ryder BenefitsNow Service Center within 60 days of the second qualifying event.

Disability Extension

The 18-month COBRA continuation period may be extended to 29 months if a qualified beneficiary is determined by Social Security to be disabled at any time before the 60th day of the COBRA continuation period. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To be granted this extension, the qualified beneficiary must, within 60 days of the Social Security disability determination and before the end of the 18-month period: (1) notify the Ryder BenefitsNow Service Center of such disability determination; and (2) provide a copy of the determination of disability notification from the Social Security Administration.

The disabled individual must also notify the Ryder BenefitsNow Service Center within 30 days of any final determination that such individual is no longer disabled.

To notify the Ryder BenefitsNow Service Center, call 1-800-280-2999 toll-free, Monday through Friday between 8:00 a.m. and 8:00 p.m. Eastern time.
Terminating Your COBRA Continuation Coverage

The law provides that your COBRA continuation coverage may be terminated for any of the following reasons:

1. Ryder no longer provides group health coverage to any of its employees.
2. You do not pay the premium for your COBRA continuation coverage on a timely basis, as required by the Plan.
3. After the date of your election, you become covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition applicable to you.
4. After the date of your election, you become entitled to Medicare (Part A, Part B or both).
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

If your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Cost of COBRA Continuation Coverage

As allowed by federal law, you have to pay 102 percent of the applicable premium for your COBRA continuation coverage. This includes the full cost of coverage plus a two percent administration fee. However, the cost of the 11-month disability extension will be 150 percent of the applicable premium if the disabled qualified beneficiary is covered or 102 percent of the applicable premium if only non-disabled qualified beneficiaries are covered.

At the end of the COBRA continuation period, you may be eligible to enroll in an individual conversion health plan if the plan you are covered under offers this option.

Address Changes

To protect your family’s rights, you should keep the appropriate parties informed of any changes in address, as follows:

- Employee address: If your address changes, you should notify the Ryder BenefitsNow Service Center.
- Dependent address: If your spouse or dependent(s) change address (to an address other than your address), contact the RyderBenefitsNow Service Center.

You should also keep a copy for your records of any notices you send to the Ryder BenefitsNow Service Center or to the Plan Administrator.

COBRA Contact Information

If you have any questions about the Plan or your COBRA rights, please contact the Ryder BenefitsNow Service Center at 1-800-280-2999 Monday through Friday between 8:00 a.m. and 8:00 p.m. Eastern time or write to the address shown below.

Ryder BenefitsNow Service Center
P.O. Box 905757
Charlotte, NC 28290-5757

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA’s Web site.
Contact Information:

Medical Plans
United Healthcare
1-888-899-4734
www.uhc.com

Optum Bank
1-800-791-9361 or
1-866-234-8913
www.myuhc.com or
www.optumhealthbank.com

QuitPower®
1-877-QUIT-PWR
(1-877-784-8797)

Kaiser HMO Plans
1-800-464-4000 (CA)
1-800-611-1811 (GA)
1-800-966-5955 (HI)
1-800-777-7902 (Mid-Atlantic)
1-800-813-2000 (OR)
www.kp.org

Prescription Plan
Caremark Rx Plan
1-800-421-5501
www.caremark.com
Group Code: Ryder

Dental Plans
Cigna Dental PPO
Cigna Dental Indemnity
Cigna Dental Care HMO
1-800-244-6224
www.cigna.com

Vision Plan
EyeMed Vision Care
1-866-723-0513
www.eyemedvisioncare.com

Short-Term and
Long-Term Disability Plans
Liberty Mutual
1-888-481-2423

Flexible Spending
Accounts, Tuition
Reimbursement and
Adoption Assistance
Programs, COBRA
BenefitsNow Service Center
1-800-280-2999
Ryder.BenefitsNow.com

Life Insurance Plans
Securian Life
1-866-293-6047

Employee Assistance Plan
(EAP)
FEI Behavioral Health
1-800-323-0751
TTY: 1-800-833-6885
www.feibh.com/rsi

Mental Health and
Substance Abuse
United Behavioral Health
1-866-680-0995
www.liveandworkwell.com

Legal Plan
Hyatt Legal Plans
1-800-821-6400
www.hlpsvc.com

Health Advocate and
MedChoice Support™
1-866-695-8622
www.HealthAdvocate.com
Representatives available
Monday-Friday
8:00 am to 9:00 pm ET

Employee Discount Program – In addition to the customer discounts offered to employees, Ryder continues to add new programs to the mix. Log onto www.Ryder.com and go to Employee Discounts and Incentives. You will find discounts on Automotive, Consumer Goods, Mobility Services, Travel and Hotels.

Direct questions to the Ryder BenefitsNow Service Center at 1-800-280-2999. Representatives are available Monday - Friday from 8:00 a.m. – 8:00 p.m. ET. Or e-mail the Benefits Department at askhrcom@ryder.com for general benefit related questions.

The information provided herein has been provided by Ryder System, Inc. and is solely the responsibility of Ryder System, Inc. The descriptions contained in this brochure do not alter or change the terms of the official plan documents, which govern the operation of the plans. To the extent there is any conflict between the official document and this brochure, the official documents shall govern in all cases. Additionally, Ryder System, Inc. reserves the right to amend or terminate any plan at any time.