Summary Plan Description and Benefit Programs
# INTRODUCTION

<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>ELIGIBILITY</td>
<td>6</td>
</tr>
<tr>
<td>ADMINISTRATIVE INFORMATION</td>
<td>18</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>64</td>
</tr>
<tr>
<td>PRESCRIPTION</td>
<td>121</td>
</tr>
<tr>
<td>DENTAL</td>
<td>128</td>
</tr>
<tr>
<td>VISION INSURANCE</td>
<td>146</td>
</tr>
<tr>
<td>FLEXIBLE SPENDING ACCOUNTS</td>
<td>154</td>
</tr>
<tr>
<td>SHORT-TERM DISABILITY</td>
<td>167</td>
</tr>
<tr>
<td>LONG-TERM DISABILITY</td>
<td>178</td>
</tr>
<tr>
<td>LIFE INSURANCE</td>
<td>187</td>
</tr>
<tr>
<td>HYATT LEGAL PLAN</td>
<td>197</td>
</tr>
<tr>
<td>401(K) SAVINGS PLAN</td>
<td>204</td>
</tr>
<tr>
<td>OTHER BENEFITS</td>
<td>219</td>
</tr>
<tr>
<td>RETIREMENT PLAN</td>
<td>227</td>
</tr>
<tr>
<td>RYDERSHARES</td>
<td>239</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>242</td>
</tr>
<tr>
<td>RYDER SEVERANCE PLAN</td>
<td>253</td>
</tr>
<tr>
<td>RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES</td>
<td>264</td>
</tr>
</tbody>
</table>
Introduction

Your benefits make up a significant part of your total compensation. Your pay is only part of your total compensation package. Along with your paycheck, the programs below provide you the opportunity to take advantage of a benefit package that most effectively meets your personal and family needs:

- Medical Coverage
- Prescription Coverage
- Dental Coverage
- Vision Insurance Plan
- Eye Wear Discounts
- Health and Dependent Care Flexible Spending Accounts
- Disability Coverage
  - Basic and Additional Short-Term Disability
  - Basic and Additional Long-Term Disability
- Life Insurance Coverage
  - Basic Life
  - Additional Life
  - Spouse Life
  - Child(ren) Life
- Accidental Death and Dismemberment (AD&D) Insurance
- Seat Belt/Safety Net Benefit
- Motorcycle Helmet Benefit
- Business Travel Accident Insurance
- Hyatt Legal Plan
- 401(k) Savings Plan
- Other Benefits
  - Employee Assistance Program
  - Tuition Reimbursement Program
  - Health Advocate
  - Consumer’s Medical Resource
  - Adoption Assistance
  - YouDecide.com
  - Ryder System Federal Credit Union
  - Direct Deposit and Pay Cards
- Retirement Plan
- RyderShares
About this Book

This book is your Summary Plan Description (SPD) and Benefit Programs as of January 1, 2013 and contains a summary of all of the programs provided to you by Ryder System, Inc. On the following pages, you will find the most important provisions of the benefit programs offered to you as a Ryder employee.

Important Note: For some of the health and welfare plans referenced in this booklet, this booklet in combination with certain contracts and other related documents, serves as the official plan document. However, for other plans, such as the Retirement Plan and 401(k) Plan, there is a separate, stand-alone official plan document. To the extent there is any conflict between the official documents of any plan summarized in this booklet and the descriptions contain herein, the official documents shall govern in all cases. Additionally, certain of the plans described in this booklet are covered by the Employee Retirement Income Security Act of 1974 (ERISA). Provisions contained in this booklet that are mandated by ERISA shall apply only to those plans that are in fact covered by ERISA. As described herein, Ryder reserves the right to amend, modify or terminate any plan at any time and for any reason.

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.
The chart below provides an overview of benefit plans discussed in this book.

<table>
<thead>
<tr>
<th>Benefit Plan</th>
<th>Who Pays for Coverage</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Prescription</td>
<td>Ryder and you, with pre-tax dollars from your pay*</td>
<td>Annually. You may change coverage during the year only if you have a Qualified Life Event.</td>
</tr>
<tr>
<td>Prescription Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Tobacco User Credit</td>
<td>Ryder reduces your medical contribution by $10 per month.</td>
<td>Annually. If you used tobacco but successfully complete the Company-approved tobacco cessation program, you may qualify for this credit during the year.</td>
</tr>
<tr>
<td>Vision Insurance Plan</td>
<td>You, with pre-tax dollars from your pay.</td>
<td>Annually. You may change coverage during the year only if you have a Qualified Life Event.</td>
</tr>
<tr>
<td>Eye Wear Discount Program</td>
<td>Ryder</td>
<td>Participation is automatic if you are eligible to participate in a Ryder Medical Plan.</td>
</tr>
<tr>
<td>Health Care and Dependent Care</td>
<td>You, with pre-tax dollars from your pay.</td>
<td>Annually. You may change coverage during the year only if you have a Qualified Life Event.</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Short-Term Disability</td>
<td>Ryder</td>
<td>Participation is automatic. You do not need to enroll.</td>
</tr>
<tr>
<td>Basic Long-Term Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td></td>
<td></td>
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<tr>
<td>Seat Belt/Safety Net Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motorcycle Helmet Benefit</td>
<td></td>
<td></td>
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<tr>
<td>Business Travel Accident</td>
<td></td>
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</tr>
<tr>
<td>Additional Short-Term Disability</td>
<td>You, with pre-tax dollars from your pay.</td>
<td>Annually. You may decrease or drop your coverage at any time.</td>
</tr>
<tr>
<td>Additional Long-Term Disability</td>
<td>You, with post-tax dollars from your pay.</td>
<td>Annually. You may drop or decrease your coverage at any time.</td>
</tr>
<tr>
<td>Additional Life Insurance</td>
<td>You, with post-tax dollars from your pay.</td>
<td>You may drop or decrease your coverage at any time. You may add or increase coverage during annual enrollment or any time during the year if you experience a Qualified Life Event.</td>
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<tr>
<td>Spouse Life Insurance</td>
<td></td>
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<tr>
<td>Child(ren) Life Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee/Family Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>You, with post-tax dollars from your pay.</td>
<td></td>
</tr>
<tr>
<td>Hyatt Legal Plan</td>
<td>You, with post-tax dollars from your pay.</td>
<td>Annually. You may make a change to your coverage only if you experience a Qualified Life Event. The coverage change must be consistent with the change in family status.</td>
</tr>
<tr>
<td>Retirement Plan</td>
<td>Ryder</td>
<td>Plan is closed to new entrants.</td>
</tr>
<tr>
<td>401(k) Savings Plan</td>
<td>You, with pre-tax or post-tax dollars from your pay.</td>
<td>You may enroll and make changes at any time during the year.</td>
</tr>
<tr>
<td>RyderShares (Employee Stock Purchase Plan)</td>
<td>Ryder</td>
<td>Quarterly. Eligible after 90 days of employment.</td>
</tr>
<tr>
<td>Other Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition Reimbursement Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Advocate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer’s Medical Resource</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
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<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Direct Deposit and Pay Cards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please note you may not pay pre-tax dollars for non-qualified domestic partner coverage. Reference the Eligibility Section for unique tax rules on domestic partner coverage.
TABLE OF CONTENTS

Plans You Are Automatically Enrolled In .............................................................. 7
Plans You Have the Option to Enroll In ............................................................... 7
Eligibility ............................................................................................................. 8
  Employees ....................................................................................................... 8
  Dependent ..................................................................................................... 8
Dependent Eligibility Audit ............................................................................. 9
  Domestic Partner Medical, Prescription and Dental Benefits ......................... 9
Working Spouse Eligibility Rules ................................................................... 9
Coverage Categories ......................................................................................... 10
Ryder Couples and Other Ryder Family Members ......................................... 10
Enrollment ........................................................................................................ 11
When Coverage Begins .................................................................................... 11
  New Hires ..................................................................................................... 11
  Transfers ...................................................................................................... 11
  Rehires ........................................................................................................ 12
  Absence on Effective Date of Coverage ....................................................... 12
  Absence on Effective Date for Life and Accidental Death & Dismemberment ... 12
  Absence on Effective Date for Short-Term and Long-Term Disability .............. 12
Qualified Life Event Changes .......................................................................... 13
When Coverage Ends ....................................................................................... 14
Right to Certificate of Creditable Coverage .................................................... 15
Coverage for Active Employees After Age 65 ................................................ 15
Retirees ........................................................................................................... 16
  Enrollment Restrictions ............................................................................... 16
Death ............................................................................................................... 17

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Important Note: If you and/or your dependents have Medicare or will become eligible for Medicare, a Federal law gives you more choices about your prescription drug coverage. Please see the Administrative Information section of this book for more information.
Plans You Are Automatically Enrolled In
You are automatically enrolled in the following Company paid basic benefits:

- Short-Term Disability
- Long-Term Disability
- Life Insurance
- Business Travel Accident Insurance
- Seat Belt/Safety Net Benefit
- Motorcycle Helmet Benefit
- Eye Wear Discount Program
- Adoption Assistance (only if enrolled in an eligible Medical Plan)
- Tuition Reimbursement Program
- Employee Assistance Program (EAP)
- Consumer’s Medical Resource (only if enrolled in an eligible Medical Plan)
- Health Advocate (only if enrolled in an eligible Medical Plan)

Plans You Have the Option to Enroll In
As a newly hired or newly eligible employee, you have the option to enroll in the following benefits during your first 60 days of employment. You can go online at www.Ryder.BenefitsNow.com or call the BenefitsNow Service Center at 800-280-2999. You have the option to enroll in the following benefits:

- Medical Coverage
- Prescription Coverage
- Dental Coverage
- Vision Insurance Plan
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Additional Short-Term Disability Coverage
- Additional Long-Term Disability Coverage
- Additional Life Insurance Coverage
- Spouse Life Insurance Coverage
- Child(ren) Life Insurance Coverage
- Employee Accidental Death and Dismemberment Insurance Coverage
- Family Accidental Death and Dismemberment Insurance Coverage
- Hyatt Legal Plan

Generally, most coverage is effective the first of the month following 90 days of continuous full-time, active employment. If you do not elect to participate in the optional programs during your first 60 days of employment, you will generally not be provided an opportunity to elect coverage until the annual enrollment in the fall. Coverage elections made during the fall annual enrollment become effective January 1st of the following year.

As a newly hired or newly eligible employee, **you have the option to enroll** in the following benefit at any time. You can go online at www.netbenefits.fidelity.com or call the Ryder Retirement Service Center at 800-373-7300:

- 401(k) Savings Plan

Refer to the 401(k) Savings Plan section of the book for specific information regarding eligibility under this plan.
Eligibility
This section describes the Eligibility rules for you and your dependents under the Health & Welfare plans, the Dependent Eligibility Audit, Working Spouse Eligibility Rule, Coverage Categories, Ryder Couples and Other Ryder Family Members, Enrollment, When Coverage Begins, Qualified Life Event Changes, When Coverage Ends, Right to Certificate of Creditable Coverage, Coverage for Active Employees after Age 65, and Retirees.

Employees
You are eligible to participate in Medical, Prescription, Dental, Vision, Flexible Spending Accounts, Short-Term and Long-Term Disability, Life Insurance, AD&D, Hyatt Legal Plan and the 401(k) Savings Plan if you are an active, regular full-time employee of Ryder System, Inc. or any of its subsidiaries or affiliates that have elected to offer these plans to employees.

An employee shall not include any individual (1) designated by Ryder as an independent contractor and not an employee at the time of any determination, (2) being paid by or through an employee leasing company or other third party agency, (3) designated by Ryder as a freelance worker and not as an employee at the time of any determination, (4) designated by Ryder as a part-time seasonal, occasional, limited duration or temporary employee during the period the individual is so paid or designated. Any such individual shall not be an employee eligible for benefits even if he or she is later retroactively classified as a common-law employee of Ryder during any part or all of such period.

If you work under the provisions of a collective bargaining agreement or are covered under a valid, current written customer contract, you are eligible to participate if your agreement specifically provides for benefits under these plans.

Dependent
You may enroll your dependents in Medical, Prescription, Dental, Vision, Spouse Life or Child Life Insurance, Family AD&D and Hyatt Legal. You will need to provide the names and Social Security numbers of your eligible dependents. This information is necessary to comply with the Medicare Coordination of Benefit provision. Additionally, for employees who have Spouse Life Insurance, your spouse or domestic partner’s date of birth is required to be on file with the Ryder BenefitsNow Service Center. Date of birth is needed to correctly calculate Spouse Life insurance premiums based upon your spouse or domestic partner’s age. Eligible dependents include:

- your legal spouse, including your common-law spouse, to whom you are married under state law, subject to the Working Spouse Eligibility Rule;
- your domestic partner, of the same or opposite sex, if he or she has met all of the following criteria for the 12 months before the coverage effective date, subject to the Working Spouse Eligibility Rule:
  - the individual is your sole domestic partner and intends to remain so indefinitely;
  - you or the individual are not married or legally separated from each other or 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 or she resides;
  - the individual is at least eighteen (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 engaged in a committed relationship of mutual caring and support and are jointly responsible for each other’s common welfare and living expenses;
- your natural, adopted or step children up to age 26, or your child is 26 or older but is permanently and totally disabled, which means he or she is unable to support and maintain him or herself financially due to a physical or mental impairment. Eligibility for disabled dependent coverage is solely determined by the Medical Plan carrier you elect. You may apply for coverage by notifying the Ryder BenefitsNow Service Center (1) when you are first eligible to enroll in coverage or (2) if
you are already enrolled, you must request continued coverage before the dependent’s coverage would otherwise end; and

• your domestic partner’s children up to age 26.

**Dependent Eligibility Audit**

The Company will conduct eligibility audits for every dependent added to Ryder’s coverage to ensure that only dependents who meet Ryder’s eligibility requirements are covered under Ryder’s Medical, Dental and Prescription Plans. The Dependent Eligibility Audit Forms and Instructions are included in your New Hire Benefits Package. If you are enrolling a dependent into your Medical, Prescription and/or Dental coverage, you must immediately comply with the Dependent Eligibility Audit requirement or your dependents will be dropped from your insurance. Acceptable proof is limited to:

• birth certificates for children (must indicate birth parents’ names);
• current federal tax return, pages 1 and 2 of your signed and submitted tax return form (tax return must indicate filing status such as, married filing jointly, married filing separately, all dependents’ names and social security numbers);
• court documents; or
• Domestic Partner/Common Law Spouse affidavit.

If your dependents are dropped due to failure to comply with the Dependent Audit by the deadline, reinstatement of dependents’ coverage will only be allowed at the next annual enrollment, unless there is a Qualified Life Event. Intentional misrepresentation of dependent eligibility will be subject to disciplinary action, up to and including termination of benefits and termination of employment.

**Domestic Partner Medical, Prescription and Dental Benefits**

Because federal law does not recognize the rights of a domestic partner with respect to employee benefits, the employee cannot benefit from the federal income tax exclusion for benefits provided for a domestic partner or that partner’s children, unless the domestic partner and/or his or her children qualifies as a dependent under Internal Revenue Code section 152. Under IRS guidelines, the Employee is subject to tax on the fair market value of the coverage provided to the non-qualified domestic partner and his/her dependent children. As such, all domestic partners will be considered non-qualified tax dependents unless you submit federal tax documents to prove their tax-qualified status. This status is subject to review annually.

These benefits may be subject to federal, state and other applicable tax withholding and the additional employer cost to cover the dependents will be reported as imputed income on the employee’s federal W-2 Form at the end of each year in which coverage is elected for a domestic partner or for a domestic partner’s dependent children.

**Working Spouse Eligibility Rules**

If your working spouse or domestic partner has comprehensive group medical, prescription and/or dental coverage available to him or her through his or her employer, your spouse or domestic partner is **not eligible** for coverage under the Ryder System, Inc. group medical, prescription and dental plans, regardless of cost, provider networks, plan design (copays, deductibles, coinsurance) or exclusion of certain procedures. Comprehensive medical coverage includes coverage for physician services, outpatient and inpatient hospitalization and prescriptions. Comprehensive dental coverage includes coverage for preventive, basic restorative and major restorative services.

**Need to Know:**

Ryder expects all employees to comply with the Working Spouse Eligibility Rule and to take the appropriate enrollment actions regarding plan coverage for their spouse or domestic partner.
### ELIGIBILITY

<table>
<thead>
<tr>
<th>If your working spouse or domestic partner...</th>
<th>then your working spouse or domestic partner CAN be covered under Ryder’s...</th>
</tr>
</thead>
<tbody>
<tr>
<td>is not eligible for medical 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. plans do not cover hospitalization),</td>
<td>Medical and Prescription Plans.</td>
</tr>
<tr>
<td>is eligible for a Medical Plan, 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 or domestic partner...</th>
<th>then your working spouse or 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 than Ryder’s Medical Plan for physician services, hospitalization or surgery,</td>
<td>Medical and Prescription Plans.</td>
</tr>
<tr>
<td>is eligible for a comprehensive Medical Plan or dental plan, but their doctor or dentist is not in the plan’s network,</td>
<td>Medical and Prescription or Dental Plans.</td>
</tr>
<tr>
<td>is eligible for comprehensive medical, prescription and dental coverage, but the cost of coverage is more expensive than the cost for Ryder’s plans,</td>
<td>Medical, Prescription or Dental Plans.</td>
</tr>
<tr>
<td>is eligible for comprehensive dental coverage,</td>
<td>Dental Plan.</td>
</tr>
<tr>
<td>is eligible for comprehensive dental coverage, but does not offer orthodontia,</td>
<td>Dental Plan.</td>
</tr>
</tbody>
</table>

*Note: The Ryder Vision Insurance Plan is not subject to the Working Spouse Rule. Employees can enroll working spouses, even if they are offered vision insurance through their employer.*

### Coverage Categories

The Medical, Prescription, Dental and Vision Plans have four coverage categories:

- **Employee only** – covers only the employee;
- **Employee + Spouse** – provides coverage for the employee and their eligible spouse or domestic partner;
- **Employee + Child(ren)** – provides coverage for the employee and one or more eligible child; and
- **Family** – provides coverage for the employee, their spouse or domestic partner and one or more eligible child(ren).

You do not have to choose the same coverage category for each plan. However, to be eligible for Prescription Plan coverage, either you or you and your dependents must be enrolled in the Medical Plan.

### Ryder Couples and Other Ryder Family Members

If both you and your spouse are Ryder employees, only one of you needs to enroll in the Medical, Prescription, Dental or Vision Plans. The other may be covered as a dependent. You may not be enrolled as an employee and as a dependent in the Medical, Prescription, Dental or Vision Plans. If you have children, only one of you may cover your children.
However, under the Additional Life Insurance and Accidental Death and Dismemberment (AD&D) plans, you may elect Additional Life and Accidental Death and Dismemberment (AD&D) coverage as both an employee and as a spouse. If you have children, the children may be covered under only one parent for Child(ren) Life and AD&D.

If any child qualifies as an eligible Ryder employee, he or she is not eligible to be covered as a dependent child under a Ryder parent’s Child Life and Family AD&D plans.

**Enrollment**

You will receive an enrollment package shortly after you start working for the Company and/or you become eligible to enroll in the Medical, Prescription, Dental, Vision Insurance, Flexible Spending Accounts, Additional Short-Term Disability (STD)*, Additional Long-Term Disability (LTD)**, Additional Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment (AD&D), and the Hyatt Legal Plan. All enrollment opportunities have a deadline date.

- if you are a newly hired employee, you must elect to participate within 60 days after your date of hire;
- if you are not a newly hired employee, you must elect to participate within 60 days after the date you become eligible to enroll;
- if you are a rehired employee within 24 months from your most recent termination date, you must elect to participate in plan coverage within 30 days of your date of rehire; or
- if you were rehired after 24 months from the date of termination, you must elect to participate in plan coverage within 60 days of your date of rehire.

*Additional STD is only available for Hourly employees. Salaried employees are automatically enrolled in the Salary Continuance Plan.

**You are automatically enrolled for Basic LTD coverage. Additional LTD is available for both Hourly and Salaried employees. Refer to the LTD section.

If you do not elect coverage by the deadline date, you will not be able to enroll in benefits until Annual Enrollment at the end of the year, or when you have a Qualified Life Event. Any coverage elected during Annual Enrollment will become effective on January 1 of the following year. Some plans are subject to approval by the insurance carrier if you decide to enroll after your initial enrollment date.

**When Coverage Begins**

**New Hires**

If you elect coverage when you first become eligible to enroll, your coverage begins on the first of the month following 90 days of continuous, regular, active full-time employment. If you are on medical leave during the 90-day waiting period, you will be treated as being at work during your medical leave days for purposes of eligibility for all benefits. In any case, to be eligible for any benefits, you must have worked for at least one full day. If for any reason during this period, your service is interrupted by a personal or other leave of absence not due to your own medical condition, your 90-day waiting period will stop. When you return from leave you will be subject to a new 90-day waiting period before benefits are effective. If your absence is due to qualified military service (as defined by USERRA), upon your return to work, your waiting period will continue where it left off.

**Transfers**

If you were previously covered by a collective bargaining agreement and become eligible for the Ryder Benefits Program, your coverage will be effective on the day you change from union to non-union status, if you have been continuously employed by the Company for 90 days, as a regular full-time active employee. If you have not yet been continuously employed by the Company for 90 days, your days worked under the collective bargaining agreement will count toward the 90-day waiting period. In any case, to be eligible for any benefits, you must have worked for at least one full day.
ELIGIBILITY

Rehires
If you previously worked for Ryder System, Inc. or one of its subsidiaries or affiliates and are rehired, the date your coverage begins is determined by the length of time between your date of termination and date of rehire. If you are a rehired employee, coverage is effective the first of the month following the date of rehire if:

- you are rehired within 24 months of the date of termination; and
- you have previously met the 90-day waiting period;
- except, if you have not previously met the 90-day waiting period, coverage begins on the first of the month following 90 days of continuous full-time active employment from your most recent rehire date.

If you are rehired after 24 months from the date of termination, coverage is effective the first of the month following 90 days of continuous, active full-time employment.

If you are on medical leave during any 90-day waiting period, you will be treated as being at work during your medical leave days for purposes of determining your benefits begin date. In any case, to be eligible for any benefits, you must have worked for at least one full day.

Absence on Effective Date of Coverage
If you are not actively at work full-time on the date your coverage is scheduled to begin, your coverage will be delayed until you return and are actively at work for one full day. This delay does not apply if your absence from work is due to your own medical leave, in which case you will be treated as being actively at work on the day your coverage begins. You are considered to be actively at work while on vacation or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. If you changed your coverage option during Annual Enrollment and you are not actively at work on January 1 of the next calendar year, you will be covered under the prior year's coverage option until you return to work.

Absence on Effective Date for Life and Accidental Death & Dismemberment
If you are not actively at work full-time on the date your coverage is scheduled to begin, your coverage will be delayed until you have been actively at work for one full day. If you changed your coverage option during Annual Enrollment and you are not actively at work on the day your new coverage is scheduled to begin, you will be covered under the prior year's coverage option until you return to work.

You are considered to be actively at work while on vacation or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. If you changed your coverage option during Annual Enrollment and you are not actively at work on January 1 of the next calendar year, you will be covered under the prior year's coverage option until you return to work.

If a dependent is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date his or her coverage would become effective, the new coverage will begin as of the date when the dependent is no longer totally disabled.

Absence on Effective Date for Short-Term and Long-Term Disability
If you are not actively at work on a full-time basis on the date your STD and LTD coverage is scheduled to begin, your coverage will be delayed until you have been actively at work for one full day. You are considered to be actively at work when you are performing the duties of your job at your normal place of work. You are considered to be actively at work while on vacation or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. If you changed your coverage option during Annual Enrollment and you are not actively at work on January 1 of the next calendar year, you will be covered under the prior year's coverage option until you return to work.
Qualified Life Event Changes
You cannot change or enroll in coverage after your initial enrollment opportunity unless you experience a Qualified Life Event. You have 31 days from the date of the event to add or drop coverage, add or drop your dependents or change your dependent coverage category. You may not change from one plan option to another in the middle of any calendar year. Generally, the change requested must be consistent with the Qualified Life Event.

Below is a list of Qualified Life Events:

- marriage, divorce, or legal separation of the employee;
- birth, adoption or placement for adoption of a child;
- death of a spouse or other dependent;
- spouse’s gain or loss of employment or dependent gains or loses coverage;
- employee’s or spouse’s change in employment status from full-time to part-time (or vice versa);
- employee or spouse taking an unpaid leave of absence;
- change of residence if it results in becoming ineligible for your current health coverage;
- dependents satisfying or ceasing to satisfy eligibility requirements (i.e., a dependent child who has reached the plan’s maximum age requirement);
- changes in coverage required by a judgment, decree or order;
- entitlement to Medicare;
- a significant change in health care coverage for employee and/or spouse that is attributable to spouse’s employment (does not apply to the Health Flexible Spending Account Plan); cost changes for the Dependent Care Assistance Program does not apply if the cost change is made by a relative of the Employee or Spouse;
- other events approved by the plan administrator and are consistent with IRS statutes or regulations;
- you and/or your dependent(s) lose other health coverage (but not due to failure to pay premiums on a timely basis, voluntary disenrollment, or termination for cause);
- the Company contributions to the other coverage have stopped; or
- the other coverage was COBRA and the maximum COBRA coverage period ends.

The loss of your selected network provider in any of the Medical, Dental or Vision Plans do not allow you to make changes in your plan or coverage election.

The date in which you and your domestic partner meet all of the Ryder domestic partner eligibility criteria is not considered a Qualified Life Event by the IRS. Therefore, a newly eligible domestic partner and/or his or her dependents can only be added to coverage during Annual Enrollment. Once a domestic partner or his or her dependents are otherwise eligible, other Qualified Life Events apply.

Coverage changes to the Hyatt Legal Plan must be consistent with the Qualified Life Event, but in no event can you cancel coverage during the year.

You may decrease or terminate coverage in Additional Long-Term Disability, Additional Life, Spouse Life, Child(ren) Life, Employee and Family Accidental Death & Dismemberment at any time during the year. However, requests to re-enroll or increase your Additional Long-Term Disability, Additional Life, or Spouse Life coverage during any subsequent Annual Enrollment may be subject to insurance carrier approval.

You may begin, end, decrease or increase your contribution in the Health Care or Dependent Care Spending Accounts as long as it is consistent with the Qualified Life Event.

Changes to the Non-Tobacco User Credit plan can only be made:

- during Annual Enrollment;
- you successfully complete a Company-approved tobacco cessation program; or
ELIGIBILITY

- you experience a Qualified Life Event where you remove your spouse/domestic partner from your coverage and, in doing so, you then qualify for the Credit, provided you are tobacco-free.

If a tobacco cessation program is successfully completed, you may elect the Non-Tobacco User Credit at that time, provided your enrolled spouse/domestic partner is also tobacco-free.

To make a change to your benefits, contact the Ryder BenefitsNow Service Center at 800-280-2999 within 31 days of the Qualified Life Event. Changes become effective on the date of the Qualified Life Event.

When Coverage Ends
Your coverage under the Medical, Prescription, Dental and Vision generally ends on the last day of the month when:
- your employment with the Company is terminated;
- you change to an ineligible status;
- you cancel your coverage;
- you stop making contributions; or
- Ryder changes or no longer offers the program.

Your dependents’ coverage under the Medical, Prescription, Dental and Vision generally ends on the last day of the month when:
- your coverage ends;
- your dependent, such as your spouse, domestic partner, child or spouse’s or domestic partner’s child, no longer meets the definition of a dependent; or
- you cancel dependent coverage.

Your participation in the Flexible Spending Accounts generally ends the day:
- your employment with the Company is terminated;
- you change to an ineligible status;
- Ryder amends or terminates the plan; or
- you stop making contributions to your account(s);

If your employment with Ryder ends during the calendar year, your participation ends on the day you stop working, unless you choose to continue participation in the Health Care Account through COBRA continuation coverage. If you do not choose to continue participation through COBRA, only expenses up to the day you terminate are eligible for reimbursement. Continuation coverage is explained in greater detail in the Administrative Information section of this book. Continuation coverage is not available for the Dependent Care Account, but you may continue to submit claims incurred after the day you stop working until you use up the money in your account. The deadline for submitting Flexible Spending Account claims for the calendar year in which you terminate still applies.

Your Short-Term and Long-Term Disability coverage generally ends when:
- you leave the Company (the last day of active employment);  
- you change to an ineligible status;  
- you are temporarily laid off;  
- you take a leave of absence, including a leave for military service;  
- you are absent due to a general work stoppage, including a strike or lockout;  
- you cancel your coverage;  
- you stop making contributions for plans which require it;  
- Ryder changes, or no longer offers the program; or  
- the date the policy or plan is cancelled.
Your **Life Insurance and AD&D** coverage generally ends on the day:
- you leave the Company (the last of active employment);
- you change to an ineligible status;
- you cancel your coverage;
- you stop contributions for additional coverage (the last day of the month for which you made any required contributions);
- Ryder no longer offers the program; or
- the date the policy or plan is cancelled.

Your **Spouse and Child Life Insurance** coverage generally ends on the earliest of the date:
- your coverage ends;
- you stop contributions for dependent life insurance coverage (the last day of the month for which you made any required contributions);
- the dependent is no longer eligible for coverage; or
- the date the policy or plan is cancelled.

Your spouse or domestic partner is no longer eligible for coverage in the event you are divorced or when your domestic partner ceases to meet the criteria for coverage. Your children are no longer considered eligible dependents when they reach age 26, unless they have been approved by your Medical Plan benefits administrator to be disabled due to a mental or physical handicap.

You must contact the Ryder BenefitsNow Service Center to drop Spouse and/or Child Life and Family AD&D insurance coverage for ineligible dependents within 31 days of the date they became ineligible. Benefits under the Life and AD&D insurance plans are not payable to you if your dependents are deemed ineligible, regardless if you were paying the monthly premiums.

Your coverage under the health and welfare plans may be terminated or suspended if you provide any false information, misrepresentation, or misstatement of material fact when you enroll, or with respect to any request for benefits. Any such termination or suspension of coverage will be made in accordance with the Patient Protection and Affordable Care Act and the regulations and guidance issued thereunder.

Coverage for all plans may be reinstated, at the Company’s discretion, one year after suspension of benefits because of false information, if the falsely obtained benefits are repaid. Such falsification may result in other disciplinary action, as outlined in your Ryder Employee Handbook.

If you are laid off due to lack of work, coverage will end on the last day of the month you were laid off. If your employment is continued due to a leave of absence, an injury or sickness, your coverage may continue, until the date your employment ends.

**Right to Certificate of Creditable Coverage**

When your **Medical, Prescription and Dental** coverage ends, the plan is required to provide a written certification of how long your coverage was in effect. The purpose of this certificate of creditable coverage is to help you obtain coverage under another plan.

You will automatically be sent a certificate of creditable coverage at the time your coverage ends and again when continuation of coverage under COBRA (if elected) ends. You also may request a certificate of creditable coverage from the Ryder BenefitsNow Service Center at 800-280-2999 at any time within the 24-month period after your plan coverage ends.

**Coverage for Active Employees After Age 65**

If you continue working after age 65, your coverage under the Medical and Prescription Plans may continue. If you or a dependent enroll for Medicare, the Ryder plan will be primary. Medicare benefits will supplement this plan's benefits.
Ryder has determined that the prescription drug coverage provided under the Prescription Plan is, on average, at least as good as the standard Medicare prescription drug coverage. This means that you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage. Please review the Notice of Creditable Coverage in the Administrative Section of this book, which provides important information about how the Prescription Plan coverage interacts with Medicare Part D coverage.

Retirees
If you retire from the Company on or after age 55 with at least 15 years of service, you may be eligible for coverage under the Ryder Retiree Medical and Prescription Plan. Eligibility is determined based on your organizational assignment at the time your employment ends with the Company.

Note: If you are currently working in an organizational assignment that provides for participation in the Ryder Retiree Medical and Prescription Plan, you may lose eligibility if (prior to your retirement) you transfer to an organizational assignment that does not provide for participation in the Ryder Retiree Medical and Prescription Plan. Eligibility for the Ryder Retiree Medical and Prescription Plan will be determined based on your organizational assignment at the time you leave the Company.

Note: If you were covered under a Union Medical and Prescription Plan as an active employee, you are not eligible for the Ryder Retiree Medical and Prescription Plan when your employment ends.

For information about medical and prescription coverage that may be available when you retire, contact the Ryder BenefitsNow Service Center.

Enrollment Restrictions
Retirees and their dependents, who are eligible for Ryder’s retiree medical and prescription coverage, are limited to their initial enrollment upon retirement and one subsequent enrollment prior.

- if you enroll in coverage upon your retirement and decide to drop your coverage sometime in the future, you only have one additional opportunity to enroll again prior to age 65, or Medicare entitlement; 
- if, upon your retirement, you waive coverage in the Ryder Retiree Medical and Prescription Plans (or do not enroll during your enrollment window) or enroll for coverage through a COBRA right election, you will have only one additional opportunity to enroll again prior to age 65. If you waive coverage again after enrolling, you will not have another opportunity to re-enroll.

This limitation also applies to your eligible dependents. Dependents can be enrolled in retiree medical and prescription coverage only if they were your eligible dependents at the time of your retirement. They can be added to or dropped from your coverage only during the Annual Enrollment event, which takes place once per year or if you experience a qualified life-changing event (e.g., divorce, spouse loses coverage elsewhere, etc.).

Medical and Prescription benefits will be extended to:

- you, until you become age 65 (your coverage ends at the end of the month prior to the month in which you turn 65), or until you become eligible for Medicare, whichever is earlier; 
- your children, or the children of your spouse or domestic partner, if they were eligible dependents at the time of your retirement. Such children will be covered until they no longer meet the eligibility requirements of the Medical and Prescription Plans for dependent coverage, or they are eligible for Medicare benefits, whichever comes earlier; 
- your spouse or domestic partner, if he or she is an eligible dependent at the time of your retirement. The Working Spouse Eligibility Rule applies. This means that if your working spouse or domestic partner has comprehensive group medical, and/or prescription coverage available to them through their employer, they are not eligible for coverage under the Ryder System, Inc. group Medical and Prescription Plans;
• your spouse or domestic partner will be covered until he/she:
  • reaches age 65 (his or her coverage ends at the end of the month prior to the month in which he or she turns 65) or becomes eligible for Medicare, whichever is earlier;
  • is divorced from you;
  • no longer meets the requirement of a domestic partner;
  • becomes eligible for comprehensive coverage through their employer; or
  • remarries after your death.

**Important Note:** The Company’s retiree medical benefits are not vested. The Company reserves the right to amend, modify or terminate any and all retiree medical benefits at any time, with or without notice.

**Death**

Your coverage under the Medical, Prescription, Dental, Vision, Short-Term Disability, Long-Term Disability, Life Insurance, AD&D insurance and Dependent Life Insurance plans, as applicable, ends on the date of your death. Refer to the “Events that Affect Your Benefits” Section for more information.

Your dependents’ coverage under the Medical, Prescription, Dental and Vision ends on the date of your death. Your dependents will be offered COBRA continuation coverage, to begin the day after your death. Ryder covers the cost of COBRA continuation for your dependents up to the first 60 days of such coverage.
# TABLE OF CONTENTS

Administrative Information ........................................................................................................... 20
  Plan Sponsor ............................................................................................................................... 20
  Plan Administrator ..................................................................................................................... 20
  Benefits Administrator .............................................................................................................. 20
  Employer Identification Number ............................................................................................... 20
  Service of Legal Process ........................................................................................................... 20
  Plan Year and Plan Records ..................................................................................................... 21
  Plan Documents ....................................................................................................................... 21
  Assignment of Benefits ............................................................................................................ 21
  Plan Amendment and Termination ........................................................................................... 21
  Employment ............................................................................................................................. 21

Funding of Benefits ...................................................................................................................... 21
  Cost of Coverage for Active Employees .................................................................................. 22
  Effect on Other Benefits .......................................................................................................... 22
  Plan Trustees ............................................................................................................................ 22

Continuation Coverage Through COBRA .................................................................................. 23
  Qualifying Life Events .............................................................................................................. 23
  Notice of Qualifying Life Event ............................................................................................... 24
  Type of Coverage ..................................................................................................................... 24
  Maximum Coverage Periods ..................................................................................................... 24
  Disability Extension .................................................................................................................. 25
  COBRA Qualifying Events and Maximum Coverage Period .................................................. 25
  Cost of Coverage after Termination ....................................................................................... 25
  When COBRA Coverage Ends ................................................................................................ 25

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families ......................................................... 26

HIPAA Requirements and Coverage Certificates (Applies to All Medical Plans) ........................................................................................................................................................................... 29
  Health Insurance Portability and Accountability Act (HIPAA) Requirements and Coverage Certificates ........................................................................................................................................................................... 29
  Uniformed Services Leave ....................................................................................................... 29
  FMLA Leave .............................................................................................................................. 30
  Qualified Medical Child Support Orders .................................................................................. 30

Compliance with the Health Insurance Portability and Accountability Act (HIPAA) ........................................................................................................................................................................... 30

HIPAA Notice of Privacy Practices ............................................................................................ 31

Patient Protection and Affordable Care Act ("PPACA") ................................................................ 38
  Patient Protection Notices ....................................................................................................... 38

Benefit Claims and Appeals Process .......................................................................................... 38

Claims and Appeals for Benefits under the UnitedHealthcare Medical Plans ........................................................................................................................................................................... 39

Claims and Appeals for Benefits under the Caremark Rx Prescription Plan ................................ 46

Claims and Appeals for Benefits under the Cigna Dental Plan .................................................. 49

Claims and Appeals for Benefits Under the Ryder System, Inc. Disability Plans ........................................................................................................................................................................... 51

Claims and Appeals for Benefits Under All Other Ryder System, Inc. Plans ................................ 52

Who To Send Your Claims and Appeals To ............................................................................... 54

Your ERISA Rights ...................................................................................................................... 55
  Receive Information About Your Plan and Benefits .................................................................. 55
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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
Administrative Information

This section of your benefit book reviews:

- who sponsors, insures and administers each Ryder System, Inc. Benefit Plan;
- how and when you can obtain continuation coverage under COBRA;
- how to file a claim appeal; and
- your legal rights as a plan participant under the federal law code commonly known as the 
  Employee Retirement Income Security Act of 1974 (ERISA), as well as under the Health 
  Insurance Portability and Accountability Act of 1996 ("HIPAA") and Medicare Part D.

Plan Sponsor

Ryder System, Inc. sponsors all of the plans described in this book.

Plan Administrator

The plan administrator for all plans is the Vice President of Compensation and Benefits of Ryder System, Inc., except for the 401(k) Savings Plan and the Retirement Plan where the Retirement Committee is the Plan Administrator. The plan administrator (or, where applicable, any duly authorized delegatee of the plan administrator) shall have the exclusive right, power, and authority in its sole and absolute discretion, to administer, apply and interpret all the plans and any other documents and to decide all factual and legal matters arising in connection with the operation of administration of the plans.

Without limiting the generality of the foregoing paragraph, the plan administrator (or, where applicable, any duly authorized delegatee of the plan administrator) shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions (including factual decisions) with respect to the eligibility for, and the amount of, benefits payable under the plans to employees or participants or their beneficiaries;
- formulate, interpret and apply rules, regulations and policies necessary to administer the plans;
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits, and all other determinations made under the plans;
- resolve and/or clarify any factual or other ambiguities, inconsistencies and omissions arising under this Summary Plan Description, the plans or other plan documents;
- process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the plan administrator (or, where applicable, any duly authorized delegatee of the plan administrator) with respect to any matter arising under the plans shall be final and binding on the employer, employee, participant, beneficiary, and all other parties affected thereby.

Benefits Administrator

The name, address and phone number for each plan’s benefits administrator is shown in the chart at the end of this section, which is entitled “Ryder System, Inc. Benefit Plan Administrative Information” (the “Chart”). The chart also includes each plan’s:

- official name;
- number, as reported to the U. S. Department of Labor;
- type, as defined under ERISA; and
- funding information.

Employer Identification Number

The plan sponsor’s Employer Identification Number (EIN), which is assigned by the IRS, is 59-0739250.
Service of Legal Process
Service of legal process for the plans may be made to:

The Plan Administrator
Ryder System, Inc.
c/o Vice President, Compensation and Benefits
11690 NW 105th Street
Miami, FL 33178-1103

Plan Year and Plan Records
Ryder System, Inc. plan records are kept on a calendar year basis – beginning January 1 and ending December 31 of each year. The calendar year is also the plan year.

Plan Documents
This book summarizes the key provisions of your Ryder System, Inc. Benefits Plans and programs. The specific provisions of the Ryder System, Inc. 401(k) Savings Plan and the Retirement Plan are contained in the official plan documents, which include contracts between Ryder System, Inc. and the benefits administrators and trustees. If any question arises about the nature and extent of your benefits, the formal language of the plan documents will govern.

This book, in combination with the contracts between Ryder System, Inc. and the benefits administrators, trustees and other related documents, serves as the official plan document for the health and welfare plans described herein.

Assignment of Benefits
Generally, Ryder System, Inc. benefits may not be assigned, anticipated or allocated except, as described in the Life Insurance and AD&D sections, or when required by law under a Qualified Domestic Relations Order as applicable to the Retirement Plan and the Employee 401(k) Savings Plan.

Plan Amendment and Termination
Ryder System, Inc. expects to continue all plans discussed in this book. However, the Company reserves the right to amend, modify or terminate the plans at any time and for any reason in whole or in part and with respect to active employees or retirees. Additionally, the Company’s benefit design can change in future years, which may affect your coverage or that portion you pay for your benefits.

The Ryder System, Inc. 401(k) Savings Plan and Retirement Plan are subject to continuing approval by the Internal Revenue Service and may be modified as needed to make or keep the plans qualified under the Internal Revenue Code.

Employment
This document and the benefits described in it are not an employment contract and do not affect the right of either you or the Company to terminate your employment at any time, without cause or notice.

Funding of Benefits
Your benefit plans and programs are funded by a combination of Company and employee contributions. Ryder makes contributions to, or makes payments under, each benefit plan using the general assets of the Company. Your contributions generally are the per-paycheck amounts you pay to participate in these programs.
**Cost of Coverage for Active Employees**

**Pre-Tax Deductions: Medical, Prescription, Dental, Vision and Additional Short-Term Disability Plans**

The Company pays a portion of the cost of providing your coverage and you pay a share of the cost through regular payroll contributions. The amount of your contributions depends on the level of benefits you select and the number of dependents you cover. Your Enrollment Worksheet and/or your Confirmation Statement shows you the current cost of your benefit elections.

Pre-tax deductions means that they are taken from your pay before federal income and Social Security taxes are deducted. (Your contributions may also be exempt from state and local taxes, depending on where you live.)

If you experience a Qualified Life Event and change any of your benefit elections, the cost of your coverage will be adjusted accordingly based on your Qualified Life Event. Your new contributions will be deducted as soon as possible following the date of the Qualified Life Event.

If you are absent from work due to disability, an approved leave or a leave permitted by the Family Medical Leave Act, your coverage may continue, but you must make any required contributions, in order for coverage to remain in effect.

Under the Medical and Prescription Plans, employees cannot benefit from the federal income tax exclusion for benefits provided for a domestic partner or that partner’s children, unless the domestic partner and/or their children qualify as a dependent under Internal Revenue Code section 152. Under IRS guidelines, the Employee is subject to tax on the fair market value of the coverage provided to the non-qualified domestic partner and their dependent children. As such, those taxable benefits will be reported as imputed income on the employee’s federal W-2 Form at the end of each year in which coverage is elected for a domestic partner and/or their dependent children.

**Important Note:** Please keep in mind that the Company reserves the right to correct the amount of your or your eligible dependents’ contributions at any time and for any reason.

**Post-Tax Deductions: Additional Life Insurance, Spouse Life Insurance, Child Life Insurance, Employee/Family Accidental Death & Dismemberment (AD&D), Additional Long-Term Disability and the Hyatt Legal Plan**

You pay for the cost through regular payroll contributions on a post-tax basis. Post-tax deductions means that deductions are taken from your pay after federal income and Social Security taxes are deducted.

**Note:** Ryder provides the following benefits to you at no cost: Basic Life Insurance, Basic Short-Term Disability, Basic Long-Term Disability, Seat Belt Coverage, Business Travel Accident Coverage, Employee Assistance Program (EAP), and the Vision Discount Plan.

**Effect on Other Benefits**

Because many of your Company benefits are based on your annual pay, it is important to note that using pre-tax dollars to purchase your benefits does not affect your other pay-related benefits.

**Plan Trustees**

The Retirement Plan and 401(k) Savings plans are at least partially funded through trusts, which are established solely for plan purposes. The trustees hold the assets of the trusts.

- the trustee for the Ryder System, Inc. Retirement Plan is BNY Mellon Bank
- the trustee for the Ryder System, Inc. 401(k) Savings Plan is Fidelity Management Trust Company
Continuation Coverage Through COBRA
The Federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) requires employers who sponsor group health plans to offer employees and their families the opportunity to temporarily extend their health coverage on a self-pay basis. COBRA allows for health coverage to be offered at group rates in certain circumstances where coverage under the plan would otherwise end. This temporary extension is called continuation coverage. It applies to medical, prescription, dental and vision coverage as well as the health care reimbursement account.

Domestic partners, of the same or opposite sex, and their children are not qualified beneficiaries under COBRA. However, Ryder extends rights similar to COBRA to eligible domestic partners and their children, who are identified as dependents in the Eligibility section. As such, the following description of COBRA coverage also applies to eligible domestic partners and their children, unless otherwise indicated.

Qualifying Life Events
The events that trigger COBRA rights are called qualifying life events. As a Ryder employee, you have a right to elect continuation coverage if:
- you lose your group health coverage because of your voluntary or involuntary termination of employment (except for gross misconduct); or
- you have a reduction in your hours of employment.

If you are the spouse or domestic partner of a Ryder employee and are covered by the Ryder health plan, in accordance with the definition of "Dependents" in the Eligibility section, you have the right to elect continuation coverage because of:
- the death of your spouse or domestic partner;
- the termination of your spouse’s or domestic partner’s employment (for any reason other than gross misconduct);
- a reduction in your spouse’s or domestic partner’s hours of employment;
- divorce;
- you and your domestic partner no longer meet the eligibility requirements for domestic partner coverage, which are set forth in the Eligibility section of this book; or
- your spouse or domestic partner becomes eligible for Medicare.

Dependent child(ren) of employees or their spouses/ domestic partners covered by the Ryder health plan, in accordance with the definition of dependent under the Eligibility section, have a right to elect continuation coverage because of:
- the death of a parent or of a parent’s spouse or domestic partner who is a Ryder employee;
- the termination of a parent or of a parent’s spouse or domestic partner who is a Ryder employee for any reason (except gross misconduct);
- a reduction in the parent’s or of a parent’s spouse’s or domestic partner’s hours of employment with Ryder;
- a parent or a parent’s spouse or domestic partner who is a Ryder employee becomes eligible for Medicare; or
- ceasing to meet the eligibility requirements for dependents under the health plans.

Individuals receiving retiree health benefits (and their dependents), may elect continuation coverage because of:
- a loss of coverage resulting from a bankruptcy proceeding under Title 11, United States Code with respect to Ryder.

Please note that to be eligible for continuation coverage, the qualifying event must result in the loss of health coverage for the eligible employee and the dependent (whether spouse, domestic partner or child).
Notice of Qualifying Life Event
Ryder is responsible for notifying the Ryder BenefitsNow Service Center of an employees’ death, termination, or reduction in hours of employment.

You, your covered spouse, your covered domestic partner or your covered dependent children are responsible for informing the Ryder BenefitsNow Service Center, within 31 days after the event occurs, when:

- you and your spouse have divorced;
- you and your domestic partner no longer meet the eligibility requirements for domestic partner coverage, which are set forth in the Eligibility section;
- a child no longer qualifies as a dependent under the health or child life insurance plans; or
- you have a Medicare entitlement.

Each individual who is eligible for continuation coverage is entitled to make a separate election. In other words, your spouse, your domestic partner or dependent child is entitled to elect continuation coverage even if you do not.

The option of electing COBRA Continuation Coverage must be offered during a period beginning no later than when the individual would otherwise lose coverage under the Plan (the termination date) and ends no earlier than 60 days after;

- the date the individual is notified of his/her COBRA Continuation Coverage rights by the employer; or
- the termination date, whichever date is later.

Thus, the election period under all circumstances must last at least 60 days.

Any election by a qualified beneficiary (other than a dependent child) is considered an election by other qualified beneficiaries who would otherwise lose coverage by reason of the same Qualifying Event. Therefore, a spouse, former spouse or domestic partner who has been a qualified beneficiary under the Plan may elect COBRA Continuation Coverage on his/her own behalf and on behalf of qualified dependent children. COBRA Continuation coverage may not be conditioned directly or indirectly upon the insurability of the qualified beneficiary.

Please note that if you are an individual who qualifies for trade assistance under the Trade Act of 2002, you may be entitled to a second COBRA election period. Please contact the Plan Administrator if you need more information.

In addition, a dependent child born to or adopted by an employee and/or his or her domestic partner during a period of COBRA coverage has the right to continuation coverage. Such a child may be added to continuation coverage on notification to the plan administrator within 30 days of the birth or adoption.

Type of Coverage
Ryder is required to allow you to purchase coverage, which, as of the time coverage is being provided, is equal to the coverage being provided under the plan for similarly situated active employees or family members. If coverage under the plan is modified for similarly situated active employees, your coverage will be modified as well.

Maximum Coverage Periods
The law requires that your dependents be given the opportunity to maintain continuation coverage for 36 months from the date of the qualifying event, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA continuation coverage period is 18 months from the date of the termination or reduction in hours. This 18-month coverage period (or 29 months under the disability extension) may be extended (for up to 36 months from
the date of the termination or reduction in hours) if another qualifying event (such as death, divorce, legal separation, or Medicare entitlement) occurs during the initial 18-month (or 29 month) coverage period.

If your qualifying event is the end of employment (for reasons other than gross misconduct) or reduction of employee’s hours of employment and you become entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your dependents will last until 36 months after the date of the Medicare entitlement.

**Disability Extension**

The 18-month coverage period may be extended (for up to 29 months from the date of the termination or reduction in hours) if the Social Security Administration determines that you or an eligible dependent was disabled at any time during the first 60 days of continuation coverage.

To be eligible for additional continuation coverage due to disability, you or your dependent must notify the plan administrator of the Social Security Administration’s determination within 60 days of the determination and before the end of the original 18-month continuation coverage period. If the continuation coverage period is extended from 18 months to 29 months due to a Social Security Administration determination of disability, you will pay 150% of the premium during the extension period. You may be required to provide a copy of the Social Security Administration Disability Award.

<table>
<thead>
<tr>
<th>COBRA Qualifying Events</th>
<th>Maximum Coverage Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee</td>
</tr>
<tr>
<td>Employee loses coverage due to reduced work hours</td>
<td>18</td>
</tr>
<tr>
<td>Employee terminates for any reason (except gross misconduct)</td>
<td>18</td>
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<tr>
<td>Employee/dependent is disabled under the Social Security Act</td>
<td>29</td>
</tr>
<tr>
<td>Employee dies *</td>
<td>N/A</td>
</tr>
<tr>
<td>Employee and spouse divorce</td>
<td>N/A</td>
</tr>
<tr>
<td>Employee and domestic partner terminate relationship **</td>
<td>N/A</td>
</tr>
<tr>
<td>Employee becomes entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>Child no longer qualifies as a dependent</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Ryder pays the cost of the first 60 days of COBRA coverage for the surviving covered dependents, following the death of an active employee.

** Dependents who are domestic partners and their children are not qualified beneficiaries under COBRA. However, Ryder extends COBRA-like rights to domestic partners and their children, so that these time frames apply to such dependents.

**Cost of Coverage after Termination**

You do not have to show that you are insurable to choose continuation coverage. However, you have to pay 102% of the premium for your continuation coverage. If you have your coverage extended because you are disabled, you will have to pay 150% of the premium for coverage after the 18th month. There is a grace period of 30 days before premium payments are due. Your first payment must include the entire premium amount owed to bring your premiums current and is due 45 days after you make your COBRA election through the Ryder BenefitsNow Service Center.

**When COBRA Coverage Ends**

COBRA continuation coverage may end before the maximum coverage period for any of the following reasons:

- Ryder no longer provides group health coverage to any of its employees;
- the premium for your continuation coverage is not paid on time;
you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing conditions;

- you become entitled to Medicare (COBRA coverage for dependents will not be affected by your Medicare eligibility and dependent coverage may be extended due to a second qualifying event);

- 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 more than 18 months after the termination of your employment or reduction in hours;

- for retired employees receiving COBRA continuation coverage because of bankruptcy proceedings, the death of the covered employee or beneficiary or in the case of a surviving spouse or dependent, 36 months after the date of the death of the covered employee.

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from the Company, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for the Plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your dependents to enroll in the Plan – as long as you and your dependents are eligible, but not already enrolled in the Plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2013. You should contact your State for further information on eligibility.

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 855-692-5447</td>
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<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone (Outside of Anchorage): 888-318-8890               Phone (Anchorage): 907-269-6529</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>ARIZONA – CHIP</th>
<th>Website: <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone (Outside of Maricopa County): 877-764-5437     Phone (Maricopa County): 602-417-5437</td>
<td></td>
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</tbody>
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<thead>
<tr>
<th>COLORADO – Medicaid</th>
<th>Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Phone (In state): 800-866-3513             Medicaid Phone (Out of state): 800-221-3943</td>
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</tbody>
</table>

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<thead>
<tr>
<th>FLORIDA – Medicaid</th>
<th>Website: <a href="https://www.flmedicaidplrecovery.com/">https://www.flmedicaidplrecovery.com/</a></th>
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</thead>
<tbody>
<tr>
<td>Phone: 877-357-3268</td>
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<tr>
<td>State</td>
<td>Medicaid Type</td>
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<tr>
<td>Idaho</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>Mississippi</td>
<td>Medicaid</td>
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<tr>
<td>Iowa</td>
<td>Medicaid</td>
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<tr>
<td>Kentucky</td>
<td>Medicaid</td>
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<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>Minnesota</td>
<td>Medicaid</td>
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<td>Missouri</td>
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<tr>
<td>Nebraska</td>
<td>Medicaid</td>
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<tr>
<td>Nevada</td>
<td>Medicaid</td>
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<tr>
<td>State</td>
<td>Medicaid and CHIP</td>
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<tr>
<td><strong>NEW JERSEY</strong></td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
</tr>
<tr>
<td></td>
<td>Medicaid Phone: 800-356-1561</td>
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<tr>
<td></td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
</tr>
<tr>
<td></td>
<td>CHIP Phone: 800-701-0710</td>
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<tr>
<td><strong>NEW YORK</strong></td>
<td>Medicaid Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a></td>
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<tr>
<td></td>
<td>Phone: 800-541-2831</td>
</tr>
<tr>
<td><strong>NORTH CAROLINA</strong></td>
<td>Medicaid and CHIP Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a></td>
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<tr>
<td></td>
<td>Phone: 919-855-4100</td>
</tr>
<tr>
<td><strong>NORTH DAKOTA</strong></td>
<td>Medicaid Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
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<tr>
<td></td>
<td>Phone: 800-755-2604</td>
</tr>
<tr>
<td><strong>OKLAHOMA</strong></td>
<td>Medicaid and CHIP Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
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<td></td>
<td>Phone: 888-365-3742</td>
</tr>
<tr>
<td><strong>OREGON</strong></td>
<td>Medicaid and CHIP Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a></td>
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<td></td>
<td><a href="http://www.hijossaludablesoregon.gov">http://www.hijossaludablesoregon.gov</a></td>
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<td></td>
<td>Phone: 877-314-5678</td>
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<tr>
<td><strong>PENNSYLVANIA</strong></td>
<td>Medicaid Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
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<tr>
<td></td>
<td>Phone: 800-692-7462</td>
</tr>
<tr>
<td><strong>RHODE ISLAND</strong></td>
<td>Medicaid Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 401-462-5300</td>
</tr>
<tr>
<td><strong>SOUTH CAROLINA</strong></td>
<td>Medicaid Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 888-549-0820</td>
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<tr>
<td><strong>SOUTH DAKOTA</strong></td>
<td>Medicaid Website: http://dss_sd.gov</td>
</tr>
<tr>
<td></td>
<td>Phone: 888-828-0059</td>
</tr>
<tr>
<td><strong>TEXAS</strong></td>
<td>Medicaid Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
</tr>
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<td></td>
<td>Phone: 800-440-0493</td>
</tr>
<tr>
<td><strong>UTAH</strong></td>
<td>Medicaid and CHIP Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 866-435-7414</td>
</tr>
<tr>
<td><strong>VERMONT</strong></td>
<td>Medicaid Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 800-250-8427</td>
</tr>
<tr>
<td><strong>VIRGINIA</strong></td>
<td>Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
</tr>
<tr>
<td></td>
<td>Medicaid Phone: 800-432-5924</td>
</tr>
<tr>
<td></td>
<td>CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a></td>
</tr>
<tr>
<td></td>
<td>CHIP Phone: 866-873-2647</td>
</tr>
<tr>
<td><strong>WASHINGTON</strong></td>
<td>Medicaid Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 800-562-3022 ext. 15473</td>
</tr>
</tbody>
</table>
WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2013, or for more information on special enrollment rights, you can contact either:
U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
866-444-EBSA (3272) 877-267-2323, Ext. 61565

HIPAA Requirements and Coverage Certificates (Applies to All Medical Plans)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to provide certification of prior health plan coverage to certain participants, former participants, and beneficiaries. Under HIPAA, a group health plan that excludes pre-existing conditions from coverage must reduce the length of time of the exclusion period by the total number of days of your prior creditable coverage. Creditable coverage includes coverage through group health insurance, COBRA, Medicare, and Medicaid.

When you or an eligible dependent becomes eligible for COBRA and elects to be covered by COBRA, you will be provided with a certificate that indicates coverage under the plan from when you first enrolled to the date you elect COBRA coverage. Certificates will be provided to you and any dependents that are electing COBRA coverage.

Health Insurance Portability and Accountability Act (HIPAA) Requirements and Coverage Certificates
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes protection for people who have pre-existing medical conditions when they change health coverage due to a change in employment. Before HIPAA, if you changed employment and then elected group health coverage, services relating to any pre-existing medical conditions may not have been covered under the new plan for a number of months, depending on plan provisions. Under HIPAA, it is possible to offset this gap in coverage by creditable coverage you have under a prior group health plan. Continuous creditable coverage means you did not have a break in coverage for more than 63 days.

Creditable coverage includes coverage through group health insurance, COBRA, Medicare, Medicaid, military-sponsored health care, Indian Health Service, a state high-risk pool, and the Federal Employees Health Benefits plan.

When your Ryder System, Inc. coverage ends, you will receive a statement listing the creditable coverage you earned while covered under the Ryder health plans. Your statement will arrive within 14 days of the date the Ryder BenefitsNow Service Center receives notification of when your coverage ended. In addition, a certificate of creditable coverage will be provided to you and/or any beneficiary upon receipt of a request for such certificate if that request is received by the Ryder BenefitsNow Service Center within 24 months after you and/or your beneficiary loses coverage.

Uniformed Services Leave
Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you and your covered dependents will be entitled to elect COBRA coverage the same as if you had experienced
one of the “qualifying events” as described above. You are eligible if you fail to work at least 30 hours per week for more than 31 days because of duty in any of the following Uniformed Services:

- the Armed Forces;
- the Army National Guard and the Air Force National Guard when engaged in active duty training, inactive duty training, or full-time National Guard duty;
- the Commissioned Corps of the Public Health Service; and
- other categories of personnel designated by the President of the United States in time of war or emergency.

This extended coverage will last no more than 24 months and cannot be extended regardless of the occurrence of any other subsequent event. All rights guaranteed by USERRA are dependent on Uniformed Service that ends honorably. In general, the rights guaranteed by USERRA do not apply if the aggregate length of your military leave exceeds five years. If you elect coverage, you will be responsible for the appropriate COBRA premiums.

**FMLA Leave**

If you take family or medical leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you have the option to continue medical coverage during your absence or suspend coverage while you are on FMLA leave. If you choose to continue medical coverage during your absence, you are responsible for the appropriate monthly contribution for coverage during the leave. The coverage will continue as if you were actively working until the earlier of the expiration date of your FMLA leave or the date you give notice to the Company that you will not return from your leave.

**Qualified Medical Child Support Orders**

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement. If the Plan Administrator receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent.

**Note:** A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

**Compliance with the Health Insurance Portability and Accountability Act (HIPAA)**

The receipt use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as HIPAA). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan’s business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. The following are some of the measures taken to protect your health information. Additional measures are described in the HIPAA Notice of Privacy Practice following this section:

- if Ryder System, Inc. discloses to any of its agents or subcontractors any of your protected health information that it receives from the group health plans that it sponsors, Ryder System, Inc. will require the agent or subcontractor to handle your protected health information and keep it private to the same extent as if your information was handled directly by Ryder System, Inc.;
- Ryder System, Inc. will not use or disclose your protected health information for employment-related actions or decision or in connection with any other benefit or benefit plan sponsored by Ryder System, Inc., unless you provide written authorization;
certain employees under the control of Ryder System, Inc. may be given access to your protected health information on behalf of Ryder System, Inc. in Ryder System, Inc.’s capacity as group health plan sponsor, and these employees may use your protected health information solely for the plan administration functions set forth in this summary plan description. These employees include, but are not limited to, employees in the following functional departments:
- Employee Benefits Department;
- Benefits Accounting Department;
- Legal Department;
- Internal Audit Department; and
- HRIS Department;

if any of these employees or workforce use or disclose your protected health information in violation of the rules that are set out in this Summary Plan Description, those employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If Ryder System, Inc. becomes aware of any such violation, it will promptly report the violation to your group health plans and will cooperate with your group health plans to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

The following are additional measures that Ryder System, Inc. will take to reasonably and appropriately safeguard the electronic protected health information that it receives, creates or maintains from, or on behalf of, the group health plans in its capacity as the sponsor of those plans. These measures, which are required under the HIPAA security regulations, have been in effect since April 20, 2005.

- Ryder System, Inc. will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits from or on behalf of, the group health plans that it sponsors.

RYDER SELF-INSURED GROUP HEALTH PLANS

HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully, and share it with your spouse and other dependents who are covered under the plan.

Who will follow this Notice?

This Notice applies to:

- The Ryder System, Inc. (“Ryder”) Benefits Office administering the Ryder Group Health Plan(s) and
- The self-insured services that the Ryder Group Health Plan(s) provide through the following third party administrators: (referred to in this Notice collectively as the “Plan’s Administrators”):
  United Healthcare, Cigna Dental, AonHewitt, Your Spending Account (YSA) Administered Health Care Flexible Spending Account, and Caremark, Inc.

The activities of the Ryder Benefits Office and all of the Plan’s Administrators’ services are referred to collectively in this Notice as the “Plan.”

The insurers and HMOs of Ryder’s fully insured health benefits will be sending out their own privacy notices.
INTRODUCTION

During the course of providing you with health coverage, the Plan will have access to information about you that has been deemed to be “protected health information” by rules issued under the Health Insurance Portability and Accountability Act of 1996, commonly known as “HIPAA.” This Notice describes the medical information practices of the Plan and that of any third party that assists in the administration of the Plan. The Notice also explains the Plan’s obligations and your rights regarding the use and disclosure of your protected health information.

If you have any questions about this Notice, please contact the Plan’s Privacy Officer at Ryder, at the address and phone number listed at the end of this Notice, or you can contact any of the Plan’s Administrators directly to request more details about each of the Plan’s Administrators’ privacy policies.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal information. We are committed to protecting your medical information. Under HIPAA, your protected health information (“PHI”) includes any individually identifiable information (including your name, address, date of birth, employee ID number, and Social Security number) that is linked to your past, present or future physical or mental health, the health care that you have received or payment for your health care. This Notice covers any such PHI that is maintained by or for the Plan. Your personal physician or other health care providers may have different policies or notices regarding their use and disclosure of your PHI.

The Plan is required by law to:

- Make sure that your PHI is kept private;
- Provide you with this Notice of the Plan’s legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice (as set forth below or as it may be amended from time to time).

HOW WE MAY USE AND DISCLOSE YOUR PHI

Uses and Disclosures for Treatment, Payment and Health Care Operations

The Plan may use or disclose your PHI in connection with your receiving treatment from a health care provider, payment for such treatment and for the Plan’s health care operations (or for certain very limited health care operations of other health plans or health care providers with whom the Plan coordinates payment for your care). Generally the Plan will make every reasonable effort to disclose only the minimum necessary amount of PHI to achieve the purpose of the use or disclosure.

For Treatment: Although the Plan does not provide treatment, the Plan may use or disclose your PHI to support the provision, coordination or management of your health care treatment. Specifically, the Plan may disclose your PHI to your health care providers, including doctors, nurses, technicians or other hospital personnel who are involved in taking care of you. For example, in the event of an emergency and you are unable to provide your medical history to your physician, the Plan’s service providers may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment: “Payment” generally means activities in connection with processing claims for your health care (including billing, claims management, subrogation, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). The Plan may use or disclose your PHI to determine your eligibility for Plan benefits, to facilitate the payment for treatment or services you receive from your health care providers, to determine benefit responsibility under the Plan, or to coordinate your Plan coverage with another health plan. For example, the Plan may disclose your PHI to
your health care provider to determine whether a particular treatment is medically necessary, or to
determine whether the Plan will cover the treatment. The Plan may also share PHI with a utilization
review or pre-certification service provider. Additionally, the Plan may share PHI with another
organization to assist in the adjudication or subrogation of claims.

For Health Care Operations: The Plan may use or disclose your PHI as part of the general
administrative or business functions of the Plan that the Plan must perform in order to function as a health
plan. For example, the Plan may need to review your PHI as part of the Plan’s efforts to uncover
instances of health care provider abuse and fraud. Additionally, the Plan may use your PHI in connection
with: conducting quality assessment and improvement activities and other activities relating to Plan
coverage, submitting claims for stop-loss (or excess loss) coverage, conducting or arranging for medical
review, legal services, or audit services.

Disclosure To Third Parties: In any circumstance where the Plan discloses PHI to a third party that
performs a service on behalf of the Plan (i.e., a Business Associate), the Plan will have a written contract
with that entity which requires the entity to also protect the privacy of your PHI.

Disclosures to the Plan Sponsor and Your Representatives

Disclosure to the Plan Sponsor: The Plan may disclose your PHI to designated Ryder System, Inc.
personnel so they can carry out their Plan-related administrative functions, including the uses and
disclosures described in this Notice. Such disclosures will be made only to the individuals who are
employed in the Ryder Benefits Department, Law Department, Benefits Accounting Department, HRIS
Department, and Internal Audit Department. These individuals will protect the privacy of your health
information and ensure it is used only as described in this Notice or as permitted by law. Unless
authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other
Ryder System, Inc. employee or department other than the Benefits, Law, Benefits Accounting, HRIS,
and Internal Audit Departments and (2) will not be used by Ryder System, Inc. for any employment-
related actions and decisions or in connection with any other employee benefit plan sponsored by Ryder
System, Inc.

In addition, the Plan may disclose “summary health information” to Ryder System, Inc. for obtaining
premium bids or modifying, amending or terminating the Plan. Summary health information summarizes
the claims history, claims expenses or type of claims experienced by a group health plan. Identifying
information will be deleted from summary health information, in accordance with federal privacy rules.

Disclosure Pursuant to Those Involved in Your Care: The Plan may disclose to a member of your
family, other relative or a close personal friend PHI that is directly relevant to the person’s involvement
with your medical care or payment for your care, provided that you have either authorized the disclosure
or you have not notified the Plan that you object to the disclosure.

Disclosure to Your Personal Representatives: The Plan may disclose your PHI to your personal
representative in accordance with applicable state law or HIPAA (e.g., parents of children under 18, those
with unlimited powers of attorney, etc.). In addition, you may authorize a personal representative to
receive your PHI and act on your behalf. Contact the Plan’s Privacy Officer at Ryder, or if in connection
with PHI held by one of the Plan’s Administrators, you may contact those Plan’s Administrators directly, to
obtain a copy of the appropriate form to authorize the people who may receive this information.

Other Permitted Uses and Disclosures

The Plan may also use or disclose your PHI without your consent or authorization for any of the following
purposes:

Reminders: The Plan may use your PHI to provide you with reminders. For example, the Plan may use
your child’s date of birth to remind you that you may purchase COBRA continuation coverage for your
child who would otherwise lose coverage under the Plan due to age or student status.

**Treatment Alternatives:** The Plan may use your PHI to inform you about treatment alternatives.

**Health-Related Benefits and Services:** The Plan may use or disclose your PHI to inform you about
other health-related benefits and services that may be of interest to you.

**Required By Law:** The Plan may use or disclose your PHI to the extent that the Plan is required to do so
by federal, state or local law. If required by law, you may be notified of any such uses or disclosures.

**Public Health:** The Plan may disclose your PHI for public health and safety purposes to a public health
authority that is permitted by law to collect or receive the information. Your PHI may be used or disclosed
for the purpose of preventing or controlling disease (including communicable diseases), injury or
disability. If directed by the public health authority, the Plan may also disclose your PHI to a foreign
government agency that is collaborating with the public health authority. The Plan may also disclose your
PHI to any authorized public or private entities assisting in disaster relief efforts.

**Health Oversight:** The Plan may disclose your PHI to a health oversight agency for activities authorized
by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this
information include government agencies that oversee the health care system, government benefit
programs, other government regulatory programs and civil rights laws.

**Abuse Or Neglect:** The Plan may disclose your PHI to any public health authority authorized by law to
receive information about abuse, neglect or domestic violence if the Plan reasonably believes that you
have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made
consistent with the requirements of applicable federal and state laws, and the Plan will inform you that
such a disclosure has been or will be made unless that notice will cause a risk of serious harm.

**To Avert A Serious Threat to Health or Safety:** The Plan may use or disclose your PHI when
necessary to prevent a serious threat to your health and safety or the health and safety of the public or
another person. Any disclosure, however, would only be to someone reasonably able to help prevent or
lessen the threat.

**Legal Proceedings:** The Plan may disclose your PHI in the course of any judicial or administrative
proceeding, in response to an order of a court or administrative tribunal. In addition, the Plan may
disclose your PHI under certain conditions in response to a subpoena, court-ordered discovery request or
other lawful process, in which case reasonable efforts must be undertaken by the party seeking the PHI
to notify you and give you an opportunity to object to the disclosure.

**Law Enforcement:** The Plan may disclose your PHI if requested by a law enforcement official as part of
certain law enforcement activities.

**Coroners, Funeral Directors, and Organ Donation:** The Plan may disclose your PHI to a coroner or
medical examiner for identification purposes, or other duties authorized by law. The Plan may also
disclose your PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry
out his/her duties. The Plan may disclose such information in reasonable anticipation of death. The Plan
may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

**Research:** The Plan is permitted to disclose your PHI to researchers when their research has been
approved by an institutional review board or privacy board that has established protocols to ensure the
privacy of your PHI.
Military Activity and National Security: When the appropriate conditions apply, the Plan may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. The Plan may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.

Workers’ Compensation: The Plan may disclose your PHI to comply with workers’ compensation laws and other similar legally established programs.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.

Required Uses and Disclosures: The Plan must make disclosures of PHI to the Secretary of the U.S. Department of Health and Human Services (“HHS”) to investigate or determine the Plan’s compliance with the federal regulations regarding privacy.

Fundraising: The Plan, or an authorized third party on the Plan's behalf, may contact you for fundraising purposes. If you are contacted for such fundraising purposes, you have the right to opt out of receiving such communication.

OTHER USES AND DISCLOSURES OF PHI

Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require an authorization. Other uses and disclosures of your PHI not covered by this Notice or HIPAA, or other laws that apply to the Plan, will only be made with your written authorization. For example, a written authorization from you would be necessary to disclose your PHI to another benefit plan, or to your authorized representative, or in connection with litigation, unless otherwise permitted or required as outlined above.

If you provide the Plan with written authorization to use or disclose your PHI for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, you understand that the Plan is unable to take back any disclosures already made with your authorization, and is required to retain records of the care provided to you.

The Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding the PHI that the Plan maintains:

Right to Inspect and Copy: As long as the Plan maintains it, you may inspect and obtain a copy of your PHI that is contained in a “designated record set,” as defined below. In general, the Plan will provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. If necessary, the Plan may extend the time for processing your request up to an additional 30 days. The Plan may impose a fee to cover the costs of copying and postage and may require you to submit your request in writing. If your health record is maintained electronically, you have the right to receive such electronic PHI in the electronic form and format you request if it is readily producible or, if not, in a readable electronic form and format agreed to by you and the Plan. The Plan may charge you for the cost of any electronic medical (other than email) used to provide your electronic PHI.
The Plan may deny your request to inspect and copy your PHI in certain limited circumstances. For example, under federal law, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and to HHS.

A “designated record set” includes your medical records and billing records that are maintained by or for a covered health care provider, and in connection with the Plan, includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan or other information used in whole or in part by or for a health plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

**Right to Request a Restriction on the Use and Disclosure of Your PHI:** You may ask the Plan to restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations. You may also request that the Plan restrict uses and disclosures of your PHI to family members, relatives, friends or other persons identified by you who are involved in your care.

However, the Plan is not required to agree to a restriction that you request. If the Plan does agree to the request, the Plan will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or the Plan terminates the restriction with or without your agreement. If you do not agree to the termination, the restriction will continue to apply to PHI created or received prior to the Plan’s notice to you of the Plan’s termination of the restriction.

To request a restriction, you must submit the requests in writing to the Plan indicating (1) what information you want to restrict, (2) whether you want to restrict use, disclosure or both, and (3) to whom you want the restriction to apply.

**Right to Request to Receive Confidential Communications by Alternative Means or at an Alternative Location:** The Plan will accommodate your reasonable written request to receive communications of PHI from the Plan by alternative means or at alternative locations (e.g., contact you at work, instead of at home) if the request includes a statement that disclosure using the Plan’s regular communications procedures could endanger you.

**Right to Amend Your PHI:** If you believe that PHI that the Plan has about you is incorrect or incomplete, you may request that it be amended. Your request must be made in writing and you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask us to amend information that:

- did not originate with the Plan, unless the person or entity that originated the PHI is no longer available to make the amendment;
- is not contained in the records maintained by the Plan;
- is not part of the information that you would legally be permitted to inspect and copy; or
- is accurate and complete.

The Plan will act on your request for an amendment (either denying or granting it) no later than 60 days after receipt of your request. If necessary, the Plan may extend the time for processing your request up to an additional 30 days. If this should happen, you will be notified in writing as to why there is a delay. If your request is denied, you will be provided with a written explanation of the basis for the denial. You will also be provided with an explanation of your right to submit a written statement disagreeing with the
denial and your right to have that statement included with any future disclosures of that PHI.

Right to an Accounting of Disclosures: You have the right to submit a written request for an accounting (i.e., a list) of certain disclosures of your PHI. In general, the Plan is required to comply with your request, subject to certain exceptions, such as where the disclosure was made:

in connection with your receiving treatment, the Plan’s payment for such treatment and for health care operations;
- to you regarding your own PHI;
- pursuant to your written authorization;
- to a person involved in your care or for other permitted notification purposes;
- for national security or intelligence purposes; or
- to a correctional institution or law enforcement official.

You have the right to receive an accounting of disclosures of PHI made within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2003. Your request should indicate the form in which you want the list (e.g., paper or electronic). The first accounting you request within a 12-month period will be free of charge. For additional requests within the 12-month period, the Plan will charge you for the costs of providing the accounting. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

The Plan will act on your request for an accounting no later than 60 days after receipt of your request. This time period may be extended, where necessary, for an additional 30 days. If this should happen, you will be notified in writing concerning the reasons for the delay and the date by which the Plan will provide the accounting.

Right to Receive Breach Notification

You have the right to and will receive notification if a breach of your unsecured PHI requiring notification occurs.

HOW TO EXERCISE ANY OF THESE RIGHTS

If you would like to exercise any of the above-described rights in connection with the Plan’s information held by any of the Plan’s Administrators, you may contact the Plan’s Administrators directly (using the telephone numbers and addresses provided to you directly by those of the Plan’s Administrators from whom you receive services) or, if you are unable to reach the Plan’s Administrators, you can contact the Plan’s Privacy Officer at Ryder at the address below.

Right to Obtain a Paper Copy of this Notice: You may request a paper copy of the Plan’s Privacy Notice at any time, even if you have previously agreed to accept the Notice electronically. Requests should be made to the Plan’s Privacy Officer at Ryder.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a written complaint with us at the address below or with the regional offices of the Office of Civil Rights for the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

THE PLAN IS REQUIRED TO ABIDE BY THE TERMS OF THIS NOTICE. HOWEVER, THE PLAN RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS OR ANY SUBSEQUENT NOTICE AT ANY TIME. IF THE PLAN ELECTS TO MAKE A
CHANGE, THE REVISED NOTICE WILL BE EFFECTIVE FOR ALL PHI THAT THE PLAN MAINTAINS AT THAT TIME. WITHIN 60 DAYS OF ANY MATERIAL REVISION OF THE PLAN’S PRIVACY PRACTICES, THE PLAN WILL DISTRIBUTE A NEW NOTICE IN THE SAME OR SIMILAR MANNER IN WHICH YOU RECEIVED THIS NOTICE.

FOR QUESTIONS OR REQUESTS

If you have any questions regarding this Notice or the subjects addressed in it, or would like to submit a written request as described above, you may contact the Plan’s Administrators directly or you may contact the Plan’s Privacy Officer at Ryder as follows:

Privacy Officer
Assistant General Counsel
Ryder System, Inc.
11690 NW 105th Street
Miami, FL 33178-1103
305-500-3988

The use and disclosure of PHI by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

Patient Protection and Affordable Care Act (“PPACA”)

Patient Protection Notices
The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Benefit Claims and Appeals Process
You or your beneficiary (or duly authorized representative) must file a claim to receive benefits to which you are entitled under any of the Ryder System, Inc. benefit plans or programs. Each Ryder System, Inc. benefit plan has a different party with whom you should file your initial claim for benefits (or your appeal of a denied claim). Please check the “Who To Send Your Claims and Appeals To” chart, located at the end of this section. In addition, the plan-specific chapters of the SPD contain information about filing claims and appeals.

Below are the general guidelines for filing your claim for benefits. Please note that different types of benefit claims will have different guidelines and time deadlines. For your claims for group health benefits under the Ryder System, Inc. Medical Plan, Prescription Plan, Dental Plan and Health Care Flexible Spending Account Plan, the guidelines for resolving your claim will depend on whether the claim is for: (i) pre-service care, (ii) post-service care, (iii) urgent care, or (iv) concurrent care. These terms are defined below.
Claims and Appeals for Benefits under the UnitedHealthcare Medical Plans

Network Benefits
In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance. Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits
If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

How To File Your Claim for Non-Network Benefits
You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:
- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you. The above information should be filed with UnitedHealthcare at the address on your ID card. After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:
- the provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements
Each month that UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's
medical costs by providing claims information in easy-to-understand terms. If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)
You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com.

Timely Filing of Claims
All claim forms for services must be submitted within one year after the end of the year in which expenses are incurred, whether you are filing the claim on your own or your dependent(s)’ behalf, or whether your provider (physician, hospital, laboratory, etc.) is filing the claim on your or your dependent(s)’ behalf. It is your responsibility to ensure that all of your claims and your dependent(s)’ claims are filed timely. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Ryder. This timeliness requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient stay, the date of service is the date your Inpatient stay ends.

Claim Denials and Appeals
If Your Claim Is Denied
If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim
If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal. Refer to the chart at the end of this section.

Types of Claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal
UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.
Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

**Filing a Second Appeal**
Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

**Note:** Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

**Federal External Review Program**
If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare’s determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:
- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare’s decision.

An external review request should include all of the following:
- a specific request for an external review;
- the Covered Person’s name, address, and insurance ID number;
- your designated representative’s name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:
- a standard external review; and
- an expedited external review.

**Standard External Review**
A standard external review is comprised of all of the following:
- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:
is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; has exhausted the applicable internal appeals process; and has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare 's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare’s determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expeditied External Review
An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care
service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare. You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

**Timing of Appeals Determinations**

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- **Urgent Care request for Benefits** - a request for Benefits provided in connection with Urgent Care services;
- **Pre-Service request for Benefits** - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided; and
- **Post-Service** - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.
The tables below describe the time frames which you and UnitedHealthcare are required to follow.

### Urgent Care Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
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</thead>
<tbody>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>24 hours</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits to UnitedHealthcare within:</td>
<td>48 hours after receiving notice of additional information required</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
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*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.*

### Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:</td>
<td>5 days</td>
</tr>
<tr>
<td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must then provide completed request for Benefits information to UnitedHealthcare within:</td>
<td>45 days</td>
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<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
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<tr>
<td>• if the initial request for Benefits is complete, within:</td>
<td>15 days</td>
</tr>
<tr>
<td>• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>15 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>15 days after receiving the second level appeal</td>
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</table>
### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
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<tr>
<td>- if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>- after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
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<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
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<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

### Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

### Limitation of Action

You cannot bring any legal action against Ryder or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Ryder or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Ryder or the Claims Administrator.

You cannot bring any legal action against Ryder or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Ryder or the Claims Administrator you must do so...
within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Ryder or the Claims Administrator.

Claims and Appeals for Benefits under the Caremark Rx Prescription Plan

If Your Claim Is Denied
If your claim for a prescription drug is denied in whole or in part, you have the right to file a formal written appeal with the Plan Administrator as described below.

How To Appeal A Denied Claim
If you wish to appeal a denied pre-service request or post-service claim as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit an urgent care appeal in writing. Your appeal should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date you attempted to fill your prescription;
- the reason you disagree with the denial; and
- any other documentation and other written information to support your request.

You or your authorized representative must send your written appeal to the following address:

Benefits Department
11690 NW 105 Street
Miami, FL  33178-1103
Fax: 305-500-4342

Review of an Appeal
The Plan Administrator will conduct a full and fair review of your written appeal. The appeal will be reviewed by an appropriate individual(s) who did not make the initial benefit determination. This individual(s) will take into consideration all the documents and information you submitted to support your appeal. The Plan Administrator will respond to your appeal in the following timeframes:

- Pre-Service Claims: 15 days
- Post Service Claims: 30 days
- Urgent Care Claims: 72 hours

Federal External Review Process (Non-Expedited)
If your claim is denied you may request, in writing, an External Review of such Claim within 4 months after receiving notice of the Final Internal Adverse Benefit Determination. Your request should include your name, contact information including mailing address and daytime phone number, your member ID number, and a copy of the coverage denial. Your request for External Review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 866-443-1172

Preliminary Review
Within 5 days of receiving your request for External Review, CVS Caremark will conduct a “preliminary review” to ensure that the request qualifies for External Review. In this preliminary review, CVS Caremark will determine whether:
you are or were covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided;

- the Adverse Benefit Determination or Final Internal Adverse benefit Determination does not relate to the member’s failure to meet the Plan’s requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;

- you have exhausted the Plan’s internal appeal process (unless the Claim is “deemed exhausted” under the ACA); and

- you have provided all the information and forms necessary to process the External Review.

In addition, CVS Caremark will review the request for External Review to determine whether it involves a Claim Involving Medical Judgment. If CVS Caremark determines that the request does not involve a Medical Judgment, it will forward the request for External Review to an IRO for further review. The IRO determines whether the request for External Review involves a Claim Involving Medical Judgment as soon as possible. Within one day after completing its preliminary review, CVS Caremark will notify you, in writing, that: (i) the request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO
If your request for External Review is complete and the Claim is eligible for External Review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify you of its acceptance of the assignment. You will then have 10 days to provide the IRO with any additional information you want the IRO to consider. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan and the Plan Sponsor. The IRO may consider information beyond the records for the denied Claim, such as:

- medical records;
- the attending health care professional’s recommendations;
- reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating physician;
- the terms of the Plan to ensure that the IRO’s decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;
- any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law); and
- the opinion of the IRO’s clinical reviewer(s) after considering all information and documents applicable to the member’s request for External Review, to the extent such information or documents are available and the IRO’s clinical reviewer(s) considers it appropriate.

Timing of IRO’s Determination
The IRO will provide you and CVS Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review. The IRO’s notice will contain:

- a general description of the reason for the request for External Review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the claim amount [if available], and the reasons for the previous denials);
- the date the IRO received the External Review assignment from CVS Caremark, and the date of the IRO’s decision;
- references to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
• a discussion of the principal reason(s) for the IRO’s decision, including the rationale for the
decision, and any evidence-based standards that were relied upon by the IRO in making its
decision;
• a statement that the determination is binding except to the extent that other remedies may be
available under State or Federal law to the either the Plan or to you;
• a statement that you may still be eligible to seek judicial review of any adverse External Review
determination; and
• current contact information, including phone number, for any applicable office of health insurance
consumer assistance or ombudsmen available to assist you.

Reversal of the Plan's Prior Decision
If CVS Caremark, acting on the Plan’s behalf, receives notice from the IRO that it has reversed the prior
adverse determination of your Claim, CVS Caremark will immediately provide coverage or payment for
the Claim.

Federal External Review Process (Expedited)
You may request an expedited External Review:
• if you receive an Adverse Benefit Determination related to a Claim Involving Medical Judgment
that involves a medical condition for which the timeframe for completion of an expedited internal
appeal would seriously jeopardize your life or health, and/or could result in failure to regain
maximum function, and you have filed a request for an expedited internal appeal; or
• if you receive a Final Internal Adverse Benefit Determination related to a Claim Involving Medical
Judgment that involves: (i) a medical condition for which the timeframe for completion of a
standard External Review would seriously jeopardize your life or health, and/or could result in
failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a
prescription drug benefit for which you have received emergency services, but have not been
discharged from a facility.

Request for Review
If your situation meets the definition of urgent under the law, the external review of the Claim will be
conducted as expeditiously as possible. In that case, your or your physician may request an expedited
external review by calling the Customer Care toll-free at the number on their benefit ID card or contacting
their benefits office. The request should include your name, contact information including mailing address
and daytime phone number, member ID number, and a description of the coverage denial. Alternatively, a
request for expedited External Review may be faxed; contact information and coverage denial
description, and supporting documentation may be faxed to the attention CVS Caremark External Review
Appeals Department at fax number 866-689-3092. All requests for expedited review must be clearly
identified as "urgent" at submission.

Preliminary Review
Immediately on receipt of your request for expedited External Review, CVS Caremark will determine
whether the request meets the reviewability requirements described above for standard External Review.
Immediately upon completing this review, CVS Caremark will notify you that: (i) your request for External
Review is complete, and may proceed; (ii) the request is not complete, and additional information is
needed (along with a list of the information needed to complete the request); or (iii) the request for
External Review is complete, but not eligible for review.

Referral to IRO
Upon determining that your request is eligible for expedited External Review, CVS Caremark will assign
an IRO to review the member’s Claim. CVS Caremark will provide or transmit all necessary documents
and information considered in making the Adverse Benefit Determination or Final Adverse Benefit
Determination to the assigned IRO electronically, by telephone, by fax, or by any other available
expeditious method. The assigned IRO, to the extent the information or documents are available and
the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for External Review, the IRO will review your Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.

Timing of the IRO’s Determination
The IRO must provide you and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for External Review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and CVS Caremark, on behalf of the Plan, with written confirmation of its decision.

Authority for Review
CVS Caremark will be responsible only for conducting the preliminary review of your request for External Review, ensuring that you are timely notified of the decision as to eligibility for External Review, and for assigning the request for External Review to an IRO. The actual External Review of your appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the External Review performed by an IRO.

Claims and Appeals for Benefits under the Cigna Dental Plan

How to File Your Claim
Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form. You may get the required claim forms from the website listed or by calling Member Services using the toll-free number.

Timely Filing
Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

Appeal Process
For the purposes of this section, any reference to “you,” “your,” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. “Physician Reviewers” are licensed Dentists depending on the care, service or treatment under review.

Appeals Procedure
Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write using the toll-free number or address on your Benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. For level-one appeals, Cigna will respond in writing with a decision within 30 calendar days after receiving an appeal for a post service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.
Level-Two Appeal
If you are dissatisfied with the level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal. Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician reviewer. You may present your situation to the Committee in person or by conference call. For level-two appeals Cigna will acknowledge in writing receipt of your request and schedule a Committee review. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee’s decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Independent Review Procedure
If you are not fully satisfied with the decision of Cigna’s level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant’s rights to any other benefits under the plan. There is no charge for you to initiate this Independent Review Process. Cigna will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna’s level-two appeal review denial. Cigna will then forward the file to the IRO. The IRO will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by Cigna’s Dentist reviewer, the review shall be completed within 3 days. The Independent Review Program is a voluntary program arranged by Cigna.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information
Relevant information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the
claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action
If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

Claims and Appeals for Benefits Under the Ryder System, Inc. Disability Plans

The following guidelines are for claims that you file for benefits under the Ryder System, Inc. Short-Term Disability Plan and Long-Term Disability Plan. Please refer to these sections of the SPD for more specific details on how to properly file a claim.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the appropriate Claim Administrator will notify you (or your duly authorized representative) within 45 days of receiving your claim.

There may be two extension periods of up to 30 days each, provided that the Claim Administrator determines that such an extension is necessary due to circumstances beyond the control of the plan. In the event of such an extension, notice of the extension will be provided to you before expiration of the initial 45-day period (or before expiration of the first 30-day extension, in the case of a second extension). The notice will explain the circumstances requiring the extension and inform you of the date by which the Claim Administrator expects to make a decision. The notice will also specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days in which to provide the specified information.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Claim Administrator’s request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed;
- what procedures you should follow to get your claim reviewed again by the appropriate Appellate Body (as listed in each Plan’s section of this SPD and the chart located at the end of this section), and the time limits applicable to such procedures;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination,
applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, within 180 days after you receive the notice of denial, submit your written request for review to the appropriate Appellate Body. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim.

You will be notified of the decision on review within 45 days after the plan’s receipt of your request for review, unless the Appellate Body determines that special circumstances require an extension of time for processing. If such a determination is made, you will be notified of the extension in writing before the end of the 45-day period. The extension will not exceed a period of 45 days from the end of the initial 45-day period. The extension notice will indicate the special circumstances requiring the extension as well as the date by which the Appellate Body expects to make the determination on review.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Appellate Body’s request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the following:

- the specific reason(s) for the adverse determination;
- references to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement of your right to bring an action under Section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

All decisions on review are final and binding on all parties.

Claims and Appeals for Benefits Under All Other Ryder System, Inc. Plans
(i.e., claims that are not for group health or disability benefits)

The following guidelines are for claims that you file for benefits under the Ryder System, Inc. 401(k) Savings Plan, Retirement Plan, Flexible Spending Account Plans, AD&D Plan, Group Life and Supplemental Life Plans, Severance Plans and Tuition Reimbursement.
If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the appropriate Claim Administrator (as listed in each Plan’s section of this SPD and on the chart located at the end of this section) will notify you (or your duly authorized representative) within 90 days of receiving your written claim.

This 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the Claim Administrator expects to make the benefit determination, before the end of the initial 90-day period.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination; the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed; and
- what procedures you should follow to get your claim reviewed again by the appropriate Appellate Body and the time limits applicable to such procedures.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, within 60 days after you receive the notice of denial, submit your written request for review to the appropriate Appellate Body (as listed in each Plan’s section of this SPD and on the chart entitled Who to Send Your Claims and Appeals To located in this section). In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim.

You will be notified of the decision on review within 60 days after the plan’s receipt of your request for review, unless the Appellate Body determines that special circumstances require an extension of time for processing. If such a determination is made, you will be notified of the extension in writing before the end of the 60-day period. The extension will not exceed a period of 60 days from the end of the initial 60-day period. The extension notice will indicate the special circumstances requiring the extension as well as the date by which the Appellate Body expects to make the determination on review.

With regard to your non-retirement benefits, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Appellate Body’s request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the following:

- the specific reason(s) for the adverse determination;
- references to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- a statement of your right to bring an action under Section 502(a) of ERISA.

All decisions on review are final and binding on all parties.
**External Review Process**
Your claim may be eligible for an external review through an independent review organization. For more information about the external review process or to inquire if your claim is eligible for a review by an independent review organization, please contact the plan administrator.

**Who To Send Your Claims and Appeals To**

<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>Claim Administrator</th>
<th>Appellate Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ryder System, Inc. Medical Plan</td>
<td>United Healthcare – Claims Administrator</td>
<td>United Healthcare – Claims Administrator (send both levels of appeal to United Healthcare)</td>
</tr>
<tr>
<td>The Ryder System, Inc. Prescription Plan</td>
<td>Caremark – Claims Administrator</td>
<td>Caremark – Claims Administrator (send appeals to Ryder)</td>
</tr>
<tr>
<td>EAP Program</td>
<td>FEI Behavioral Health – Claims Fiduciary</td>
<td>FEI Behavioral Health (send both levels of appeal to FEI Behavioral Health)</td>
</tr>
<tr>
<td>The Ryder System, Inc. Dental Plan</td>
<td>Cigna Dental Care – Claims Administrator</td>
<td>Cigna Dental Care – Claims Administrator (send both levels of appeal to Cigna Dental Care)</td>
</tr>
<tr>
<td>The Ryder System, Inc. Health Care Flexible Spending Account Plan</td>
<td>Your Spending Account (YSA) – Claims Fiduciary</td>
<td>Your Spending Account (YSA) – Claims Administrator (send both levels of appeal to YSA)</td>
</tr>
<tr>
<td>The Ryder System, Inc. Dependent Care Flexible Spending Account Plan</td>
<td>Your Spending Account (YSA) – Claims Fiduciary</td>
<td>Your Spending Account (YSA) – Claims Administrator (send both levels of appeal to YSA)</td>
</tr>
<tr>
<td>The Ryder System, Inc. Short-Term Disability Plan</td>
<td>Liberty Mutual Group – Claims Administrator</td>
<td>Liberty Mutual Group – Claims Administrator</td>
</tr>
<tr>
<td>The Ryder System, Inc. Long-Term Disability Plan</td>
<td>Liberty Mutual Group – Claims Administrator</td>
<td>Liberty Mutual Group – Claims Administrator</td>
</tr>
<tr>
<td>The Ryder System, Inc. AD&amp;D Plan</td>
<td>Minnesota Life – Claims Administrator</td>
<td>Minnesota Life – Claims Administrator</td>
</tr>
<tr>
<td>The Ryder System, Inc. Group Life and Supplemental Life Plan</td>
<td>Minnesota Life – Claims Administrator</td>
<td>Minnesota Life – Claims Administrator</td>
</tr>
<tr>
<td>The Ryder System, Inc. 401(k) Savings Plan</td>
<td>The Ryder System, Inc. Retirement Committee</td>
<td>The Ryder System, Inc. Retirement Committee</td>
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<td>The Ryder System, Inc. Retirement Plan</td>
<td>The Ryder System, Inc. Retirement Committee</td>
<td>The Ryder System, Inc. Retirement Committee</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>A.C. Newman &amp; Company</td>
<td>A.C. Newman &amp; Company – Claims Administrator</td>
</tr>
<tr>
<td>Tuition Reimbursement Program</td>
<td>The Ryder System, Inc. Plan Administrator</td>
<td>The Ryder System, Inc. Plan Administrator</td>
</tr>
<tr>
<td>Severance Plans</td>
<td>The Ryder System, Inc. Plan Administrator</td>
<td>The Ryder System, Inc. Plan Administrator</td>
</tr>
</tbody>
</table>

Please remember that if your claim is denied your written notification of the denial will include information regarding where to send your request for an appeal. If that contact information differs in any way from the information contained in this SPD, send your request for appeal to the address stated in the written notification of your initial claim denial.

If you have any questions regarding any aspect of the claims and appeals process, please call the Ryder BenefitsNow Service Center at 800-280-2999.
Your ERISA Rights
As a participant in the plans described in this book, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
- examine without charge, at the plan administrator’s office and at other specified locations, all documents governing the plan, including plan documents, insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
- obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including plan documents, insurance contracts, collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies; and
- receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of his or her summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse, or dependent if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance insurer when:
  - you lose coverage under the plan;
  - you become entitled to elect COBRA continuation coverage;
  - your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one—including your employer, your union, or any other person—may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare or pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack of a decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If the plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact:

- the Employee Benefits Security Administration (“EBSA”), U.S. Department of Labor. Contact Information for EBSA, including the regional office in your area, is located at www.askEBSA.dol.gov, or you can call EBSA toll free at 866-444-EBSA (3272). Alternatively, you can find the EBSA regional office in your area in your local telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210; or
- you may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

**Statement of Rights under the Newborn’s and Mothers’ Health Protection Act**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by caesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or the newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

**Women’s Health and Cancer Rights Act of 1998**

As required by the Women’s Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• prostheses and treatment of physical complications of the mastectomy, including lymphedema.
Medicare Part D Notices

Notice of Creditable Coverage

Medicare Part D – Important if you are 65 or over, or otherwise Medicare eligible

Important Notice from Ryder System, Inc.
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ryder System, Inc. and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Ryder System, Inc. has determined that the prescription drug coverage offered by the Caremark Plans, Humana Puerto Rico Plan, Blue Care Network, Geisinger Health Plan and all Kaiser Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Special Note for Retirees: Once you or a covered dependent reaches age 65, prescription coverage cannot be continued through Ryder.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer/union-sponsored coverage you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare drug plan and drop your Ryder System, Inc. prescription drug coverage, be aware that you and your dependents may not be able to or in some cases cannot get this coverage back.

You should also know that if you drop or lose your coverage with Ryder System, Inc. and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ryder System, Inc. ends or changes. You also may request a copy.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the U.S. Social Security Administration on the Web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).
Notice of Non-Creditable Coverage

Medicare Part D – Important if you are 65 or over or otherwise Medicare-eligible

Important Notice from Ryder System, Inc.
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ryder System, Inc. and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Ryder System, Inc. has determined that the prescription drug coverage offered by the Starbridge Sickness and Accident Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a different Ryder Prescription Plan or a Medicare drug plan, than if you only have prescription drug coverage from the Starbridge Sickness and Accident Plan.

3. You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully—it explains your options.

Consider joining a different Ryder Prescription Plan or a Medicare drug plan. You can keep your coverage from Ryder System, Inc. regardless of whether or not it is as good as Medicare drug plan. However, because your existing coverage is, on average, NOT at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Special Note for Retirees: Once you or a covered dependent reaches age 65, prescription coverage cannot be continued through Ryder.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose or decide to leave employer/union-sponsored coverage you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

You need to make a decision.
When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare drug plan and drop your Ryder System, Inc. prescription drug coverage, be aware that you and your dependents may not be able to, or in some cases, cannot get this coverage back.
You should also know that if you drop or lose your coverage with Ryder System, Inc. and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ryder System, Inc. ends or changes. You also may request a copy.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the U.S. Social Security Administration on the Web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).
<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Number</th>
<th>Plan Type</th>
<th>Funding</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ryder System, Inc. Flexible Benefits Plan (Medical Plan)</td>
<td>527</td>
<td>Welfare and fringe benefit</td>
<td>Combination of employer and employee funding</td>
<td>United Healthcare PO Box 30432 Salt Lake City, Utah 84130-0432 888-899-4734 <a href="http://www.myuhc.com">www.myuhc.com</a>, or <a href="http://www.uhc.com">www.uhc.com</a></td>
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<td>The Ryder System, Inc. Flexible Benefits Plan (Prescription Plan)</td>
<td>527</td>
<td>Welfare and fringe benefit</td>
<td>Combination of employer and employee funding</td>
<td>Caremark, Inc. 2211 Sanders Road Northbrook, IL. 60062 800-323-8083 <a href="http://www.caremark.com">www.caremark.com</a></td>
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<tr>
<td>The Ryder System, Inc. Flexible Benefits Plan (Employee Assistance Program)</td>
<td>527</td>
<td>Welfare and fringe benefit</td>
<td>Combination of employer and employee funding</td>
<td>FEI Behavioral Health 11700 west Lake Park Drive Milwaukee, WI. 53224 800-323-0751 <a href="http://www.feibh.com/rsi">www.feibh.com/rsi</a></td>
</tr>
<tr>
<td>The Ryder System, Inc. Flexible Benefits Plan (Dental Plan)</td>
<td>527</td>
<td>Welfare and fringe benefit</td>
<td>Combination of employer and employee funding</td>
<td>Cigna Dental Care 300 NW 82nd Avenue Plantation, FL 33324 800-244-6224 <a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cigna Dental 900 Cottage Grove Road Hartford, CT 06152-2129 800-525-5803 <a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>The Ryder System, Inc. Flexible Benefits Plan (Health Care Flexible Spending Account)</td>
<td>527</td>
<td>Welfare and fringe benefit</td>
<td>Participant contributions</td>
<td>YSA Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407 800-280-2999</td>
</tr>
<tr>
<td>The Ryder System, Inc. Flexible Benefits Plans (Dependent Care Flexible Spending Account)</td>
<td>527</td>
<td>Welfare and fringe benefit</td>
<td>Participant contributions</td>
<td>YSA Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407 800-280-2999</td>
</tr>
<tr>
<td>The Ryder System, Inc. Short-Term Disability Plan</td>
<td>512</td>
<td>Welfare</td>
<td>Combination of employer and employee funding</td>
<td>Liberty Mutual Group 13830 Ballantyne Corporate Place, Ste 400 Charlotte, NC 28277 800-291-0112, ext. 23967</td>
</tr>
<tr>
<td>The Ryder System, Inc. Long-Term Disability Plan</td>
<td>504</td>
<td>Welfare</td>
<td>Insured</td>
<td>Liberty Mutual Group 13830 Ballantyne Corporate Place, Ste 400 Charlotte, NC 28277 800-291-0112, ext. 23967</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Plan Number</td>
<td>Plan Type</td>
<td>Funding</td>
<td>Contact Information</td>
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</table>
| The Ryder System, Inc. Flexible Benefits Plan (AD&D Plan) | 527         | Welfare                         | Insured     | Minnesota Life Insurance Company  
400 Robert Street North  
St. Paul, MN  55101  
651-665-4055 |
| The Ryder System, Inc. Flexible Benefits Plan (Group Life and Supplemental Life Plan) | 527         | Welfare                         | Insured     | Minnesota Life Insurance Company  
400 Robert Street North  
St. Paul, MN  55101  
651-665-4055 |
| The Ryder System, Inc. 401(k) Savings Plan             | 005         | Defined contribution            | Trust fund  | Fidelity Institutional Services  
P.O. Box 9233  
Boston, MA 02205  
800-373-7300 |
| The Ryder System, Inc. Retirement Plan                 | 001         | Defined benefit (pension)       | Trust Fund  | Fidelity Institutional Services  
P.O. Box 9233  
Boston, MA 02205  
800-373-7300 |
| The Ryder System, Inc. Vision Insurance Plan           | 528         | Welfare                         | Insured     | EyeMed Vision Care  
4000 Luxottica Place  
Mason, OH  45040  
866-723-0513  
[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) |
4969 McKinley Avenue  
Suite 202  
Fresno, CA. 93727-1968 |
| The Ryder System, Inc. Hyatt Legal Plan                | 515         | Welfare                         | Participant contributions  | Hyatt Legal Plan, Inc.  
1215 Superior Ave.  
Cleveland, OH 44114-3292  
800-821-6400  
[www.hlpsvc.com](http://www.hlpsvc.com) |
| Ryder Severance Plan                                   | 526         | Welfare                         | Employer funding | The Plan Administrator  
Ryder System, Inc.  
c/o Vice President,  
Compensation and Benefits  
11690 NW 105th Street  
Miami, FL 33178-1103 |
| Ryder Severance Plan for Eligible Supply Chain Employees | 529         | Welfare                         | Employer funding | The Plan Administrator  
Ryder System, Inc.  
c/o Vice President,  
Compensation and Benefits  
11690 NW 105th Street  
Miami, FL 33178-1103 |
TABLE OF CONTENTS

Introduction and Plan Options ........................................................................................................... 67
UnitedHealthcare Medical Plans ........................................................................................................ 67
Other Health Plans ........................................................................................................................... 68
Non-Tobacco User Credit .................................................................................................................. 68

Highlights of the UnitedHealthcare (UHC) Medical Plan Options .................................................. 69
UHC Option 1 Plan Chart ................................................................................................................... 69
UHC Option 2 Plan Chart ................................................................................................................... 72
UHC Option 3 Plan Chart ................................................................................................................... 75
UHC Option 1 Passive PPO Chart ...................................................................................................... 78
UHC Option 3 Passive PPO Chart ...................................................................................................... 80
UnitedHealthcare Choice Plus Plans (UHC Option 1, UHC Option 2, UHC Option 3) ................. 82
UnitedHealthcare Passive PPO Plans (UHC Option 1 Passive PPO and UHC Option 3 Passive PPO) .......................................................................................................................... 82

How UnitedHealthcare Medical Plans Work ................................................................................. 82
Network and Non-Network Benefits ............................................................................................... 82
Network Benefits .............................................................................................................................. 83
Non-Network Benefits ...................................................................................................................... 83
Health Services from Non-Network Providers Paid as Network Benefits ........................................ 84
If You Are Looking for a Network Provider .................................................................................... 84
Possible Limitations on Provider Use ............................................................................................... 84
Annual Maximum ............................................................................................................................. 84
Annual Deductible ............................................................................................................................ 84
Coinsurance ....................................................................................................................................... 84
Coinsurance – Example ..................................................................................................................... 85
Out-of-Pocket Maximum .................................................................................................................. 85

Personal Health Support Services ................................................................................................... 85
Prior Authorization ........................................................................................................................... 86
Covered Health Services which Require Prior Authorization .......................................................... 86
Special Note Regarding Medicare ................................................................................................... 88

What the UnitedHealthcare Medical Plans Cover .......................................................................... 88
Eligible Expenses Payable by the Plan ............................................................................................... 88
Covered Health Services .................................................................................................................. 89
Acupuncture Services ....................................................................................................................... 89
Ambulance Services ........................................................................................................................ 89
Cancer Resource Services ............................................................................................................... 90
Chiropractic, Spinal Treatment and Osteopathic Manipulative Therapy ....................................... 90
Congenital Heart Disease (CHD) Services ....................................................................................... 91
Dental Services ................................................................................................................................. 91
Diabetes Services ............................................................................................................................. 92
Durable Medical Equipment (DME) ............................................................................................... 92
Emergency Health Services - Outpatient ......................................................................................... 93
Home Health Care .......................................................................................................................... 94
Hospice Care ..................................................................................................................................... 94
Hospital - Inpatient Stay .................................................................................................................... 94
Kidney Resource Services (KRS) ................................................................................................... 94
Maternity Services ........................................................................................................................... 95
Mental Health Services ................................................................................................................... 95
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders ................ 96
Obesity Surgery .................................................................................................................................. 97
Orthognathic Surgery ...................................................................................................................... 97
Orthotics .......................................................................................................................................... 97

Non-Tobacco User Credit ................................................................................................................ 68
Other Health Plans .......................................................................................................................... 68
Ostomy Supplies ................................................................. 98
Outpatient Surgery, Diagnostic and Therapeutic Services ........................................ 98
Physician's Office Services - Sickness and Injury; Injections received in a Physician's Office ................................................................. 99
Preventive Care Services .......................................................................................... 99
Private Duty Nursing - Outpatient ......................................................................... 99
Professional Fees for Surgical and Medical Services ............................................... 100
Prosthetic Devices ..................................................................................................... 100
Reconstructive Procedures ........................................................................................ 100
Rehabilitation Services - Outpatient Therapy ............................................................ 101
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services ............................. 101
Substance Use Disorder Services ............................................................................. 102
Surgical Procedures – Multiple .................................................................................. 103
Transplantation Services ........................................................................................... 103
Urgent Care Center Services ..................................................................................... 104

Resources to Help You Stay Healthy ........................................................................ 104
Consumer Solutions and Self-Service Tools .............................................................. 104
Health Assessment .................................................................................................... 104
Health Improvement Plan .......................................................................................... 104
Treatment Decision Support ...................................................................................... 105
UnitedHealth PremiumSM Program ......................................................................... 105
www.myuhc.com ....................................................................................................... 105
Registering on myuhc.com ......................................................................................... 106

Disease and Condition Management Services .......................................................... 106
Cancer Support Program ............................................................................................ 106
Diabetes Prevention and Control ............................................................................... 106
HealthNotesSM .......................................................................................................... 107

Wellness Programs ...................................................................................................... 107
Healthy Pregnancy Program ......................................................................................... 107
Tobacco Cessation Program (QuitPower) .................................................................. 107

What the UnitedHealthcare Medical Plans Will Not Cover (Exclusions) ............... 108
Alternative Treatments ............................................................................................... 108
Comfort or Convenience ............................................................................................ 108
Dental .......................................................................................................................... 108
Drugs (Refer to the Prescription Plan Section) ............................................................ 109
Experimental or Investigational Services or Unproven Services ............................. 109
Foot Care .................................................................................................................... 109
Medical Supplies and Appliances .............................................................................. 109
Mental Health/Substance Use Disorder ..................................................................... 110
Nutrition ....................................................................................................................... 110
Physical Appearance .................................................................................................. 111
Providers ..................................................................................................................... 111
Reproduction .............................................................................................................. 111
Transplants ................................................................................................................ 111
Travel ............................................................................................................................ 111
Vision and Hearing ...................................................................................................... 112
All Other Exclusions (this list is not intended to be all-inclusive) .............................. 112

Claims Procedures ..................................................................................................... 114
Coordination of Benefits (COB) ............................................................................... 114
Determining which Plan is Primary ......................................................................... 114
Determining Primary and Secondary Plan – Examples ......................................... 115
When This Plan is Secondary .................................................................................... 116
Determining the Allowable Expense If This Plan Is Secondary ................................. 116
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is an allowable expense?</td>
<td>116</td>
</tr>
<tr>
<td>When a Covered Person Qualifies for Medicare</td>
<td>116</td>
</tr>
<tr>
<td>Right to Receive and Release Needed Information</td>
<td>116</td>
</tr>
<tr>
<td>Overpayment and Underpayment of Benefits</td>
<td>117</td>
</tr>
<tr>
<td>COB and Benefit Claims</td>
<td>117</td>
</tr>
<tr>
<td>Refund of Overpayments</td>
<td>117</td>
</tr>
<tr>
<td>Subrogation and Reimbursement</td>
<td>117</td>
</tr>
<tr>
<td>Right of Recovery</td>
<td>117</td>
</tr>
<tr>
<td>Right to Subrogation</td>
<td>118</td>
</tr>
<tr>
<td>Right to Reimbursement</td>
<td>118</td>
</tr>
<tr>
<td>Third Parties</td>
<td>118</td>
</tr>
<tr>
<td>Subrogation and Reimbursement Provisions</td>
<td>118</td>
</tr>
<tr>
<td>Subrogation – Example</td>
<td>120</td>
</tr>
</tbody>
</table>

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
Introduction and Plan Options

UnitedHealthcare Medical Plans
This section of your Summary Plan Description (SPD) is designed to provide you with information about the Ryder System, Inc. Medical Plan consisting of the following UnitedHealthcare (UHC) options. Eligibility for some of the plans is based on the zip code for your address of record. Each Option described below has specific annual deductibles, coinsurance and annual out-of-pocket maximum. These specifics are illustrated in the charts found in the “Highlights of the UnitedHealthcare (UHC) Medical Plan Options” in this Medical section of the Summary Plan Description Book.

- **UHC Option 1 Plan – utilizing providers in the UnitedHealthcare Choice Plus network** – a nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services and 100% for preventive care providing you utilize network services. If you don’t use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). Non-network charges over this reimbursement rate are not covered by the Plan.

- **UHC Option 2 Plan – utilizing providers in the UnitedHealthcare Choice Plus network** – a nationwide network of doctors, facilities and specialists. The plan pays 75% of covered services and 100% for preventive care providing you utilize network services. If you don’t use network doctors and facilities, the plan pays up to 50% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). Non-network charges over this reimbursement rate are not covered by the Plan.

- **UHC Option 3 Plan - utilizing providers in the UnitedHealthcare Choice Plus network** – a nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services and 100% for preventive care providing you utilize network services. If you don’t use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). Non-network charges over this reimbursement rate are not covered by the Plan.

- **UHC Option 1 Passive PPO Plan** – a limited nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services and 100% for preventive care. When you receive services from providers who are not a part of the network, you are provided coverage by a fee-for-service plan, which pays benefits based on whether or not the service meets the definition of an Eligible Expense and whether of not it is a Covered Health Service. You and your dependents may receive care from any qualified licensed doctor, hospital or other health care facility. Fee-for-service arrangements allow the member the greatest flexibility in choosing health care professionals and hospitals that are not part of the contracted network; however, when Non-Network providers are used, the portion of expense to the member is generally much higher than if Network providers were used.

- **UHC Option 3 Passive PPO Plan** – a limited nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services and 100% for preventive care. When you receive services from providers who are not a part of the network, you are provided coverage by a fee-for-service plan, which pays benefits based on whether or not the service meets the definition of an Eligible Expense and whether of not it is a Covered Health Service. You and your dependents may receive care from any qualified licensed doctor, hospital or other health care facility. Fee-for-service arrangements allow the member the greatest flexibility in choosing health care professionals and hospitals that are not part of the contracted network; however, when Non-
Network providers are used, the portion of expense to the member is generally much higher than if Network providers were used.

- **No Coverage Option** – You may also choose to waive medical coverage.

**Other Health Plans**
These plans are not described in this Summary Plan Description Book. Plan information for these plans is available directly through the respective Health Plans.

- Blue Care C and Blue Care D Plans
- Humana PPO Plan
- Geisinger Health Plan
- Kaiser Permanente
- Starbridge Sickness and Accident Plan (Limited-Benefit Plan)

**Non-Tobacco User Credit**
If you or your covered Spouse or Domestic Partner does not use tobacco products, you can elect the non-tobacco user credit and receive a monthly premium credit towards 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 plan year.

Ryder defines a tobacco user as someone who uses any tobacco products (i.e., smoking cigarettes, pipes, cigars or using chewing tobacco) regardless of frequency. Your enrollment in the Non-Tobacco User Credit Plan must be accurate and truthful. Any intentional misrepresentation will subject you to immediate and appropriate disciplinary action, up to and including termination of benefits and termination of employment.

Generally, changes to this credit plan can only be made during Annual Enrollment. However, if you successfully complete the QuitPower tobacco cessation program through UHC, you may elect the Non-tobacco User Credit at that time, provided that your covered Spouse/Domestic Partner is also tobacco-free. If your Spouse/Domestic partner is a tobacco user and you are making a change outside of Annual Enrollment to remove your Spouse/Domestic Partner from your coverage, you may be eligible for the tobacco free credit providing you are tobacco free.

**Note:** If you work under the provisions of a collective bargaining agreement or are covered under a valid written customer contract, you are eligible to participate in this credit plan, if your current agreement specifically provides for this credit.
Highlights of the UnitedHealthcare (UHC) Medical Plan Options

UHC Option 1 Plan Chart
Claims Administrator UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$600/ individual</td>
<td>$1,200/ individual</td>
</tr>
<tr>
<td></td>
<td>$1,800/ family</td>
<td>$3,600/ family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$5,000/ individual</td>
<td>$10,000/ individual</td>
</tr>
<tr>
<td></td>
<td>$10,000/ family</td>
<td>$20,000/ family</td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Plan pays 100% after network deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Includes Colonoscopies (Diagnostic included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient and outpatient hospital services</strong></td>
<td>Semi-private room and board, intensive care, cardiac care, well baby care</td>
<td>Plan pays 80% after network deductible</td>
</tr>
<tr>
<td><strong>Emergency room services</strong></td>
<td>Plan pays 80% after network deductible</td>
<td>Plan pays 80% after network deductible</td>
</tr>
<tr>
<td>Includes all medically necessary treatment. You must call your medical provider within 48 hours of your admission to a hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>For conditions requiring immediate care when your doctor is not available or after normal hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health/Substance Use Disorder</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Plan pays 80% after network deductible</td>
<td>Plan pays 60% after network deductible</td>
</tr>
<tr>
<td>90% after annual deductible if you use UHC Premium Cardiac Care Centers for cardiac surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy treatment</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Injections, serum, and office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab and X-ray services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Diagnostic</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Diagnostic lab and x-ray services are subject to annual deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>Network</td>
<td>Non-Network*</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Home health care</strong>&lt;br&gt;Limited to 40 days per calendar year, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Skilled nursing facility/Inpatient rehabilitation</strong>&lt;br&gt;Confinement and skilled nursing services in a hospital or specialized facility&lt;br&gt;Limited to 90 days per calendar year, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Outpatient rehabilitation</strong>&lt;br&gt;Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined&lt;br&gt;Cardiac or pulmonary rehabilitation services, with no visit limit</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Chiropractic services</strong>&lt;br&gt;Spinal manipulation and modalities&lt;br&gt;35 visits per calendar year, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong>&lt;br&gt;Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Hospice care</strong>&lt;br&gt;Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Maternity</strong>&lt;br&gt;Physician’s office services, surgical and medical service fees, hospital inpatient/outpatient</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Infertility</strong>&lt;br&gt;Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
</tbody>
</table>
**UHC Option 1 Plan Chart, continued**
Claims Administrator UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ transplants</strong> <em>(UHC Transplant Resource Services must be used)</em></td>
<td>Plan pays 80% after annual deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient/outpatient surgery, and hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel and lodging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrelated bone marrow donor search</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* If you don’t use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the Plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). Non-network charges over this reimbursement rate are not covered by the Plan.

**Important Note:** One of the most expensive decisions you can make is to seek care from non-network providers. Only when non-network expenses are charged at the Medicare reimbursement rate will the maximum annual member cost be limited to $10,000. But providers typically charge far in excess of Medicare reimbursement rates, in which case the difference is not applied to the annual non-network out-of-pocket maximum. Therefore, the maximum annual out-of-pocket expense for non-network care can exceed $10,000 per person on an unlimited basis.

**Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.**
## UHC Option 2 Plan Chart

Claims Administrator UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td><strong>$1,300/ individual</strong></td>
<td><strong>$2,600/ individual</strong></td>
</tr>
<tr>
<td></td>
<td><strong>$3,900/ family</strong></td>
<td><strong>$7,800/ family</strong></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td></td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td><strong>$5,000/ individual</strong></td>
<td><strong>$10,000/ individual</strong></td>
</tr>
<tr>
<td></td>
<td><strong>$10,000/ family</strong></td>
<td><strong>$20,000/ family</strong></td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td></td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td><strong>Plan pays 100%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td>Includes Colonoscopies (Diagnostic included)</td>
<td></td>
<td>no annual deductible</td>
</tr>
<tr>
<td><strong>Inpatient and outpatient hospital services</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td>Semi-private room and board, intensive care, cardiac care, well-baby care</td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td><strong>Emergency room services</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 75%</strong></td>
</tr>
<tr>
<td>Includes all medically necessary treatment. You must call your medical provider within 48 hours of your admission to a hospital</td>
<td>after annual deductible</td>
<td>after network deductible</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td>For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare</td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td>For conditions requiring immediate care when your doctor is not available or after normal hours</td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Use Disorder</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td></td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td></td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td></td>
<td><strong>85% after annual deductible</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>if you use UHC Premium Cardiac Care Centers for cardiac surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Allergy treatment</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td>Injections, serum, and office visits</td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab and X-ray services</strong></td>
<td><strong>Plan pays 75%</strong></td>
<td><strong>Plan pays 50%</strong></td>
</tr>
<tr>
<td>Diagnostic**</td>
<td>after annual deductible</td>
<td>after annual deductible</td>
</tr>
<tr>
<td>Diagnostic lab and x-ray services are subject to annual deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td>Plan Pays 100%</td>
<td></td>
</tr>
</tbody>
</table>
## UHC Option 2 Plan Chart, continued

Claims Administrator UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home health care</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Limited to 40 days per calendar year, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing facility/Inpatient rehabilitation</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Confinement and skilled nursing services in a hospital or specialized facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 90 days per calendar year, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient rehabilitation</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac or pulmonary rehabilitation services, with no visit limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic services</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Spinal manipulation and modalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 visits per calendar year, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Physician’s office services, surgical and medical service fees, hospital inpatient/outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infertility</strong></td>
<td>Plan pays 75% after annual deductible</td>
<td>Plan pays 50% after annual deductible</td>
</tr>
<tr>
<td>Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**UHC Option 2 Plan Chart, continued**

Claims Administrator UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ transplants</strong> (UHC Transplant Resource Services must be used) Inpatient/outpatient surgery, and hospitalization Travel and lodging Unrelated bone marrow donor search</td>
<td>Plan pays 75% after annual deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* If you don’t use network doctors and facilities, the plan pays up to 50% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). Non-network charges over this reimbursement rate are not covered by the Plan.

**Important Note:** One of the most expensive decisions you can make is to seek care from non-network providers. Only when non-network expenses are charged at the Medicare reimbursement rate will the maximum annual member cost be limited to $10,000. But providers typically charge far in excess of Medicare reimbursement rates, in which case the difference is not applied to the annual non-network out-of-pocket maximum. **Therefore, the maximum annual out-of-pocket expense for non-network care can exceed $10,000 per person on an unlimited basis.**

**Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of the wellness exam.**
### UHC Option 3 Plan Chart

**Claims Administrator: UnitedHealthcare**

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$350/ individual</td>
<td>$700/ individual</td>
</tr>
<tr>
<td></td>
<td>$1,050/ family</td>
<td>$2,100/ family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$5,000/ individual</td>
<td>$10,000/ individual</td>
</tr>
<tr>
<td></td>
<td>$10,000/ family</td>
<td>$20,000/ family</td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Plan pays 100% no annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Includes Colonoscopies (Diagnostic included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient and outpatient hospital services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Semi-private room and board, intensive care, cardiac care, well-baby care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency room services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after network deductible</td>
</tr>
<tr>
<td>Includes all medically necessary treatment. You must call your medical provider within 48 hours of your admission to a hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>For conditions requiring immediate care when your doctor is not available or after normal hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health/Substance Use Disorder</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Allergy treatment</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Injections, serum, and office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab and X-ray services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Diagnostic**</td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab and x-ray services are subject to annual deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive****</td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>Network</td>
<td>Non-Network*</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 40 days per calendar year, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Skilled nursing facility/Inpatient rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confinement and skilled nursing services in a hospital or specialized facility</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Limited to 90 days per calendar year, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td>Cardiac or pulmonary rehabilitation services, with no visit limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal manipulation and modalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 visits per calendar year, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splints, braces, non-surgically implanted prosthesis, specified medical equipment for use in the home</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s office services, surgical and medical service fees, hospital inpatient/outpatient</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
<tr>
<td><strong>Infertility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 60% after annual deductible</td>
</tr>
</tbody>
</table>
### UHC Option 3 Plan Chart, continued

Claims Administrator UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ transplants</strong> (UHC Transplant Resources Services must be used) Inpatient/outpatient surgery and hospitalization Travel and lodging Unrelated bone marrow search</td>
<td>Plan pays 80% after annual deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* If you don’t use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the Plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). Non-network charges over this reimbursement rate are not covered by the Plan.

**Important Note:** One of the most expensive decisions you can make is to seek care from non-network providers. Only when non-network expenses are charged at the Medicare reimbursement rate will the maximum annual member cost be limited to $10,000. But providers typically charge far in excess of Medicare reimbursement rates, in which case the difference is not applied to the annual non-network out-of-pocket maximum. **Therefore, the maximum annual out-of-pocket expense for non-network care can exceed $10,000 per person on an unlimited basis.**

**Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.**
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>An annual deductible</strong></td>
<td>$600/ individual</td>
<td>$600/ individual</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td>$5,000/ individual</td>
<td>$5,000/ individual</td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Inpatient and outpatient hospital services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Emergency room services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Use Disorder</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Allergy treatment</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Lab and X-ray services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
</tbody>
</table>
### UHCH Option 1 Passive PPO Chart, continued

**Claims Administrator UnitedHealthcare**

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home health care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 40 days per calendar year, network/non-network combined</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Skilled nursing facility/Inpatient rehabilitation</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Confinement and skilled nursing services in a hospital or specialized facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 90 days per calendar year, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient rehabilitation</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac or pulmonary rehabilitation services, with no visit limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Spinal manipulation and modalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 visits per calendar year, network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Physician’s office services, surgical and medical service fees, hospital inpatient/outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infertility</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organ transplants (UHC Transplant Resources Services must be used)</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient/outpatient surgery and hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel and lodging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrelated bone marrow search</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.*
## UHC Option 3 Passive PPO Chart

### Claims Administrator
UnitedHealthcare

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$350/ individual</td>
<td>$350/ individual</td>
</tr>
<tr>
<td></td>
<td>$1,050/ family</td>
<td>$1,050/ family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$5,000/ individual</td>
<td>$5,000/ individual</td>
</tr>
<tr>
<td></td>
<td>$10,000/ family</td>
<td>$10,000/ family</td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Includes Colonoscopies (Diagnostic included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient and outpatient hospital services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Semi-private room and board, intensive care, cardiac care, well-baby care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency room services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Includes all medically necessary treatment, You must call your medical provider within 48 hours of your admission to a hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>For conditions requiring immediate care when your doctor is not available or after normal hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health/Substance Use Disorder</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>90% after annual deductible if you use UHC Premium Cardiac Care Centers for cardiac surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy treatment</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Injections, serum, and office visits</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Lab and X-ray services</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Diagnostic*</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Diagnostic lab and x-ray services are subject to annual deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>
## UHC Option 3 Passive PPO Chart, continued

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Home health care</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Limited to 40 days per calendar year,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Skilled nursing facility/Inpatient</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>rehabilitation**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confinement and skilled nursing services in a hospital or specialized facility</td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td>Limited to 90 days per calendar year,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>network/non-network combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient rehabilitation</strong></td>
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<td><strong>Durable medical equipment</strong></td>
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<td><strong>Hospice care</strong></td>
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<td>Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies</td>
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<td><strong>Organ transplants</strong> (UHC Transplant Resource Services must be used)**</td>
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<td>Inpatient/outpatient surgery and hospitalization</td>
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<tr>
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</tr>
</tbody>
</table>

*Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.*
MEDICAL PLAN

UnitedHealthcare Choice Plus Plans (UHC Option 1, UHC Option 2, UHC Option 3)
The Choice Plus Network is a group of healthcare providers that agree to provide services to participants at reduced costs.
- When you receive care from providers who are in the Choice Plus network, you receive the network level of benefits.
- When you see providers who are not a part of the Choice Plus Network, for Option 1 and Option 3 the plan pays benefits up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). For Option 2 the plan pays benefits up to 50% of Eligible Expenses Payable by the Plan after the annual deductible is met. Non-network charges over the Eligible Expenses reimbursement rate are not covered by the Plan.
- Preventive care, such as well-baby and well-child checkups, immunizations, and routine physicals for adults and children are covered at 100% when network providers are used.
- Your physician may suggest you seek care from other physicians, specialists, and outpatient or inpatient facilities. It is your responsibility to determine if a provider participates in the plan in order to receive maximum benefits under the plan. A list of Choice Plus network providers in the UHC Plans is available by calling UnitedHealthcare Member Services at 888-899-4734 or online at www.uhc.com.

UnitedHealthcare Passive PPO Plans (UHC Option 1 Passive PPO and UHC Option 3 Passive PPO)
The Passive PPO Plans have a limited nationwide network of doctors, facilities and specialists. When you receive services from providers who are not a part of the network, you are provided coverage by a fee-for-service plan, which bases its reimbursement on reasonable and customary charges and pays benefits based on whether or not the service meets the definition of an Eligible Expense and whether or not it is a Covered Health Service. You and your dependents may receive care from any qualified licensed doctor, hospital or other health care facility.
- You will receive the same network level of benefits whether you choose a provider in the Choice Plus Network or outside of the network. However, when you receive care from providers who are not part of the UnitedHealthcare network, you do not have the advantage of the UnitedHealthcare network’s negotiated rates.
- Preventive care, such as well-baby and well-child checkups, immunizations, and routine physicals for adults and children are covered at 100% whether a network provider is used or not.
- You are encouraged to use network providers when available, in order to receive maximum benefits under the plan. A list of Choice Plus network providers in the UHC Plans is available by calling UnitedHealthcare Member Services at 888-899-4734 or online at www.uhc.com.

How UnitedHealthcare Medical Plans Work

Network and Non-Network Benefits
As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply. You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits. You are responsible for determining whether or not your providers participate in UnitedHealthcare’s network so that you are maximizing your benefits under the Medical Plan.
Network Benefits
Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

When you use Network providers:
- You will pay United-Healthcare’s negotiated rates for inpatient and outpatient network services until you reach your annual deductible. The annual deductible varies depending on the plan in which you are enrolled.
- Once you have met your annual deductible, depending on the plan in which you are enrolled, the plan will pay either 80% or 75% of network claims and you pay the remaining 20% or 25% of all covered claims. You continue to pay 20% or 25% of all covered claims until you reach your annual out-of-pocket maximum for the calendar year.
- After you meet your out-of-pocket maximum, the plan pays 100% of covered eligible expenses for the remainder of the calendar year.

Non-Network Benefits
Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

When you use Non-Network providers:
- You will pay 100% of your expenses until you reach the annual deductible (including preventive care). When you receive care from providers who are not part of the United-Healthcare Choice Plus network, you pay a higher deductible and you do not have the advantage of the United-Healthcare network’s negotiated rates.
- After the annual deductible is met, for Option 1 and Option 3 the plan pays benefits up to 60% of Eligible Expenses Payable by the Plan (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the United-Healthcare Medical Plans Cover”). For Option 2 the plan pays benefits up to 50% of Eligible Expenses Payable by the Plan after the annual deductible is met. Non-network charges over the Eligible Expenses reimbursement rate are not covered by the Plan.
- The maximum annual out-of-pocket expense for non-network care can exceed $10,000 per person on an unlimited basis. Only when non-network expenses are charged at the Medicare reimbursement rate will the maximum annual member cost be limited to $10,000. The more common scenario is for a doctor or hospital to charge far in excess of Medicare reimbursement rates, in which case the difference is not applied to the maximum non-network out-of-pocket maximum. One of the most expensive decisions you can make is to seek care from non-network providers.

Note: Services by non-network providers under the United-Healthcare Option 1 Passive PPO and United-Healthcare Option 3 Passive PPO Plans are covered on a different basis than the Choice Plus Options. The United-Healthcare Passive PPO Plans are the only plans where you are able to use non-network providers and pay the same deductible and coinsurance as if using a network provider.
However, when you receive care from Non-Network providers, you do not have the advantage of UnitedHealthcare’s negotiated rates. These Passive PPO plans are only available to employees that live in an area where the number of UnitedHealthcare network providers is limited.

**Health Services from Non-Network Providers Paid as Network Benefits**
If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

**If You Are Looking for a Network Provider**
In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com. Network providers are independent practitioners and are not employees of Ryder or UnitedHealthcare.

**Possible Limitations on Provider Use**
If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

**Annual Maximum**
The annual maximum benefit under the Ryder System, Inc. UnitedHealthcare, medical self-insured plans is $2,000,000 of Essential Benefits, on a combined basis. Generally the following are considered to be Essential Benefits under the Patient Protection and Affordable Care Act: ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Annual Deductible**
The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

**Coinsurance**
Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.
**Medical Plan**

**Coinsurance – Example**
Let’s assume that you participate in UnitedHealthcare Choice Plus Option 1 and that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

**Out-of-Pocket Maximum**
The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Applies to the Network Out-of-Pocket Maximum?</th>
<th>Applies to the Non-Network Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>The amounts of any reductions in Benefits you incur by not obtaining prior authorization from Personal Health Support when required. Generally, if authorization from Personal Health Support is not obtained when required, Benefits will be reduced by 20% of Eligible Expenses.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Important Note:** If Prior Authorization is not received, your benefits may be reduced by 20%. In such cases, any expense not paid by the plan will not count toward your Annual Deductible or Out-of-Pocket Maximum.

**Personal Health Support Services**
UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.
Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.

- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

**Prior Authorization**

UnitedHealthcare requires prior authorization for certain Covered Health Services. Generally, if authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. Services for which prior authorization is required are identified below and in What the UnitedHealthcare Medical Plans Cover section of this Book within each Covered Health Service category.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

**Covered Health Services which Require Prior Authorization**

Network providers are generally responsible for obtaining prior authorization from Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from Personal Health Support.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and
Network providers cannot bill you for services they fail to prior authorize as required. You can contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from Personal Health Support before you receive these services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support has not provided prior authorization.

**Important Note: If Prior Authorization is not received, your benefits may be reduced by 20%. In such cases, any expense not paid by the plan will not count toward your Annual Deductible or Out-of-Pocket Maximum.**

The services that require Personal Health Support authorization are:

- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Congenital Heart Disease services;
- CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis;
- Dental services;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent;
- Genetic Testing (e.g., BRCA);
- Home health care;
- Hospice care - inpatient;
- Hospital Inpatient Stay;
- Maternity care that exceeds the delivery timeframes as described in What the UnitedHealthcare Medical Plans Cover section of this Book;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility);
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Surgery - diagnostic catheterization and electrophysiology implant and sleep apnea surgeries as described under Surgery - Outpatient in What the UnitedHealthcare Medical Plans Cover section of this Book;
- Therapeutics - outpatient dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound as described under Therapeutic Treatments - Outpatient in What the UnitedHealthcare Medical Plans Cover section of this Book; and
- Transplantation services.

When you choose to receive services from non-Network providers, UnitedHealthcare urges you to confirm with Personal Health Support that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- the cosmetic procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is
always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- the experimental, investigational or unproven services exclusion; or
- any other limitation or exclusion of the Plan

For prior authorization timeframes, and reductions in Benefits that apply if you do not obtain prior authorization from Personal Health Support, see What the UnitedHealthcare Medical Plans Cover section of this Book.

Special Note Regarding Medicare
If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in the Coordination of Benefits (COB) section of this Book.

What the UnitedHealthcare Medical Plans Cover

Eligible Expenses Payable by the Plan
Eligible Expenses Payable by the Plan are charges for Covered Health Services that are provided while the Plan is in effect. Covered Health Services are those health services, including services or supplies, which UnitedHealthcare determines to be:
- Medically Necessary;
- included in this section of this Book describing Covered Health Services;
- provided to a Covered Person who meets the Plan's eligibility requirements as described in the Eligibility section of this Book; and
- not identified as Exclusion under the Plan.
For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. Ryder has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Important Note: Any amount not reimbursed because you did not follow the recommendations of the claims administrator will not apply toward your annual deductible or your out-of-pocket maximums.

For Network Benefits, Eligible Expenses are the contracted fee(s) with that provider.

For Non-Network Benefits, Eligible Expenses are determined by negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator. If rates have not been negotiated, then one of the following amounts applies:
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
- When a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix, Inc. If the Ingenix, Inc. relative value scale becomes no longer available, a comparable scale will be used. The Claims Administrator and Ingenix, Inc. are related companies through common ownership by UnitedHealth Group.
  - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50% of
the provider’s billed charge, except that certain Eligible Expenses for mental health and substance use disorder services are based on 80% of the billed charge.

The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

These provisions do not apply if you receive Covered Health Services from a non-Network provider in an Emergency, as defined in the Definitions Section of this book. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of Coinsurance.

Eligible Expenses are subject to the Claim Administrator’s reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

**Covered Health Services**

This section describes the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. Services that are not covered are described in the What the UnitedHealthcare Medical Plans Will Not Cover - Exclusions section of this Book.

Unless otherwise noted, benefits will be paid, after the annual deductible is met, at the percentage of network/non-network Eligible Expenses Payable by the Plan applicable to the UnitedHealthcare medical option in which you participate (i.e., Choice Plus Options 1, 2 or 3; Passive PPO Options 1 or 3).

**Acupuncture Services**

Acupuncture services for pain therapy when the service is performed by a provider in the provider’s office, when the provider is either practicing with in the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of:

- nausea of chemotherapy;
- post-operative nausea; and
- nausea of early pregnancy.

**Ambulance Services**

- **Emergency only**
  Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

- **Non-Emergency**
  Transportation by professional ambulance (not including air ambulance) between medical facilities. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior
authorization from Personal Health Support as soon as possible prior to the transport. If authorization from Personal Health Support is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

**Cancer Resource Services**
UnitedHealthcare will arrange for access to certain of its Network providers participating in the Cancer Resource Services Program for the provision of oncology services. You may be referred to Cancer Resource Services by UnitedHealthcare, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program.

**Transportation and Lodging (Meals Are Excluded)**
A Cancer Resource Services nurse consultant will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the individual receiving cancer-related treatment associated with the Cancer Resource Services program, and a companion are available under this Plan as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up;
- reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people;
- travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Facility; and
- if the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Facility provider performing the services (even if you self refer to a provider in that Network). The term *Designated Facility* is defined in the Definitions section of this Book.

**Chiropractic, Spinal Treatment and Osteopathic Manipulative Therapy**
Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day. Up to 35 visits to a chiropractor are covered per calendar year, network/non-network combined.

Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving Manipulative Treatment or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.
**Congenital Heart Disease (CHD) Services**

The Plan pays Benefits for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and are not an Experimental or Investigational Service or an Unproven Service. CHD services may be received at a Congenital Heart Disease Resource Services program.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

**Transportation and Lodging (Meals Are Excluded)**

A CHD Services nurse consultant will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the individual receiving cancer-related treatment associated with the CHD Services program, and a companion are available under this Plan as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up;
- reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people;
- travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Facility as defined described in the Definitions section of this Book; and
- if the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

There are specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about CHD services.

Please remember for Non-Network Benefits, you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as congenital heart disease surgery arises. If authorization from United Resource Networks or Personal Health Support is not obtained, Benefits for Covered Health Services will be reduced by 20% of Eligible Expenses.

**Dental Services**

- **Accident**
  
  Dental services are covered by the Plan when all of the following are true:
  - treatment is necessary because of accidental damage;
  - dental services are received from a Doctor of Dental Surgery, "D.D.S." or a Doctor of Medical Dentistry, "D.M.D."
  - the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

  The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:
  - dental services related to medical transplant procedures;
  - initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
  - direct treatment of acute traumatic Injury, cancer or cleft palate.
Benefits are available only for treatment of a sound, natural tooth.

The Physician or dentist must certify that the injured tooth was:

- a virgin or unrestored tooth; or
- a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- started within three months of the accident; and
- completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

- Wisdom teeth, impacted only.

Please remember that you should obtain prior authorization from Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to obtain authorization before the initial Emergency treatment. You should also obtain prior authorization from Personal Health Support as soon as possible before treatment of impacted wisdom teeth begins. When you obtain authorization, Personal Health Support can determine whether the service is a Covered Health Service.

**Diabetes Services**

- Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care
  Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

- Diabetic Self-Management Items
  Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:
  - blood glucose monitors;
  - insulin syringes with needles;
  - blood glucose and urine test strips;
  - ketone test strips and tablets; and
  - lancets and lancet devices.

Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section.

**Durable Medical Equipment (DME)**

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable; and
- not of use to a person in the absence of a disease or disability.
If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:
- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions; and
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.

UnitedHealthcare provides Benefits for a single unit of Durable Medical Equipment (example: one insulin pump) and provide repair for that unit.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing network Physician. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

Emergency Health Services - Outpatient
The Plan pays for services that are required to stabilize or initiate treatment in an Emergency.

Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified as soon as reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date Personal Health Support determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Please remember for Non-Network Benefits, you should notify Personal Health Support as soon as is reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Penalties: If you do not follow notification procedures for emergency admissions, your benefits may be reduced. In such cases, any expenses not paid by the plan will not count toward your deductible or out-of-pocket maximum.
**MEDICAL PLAN**

**Home Health Care**
Covered Health Services are services received from a Home Health Agency that are both of the following:
- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when Skilled Care is required.

UnitedHealthcare will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving services or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

Up to 40 visits are covered per calendar year, network/non-network combined.

**Hospice Care**
The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving services. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

**Hospital - Inpatient Stay**
Hospital Benefits are available for:
- non-Physician services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support as follows:
- for elective admissions: five business days before admission or as soon as is reasonably possible;
- for non-elective admission (or admissions resulting from an Emergency): as soon as is reasonably possible.

If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

**Kidney Resource Services (KRS)**
(These Benefits are for Covered Health Services provided through KRS only)
The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Facilities participating in the Kidney Resource Services (KRS) program.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:
- prior to vascular access placement for dialysis; and
- prior to any ESRD services.
You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. The term **Designated Facility** is defined in the Definitions section of this Book.

If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

**Maternity Services**

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns’ and Mothers’ Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Please remember for Non-Network Benefits you must obtain prior authorization from Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If authorization from Personal Health Support is not obtained, Benefits for the extended stay will be reduced by 20% of Eligible Expenses.

**Mental Health Services**

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
MEDICAL PLAN

- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:
- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services
Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Please refer to the Personal Health Support section of this Book for the specific services that require notification. Please call the phone number that appears on your ID card. Without authorization, Benefits will be reduced by 20% of Eligible Expenses.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders
The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:
- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:
- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:
- Partial Hospitalization/Day Treatment; and
MEDICAL PLAN

- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:
  - Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Please refer to the Personal Health Support section of this Book for the specific services that require notification. Please call the phone number that appears on your ID card. Without authorization, Benefits will be reduced by 20% of Eligible Expenses.

**Obesity Surgery**
The Plan covers surgical treatment of morbid obesity provided by or under the direction of a Physician provided either of the criteria is met:
  - you have a minimum Body Mass Index (BMI) of 40;
  - you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.
  - the surgery must be performed in a Network Hospital by a Network surgeon. This is true even if there are no Network Hospitals near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, and are not Experimental or Investigational or Unproven Services.

**Transportation and Lodging (Meals Are Excluded)**
A nurse consultant will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the individual receiving cancer-related treatment associated with the Obesity Surgery program, and a companion are available under this Plan as follows:
  - transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up;
  - reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people;
  - travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Facility as defined in the Definitions section of this book; and
  - if the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

To receive Benefits for Obesity Surgery, you must contact Personal Health Services prior to obtaining Covered Health Services. The Plan will only pay Benefits for Obesity Surgery if Personal Health Services provides the proper authorization to the Designated Surgeon/Facility providers performing the services (even if you self refer to a provider in that Network).

**Orthognathic Surgery**
Orthognathic surgery (procedure to correct underbite or overbite) including diagnosis and treatment of the jawbone is covered. In addition, surgical exposure or removal of impacted wisdom teeth, including related X-ray, and osseous surgery (tissue and bone grafting) is covered.

**Orthotics**
The following orthotics are covered. No other orthotics are covered:
Shoe/Shoe Orthotics/Shoe Inserts/Arch Supports, prescribed by physician; and
Cranial Orthotics (Helmets) custom molded, prescribed by physician.

**Ostomy Supplies**
Benefits for ostomy supplies are limited to:
- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

**Outpatient Surgery, Diagnostic and Therapeutic Services**

- **Outpatient Surgery**
  The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

  Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

  When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

  Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support for diagnostic catheterization, electrophysiology implant and sleep apnea surgeries five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

- **Outpatient Diagnostic Services**
  The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:
  - Lab and radiology/X-ray.
  - Mammography testing.

  Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

  When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

  This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

- **Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI and Nuclear Medicine**
  The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

  Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

  Please remember that you should obtain prior authorization from Personal Health Support as soon as possible before treatment begins. When you obtain authorization, Personal Health Support can determine whether the service is a Covered Health Service.

- **Outpatient Therapeutic Treatments**
The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under "Physician's Office Services" below.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before scheduled dialysis services are received and for intensity modulated radiation therapy and MR-guided focused ultrasounds or, for non-scheduled services, within one business day or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

**Physician's Office Services - Sickness and Injury; Injections received in a Physician's Office**

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Benefits for preventive services are described under "Preventive Care Services" in this section.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support for Genetic Testing. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

**Note:** Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

**Preventive Care Services**

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

**Private Duty Nursing - Outpatient**

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a
Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.). Any combination of Network Benefits and Non-Network Benefits is limited to $50,000 per lifetime.

**Professional Fees for Surgical and Medical Services**
The Plan pays for professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

**Prosthetic Devices**
Benefits are paid by the Plan for prosthetic devices that replace a limb or body part including:
- artificial limbs;
- artificial eyes; and
- breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. UnitedHealthcare provides Benefits for a single purchase, including repairs, of a type of prosthetic device.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

**Note:** Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

**Reconstructive Procedures**
Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Procedures are services considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.
MEDICAL PLAN

Please remember that you must obtain prior authorization from Personal Health Support five business days before undergoing a Reconstructive Procedure. When you obtain prior authorization, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy
The Plan provides short-term outpatient rehabilitation services for:
- physical therapy;
- occupational therapy;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits under this section include rehabilitation services provided in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility.

Please note that the Plan will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from injury, sickness, stroke, cancer, Autism Spectrum Disorders or a congenital anomaly.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Benefits are limited to:
- 35 visits per calendar year for physical therapy;
- 35 visits per calendar year for occupational therapy;
- 35 visits per calendar year for speech therapy;
- No visit limit per calendar year for pulmonary rehabilitation therapy; and
- No visits limit per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for up to 90 days (network/non-network combined) if confinement is for continued treatment of the condition that caused the initial hospitalization and admission is within 15 days after discharge from the hospital. Benefits are available for:
- services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are considered Intermittent Care (such as physical therapy three times a week).
Benefits are NOT available for custodial, maintenance or Domiciliary Care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support as follows:
- for elective admissions: five business days before admission or as soon as is reasonably possible;
- for non-elective admission (or admissions resulting from an Emergency): as soon as is reasonably possible.

If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

**Substance Use Disorder Services**

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:
- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:
- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

**Special Substance Use Disorder Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use.

Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Please refer to the Personal Health Support section of this Book.
for the specific services that require notification. Please call the phone number that appears on your ID card. Without authorization, Benefits will be reduced by 20% of Eligible Expenses.

**Surgical Procedures – Multiple**
Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered expenses for multiple surgical procedures are limited, as follows:
- Covered expenses for a secondary procedure are limited to 50% of the covered expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered expenses for any subsequent procedure are limited to 50% of the covered expense that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

**Transplantation Services**
Examples of transplants for which Benefits are available include but are not limited to:
- bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility as defined in the Definitions section of this book. If a separate charge is made for a bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search;
- heart transplants;
- heart/lung transplants;
- lung transplants;
- kidney transplants;
- kidney/pancreas transplants;
- liver transplants;
- liver/small bowel transplants;
- pancreas transplants; and
- small bowel transplants.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

**Transportation and Lodging (Meals Are Excluded)**
The Claims Administrator will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient and a companion are available under this Plan as follows:
- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.
Please remember that you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If authorization from United Resource Networks or Personal Health Support is not obtained and if, as a result, the services are not performed at a Designated Facility, no Benefits will be paid and you will be responsible for paying all charges.

**Urgent Care Center Services**
The Plan pays for Covered Health Services received at an Urgent Care Center. When Urgent Care services are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

**Resources to Help You Stay Healthy**
Ryder believes in giving you the tools you need to be an educated health care consumer. To that end, Ryder has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:
- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

*Note:* Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Ryder are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the information.

**Consumer Solutions and Self-Service Tools**

**Health Assessment**
You and your covered Spouse/Domestic Partner are invited to learn more about your health and wellness at [myuhc.com](http://myuhc.com) and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to [myuhc.com](http://myuhc.com). After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link.

**Health Improvement Plan**
You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile. Online coaching is available for:
- nutrition;
- exercise,
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.
To help keep you on track with your Health Improvement Plan and online coaching, you’ll also receive personalized messages and reminders – Ryder’s way of helping you meet your health and wellness goals.

**Treatment Decision Support**
In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:
- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:
- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

**UnitedHealth Premium℠ Program**
UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:
- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare’s quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto [myuhc.com](http://myuhc.com) or call the toll-free number on your ID card.

**www.myuhc.com**
UnitedHealthcare's member website, [www.myuhc.com](http://www.myuhc.com), provides information at your fingertips anywhere and anytime you have access to the Internet. [myuhc.com](http://myuhc.com) opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With [myuhc.com](http://myuhc.com) you can:
- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
• use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on myuhc.com
If you have not already registered as a myuhc.com subscriber, simply go to myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit myuhc.com and:
• make real-time inquiries into the status and history of your claims;
• view eligibility and Plan Benefit information, including Coinsurance and Annual Deductibles;
• view and print all of your Explanation of Benefits (EOBs) online; and
• order a new or replacement ID card or print a temporary ID card.

To learn more about a condition or treatment, log on to myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program
UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at 866-936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see What the UnitedHealthcare Medical Plans Cover section of this Book under the heading Cancer Resource Services (CRS).

Diabetes Prevention and Control
UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.
Participation is completely voluntary and without extra charge. There are no Coinsurances or Deductibles that need to be met when services are received as part of the DPP or DCP programs. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPCA call center directly at 888-688-4019.

HealtheNotesSM
UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.
If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program
If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:
- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Tobacco Cessation Program (QuitPower)
UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will more than double your chance of successfully quitting tobacco.

This six (6) month program offers:
- home fulfillment of up to 8 weeks of over-the-counter nicotine replacement therapy, patches or gum;
- toll free telephone access to a dedicated tobacco cessation coach (you will receive up to eight (8) scheduled coaching sessions and may place unlimited calls for support when you have a question);
help to identify and avoid common reasons why quit attempts fail, including weight gain and stress management; and
educational articles, quizzes and progress tracking tools designed to provide support through this program.

You can receive Nicotine Replacement Therapy up to twice annually (once per program).

Participation is completely voluntary, confidential, and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

**What the UnitedHealthcare Medical Plans Will Not Cover (Exclusions)**

This section includes services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in What the UnitedHealthcare Medical Plans Cover section of this Book.

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

Also, please review all limits described in the What the UnitedHealthcare Medical Plans Cover section of this Book carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

**Alternative Treatments**
- acupressure;
- aromatherapy;
- hypnotism;
- massage therapy;
- rolfing;
- other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
- services received by a naturopath;
- holistic or homeopathic care.

**Comfort or Convenience**
- television;
- telephone;
- beauty/barber service;
- guest service;
- supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - air conditioners;
  - air purifiers and filter;
  - batteries and battery chargers;
  - dehumidifiers;
  - humidifiers;
  - devices and computers to assist in communication and speech;
  - home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

**Dental**
- dental care, except as described in What the UnitedHealthcare Medical Plans Cover section of this Book under the heading Dental Services;
• preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  • extraction, restoration and replacement of teeth;
  • medical or surgical treatments of dental conditions;
  • services to improve dental clinical outcomes;
  • dental implants;
  • dental braces;
  • dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; however, this exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in What the UnitedHealthcare Medical Plans Cover section of this Book;
• treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Drugs (Refer to the Prescription Plan Section)
• prescription drug products for outpatient use that are filled by a prescription order or refill;
• self-injectable medications;
• non-injectable medications given in a Physician’s office except as required in an Emergency;
• over the counter drugs and treatments.

Experimental or Investigational Services or Unproven Services
Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Foot Care
• hygienic and preventive maintenance foot care. Examples include the following:
  • cleaning and soaking the feet;
  • applying skin creams in order to maintain skin tone;
  • other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
• treatment of flat feet;
• treatment of subluxation of the foot.

Medical Supplies and Appliances
• devices used specifically as safety items or to affect performance in sports-related activities;
• prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  • elastic stockings;
  • ace bandages;
  • gauze and dressings;
  • syringes;
  • diabetic test strips;
• orthotic appliances other than foot orthotics and cranial banding as described under Durable Medical Equipment (DME).
• tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment as described in What the UnitedHealthcare Medical Plans Cover section of this Book under the heading Durable Medical Equipment.
MEDICAL PLAN

Mental Health/Substance Use Disorder
Exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders and/or Substance Use Disorder Services in What the UnitedHealthcare Medical Plans Cover section of this Book.

- services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
  - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
  - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
  - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
  - not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
- Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
- treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);
- educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
- tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
- learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
- intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and
- any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

- megavitamin and nutrition based therapy;
- nutritional counseling for either individuals or groups including weight loss programs, health clubs and spa programs;
- food of any kind. Foods that are not covered include:
  - enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
• foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
• oral vitamins and minerals;
• meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
• other dietary and electrolyte supplements.

Physical Appearance
• Cosmetic Procedures. Examples include:
  • pharmacological regimens, nutritional procedures or treatments;
  • scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
  • skin abrasion procedures performed as a treatment for acne;
• replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in What the UnitedHealthcare Medical Plans Cover section of this Book;
• physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;
• weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded;
• wigs regardless of the reason for the hair loss;
• services received from a personal trainer;
• liposuction.

Providers
• services performed by a provider who is a family member by birth or marriage, including Spouse/Domestic Partner, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
• services performed by a provider with your same legal residence;
• services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  • has not been actively involved in your medical care prior to ordering the service; or
  • is not actively involved in your medical care after the service is received.
This exclusion does not apply to mammography testing.

Reproduction
• health services and associated expenses for infertility treatments;
• surrogate parenting;
• the reversal of voluntary sterilization;
• fees or direct payment to a donor for sperm or ovum donations;
• monthly fees for maintenance and/or storage of frozen embryos;
• health services and associated expenses for elective abortion;
• fetal reduction surgery;
• health services associated with the use of non-surgical or drug-induced Pregnancy termination.

Transplants
• health services for organ, multiple organ and tissue transplants, except as described in Transplantation Services in What the UnitedHealthcare Medical Plans Cover section of this Book, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
MEDICAL PLAN

- health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);
- health services for transplants involving mechanical or animal organs;
- transplant services that are not performed at a Designated Facility as defined in the Definitions section of this book;
- any multiple organ transplant not listed as a Covered Health Service under the heading Transplantation Health Services in What the UnitedHealthcare Medical Plans Cover section of this Book, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

Travel
- health services provided in a foreign country, unless required as Emergency Health Services;
- travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered services rendered at United Resource Networks participating programs or Designated Facilities may be reimbursed at our discretion.

Vision and Hearing
- implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
- purchase cost and associated fitting charges for eyeglasses or contact lenses, except for the first set of contact lenses and/or eyeglasses needed due to surgery which removes the natural lens;
- eye exercise or vision therapy other than as a treatment for strabismus (misalignment of the eyes);
- surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy;
- hearing aids or examinations for their prescription or fitting, except for one aid or one pair per lifetime; this is a one-time benefit limited to $1,000 maximum (batteries are not covered);
- bone anchored hearing aids except when either of the following applies:
  - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
  - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions;

All Other Exclusions (this list is not intended to be all-inclusive)
1. health services and supplies that do not meet the definition of a Covered Health Service.
2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
   - related to judicial or administrative proceedings or orders;
   - conducted for purposes of medical research;
   - required to obtain or maintain a license of any type;
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
4. charges for any injury, condition, illness or disease incurred as a result of any accident involving an automobile, boat, plane, dirt bike, motorcycle, bicycle, bus, or other vehicle. Benefits may be deemed
eligible once complete accident details are received by the plan and you agree to the subrogation provision of the plan;

5. charges for any illness or injury for which expenses were incurred, services received, or treatment given before the effective date of coverage;

6. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;

7. health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;

8. in the event that a Non-Network provider waives Coinsurance and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or the Annual Deductible are waived;

9. charges in excess of Eligible Expenses or in excess of any specified limitation;

10. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;

11. non-surgical treatment of obesity, including morbid obesity;

12. surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 40) except for Class III obesity;

13. growth hormone therapy;

14. sex transformation operations;

15. gender-reversal;

16. custodial Care or maintenance care;

17. domiciliary Care;

18. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

19. Private Duty Nursing - Inpatient;

20. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in What the UnitedHealthcare Medical Plans Cover section of this Book;

21. rest cures;

22. psychosurgery;

23. treatment of benign gynecomastia (abnormal breast enlargement in males);

24. medical and surgical treatment of excessive sweating (hyperhidrosis);

25. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;

26. appliances for snoring;

27. marriage counseling;

28. smoking cessation programs, other than the QuitPower Program;

29. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;

30. any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment;

31. any charge for services, supplies or equipment advertised by the provider as free;

32. any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency;

33. any charges prohibited by federal anti-kickback or self-referral statutes;

34. services resulting from the commission of a felony;

35. treatment or services when confined in a prison, jail, or other penal institution;

36. examinations or treatment ordered by a court in connection with legal proceedings;

37. items, which have value to the participant in the absence of an illness or injury being treated;

38. chelation therapy, except to treat heavy metal poisoning;

39. any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services;

40. outpatient rehabilitation services, spinal treatment, manipulative treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition
which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring;

41. spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies;

42. speech therapy to treat stuttering, stammering, or other articulation disorders;

43. breast reduction except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in What the UnitedHealthcare Medical Plans Cover section of this Book;

44. foreign language and sign language services;

45. panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to Reconstruction - Post-Mastectomy in What the UnitedHealthcare Medical Plans Cover section of this Book;

46. insulin.

**Claims Procedures**

See the Administrative Information section of this Summary Plan Description Book for specific procedures regarding medical claims.

**Coordination of Benefits (COB)**

The Coordination of Benefits (COB) rules applies if you or your enrolled dependents are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional “fault” type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, the COB process determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

**Do not forget to update your Dependents' Other Medical Coverage Information**

Avoid delays on your Dependent claims by updating your Dependent's other medical coverage information. Just log on to [www.myuhc.com](http://www.myuhc.com) or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

**Determining which Plan is Primary**

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
the parents are married or living together whether or not they have ever been married and not legally separated; or
• a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
• if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  • the parent with custody of the child; then
  • the Spouse/Domestic Partner of the parent with custody of the child; then
  • the parent not having custody of the child; then
  • the Spouse/Domestic Partner of the parent not having custody of the child;
• plans for active employees pay before plans covering laid-off or retired employees;
• the plan that has covered the individual claimant the longest will pay first; The expenses must be covered in part under at least one of the plans; and
• finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

**Determining Primary and Secondary Plan – Examples**

1) Let's say you and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse/Domestic Partner's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse/Domestic Partner's birthday to determine which plan pays first. If you were born on June 11 and your Spouse/Domestic Partner was born on May 30, your Spouse/Domestic Partner's plan will pay first.

3) Again, let's say you and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse/Domestic Partner's birthday to determine which plan pays first. If both parents have the same birthday, the plan that covered one parent longer will be primary.

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<table>
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<th>Father: June 11</th>
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<tr>
<td></td>
<td><strong>Mother's Plan is Primary</strong></td>
<td></td>
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</tr>
</tbody>
</table>
MEDICAL PLAN

When This Plan is Secondary
If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total.

Determining the Allowable Expense If This Plan Is Secondary
If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans’ reasonable and customary charges.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan Is Primary
To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays Benefits second:

- Employees with active current employment status age 65 or older and their Spouses/Domestic Partners age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare
If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.
**Overpayment and Underpayment of Benefits**

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses. If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

**COB and Benefit Claims**

To avoid delays in processing your claim when non-duplication applies, file claims with the primary plan first.

**Important Note:** When you receive an explanation of benefits (EOB) from the primary plan, submit the claim to the secondary plan with a copy of the itemized bill and a copy of the EOB. The secondary plan needs this information to process your claim.

If the plan pays more than it should when another plan is involved, it will request a repayment of benefits from the other plan or from you.

**Refund of Overpayments**

If Ryder pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Ryder if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Ryder made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount Ryder paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help Ryder get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Ryder may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Ryder may have other rights in addition to the right to reduce future Benefits.

**Subrogation and Reimbursement**

This section describes how your benefits are impacted if you suffer a Sickness or Injury caused by a third party. The Plan has a right to subrogation and reimbursement, as defined below.

**Right of Recovery**

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
MEDICAL PLAN

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation
The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement
The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties
The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers’ compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions
As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party;
- the Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys’ fees. No
so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right;

- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights;

- Benefits paid by the Plan may also be considered to be Benefits advanced;

- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses;

- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid;

- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you;

- you may not accept any settlement that does not fully reimburse the Plan, without its written approval;

- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party;

- the Plan's rights will not be reduced due to your own negligence;

- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain;

- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim;

- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries;

- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan;

- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person; and

- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver’s insurance carrier to recover the cost of those Benefits.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>122</td>
</tr>
<tr>
<td>Prescription Plan</td>
<td>122</td>
</tr>
<tr>
<td>Variations in Coverage</td>
<td>122</td>
</tr>
<tr>
<td>Highlights of the Prescription Plans</td>
<td>123</td>
</tr>
<tr>
<td>Brands and Generics</td>
<td>123</td>
</tr>
<tr>
<td>Preferred Drug List Medications</td>
<td>123</td>
</tr>
<tr>
<td>Biotech Specialty Medications</td>
<td>123</td>
</tr>
<tr>
<td>How the Prescription Plan Works</td>
<td>124</td>
</tr>
<tr>
<td>When you fill a prescription at a Retail Pharmacy</td>
<td>124</td>
</tr>
<tr>
<td>When you fill a prescription through Mail Services</td>
<td>124</td>
</tr>
<tr>
<td>What the Prescription Plan Covers</td>
<td>124</td>
</tr>
<tr>
<td>What the Prescription Plan Does Not Cover (this list is not intended to be all inclusive)</td>
<td>125</td>
</tr>
<tr>
<td>Exclusions and Limitations</td>
<td>125</td>
</tr>
<tr>
<td>Specialty Guideline Management</td>
<td>125</td>
</tr>
<tr>
<td>Mail Service Prescription Program</td>
<td>126</td>
</tr>
<tr>
<td>How the Mail Order Prescription Plan Works</td>
<td>126</td>
</tr>
<tr>
<td>Prescriptions Available Only Through Mail Service</td>
<td>126</td>
</tr>
<tr>
<td>If a Claim for Benefits is Denied</td>
<td>127</td>
</tr>
</tbody>
</table>

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
Introduction
This section provides you with information about the Ryder System, Inc. Prescription Plan. You must elect Medical Plan coverage in order to elect coverage under the Prescription Plan. Your coverage category for the Prescription Plan can be no greater than your coverage category for the Medical Plan. You cannot enroll dependents in Prescription Plan coverage if they are not enrolled in Medical Plan coverage. However, you may elect not to enroll a Dependent in Prescription Plan coverage if they are enrolled in Medical Plan coverage. For example, you may elect Family coverage for your Medical Plan and Employee + Spouse for the Prescription Plan.

Prescription Plan
The program is a managed prescription drug plan that provides prescription drug coverage to you through a national network of participating pharmacies.

To use the program, you may purchase up to a 30-day supply of medication at a participating retail pharmacy by presenting your Prescription Program ID card and the physician’s original prescription. You will be required to pay either a copay or coinsurance depending on whether you purchase brand name or generic drugs. If you use a participating pharmacy, no paperwork or claim forms are necessary.

Long-term, maintenance medications must be obtained through the 90-day Mail Service Program or a CVS Pharmacy. The Mail Service Program or the option of CVS Pharmacy provides you with two convenient and cost-effective ways to purchase up to a 90-day supply of maintenance medication. Maintenance medications include those prescription drugs you take on an ongoing basis for conditions such as diabetes, ulcers, arthritis or heart disease. If a member continues to fill a maintenance medication at a non-CVS retail store after their second fill or if a member does not fill a prescription with a 90-day supply at a CVS retail store, a penalty will apply.

The Prescription Plan, either at the retail pharmacy or through the Mail Services Program, requires the use of generic drugs when they are available. Many, but not all drugs are available in a generic form. Prescriptions that are available as generic have two names, the trademark or brand name, and the chemical or generic name. By law, both brand name and generic drugs must meet the same standards for safety, purity, strength and quality. All prescriptions are filled with the generic version when available.

If you wish to have the brand name drug rather than the generic equivalent, the plan allows for the substitution, however, your cost for the drug is higher. If you choose a brand name medication, you will be responsible for the brand copay (or coinsurance if applicable) plus the cost difference between the brand name and generic drug, even if dispensed as written (DAW) is indicated on the prescription. If a generic drug is not available, you pay either the brand/Preferred Drug List or the brand/Non-Preferred Drug List copay (or coinsurance if applicable) for the prescription.

Variations in Coverage
The Prescription Plan is designed to cover all Company employees nationwide; however, because of certain state laws and plan designs, there are some variations in coverage for employees in certain locations.

If you are covered by one of the following Medical Plans: Starbridge Sickness and Accident, Blue Care Network, Humana (PR), Kaiser (CA, GA, HI, OH, OR, Mid-Atlantic region), or Geisinger Health Plan, you are not eligible for the prescription program through the Ryder Prescription Plan. Your prescription coverage is provided by your Medical Plan.
## Highlights of the Prescription Plans

Administered by Caremark Prescription Services

<table>
<thead>
<tr>
<th></th>
<th>Retail Program</th>
<th>Mail Service Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Must use network pharmacy</td>
<td>Or CVS Retail Store</td>
</tr>
<tr>
<td></td>
<td>Limited to a 30-day supply</td>
<td>Limited to a 90-day supply</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong>*</td>
<td>$50 – does not apply to generics</td>
<td>$50 – does not apply to generics</td>
</tr>
<tr>
<td><strong>Generics</strong></td>
<td>$10 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td><strong>Preferred Drug List – Brand Name</strong>*</td>
<td>You pay 25% after annual deductible ($25 minimum-$75 maximum)</td>
<td>You pay 25% after annual deductible ($62.50 minimum-$187.50 maximum)</td>
</tr>
<tr>
<td><strong>Non-Preferred Drug List – Brand Name</strong></td>
<td>You pay 40% after annual deductible ($50 minimum-$100 maximum)</td>
<td>You pay 40% after annual deductible ($125 minimum-$250 maximum)</td>
</tr>
<tr>
<td><strong>Biotech Medication</strong></td>
<td>$100 copay after annual deductible 30-day supply subject to pre-authorization</td>
<td></td>
</tr>
<tr>
<td><strong>Caremark Customer Service</strong></td>
<td>800-421-5501  or  <a href="http://www.caremark.com">www.caremark.com</a></td>
<td></td>
</tr>
</tbody>
</table>

* If you are employed by the Supply Chain Services CPG vertical market, the annual deductible is $100 (does not apply to generics). For Non-Preferred Brand Name drugs, you pay 45% after annual deductible.

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

### Brands and Generics

Brand name drugs are drugs protected by a patent and manufactured by a specific Company. Generic drugs are manufactured according to the same chemical formula of the brand name drugs whose patents have expired. Generic drugs usually cost less. The Food and Drug Administration requires that generic drugs have the same active chemical composition, have the same potency, and be offered in the same dosage form as their brand name counterparts.

The fundamental difference between a brand name and a generic equivalent is the manufacturer and price.

### Preferred Drug List Medications

When there is no generic medication available, there may be more than one brand name drug to treat your condition. The brand name medications approved by the plan and on the Preferred Drug List have been selected by Caremark’s National Pharmacy and Therapeutics Committee for their ability to meet the patient’s needs with the best possible outcomes.

Ask your doctor to consider prescribing a brand name from your Caremark Preferred Drug List when there is more than one brand name drug available to treat your condition.

### Biotech Specialty Medications

Biotech medications are genetically engineered drugs, typically high cost injectables, used to treat rare or chronic conditions such as Hepatitis C, Multiple Sclerosis, Growth Hormone Deficiency and Hemophilia among others. Prescriptions for Biotech medications may be subject to step therapy protocols before Caremark can give authorization.
Biotech medications are delivered through Caremark’s Specialty Pharmacy. You must call Caremark at 800-237-2767 or visit www.caremark.com to verify your coverage and request authorization for the biotech therapies or medications. Following is a list of some, but not all, of the biotech medications requiring delivery through Caremark’s Specialty Pharmacy:

- **Hormone Therapies** – Humatrop, Geref, Norditropin, Lupron, Lupron Depot
- **Allergic Asthma** – Xolair
- **Psoriasis** - Stelara
- **Multiple Sclerosis** – Copaxone, Avonex, Betaseron, Novantrone, Rebif, Tysabri
- **Hepatitis B & C** - PEG, Intron/Rebetol, Roferon, Infergen, Copegus, Pegasys, Incivek, Victrelis
- **Arthritis** (Osteo and Rheumatoid) – Kineret, Enbrel, Humira, Remicade, Synvisc, Hyalgan
- **Respiratory Syncytial Virus** – Synagis
- **HIV** - Fuzeon
- **Anemia** – Epogen, Procrit, Neupogen, Leukine, Aranesp, Neumega
- **Immune Deficiency** – IGIV and others
- **Bleeding Disorders** – Recombinant and Monoclonal Factors VIII & IX, Stimate
- **Rheumatoid Arthritis** – Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan

**How the Prescription Plan Works**

You must use a participating pharmacy. There is no benefit paid if you use a non-participating pharmacy. If you must use a non-participating pharmacy in an emergency situation, you pay the full cost of the prescription and submit a claim for reimbursement. Reimbursement will be subject to the network-discounted price, minus your copay.

**When you fill a prescription at a Retail Pharmacy**

- you receive a 30-day supply of medication;
- you pay $10 copay for generic medications;
- you pay 25% after annual deductible for Preferred Drug List - Brand Name medications, to a minimum of $25 or a maximum of $75 copay per prescription; and
- you pay 40% or 45% after annual deductible for Non-Preferred Drug List - Brand Name medications, to a minimum of $50 or a maximum of $100 copay per prescription.

Most pharmacy chains and independent pharmacies participate in the retail network. For a list of pharmacies in your area, you can use the Caremark Pharmacy Locator on their website, www.caremark.com or call customer service at 800-421-5501.

**When you fill a prescription through Mail Services**

- you pay $25 copay for generic medications;
- you receive a 90-day supply of medications;
- you pay 25% after annual deductible for Preferred Drug List - Brand Name medications, to a minimum of $62.50 or a maximum of $187.50 copay per prescription; and
- you pay 40% or 45% after annual deductible for Non-Preferred Drug List - Brand Name medications, to a minimum of $125 or a maximum of $250 copay per prescription.

Your coinsurance is not reimbursed through the Medical Plan. Also, your coinsurance does not count toward the Medical Plan annual deductible and out-of-pocket maximum.

**What the Prescription Plan Covers**

The cost of prescriptions is covered if the medications:

- require a prescription to be dispensed;
- are purchased from a licensed pharmacist
- are dispensed according to the written guidelines of the physician;
• are prescribed for the treatment of an illness, sickness or injury;
• are prenatal vitamins; or
• are prescribed for birth control.

**What the Prescription Plan Does Not Cover (this list is not intended to be all inclusive)**

- medications not approved for general use by the Food and Drug Administration;
- vitamins except those required to be dispensed by a pharmacist and used for the treatment of an injury, illness or sickness;
- Norplant (contraceptive Injectable);
- fluoride and fluoride products;
- allergy serums;
- nutritional supplements;
- diet supplements;
- food supplements;
- miscellaneous diabetic supplies, i.e. glucose tabs, insulin pumps, glucose monitors, lancet devices;
- other Rx devices, i.e. ostomy supplies, glucose monitors;
- nutritional food replacements and supplements;
- infant formula;
- hormone replacement for gender reversal; and
- over-the-counter medications.

**Exclusions and Limitations**

Caremark reserves the right to exclude coverage of drugs that are being used for unapproved indications of medical conditions and/or dosage regimens determined to be experimental.

Coverage of drugs will be limited to the uses and indications for which the drug or device was licensed or for uses and indications, which are recognized in accordance of generally accepted professional medical standards in the U.S. medical community as being safe, effective and medically appropriate for use in the treatment of a condition.

In order to ensure that the pharmacy benefit is being administered in the most clinically appropriate, cost-effective way, Caremark reserves the right to:

- exclude coverage of drugs that are for unapproved indications or medical conditions, unless the use is in accordance with generally accepted medical standards and is supported by the medical literature;
- exclude coverage of dosage regimens that exceed the recommended dosing guidelines as approved by the FDA;
- deny coverage of a drug and/or drug regimen that may be deemed inappropriate based on the patient's medical condition, potential drug interaction, etc.;
- COX 2 inhibitors (Celebrex) are subject to prior authorization and step therapy protocols before Caremark can give authorization for coverage; and
- limit quantities of certain prescription drugs where it is clinically appropriate. Examples include: Viagra, Cialis, Levitra (entire class of erectile dysfunction medication).

**Specialty Guideline Management**

Caremark offers a medical management program that provides treatment guidelines for certain biotech and specialty drugs. Biotech and specialty drugs are high-cost injectable drugs used to treat chronic conditions such as, but not limited to, hepatitis-C, allergic asthma, psoriasis, hemophilia, RSV prevention, growth deficiency and rheumatoid arthritis, multiple sclerosis, osteoporosis and cancer.

Through the Specialty Guideline Management Program, Caremark will complete a Prior Authorization Review with your physician to ensure that the most appropriate drug treatment is being prescribed. Using
current evidence-based medical guidelines, the primary drug treatment recommended for your underlying medical condition will be identified. If primary drug treatment for patient’s underlying condition has not been attempted, Caremark will deny coverage for current prescription.

If you or a covered dependent are currently taking one of these drugs, or are prescribed one in the future, Caremark will notify you and your physician.

**Mail Service Prescription Program**

The Mail Service Program, administered by Caremark, provides a convenient and cost-effective way to purchase long-term medications, maintenance medications, or medication that requires a letter of medical necessity. There is a copay for up to a 90-day supply after the deductible. Long-term maintenance medications must be obtained through the Caremark’s Mail Service Program or obtained at a CVS Retail Store. This provides you with a convenient and cost-effective way to purchase a 90-day supply of maintenance medication. Maintenance medications include those prescriptions drugs you take on an ongoing basis for conditions such as diabetes, ulcers, arthritis or heart disease.

The prescription program requires the use of generic drugs when they are available. Many, but not all, drugs are available in a generic form. All prescriptions are filled with the generic version when available, even when Dispensed As Written (DAW) is indicated on your prescription. Before substituting a generic drug, Caremark will contact the prescribing physician to discuss the generic substitution, even if Dispense As Written, (DAW) is indicated on the prescription.

If you wish to have the brand name drug rather than the generic equivalent, your cost for the drug is higher. If you choose a brand name medication, you will be responsible for the brand copay or coinsurance plus the cost difference between the brand name and generic drug. If a generic drug is not available, you pay either the brand/Preferred Drug List or the brand/Non-Preferred Drug List copay or coinsurance for the prescription.

Biotech drugs are limited to the Mail Service Program only, and are subject to a $100 copay, and prior authorization through Caremark for a 30-day supply.

**How the Mail Order Prescription Plan Works**

To use the prescription mail order program:
- ask your doctor to give you a new prescription for your maintenance medications and indicate a 90-day supply with three refills on the prescription;
- call Caremark’s Customer Service at 800-421-5501 to request a mail service order form or you can go to a CVS Retail Store to fill the prescription;
- if you choose to call Caremark, you should find out if your prescription is for a generic, Preferred Drug List or brand name medication; and
- send the order form, your prescription and your payment to: CVS Caremark, PO Box 94467, Palatine, IL  60094-4467.

To review your mail order prescriptions, you can call 800-344-8075 or go online to www.caremark.com.

**Prescriptions Available Only Through Mail Service**

Some prescription medications are filled only through the mail order program. These prescription medications include, but are not limited to:

- **Biotech medications**: Genetically engineered drugs typically high cost injectables used to treat rare, chronic conditions such as Rheumatoid Arthritis, Hepatitis C, Multiple Sclerosis, Growth Hormone Deficiency and Hemophilia. Biotech medications are usually only available through the Mail Service Program, and are limited to a 30-day supply. Prescriptions for Biotech medications may be subject to step therapy protocols before Caremark can give authorization; and
- **Erectile Dysfunction Drugs (e.g. Viagra, Cialis):** Limited to 30 pills for a 90-day supply, or 10 pills for a 30-day supply.

The following medications also require submission of a letter of medical necessity with the mail service profile:
- **Retin A:** Dispensed only with a non-cosmetic diagnosis; and
- **Vitamins:** Prescription vitamins, other than prescription prenatal vitamins.

**If a Claim for Benefits is Denied**
You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section for specific procedures to request a review of a denied claim.
TABLE OF CONTENTS

Introduction ........................................................................................................... 130
   The Cigna Dental Preferred Provider Organization (PPO) Plan.............................. 130
   Cigna Managed Dental Plan .................................................................................. 130
   The Cigna Dental Indemnity Plan ......................................................................... 130
   No Coverage Option ............................................................................................ 130

Cigna Dental PPO Plan Highlights ........................................................................ 131

Cigna Dental Indemnity Plan Highlights ................................................................. 132

How the Dental PPO Plan Works ......................................................................... 133
   Annual Deductible ................................................................................................ 133
   Annual Benefit Maximum ..................................................................................... 133
   Orthodontia Treatment Maximum ....................................................................... 133

How the Cigna Indemnity Dental Plan Works ......................................................... 133
   Predetermination of Benefits ............................................................................... 134

What the Dental PPO and Indemnity Plans Cover ................................................ 134
   Preventive and Diagnostic Services .................................................................... 134
   X-ray and Pathology ............................................................................................. 134
   Space Maintainers (non-orthodontic) .................................................................. 135

Basic Restorative Services .................................................................................... 135
   Oral Surgery ........................................................................................................ 135
   Extractions ........................................................................................................... 135
   Alveolar or Gingival Reconstructions .................................................................. 135
   Dental Cysts or Newplasms .................................................................................. 135
   Other Surgical Procedures .................................................................................... 135
   Anesthesia ............................................................................................................ 135
   Restorative Dentistry .......................................................................................... 136
   Endodontics ........................................................................................................ 136
   Root Canals ......................................................................................................... 136
   Recementation ..................................................................................................... 136

Major Services ....................................................................................................... 136
   Restorative .......................................................................................................... 136
   Crowns (jackets and caps) .................................................................................. 136
   Prosthodontics ..................................................................................................... 136
   Pontics .................................................................................................................. 136
   Removal Bridge (unilateral) ................................................................................. 136
   Repairs ................................................................................................................ 137
   Dentures and Partial Dentures .......................................................................... 137

Orthodontia and How Benefits Are Paid Under the PPO and Indemnity Plans 137
Orthodontia Treatment Plan ................................................................................ 137
   If orthodontia treatment had begun before your effective date of coverage ......... 137
   If orthodontia treatment begins after your effective date of coverage ............... 138
   If treatment begins before your effective date of coverage .............................. 138

What the Dental PPO and Indemnity Plans Do Not Cover ................................. 138
   Work-related injury ............................................................................................ 138
   Government plan ............................................................................................... 138
   Above usual and prevailing ................................................................................. 138
   Experimental or investigational ......................................................................... 139
   Charges for services furnished by a family member .......................................... 139
   Charge for a replacement, alteration or modification ........................................ 139
   Charge for the initial installation for a full or partial removable denture, or a removable or fixed bridge ................................................................................. 139
Crown and gold restorations are only covered when treatment is for decay or injury.  
Porcelain crowns on or replacing a tooth behind the second bicuspid, etc.  
Cosmetic charges  
Accidental injury  
Temporomandibular Joint Disorder (TMJD)  
Charge for injury or condition caused by war or similar event  
Treatment before the effective date of coverage  
Charge for vehicular accident  
Other Exclusions (this list is not intended to be all inclusive)  

Treatment in Progress

Cigna Managed Dental Plan Highlights

Cigna Managed Dental Plan

How the Cigna Managed Dental Plan Works

What the Cigna Managed Dental Plan Does Not Cover

Limitations on services covered by the plan  
Exclusions (this list is not intended to be all-inclusive)

Claims for Cigna Dental PPO and Indemnity Plans

Claims for Cigna Managed Dental Plan

Subrogation of Benefits and Restitution

No-Fault and Vehicular Dental Payments Coverage

Coordination of Benefits

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
Introduction
This section is designed to provide you with information about the following Dental benefit plans. Based on the zip code for your address of record, these options may be available to you. The dental options differ in your choice of dentists, the level of benefits, and how benefits are paid.

- Cigna Managed Dental Plan;
- the Cigna Dental PPO Plan; and
- the Cigna Dental Indemnity Plan.

The Cigna Dental Preferred Provider Organization (PPO) Plan
The Dental PPO Plan is a fee-for-service plan providing coverage for basic, preventive, and restorative dental care, as well as orthodontia, once you satisfy an annual deductible. You may choose to receive care from any licensed dental provider. When you choose to receive care from a provider who participates in Cigna’s Preferred Provider (PPO) Core Network, the plan pays a higher benefit. Dentists who participate in Cigna’s PPO Core Network have contracted with Cigna to provide dental care at reduced fees. These fees are usually lower than the fees charged by providers who do not participate in Cigna’s PPO Core Network. Preventive care received from a Cigna PPO Core Network dentist is not subject to the annual deductible.

Cigna Managed Dental Plan
When you participate in the Cigna Managed Dental Plan, you select a primary care dentist who coordinates all your dental needs and makes any necessary referrals. You do not pay a deductible. There is no annual maximum. You pay copay for each service. Copays are based on a fixed fee schedule – a patient charge schedule – for each covered service. Plan coverage may not be available in all areas.

The Cigna Dental Indemnity Plan
If you live in an area where a Dental PPO plan is not available, you will be provided coverage through the Cigna Dental Indemnity Plan. This option is a fee-for-service plan, which pays benefits based on the usual and prevailing charges for services in a particular geographic area. You and your dependents may receive care from any qualified licensed dentist.

No Coverage Option
You may also choose to waive dental coverage.
# Cigna Dental PPO Plan Highlights

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>In-Network*</th>
<th>Out-of-Network</th>
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<tr>
<td><strong>Orthodontia</strong> (Braces)</td>
<td>Plan pays 50% After annual deductible</td>
<td>Plan pays 40% After annual deductible</td>
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<td>$1,250 lifetime maximum**</td>
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* Cigna PPO Core Network
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Cigna Dental Indemnity Plan Highlights

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$1,250 lifetime maximum**

*Orthodontia payments are included in the calendar year maximum.

**The plan pays benefits based on the usual and prevailing rate for a particular geographical area. Charges over the usual and prevailing rate are not reimbursed through the plan.
How the Dental PPO Plan Works
The Cigna Dental PPO Plan pays benefits based on:
- for in-network dentists – a percentage of the pre-negotiated fee; or
- for non-network dentists – a percentage of the usual and prevailing charge.

Annual Deductible
The annual deductible is the amount of money you pay each year before the plan begins to pay benefits for covered expenses. The deductible must be met before many services are payable. Preventive care, when provided by network dentists, is not subject to the annual deductible.

For the Cigna Dental PPO Plan:
- the in-network individual deductible amount is $25 and $50 for out-of-network;
- the in-network family deductible amount is $75 for you and your family and $150 for out-of-network; and
- routine preventive care, when received from a network provider, is not subject to the annual deductible and is paid at 100%. If you receive care from an out-of-network provider, you are subject to the annual deductible of $50 and the plan pays 80%.

Annual Benefit Maximum
The annual benefit maximum is the total individual benefit amount the plan pays each year. You are responsible for expenses over the annual maximum amount. Reimbursement for orthodontia services is included in the annual benefit maximum:
- the annual benefit maximum for the Cigna Dental PPO Plan for in-network services is $1,250 per individual and $1,000 for out-of-network services (this includes orthodontia).

The annual benefit maximum does not include charges over the usual and prevailing amount, or services not covered by the dental plan.

Orthodontia Treatment Maximum
There is a lifetime limit for orthodontia treatment. Treatment begins when the first orthodontic appliance is installed and ends when the last orthodontic appliance is removed:
- the lifetime orthodontia treatment maximum for the Dental PPO Plan for in-network care is $1,250 and $1,000 for out-of-network care; and
- if you elect the Cigna Dental PPO Plan and elect no coverage the following year, no benefits will be paid in the second year. You must elect dental plan coverage for the course of the orthodontia treatment.

How the Cigna Indemnity Dental Plan Works
Because the Cigna Dental PPO Plan may not be available in all areas, you may be offered dental coverage through the Cigna Dental Indemnity Plan. This fee-for-service plan provides coverage based on the usual and prevailing charge for services. You and your dependents may receive care from any qualified licensed dentist in your area:
- you pay an annual deductible ($25 individual, $75 family) for all dental services;
- plan pays 100% for Preventive and Diagnostic Care, not subject to deductible;
- plan pays 80% for Basic Restorative expenses, after annual deductible;
- plan pays 60% coinsurance on Major Restorative expenses, after annual deductible;
- plan pays 50% on Orthodontia services, after annual deductible;
- you must file claims with the plan;
- the annual benefit maximum for the Cigna Dental Indemnity plan is $1,250 per individual regardless of where services are performed; and
- the lifetime orthodontia treatment maximum for the Cigna Dental Indemnity plan is $1,250, regardless of where the services are performed.
Predetermination of Benefits
Predetermination of benefits is a voluntary review of a Dentist’s proposed treatment plan and expected charges. It is not preauthorization of service and is not required. The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna’s dental consultant. If there is a change in the treatment plan, a revised plan should be submitted. Cigna will determine covered dental expenses for the proposed treatment plan.

If there is no predetermination of benefits, Cigna will determine covered dental expenses when it receives a claim. Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200. Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

What the Dental PPO and Indemnity Plans Cover
To be eligible for reimbursement under the Cigna Dental PPO Plan or the Cigna Dental Indemnity plan all services and supplies must be prescribed or approved as necessary by a licensed dentist. Services must be performed or supplied by a licensed dentist or a licensed hygienist under the supervision of a licensed dentist.

If a dental procedure involves the use of a local anesthetic like Novocain, the expense for the local anesthetic is included in the usual and prevailing charge for the procedure. If the dentist charges separately for the procedure and the anesthetic, the charges will be added together and the maximum allowance will be the usual and prevailing charge for the procedure performed.

The following services and supplies are covered under the Cigna Dental PPO Plan.

Preventive and Diagnostic Services
- two oral examinations in any calendar year;
- routine cleanings (two per year);
- bitewing X-rays twice during any calendar year;
- full mouth X-rays (once every 3 years);
- fluoride application (2 per calendar year);
- sealants to posterior teeth; one treatment per tooth every three years, up to age 19;
- emergency treatment of dental pain;
- space maintainers that are fixed and unrelated to orthodontic treatment;
- office visits during regular office hours;
- office visits after regular office hours (payment will be made on the basis of the service rendered or visit, whichever is greater);
- consultation by a specialist; and
- prophylaxis, including scaling and polishing, limited to two per calendar year.

X-ray and Pathology
- except for injuries, film fees include examination and diagnosis;
- single films, to a maximum of 13;
- entire denture series consisting of at least 14 films, including bitewings if necessary (once every three years);
- intra-oral, occlusal view maxillary or mandibular;
- upper or lower, extra-oral;
- bitewing films, including examination, limited to two per calendar year;
- panorama survey, maxillary and mandibular, single film (considered an entire denture series);
- biopsy and examination of oral tissue;
study models, non-orthodontic; and
microscopic examinations.

**Space Maintainers (non-orthodontic)**
- includes all adjustments within six months after installation;
- fixed space maintainer (band type);
- removal acrylic with round wire rest only;
- stainless steel clasps and/or activating wires; and
- removal, fixed or cemented inhibiting appliance to correct thumb sucking.

**Basic Restorative Services**

**Oral Surgery**
- local anesthesia and routine post-operative care.

**Extractions**
- uncomplicated;
- surgical removal of erupted tooth;
- post-operative visits, (sutures and complications) after multiple extractions and impaction; and
- removal of impacted tooth (soft tissue, partially bony, and completely bony).

**Alveolar or Gingival Reconstructions**
- alvelectomy (edentulous or in addition to removal of teeth);
- alveoloplasty with ridge extension;
- removal of palatal torus or mandibular tori; and
- excision of hyperplastic tissue or pericoronal gingival.

**Dental Cysts or Newplasms**
- incision and drainage of abscesses; and
- removal of cyst or tumor.

**Other Surgical Procedures**
- salolithomy, removal of salivary calculus;
- closure of salivary fistula;
- dilation of salivary duct;
- transplantation of tooth or tooth bud;
- removal of foreign body from bone or from soft tissue;
- maxillary sinusotomy for removal of tooth fragment or foreign body;
- closure of oral fistula of maxillary sinus;
- suquestrectomy of osteomyelitis or bone abscess, superficial;
- condylectomy of mesisectomy of temporomandibular joint;
- radical resection of mandible with bone graft;
- crown exposure to aid eruption;
- frenectomy;
- suture of soft tissue injury;
- injection of sclerosing agent into temporomandibular joint;
- treatment of trigeminal neuralgia by injection into second and third divisions; and
- osseous surgery.

**Anesthesia**
- general and IV sedation, only when medically necessary (nitrous oxide is not covered);
Restorative Dentistry
- excluding inlays, crowns (other than stainless steel), and bridges; multiple restorations and one surface will be considered a single restoration;
- amalgam filling;
- silicate cement filling;
- plastic filling;
- composite filling;
- pin retention when a part of a filling restoration;
- stainless steel crowns;
- adding teeth to partial denture; and
- replace extracted teeth, including clasps.

Endodontics
- pulp capping;
- therapeutic pulpotomy (in addition to restoration) and vital pulpotomy; and
- remineralizations, (calcium hydrozide, temporary restoration).

Root Canals
- necessary X-rays and cultures, but excluding final restoration;
- canal therapy, traditional or Sargenti method; and
- apicoectomy.

Recementation
- Inlay, crown or bridge.

Major Services
Restorative
- gold restorations and crowns are covered only when teeth cannot be restored with a filling material; and
- inlays, one or more surfaces.

Crowns (jackets and caps)
- acrylic or acrylic with gold or non-precious metal;
- porcelain or porcelain with gold or non-precious metal;
- non-precious metal (cast);
- gold (full cast or ¾ cast); and
- gold dowel pin.

Prosthodontics
- bridge abutments (see crowns).

Pontics
- cast gold (sanitary);
- cast non-precious metal;
- slotted facing (Steele’s);
- slotted pontic (Tru-Pontic type);
- porcelain fused to gold or non-precious metal; and
- plastic processed to gold or to non-precious metal.

Removal Bridge (unilateral)
- one-piece casting, gold, or chrome cobalt alloy clasp attachment (all types), including pontics.
Repairs
- crowns;
- bridges;
- dentures (full and partial);
- broken dentures, no teeth involved;
- partial denture repairs (metal); and
- replacing missing or broken teeth.

Dentures and Partial Dentures
- fees for dentures, partial dentures and relining, including adjustments within six months after installation; specialized techniques and characterizations are not eligible;
- complete upper and/or lower dentures;
- partial acrylic upper and/or lower with gold or chrome cobalt alloy clasps, all teeth and two clasps (additional clasps are extra);
- simple stress breakers;
- stayplate;
- office reline, cold cure, acrylic;
- denture reline;
- special tissue conditioning;
- denture duplication (jump case); and
- adjustment to denture more than six months after installation.

Orthodontia and How Benefits Are Paid Under the PPO and Indemnity Plans
The plan covers orthodontic procedures made in connection with the movement of teeth by means of an active appliance to correct the position of maloccluded or malpositioned teeth, including diagnostic services required by one or more of the following:
- overbite or overjet;
- crossbite; and
- upper and lower arches in either protrusive or retrusive relation of at least one cusp.

Orthodontia Treatment Plan
Orthodontic benefits are paid according to when treatment begins. The first expenses for an orthodontia service or supply must be submitted with a treatment plan that includes:
- a description of the recommended treatment;
- an estimate of how long treatment will take to complete;
- the estimated total charge for the treatment; and
- any supporting pre-treatment X-rays, study models or other diagnostic records that the benefits administrator may request.

A down payment of 25% of the total fee is charged at the beginning of the treatment. This is payable at 50% by the Cigna Dental PPO Plan. The remaining balance is prorated in quarterly payments over the course of the treatment period. Quarterly payments are made only when the provider submits evidence of continued treatment. This is payable by the Cigna Dental PPO Plan at 50% for care received from network providers and 40% for care received from out-of-network providers. Under the Cigna Dental Indemnity plan this is payable at 50% regardless of provider.

If orthodontia treatment had begun before your effective date of coverage
You must submit a treatment plan from your orthodontist. This plan must include:
- the total fee for the treatment;
- the original date of treatment; and
- the date when the bands were originally placed.
In such cases, the benefits will be determined by calculating the total dental plan liability, the number of months you are eligible for coverage, and the monthly payment.

You should remember that:

- the annual deductible applies each calendar year unless satisfied by other dental services; and
- payments made for orthodontia are also applied to the plan’s annual benefit maximum. If you have other dental work in the same calendar year, the payments for orthodontia may be reduced accordingly.

**If orthodontia treatment begins after your effective date of coverage**

The first expense for an orthodontic service or supply must be submitted in connection with a treatment plan. Payment for orthodontia is made as the work progresses as follows:

For care received from in-network providers:

- 25% of the total fee is the allowable down payment (installation fee). This is payable at 50%; and
- the balance is prorated in quarterly payments over the course of treatment, divided by the number of months of treatment. This is payable at 50%.

For care received from out-of-network providers:

- 25% of the total fee is the allowable down payment (installation fee). This is payable at 40%; and
- the balance is prorated in quarterly payments over the course of treatment, divided by the number of months of treatment. This is payable at 50%.

**If treatment begins before your effective date of coverage**

The first expense for an orthodontic service or supply must be submitted in connection with a treatment plan. Payment for orthodontia is made by determining the total liability under the dental plan, the number of eligible months and the monthly payment. Plan benefits will be determined on a pro-rated basis, considering the remaining balance and the number of months remaining in the treatment plan.

**What the Dental PPO and Indemnity Plans Do Not Cover**

The services and supplies described in this section are specifically excluded under the dental plan, even if prescribed by a dentist. This list is not intended to be all-inclusive.

**Work-related injury**

Charges in connection with:

- injury arising out of, or in the course of, any work for wage or profit;
- sickness covered by any Workers’ Compensation law, occupational disease law or similar law; or
- services covered under any Workers’ Compensation plan.

**Government plan**

Charges for a service or supply that is:

- furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
- provided by any law or governmental plan under which the patient is or could be covered, excluding Medicaid, Medicare, and benefits in excess of those of any private insurance program or to the non-governmental program.

**Above usual and prevailing**

Charges for services, treatments, supplies or medications essential to the care of the covered individual which are greater than:

- the actual charges for such services, treatment, supplies, or medications; or
- the amount normally charged for comparable services, treatments, supplies, or medications by most providers in the locality where the charges were incurred when furnished to an individual of
the same sex and age for a similar sickness or injury. The benefits administrator determines the allowable amount for each charge.

**Experimental or investigational**
Charges for services or supplies under study and which are not recognized as safe and effective for diagnosis for treatment. This includes:
- all phases of clinical trials;
- all treatment protocols based on those used in clinical trials or medications not approved by the Federal Food and Drug Administration; and
- approved medications used for unrecognized treatment indications.

**Charges for services furnished by a family member**
- a spouse, parent, child, brother, sister, or any person residing in the home.

**Charge for a replacement, alteration or modification**
Charges for a replacement, alteration or modification of a crown or gold restoration, a full or partial removable denture, a removable or fixed bridge, or for adding teeth to any of these, unless the following conditions are met:
- the dentist must supply a statement indicating that the appliance cannot be repaired; and
- the appliance must be at least 5 years old; and
- treatment must begin after the participant has been covered under the plan for 24 consecutive months; or
- the replacement is to replace one or more natural teeth for the first time, which were extracted while the participant was covered under the dental plan.

**Charge for the initial installation for a full or partial removable denture, or a removable or fixed bridge**
Charges for the initial installation for a full or partial removable denture, or a removable or fixed bridge if it includes the replacement of one or more natural teeth missing before the participant became covered under the dental plan. This does not apply if one of the following conditions is met:
- the appliance includes the replacement of a natural tooth removed while the participant was covered under the dental plan;
- the participant has been covered by the plan for 24 consecutive months; and
- the tooth was not an abutment to an appliance installed during the prior 5 years.

**Crown and gold restorations are only covered when treatment is for decay or injury**
Crown and gold restorations are only covered when treatment is for decay or injury when the tooth cannot be restored with a filling material, when the tooth is an abutment to a covered partial denture or fixed bridge, or when approved by the benefits administrator.

**Porcelain crowns on or replacing a tooth behind the second bicuspid, etc.**
Porcelain crowns on or replacing a tooth behind the second bicuspid are reimbursed at the same benefit level as if they were acrylic veneered crowns.

**Cosmetic charges**
Any charge for service furnished for cosmetic purposes, including the alteration, bleaching, or extraction and replacement of sound teeth for the purpose of changing appearance. Facings on crowns, or pontics, are always considered cosmetic. This does not apply if the service is needed as a result of accidental injuries sustained while covered under the plan.

**Accidental injury**
Any charge in connection with an injury if the charge is payable under a medical plan under which you are covered. A charge that is not payable under the medical plan may be considered by the dental plan.
Temporomandibular Joint Disorder (TMJD)
Charge in connection with treatment of TMJD of malocclusion involving joints or muscles by methods including but not limited to, crowning, wiring, or repositioning teeth.

Charge for injury or condition caused by war or similar event

Treatment before the effective date of coverage
Any charges for a course of dental work that was begun before you or your dependents were covered under the dental plan (not applicable to orthodontia), including:

- any appliance or modification of an appliance if an impression was made before the effective date of coverage;
- a crown, bridge, or gold restoration, if the tooth was prepared before the effective date of coverage; and
- root canal therapy, if the pulp chamber was opened before the effective date of coverage.

Charge for vehicular accident
Any injury, condition, illness or disease incurred as a result of any accident involving an automobile, boat, plane, dirt bike, motorcycle, bicycle, bus or other vehicle. You may not elect to make the dental plan primary to any vehicular insurance you have. The dental plan may consider benefit payments for charges incurred as the result of a vehicular accident for which expenses are not recoverable under any form of insurance or other indemnification. Proof in a form acceptable to the dental plan may be required under this provision.

Other Exclusions (this list is not intended to be all inclusive)

- service not reasonably necessary or not customarily performed, for the dental care of a specific condition;
- service not furnished by a dentist. The services of a licensed dental hygienist under the direction of a dentist, or an X-ray ordered by a dentist are covered;
- replacement of lost or stolen appliances;
- appliances, restorations or procedures needed to alter vertical dimensions, or restore occlusion, or splinting or correcting attrition or abrasion;
- tooth implants;
- myofunctional therapy;
- athletic mouth guards;
- oral hygiene, dietary or plaque control programs, or other educational programs;
- duplicate prosthetic devices or appliances;
- prescribed medications covered by any prescription plan;
- services resulting from the commission of a felony;
- treatment when confined in a prison, jail, or other penal institution;
- services for which you would be required to pay in the absence of dental reimbursement coverage;
- completion of claim form, telephone consultations, or failure to keep a scheduled visit;
- dental treatment received outside of the United States and its territories, except for emergency treatment of an accident or sudden onset of an illness, when a participant resides in that country or when a participant is on assignment in that country for the employer;
- services or supplies rendered by providers other than those specifically covered by the dental plan;
- examinations or treatment ordered by a court in connection with legal procedures.

Treatment in Progress
If certain dental treatment is in progress when you leave the Company, the dental plan may continue coverage for up to 90 days after your departure. This applies when:
• an impression was taken for dentures or fixed bridgework;
• a tooth was prepared for crown work;
• work was begun for root canal therapy (the dental plan will only pay for the completion of the root canal); or
• orthodontic treatment has already begun.

Cigna Managed Dental Plan Highlights

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<tr>
<td>Extractions</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
<tr>
<td>Crowns</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
<tr>
<td>Dentures</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
<tr>
<td>Bridges</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
<tr>
<td>(Braces)</td>
<td>Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.</td>
</tr>
</tbody>
</table>

Cigna Managed Dental Plan

The Cigna Managed Dental Plan is a managed dental care plan featuring:
• no charge for most preventive and basic dental services;
• reduced fees for other covered services;
• no claim forms; and
• no annual dollar maximums.
How the Cigna Managed Dental Plan Works
You may receive dental coverage through the plan if you live in an area where the Cigna Managed Dental Plan is available. Except in cases of emergency or with prior approval from Cigna, you are required to have all your dental care provided by dentists who are members of the Cigna Dental Care Plan network. When you join the Cigna Managed Dental Plan, you must select a dental office from a list provided by Cigna Dental. You will be issued an ID card indicating the dental office you selected. If you do not select a network dentist, Cigna may assign one for you. Your network general dentist will coordinate all your dental care, including referrals to specialists as needed. You are responsible for identifying network providers in your area. A list is available at www.cigna.com, or by calling Cigna at 800-244-6224.

What the Cigna Managed Dental Plan Does Not Cover

Limitations on services covered by the plan
- **frequency** – The frequency of certain covered services, such as cleanings, is limited. The patient charge schedule lists any limitations on frequency;
- **specialty care** – Payment authorization is required for coverage of services by a network specialist;
- **pediatric dentistry** – Coverage for referral to a pediatric dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The network general dentist shall provide care after the child’s 7th birthday; and
- **oral surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

The services or expenses listed below are not covered under the plan and are a covered individual’s responsibility at the dentist’s usual fees.

Exclusions (this list is not intended to be all-inclusive)
- services provided by a non-network dentist without Cigna Dental Health’s prior approval (except emergencies);
- services related to an injury or illness covered under Workers’ Compensation, occupational disease, or similar laws (Florida – this exclusion relates to such services paid under Workers’ Compensation, occupational disease or similar laws.);
- services not listed on the Patient Charge Schedule;
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision; or a public program other than Medicaid;
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- nitrous oxide (general anesthesia and IV sedation are covered only when medically necessary and when provided in conjunction with covered procedures);
- prescription drugs;
- procedures, appliances, or restorations if the main purpose is to:
  - change vertical dimension (degree of separation of the jaw when teeth are in contact);
  - diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on the Patient charge schedule; or
  - restore teeth that have been damaged by attrition, abrasion, erosion and/or abfraction (for California, the word “attrition” is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);
  - the completion of crown and bridge, dentures or root canal treatment already in progress on the date a covered person becomes covered by the Dental Plan. *(Note: this exclusion does not apply to Texas residents, if the procedures are otherwise covered under your Patient Charge Schedule)*;
replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or
damaged due to patient abuse, misuse or neglect;

services associated with the placement or prosthodontic restoration of a dental implant;

services considered as unnecessary or experimental in nature. (California and Maryland
residents: this exclusion should read, “Services considered unnecessary.” Pennsylvania
residents: this exclusion should read, “Services considered experimental in nature.”);

procedures or appliances for minor tooth guidance or to control harmful habits;

hospitalization, including any associated incremental charges for dental services performed in a
hospital (Benefits are available for Network Dentist charges for covered services performed in a
hospital. Other associated charges are not covered and should be submitted to the medical
carrier for benefit determination.);

services to the extent a covered person is compensated for them under any group medical plan,
no-fault auto insurance policy, or insured motorist policy (Note: This exclusion does not apply to
Arizona, Maryland, North Carolina and Pennsylvania residents. For residents of Kentucky,
services compensated under no-fault auto or insured motorist policies not excluded);

crown and bridges used solely for splinting;

resin bonded retainers and associated contours; and

pre-existing conditions are not excluded if the procedures involved are otherwise covered under
your Patient Charge Schedule.

Claims for Cigna Dental PPO and Indemnity Plans
You do not have to file claims for services received from network dentists. Your dentist will handle this
paperwork for you.

To file a claim for dental services received from non-network dentists, you may obtain a claim form from
the website listed on your identification card or by calling Member Services using the toll-free number on
your identification card.

When filing a claim you must provide this information:

- your Social Security number;
- the patient's full name, date of birth and relationship to you;
- an itemized bill from the dentist that includes name, address, and tax identification number,
diagnosis, date of service, and charge; and
- indication of whether you want payment to be made to you or directly to the dentist.

A separate claim form should be filed for each family member. Send the completed forms to the address
on your claim form. It is important that you complete the claim form in its entirety. Missing information
may cause a delay in processing your claim.

Important Note: The plan will not make any payments on claims that are submitted more than one year
after the end of the year in which expenses are incurred, regardless of whether you filed the claim for
yourself or for your dependent(s), or whether your provider (dentist, laboratory, etc.) filed the claim on
your behalf or on behalf of your dependent(s).

Claims for Cigna Managed Dental Plan
When you use a network dentist, there are no claim forms to be filed. You pay any applicable patient
charges directly to the dentist.

If a claim for benefits is denied, you will be notified in writing. If you are not satisfied with the reasons for
the denial, you may ask to have the claim reviewed. See the Administrative Information section of this
book for specific procedures to follow in requesting a review of a denied claim.
Subrogation of Benefits and Restitution

Subrogation seeks to conserve the plan assets by imposing the expense for accidental injuries suffered by participants, including their eligible dependents, on those responsible for causing such injuries. If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to the plan for benefits and receive such benefits, the plan shall then have a first priority lien and/or an equitable lien by agreement for the full amount of the benefits that are paid to you and/or your dependents should you seek to recover any monies from the third party that caused the injuries. This includes any recovery that you may receive from the third party, his insurance carrier, any other insurance or benefits program or any other party settling on this behalf, including but not limited to workers' compensation, uninsured or underinsured motorist programs, no-fault or traditional automobile insurance programs, or any other medical payment coverage (auto, homeowners or otherwise), whether through claims payment, compromise, settlement, judgment, verdict and/or any other payment.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of a third party, you should contact your attorney for advice and counsel. However, the plan cannot and does not pay for the fees your attorney might charge.

Should you seek to recover any monies from the third party that caused your injuries, or his insurance carrier, any other insurance or benefits program or any other party settling on his behalf, you must give notice to the plan administrator within ten (10) days of when either you or your attorney first attempt to recover such monies. If litigation is commenced, you are required to give five days notice to the plan administrator of any pretrial conferences. Representatives of the plan reserve the right to attend such pretrial conferences.

The plan’s lien and/or equitable lien by agreement arises through the operation of the plan. No additional restitution agreement is necessary. The plan administrator may, however, require you to sign a restitution agreement, before or after benefits are paid to you or your dependent. By accepting benefits from the plan, you agree that you will timely comply with any and all requests from the plan for documentation concerning any legal proceedings, settlement negotiations and/or medical information that may give rise to or affect the plan’s right to subrogation and/or restitution. You also agree that you will not take any action that might impair, prejudice or discharge your right to recovery or the plan’s right to subrogation and restitution.

The plan’s lien is a lien and/or an equitable lien by agreement on the proceeds of any claims payment, compromise, settlement, judgment, verdict and/or payment received from the third party, his insurance carrier, any other insurance or benefits program and/or any other party settling on his behalf. By applying for and receiving benefits from the plan in such third party situations, you agree that there is a lien running in the plan’s favor and to restore to the plan the full amount of the benefits that are paid to you and/or your dependents from the proceeds of any such claims payment, compromise, settlement, judgment, verdict and/or other payment, to the extent permitted by law.

By applying for benefits, you agree that the proceeds of any claims payment, compromise, settlement, judgment, verdict and/or payment received from the third party, his insurance carrier, any other insurance or benefits program and/or any other party settling on his behalf, if paid directly to you, will be held by you in constructive trust for the plan. The receipt of such funds makes you a fiduciary of the plan with respect to such funds and, therefore, subject to the fiduciary provisions and obligations of ERISA.

By applying for benefits, you agree that the proceeds of any claims payment, compromise, settlement, judgment, verdict and/or payment received from the third party, his insurance carrier, any other insurance or benefits program and/or any other party settling on his behalf, and paid to a person or entity other than you, including but not limited to, a trust, an attorney or an agent thereof, shall be held by such other person, entity or trust in constructive trust for the plan. The recipient of such funds is a fiduciary of the plan with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The
plan reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the plan’s subrogation or restitution rights.

By applying for benefits, you agree that any lien and/or equitable lien by agreement the plan may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the plan for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of the “common fund” doctrine, the “fund” doctrine and/or the “attorney fund” doctrine for the recovery of attorney’s fees.

The plan does not require you to seek recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the plan for any of the benefits that you applied for and accepted.

In the event you fail to notify the plan as provided for above, and/or fail to restore to the plan such funds as provided for above, the plan reserves the right, in addition to all other remedies available to it at law or equity, to withhold any other monies that might be due you from the plan for past or future claims, until such time the plan’s lien is discharged and/or satisfied.

Any and all amounts received from a third party by claims payment, compromise, settlement, judgment, verdict and/or other payments, must be applied first to satisfy your restitution obligation to the plan for the amount of expenses paid by the plan on behalf of a participant or beneficiary. The plan’s lien is a lien of first priority for the entire recovery of funds paid on your behalf, regardless of how the recovery is worded or structured or for what purposes the recovery is designated. Where the recovery from the third party is partial or incomplete, the plan’s right to restitution takes priority over the participant’s or beneficiary’s right of recovery, regardless of whether or not the participant or beneficiary has been made whole for his or her injuries or losses. The plan does not recognize and is not bound by an application of the “make whole” doctrine, the “fund” doctrine, the “collateral source rule” or any other equitable defenses that may affect the plan’s right to subrogation or restitution.

You and your dependents may not assign your rights to settlement or recovery against a third party to any other party, including your attorney, without the plan’s express, written consent.

No-Fault and Vehicular Dental Payments Coverage

In claims resulting from vehicular accidents in states where vehicular insurance contracts include provisions that relate to dental treatment, Cigna will pay covered expenses not paid by no-fault insurance, or seek reimbursement from the employee if dental benefits are recovered from both companies. The benefits paid will be coordinated to cover up to 100% of the benefits allowable under the plan.

You may not elect to make this plan primary to any vehicular insurance you have. The plan may consider benefit payments for charges incurred as the result of a vehicular accident for which expenses are not recoverable under any form of insurance or other indemnification. Proof in a form acceptable to the dental plan may be required.

Coordination of Benefits

If you or a member of your family is covered by another employer’s dental plan, there may be some duplication of benefit coverage between the Cigna dental plan and the other dental plan. The Cigna dental plan has a specific provision, Coordination of Benefits.

See the “Medical Plan” section of this book for detailed information regarding Coordination of Benefits. This provision applies to the medical and dental plans.
# TABLE OF CONTENTS

Vision Insurance Plan Highlights................................................................. 147  
Using In-Network Providers ......................................................................... 148  
Using Out-of-Network Providers .................................................................. 148  
Covered Vision Services ............................................................................... 148  
  Examination Benefit .................................................................................... 148  
  Contact Lens Benefit .................................................................................. 149  
  Frame Benefit ............................................................................................ 149  
  Lens Benefits ............................................................................................ 149  
Additional Discounts .................................................................................... 150  
Medically Necessary Contact Lenses............................................................ 150  
  Mail Order Contact Lens Replacement Program ....................................... 150  
Retinal Imaging Benefit .................................................................................. 151  
Savings on Laser Vision Correction ............................................................... 151  
EyeMed Vision Care Discount Program .......................................................... 151  
Limitations and Exclusions (this list is not intended to be all-inclusive)........ 151  
Filing Claims and Appeals ............................................................................ 151  
  Timeframes for Processing Claims ............................................................. 152  
  Timeframes for Responding to Appealed Claims ....................................... 152  
Complaint Procedure .................................................................................... 152

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
**Vision Insurance Plan Highlights**

This section of your Summary Plan Description is designed to provide you with information about the Vision Insurance Plan. EyeMed’s network of providers includes private practitioners, as well as the nation’s premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate in-network providers near you, visit [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) and choose the Access Network.

<table>
<thead>
<tr>
<th>Administered by EyeMed Vision Care</th>
<th>Your In-Network Cost</th>
<th>Your Out-of-Network Reimbursement*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam</strong></td>
<td>$0 copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Dilation as necessary</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Refraction</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Retinal Imaging</strong></td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Exam Options – Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Fit and Follow-Up</td>
<td>Up to $55</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Fit and Follow-Up</td>
<td>90% of retail price</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$0 copay, plus 80% of balance over $130</td>
<td>Up to $65</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$5 copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$5 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$5 copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Standard Progressive</td>
<td>$70 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Premium Progressive</td>
<td>$70 copay plus (80% of charge less $120 allowance)</td>
<td>Up to $40</td>
</tr>
<tr>
<td><strong>Standard Lens Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV coating</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint (solid and gradient)</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard scratch resistance</td>
<td>$0</td>
<td>Up to $11</td>
</tr>
<tr>
<td>Standard polycarbonate – Adults</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>and Children Under 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard anti-reflective coating</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Polarized</td>
<td>80% of retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Other add-ons and services</td>
<td>80% of retail price</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 copay, plus 85% of balance over $130</td>
<td>Up to $104</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 copay, plus 100% of balance over $130</td>
<td>Up to $104</td>
</tr>
<tr>
<td>Medically necessary</td>
<td>$0 (paid in full by Plan)</td>
<td>Up to $200</td>
</tr>
<tr>
<td><strong>LASIK or PRK from US Laser Network</strong></td>
<td>85% of retail price or 95% of promotional price Whichever is lesser</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note: All costs and reimbursement amounts are subject to change and should be verified with the provider or directly through EyeMed."
Your In-Network Cost | Your Out-of-Network Reimbursement*
--- | ---
Exam | Once every 12 months | Once every 12 months
Lenses or Contact Lenses | Once every 12 months | Once every 12 months
Frames | Once every 24 months | Once every 24 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.
** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

**Using In-Network Providers**
When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceed any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

**Using Out-of-Network Providers**
If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., (“FAA”), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemedvisioncare.com or by calling EyeMed’s Customer Care Center at 866-723-0513.

**Covered Vision Services**

**Examination Benefit**
- **In-Network Benefit** – A Member is entitled to a paid-in-full eye examination, including dilation, performed by a Participating Provider.
- **Out-of-Network Benefit** – A Member is entitled to an eye examination with dilation, up to a $35.00 retail value. The Member must pay at the point-of-service and will be reimbursed up to $35.00 toward an eye examination after submitting a complete claim.
- **Member Pays** – There is a $0 copayment for in-network benefit only.
- **Fitting and Follow up** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
- **Standard** Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. **Standard** benefit: member pays up to $55 of the usual and customary charge.
- **Premium** Contact Lens – all lens designs, materials and specialty fittings other than Standard Contact Lenses. **Premium** benefit: a 10% discount off of the usual and customary charge.
- **Out of Network, Fitting and Follow up** – Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.
  - **Standard** Contact lens – Not Available
  - **Premium** Contact Lens – Not Available
- **Benefit Frequency** – Once every twelve (12) months.

**Contact Lens Benefit**
- **In-Network Benefit** – In lieu of eyeglass lenses, all Members are entitled to conventional, disposable or medically necessary contact lenses for the amounts below. The Member is responsible for the balance over the allowance amount at the time of service.
  - **Conventional** – a $130.00 allowance applied toward non-disposable contact lenses. The Member is responsible for 85% of the balance amount over $130.00 at the time of service.
  - **Disposable** – a $130.00 allowance applied toward disposable contact lenses. The Member is responsible for 100% of the balance over $130.00 at the time of service.
  - **Medically Necessary** – a paid in full benefit toward medically necessary contact lenses.
- **Out-of-Network Benefit** – In lieu of the eyeglass lenses benefit, for contact lenses obtained from an out-of-network provider, a Member is entitled to the following:
  - **Conventional** – a Member is entitled to be reimbursed up to $104.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
  - **Disposable** – a Member is entitled to be reimbursed up to $104.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
  - **Medically Necessary** – a Member is entitled to be reimbursed up to $200.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
- **Member Pays** – There is no copayment.
- **Benefit Frequency** – Once every twelve (12) months.

**Frame Benefit**
- **In-Network Benefit** – A Member is entitled to a $130.00 allowance toward a frame with the purchase of prescription lenses. The Member is responsible for 80% of the balance over the $130.00 at the time of service.
- **Out-of-Network Benefit** – A Member is entitled to a reimbursement of up to $65.00 toward any frame purchased from an out-of-network provider. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
- **Member Pays** – There is no copayment.
- **Benefit Frequency** – Once every twenty-four (24) months.

**Lens Benefits**
- **In-Network Benefit** – A Member is entitled to single vision, bifocal, trifocal, standard progressive and premium progressive lenses.
- **Member Pays** – There is a $5 copay for single vision, bifocal and trifocal. For standard progressive there is a $70 copay and for premium progressive there is a $70 copay plus 80% of charge less $120 allowance.
• **Lens Options** – A Member is entitled to the following lens options for the additional amounts set forth below:

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra Violet Coating</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint (Solid &amp; Gradient)</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Scratch Resistant</td>
<td>$0</td>
<td>Up to $11</td>
</tr>
<tr>
<td>Standard Polycarbonate-Adults</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Polycarbonate-Kids under 19</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Anti-Reflective</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Polarized and Other Add-Ons</td>
<td>20% discount</td>
<td>N/A</td>
</tr>
</tbody>
</table>

• **Out-of-Network Benefit** – A Member is entitled to be reimbursed for the following: up to $25.00 for single vision; up to $40.00 for bifocal; up to $55.00 for trifocal, up to $40 for standard and progressive. The Member must pay the out-of-network provider in full at the point-of-service and file a complete claim to receive the reimbursement.

• **Benefit Frequency** – Once every twelve (12) months.

**Note:** Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance.

**Additional Discounts**

Under the Plan, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses);
- 15% off conventional contact lenses; and
- 20% off items not covered by the Plan at network providers.

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider’s professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

**Medically Necessary Contact Lenses**

The Benefit provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in spherical equivalent or more;
- **High Ametropia** exceeding –10D or +10D in spherical equivalent in either eye;
- **Keratoconus** where the member’s vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses;
- **Vision Improvement** other than Keratoconus for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

If you submit multiple qualifying conditions in support of Medically Necessary Contact Lenses, your out-of-network reimbursement will be based on the condition that reimburses the lowest amount.

The benefit may not be expanded for other eye conditions even if you, or your provider, deem contact lenses necessary for other eye conditions or visual improvement.

**Mail Order Contact Lens Replacement Program**

You can save money by ordering replacement contact lenses at competitive prices through www.eyemedcontacts.com. The contacts will be delivered directly to your home. Your plan allowance and discounts do not apply to this service.
Retinal Imaging Benefit
Retinal imaging has been provided as a discount to your vision plan. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Savings on Laser Vision Correction
EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 877-5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

EyeMed Vision Care Discount Program
If you are eligible for medical coverage under the Ryder Medical Plan, you will automatically be enrolled in EyeMed Vision Care. This program is provided at no cost to you.

The program offers you and your dependents discounts from 20% to 60% off retail eyewear costs. When you use participating providers, the plan provides employees and their dependents with $5.00 off routine eye exams and $10.00 off a contact lens exam. To participate in the program, simply present your EyeMed discount card each time you visit a participating provider to obtain eyewear. To locate participating EyeMed providers, call 877-226-1115.

Limitations and Exclusions (this list is not intended to be all-inclusive)
Benefits are not provided for services or materials arising from:
- orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
- medical and/or surgical treatment of the eye, eyes or supporting structures;
- corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan;
- services provided as a result of any Workers’ Compensation law; and
- plano non-prescription lenses and non-prescription sunglasses (except for the 20% discount), and/or contact lenses. Two pair of glasses in lieu of bifocals. Services rendered after the date an Insured Person becomes an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Filing Claims and Appeals
The EyeMed network is always growing, and provider locations are subject to change. Therefore, we recommend calling EyeMed’s Member Services Department 866-723-0513 or using the Provider Locator
service through EyeMed’s web site www.eyemedvisioncare.com to locate the EyeMed Provider closest to you.

Before you go to a participating EyeMed Provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification Card. If you should forget to take your card, be sure to say that you are participating in the Ryder Vision Insurance vision care plan so that eligibility can be verified. EyeMed Vision Care Customer Service can be reached at 866-723-0513.

When you receive services at a participating EyeMed provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses. If you choose a non-participating provider, you must complete an out-of-network claim form, attach detailed receipts and mail the information to EyeMed Vision Care. An out-of-network claim can be obtained from the EyeMed website.

**Timeframes for Processing Claims**

First American Administrators, Inc., a third-party administrator and wholly owned subsidiary of EyeMed (“hereinafter “FAA”) will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

**Timeframes for Responding to Appealed Claims**

If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include:

- the applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable;
- the item of your vision coverage that the member feels was misinterpreted or inaccurately applied;
- additional information from the member’s eye care provider that will assist FAA in completing its review of the member’s appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative’s name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

The appeal should be mailed or faxed to: FAA/EyeMed Vision Care, LLC, Attn: Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040. Fax: 513-492-3259. FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision.

**Complaint Procedure**

If you are dissatisfied with an EyeMed Provider’s quality of care, services, materials or facility or with EyeMed’s Plan administration, you should first call EyeMed Customer Care Center at 866-723-0513 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.
If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed’s Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed’s receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.
# TABLE OF CONTENTS

- **Introduction** ........................................................................................................... 156
- **Definition of Dependents for the Flexible Spending Accounts** ........................................ 156
  - Health Care Spending Account .............................................................................. 156
  - Dependent Care Spending Account ........................................................................ 156
- **Highlights of the Flexible Spending Accounts** ......................................................... 157
- **Payroll Deductions and Taxes** .................................................................................. 157
- **Dependent Care Spending Account Limit for Higher-Paid Employees** .................. 158
- **Health Care Spending Account (HCSA)** ................................................................. 158
  - Eligible Health Care Spending Account Expenses ............................................... 158
    - Dental and Orthodontic Care ............................................................................. 158
    - Therapy Treatments ......................................................................................... 158
    - Fees/Services .................................................................................................... 158
    - Hearing Expenses ............................................................................................ 159
    - Prescription Drugs .......................................................................................... 159
    - Medical Equipment ......................................................................................... 159
    - Assistance for the Handicapped ...................................................................... 159
    - Vision Care ...................................................................................................... 159
    - Psychiatric Care ................................................................................................ 159
    - Miscellaneous Charges ..................................................................................... 159
  - Ineligible Health Care Spending Account Expenses ................................................. 160
    - Dental and Orthodontic Care ............................................................................. 160
    - Therapy Treatments ......................................................................................... 160
    - Fees/Services .................................................................................................... 160
    - Prescription Drugs/Medications ........................................................................ 161
    - Disallowable Over-the-Counter Products .............................................................. 161
    - Medical Equipment ......................................................................................... 162
    - Vision Care ...................................................................................................... 162
    - Psychiatric Care ................................................................................................ 162
    - Miscellaneous Charges ..................................................................................... 162
- **Dependent Care Spending Account (DCSA)** ............................................................ 162
  - Special Limits if You Are Married ........................................................................... 163
  - Federal Child Care Tax Credit ................................................................................ 163
  - Eligible Dependent Care Spending Account Expenses .......................................... 163
  - Ineligible Dependent Care Spending Account Expenses ......................................... 163
- **Flexible Spending Account Claims** .......................................................................... 164
  - Health Care Spending Account Claims .................................................................. 164
    - How the Debit Card Works ................................................................................ 164
  - Dependent Care Spending Account Claims ............................................................. 165
    - How to File a Dependent Care Account Claim ................................................... 165
  - Account Statements ............................................................................................... 165
- **Deadline for Claim Requests** .................................................................................. 165
  - Health Care Spending Account ............................................................................. 165
  - Dependent Care Spending Account ....................................................................... 165
  - When a Request for Reimbursement Is Denied ....................................................... 166
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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
FLEXIBLE SPENDING ACCOUNTS

Introduction
This section is designed to provide you with information about the:
- Health Care Flexible Spending Account Plan; and
- Dependent Care Flexible Spending Account Plan.

Definition of Dependents for the Flexible Spending Accounts

Health Care Spending Account
Under the Health Care Spending Account a dependent is a spouse or anyone else for whom you provide financial support and claim as a dependent on your federal income tax return, if the expenses are not payable under any other plan.

Dependent Care Spending Account
Under the Dependent Care Spending Account a dependent includes:
- your child, adopted child, stepchild or foster child, who is under age 13, who resides in your household for more than one-half of the year, who does not provide more than one-half of his or her support for the year and for whom you take a dependent exemption on your tax return. If you are divorced, special rules may apply;
- your physically or mentally disabled spouse, who lives with you for more than one-half of the year; or
- any other disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one-half of the year. A disabled dependent aged 13 or older must spend at least 8 hours a day in your home. A disabled dependent who is confined to an institution for care does not qualify.

A person cannot be an eligible dependent if the person is a dependent of another person who filed a joint tax return for the year with his or her spouse (other than you). Except, this does not apply with respect to a disabled dependent who is not a citizen, national or resident of the United States or a resident of Canada or Mexico.

Dependent care expenses eligible for reimbursement through the Dependent Care Spending Account are expenses incurred so that you or your legal spouse can work. If your spouse does not work, you may not participate in the Dependent Care Spending Account unless he/she meets certain earned income requirements and is either a full-time student or mentally or physically incapable of self-care.
### Highlights of the Flexible Spending Accounts

<table>
<thead>
<tr>
<th>Account Name</th>
<th>Description/Eligible Expenses</th>
<th>Maximum Deposit/Restrictions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Spending Account</strong></td>
<td>You may deposit a portion of your earnings in the account on a pre-tax basis to pay for health care expenses that are not fully reimbursed or partially reimbursed by the medical, prescription, dental, or vision plans (including deductibles and copays, but not coverage premiums or contributions).</td>
<td>• $2,500 annually.</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>• Expenses must be incurred on or after the effective date of coverage.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expenses must be incurred on or before the end of the year or the end of the grace period.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expenses cannot be incurred after your termination date unless you contribute to a Health Care Spending Account on a post-tax basis, generally through a COBRA continuation election.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Claims may be incurred during the grace period from January 1 – March 15 of the following year. Claims incurred during the grace period may be applied to your current account or your account for the next year.</td>
<td></td>
</tr>
<tr>
<td><strong>Dependent Care Spending Account</strong></td>
<td>You may deposit a portion of your earnings in the account on a pre-tax basis to pay for day care expenses. Eligible expenses include actual care of your child, not costs for education, supplies, clothing or meals.</td>
<td>• Up to $5,000 a year (this is the maximum amount your family may deduct from taxable income).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deposit amounts may be limited for highly compensated employees.</td>
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<tr>
<td></td>
<td></td>
<td>• Married couples who file separate tax returns are limited to $2,500 per participant. In some cases, this amount may be even less, such as where the spouse has income of less than $2,500.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expenses must be incurred on or after the effective date of coverage and on or before the end of the calendar year.</td>
<td></td>
</tr>
</tbody>
</table>

You cannot transfer money from one account to the other, and you cannot use money from one account to cover expenses that should be claimed from the other account (i.e., you cannot use money from your Dependent Care Spending Account to cover medical expenses for your children).

**Payroll Deductions and Taxes**

Deductions: The annual amount you decide to deposit into each account will be deducted from your pay in equal amounts according to the number of paychecks you receive each year. If a scheduled deduction is missed during the year, it must be made up through additional payroll deductions before the end of the calendar year. Missed payroll deductions are taken from the first and subsequent payroll checks until the missing deductions are collected.
FLEXIBLE SPENDING ACCOUNTS

Taxes: The money you deposit in the accounts is deducted from your pay before federal and most state and local taxes are calculated and withheld. This lowers your taxable income and reduces the earnings shown on your W-2 form. Once deposited, you never pay taxes on this money, even after it is paid back to you in the form of a reimbursement for eligible expenses.

Social Security Taxes: are not withheld from the amount of pre-tax dollars you deposit to the accounts. Because you are reducing the Social Security tax you pay, there is a chance that your future Social Security benefits could be reduced. If this happens, the reduction is generally very small.

Dependent Care Spending Account Limit for Higher-Paid Employees
The government sets limits on the maximum that certain highly compensated employees may contribute to tax-advantaged benefits. One of them is the Dependent Care Spending Account. You will be notified if these limits apply to you. In some years, notification of contribution limits may not be made before the start of contributions. If your contribution amounts exceed this limit, your contributions will be reduced during the year or may be refunded so that your annual contribution does not exceed this limit.

Health Care Spending Account (HCSA)
You can contribute up to $2,500 to the Health Care Spending Account. Contributions deducted from your paycheck are deposited into your account. You will receive a YSA Flexible Spending Account Card. This card can be used to pay for eligible medical, prescriptions, vision and dental expenses (see the FSA Claims section for more details).

It is important to anticipate what your eligible health care expenses will be and set aside enough dollars to cover only those anticipated expenses. Per IRS Guidelines, money not used during the calendar year or during the grace period must be forfeited.

Eligible Health Care Spending Account Expenses
Expenses eligible for reimbursement must occur during the plan year or grace period. Examples of eligible expenses include, but are not limited to:

Dental and Orthodontic Care
- dental treatment;
- artificial teeth – dentures; and
- braces, orthodontic devices.

Therapy Treatments
- treatment for alcoholism or drug dependency;
- legal sterilization;
- acupuncture;
- physical therapy, medically prescribed for a specific diagnosis;
- X-ray treatments;
- fee to use swimming pool for exercises prescribed by a physician to alleviate specific medical conditions such as rheumatoid arthritis;
- smoking cessation programs;
- speech therapy; and
- vaccinations.

Fees/Services
- physicals;
- physician’s fees and hospital services;
- laboratory fees;
- nursing services for care of a specific medical ailment;
- the Social Security taxes paid with respect to wages of a nurse where nurse’s services qualify; services of Chiropractors; and Christian Science Practitioner fees.

Hearing Expenses
- hearing aids; and
- hearing aid battery.

Prescription Drugs
- medicine and drugs that require a prescription (drug name must be on receipt); and
- insulin and supplies.

Medical Equipment
- wheelchair or autoette, cost of operating and maintaining;
- crutches (purchased or rented);
- special mattress & plywood boards prescribed to alleviate arthritis;
- oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition;
- artificial limbs;
- support hose, if medically necessary;
- wigs, where necessary to the mental health of the individual who loses hair because of disease; and
- excess cost of orthopedic shoes over cost of ordinary shoes.

Assistance for the Handicapped
- cost of guide for a blind person;
- cost of note-taker for a deaf child in school;
- cost of Braille books and magazines in excess of the cost of regular editions;
- seeing eye dog, cost of buying, training, and maintaining;
- household visual alert system for deaf person;
- excess costs of specifically equipping automobile for handicapped person over the cost of an ordinary automobile; device for lifting handicapped person into automobile; and
- special devices, such as tape recorder and typewriter for a blind person.

Vision Care
- optometrist’s or ophthalmologist’s fees;
- prescription glasses;
- reading glasses;
- prescription sunglasses;
- contact lenses;
- saline solution and enzyme cleaners; and
- radial Keratotomy/PRK/Lasik surgery.

Psychiatric Care
- services of psychotherapists, psychiatrists, psychologists and medical practitioners.

Miscellaneous Charges
- X-rays;
- expense of services connected with donating an organ;
- travel for medical purposes, must have a copy of the invoice from the provider showing the date of service;
- abortion;
FLEXIBLE SPENDING ACCOUNTS

- air conditioner, when necessary for relief from allergies or for relieving difficulty in breathing;
- deductibles, coinsurance payments, and copays under your health or dental care plans;
- expenses in excess of what is covered by the Ryder System, Inc. Medical, Prescription, Dental and Vision Plans;
- tutoring fees and special schools for children with severe learning disability caused by mental or physical impairments, including nervous system disorders;
- the cost of keeping a mentally or physically handicapped person in a special home;
- hearing care, including hearing aids and special telephone and television equipment for the deaf;
- birth control pills or other birth control items prescribed by your doctor;
- certain medical expenses paid as part of a life care fee under an agreement with a retirement home;
- nurse’s board and wages;
- the cost of weight-loss programs advised by a physician to treat an existing disease;
- medical supplies and equipment such as thermometers, heating pads, oxygen, blood pressure monitoring equipment; arch supports, abdominal or back supports, truss, sacroiliac belt, and invalid chair;
- other medical and dental expenses not normally covered by insurance;
- transportation to receive health care;
- expenses paid for admission and transportation to a medical conference if the conference concerns a chronic illness suffered by you, your spouse or dependent. (To be eligible, the cost of the conference must be primarily for and necessary to the medical care for you, your spouse or your dependent. You must spend the majority of your time at the conference attending sessions on medical information. The cost of meals and lodging while attending the conference are not eligible for reimbursement);
- fertility treatments such as in-vitro fertilization and surgery, including an operation to reverse prior surgery that prevents you from having children;
- therapy received as medical treatment, including patterning exercises for a mentally handicapped child; and
- necessary legal fees paid to authorize treatment for mental illness.

For a complete list of IRS approved expenses, see IRS publication 502.

Ineligible Health Care Spending Account Expenses
Examples of expenses that are not eligible for reimbursement include, but are not limited to (this list is not intended to be all-inclusive):

Dental and Orthodontic Care
- teeth whitening or bleaching; and
- veneers

Therapy Treatments
- physical treatments unrelated to a specific health problem (i.e., massage for general well being);
- any illegal treatment;
- cosmetic surgery and procedures;
- hair transplant; and
- electrolysis.

Fees/Services
- payments to domestic help, companion, baby-sitter, chauffeur, etc. who primarily render services of a non-medical nature;
- nursemaids or practical nurses who render general care for healthy infants; and
- fees for exercise, athletic or health club memberships.
Prescription Drugs/Medications
- cost of illegal, nonprescription medication;
- cosmetic creams;
- hair loss products;
- vitamins/Nutritional supplements; and
- weight loss prescription drugs.

Disallowable Over-the-Counter Products
Include but are not limited to:
- acne medications and creams;
- allergy prevention/treatment;
- anti-gas;
- anti-itch;
- anti-diarrhea;
- asthma/wheezing/shortness of breath;
- athlete’s foot/anti-fungal;
- birth control;
- cold/allergy;
- corn/callus removal;
- cough/cold/flu/fever reducer;
- cough/loosen phlegm;
- cough suppression including cough drops;
- dandruff/seborrhea/psoriasis medications;
- ear problems/ear drying/swimmer’s ear;
- ear wax;
- eye problems;
- fever blister medication;
- head lice treatments;
- heartburn or indigestion;
- hemorrhoid;
- jock itch/anti-fungal;
- laxative/stool softeners;
- menstrual discomfort;
- mouth pain products;
- nasal decongestant;
- nausea, vomiting, or motion sickness;
- pain relief/fever reducer;
- muscle aches;
- poison treatments;
- rashes (poison ivy/oak/sumac);
- smoking cessation;
- vaginal products;
- wart removers;
- baldness/hair re-growth;
- dietary supplements (including botanicals/herbals, combination products, minerals, vitamins);
- deodorant/anti-perspirant products;
- diaper rash medications and diapers;
- mouthwashes/rinse;
- shampoos;
- skin bleaching;
- soap;
Flexible Spending Accounts

- sunscreens;
- toothpastes/dental floss and teeth whitening kits; and
- weight control.

Medical Equipment
- wigs, when not medically necessary for mental health;
- vacuum cleaner purchased by an individual with dust allergy; and
- mechanical exercise devices.

Vision Care
- service agreements or warranties; and
- sunglasses and sunclips.

Psychiatric Care
- psychoanalysis undertaken to satisfy curriculum requirements of a student; and
- marriage and family counseling.

Miscellaneous Charges
- Lamaze, childbirth, child education classes for preparation of childbirth;
- expenses of divorce when doctor or psychiatrist recommends divorce;
- cost of toiletries, cosmetics and sundry items (i.e., soap, toothbrushes);
- cost of special foods taken as a substitute for a regular diet;
- maternity clothes;
- diaper service;
- distilled water purchased to avoid drinking fluoridated city water supply;
- installation of power steering in an automobile;
- pajamas purchased to wear in a hospital;
- in-hospital telephone expense for personal calls, as well as calls to physician;
- insurance against loss of income, loss of life, limb or sight;
- union dues for sick benefits for members;
- contributions to state disability funds;
- auto insurance providing medical coverage to all persons injured in or by taxpayer’s auto;
- the cost of weight loss programs;
- premiums for insurance coverage, warranties, service agreements for medical services and supplies;
- funeral expenses;
- expenses for nutritional supplements, vitamins, herbal supplements, and natural medicines;
- outpatient meals or lodging while receiving medical care;
- health club memberships and recreational activities;
- swimming or dancing lessons;
- custodial care, or care in a nursing home that is not medical in nature; and
- the cost of illegal operations, treatment or controlled substances where rendered or prescribed by licensed or unlicensed practitioners.

For a more complete list of IRS approved expenses, please see IRS publication 502.

Dependent Care Spending Account (DCSA)
You can contribute up to $5,000 to the Dependent Care Spending Account. Contributions deducted from your paycheck are deposited into your account. Contributions are reported on your W-2, according to IRS rules.
In order for your Dependent Care Spending Account contributions to be treated as tax free, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual’s social security number. The identification number for a tax-exempt organization is its tax-exempt identification number. Your care provider should be made aware of this reporting requirement.

If you are married, you may contribute to this account only if your spouse is:
- employed outside the home;
- a full-time student at least five months of the year; or
- disabled.

**Special Limits if You Are Married**
These limits reflect the maximum amount of income you can deduct from your income taxes related to your Dependent Care Spending Account.

<table>
<thead>
<tr>
<th>If:</th>
<th>Your maximum annual contribution is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You or your spouse earn less than $5,000</td>
<td>The amount the lower-paid spouse earns</td>
</tr>
<tr>
<td>Your spouse participates in a similar reimbursement plan</td>
<td>$5,000 combined</td>
</tr>
<tr>
<td>You and your spouse, file separate federal income tax returns</td>
<td>$2,500</td>
</tr>
<tr>
<td>Your spouse is a full-time student for at least five months of the year or is disabled</td>
<td>Up to $3,000 if you have one dependent Up to $5,000 if you have two or more dependents</td>
</tr>
</tbody>
</table>

**Federal Child Care Tax Credit**
The Federal Child Care Tax Credit is a reduction of your federal income tax for dependent care expenses. The credit is subtracted from your tax liability. Depending on your family income, the Federal Child Care Tax Credit may give you a better tax break than the Dependent Care Account. It is recommended you consult your tax advisor for guidance.

**Important Note:** You cannot claim the same expenses through both the Dependent Care Account and the Federal Child Care Tax Credit, and the federal tax credit is reduced, dollar-for-dollar, by amounts contributed to the Dependent Care Account.

**Eligible Dependent Care Spending Account Expenses**
Expenses eligible for reimbursement include:
- day care provided in your home by a baby-sitter, housekeeper, or relative who is not a dependent;
- day care provided outside your home, including qualified daycare providers, day camp, preschool tuition (but not kindergarten or grades above) or other outside before- and after-school programs;
- cost of transportation furnished by a dependent care provider to or from a place where the eligible dependent receives care, such as a day camp or after school program; and
- elder care for dependents that live with you.

Most types of dependent care are covered, including:
- baby-sitting in or out of your home;
- day-care centers that meet state and local laws and regulations;
FLEXIBLE SPENDING ACCOUNTS

- home-care specialists who care for the disabled;
- centers that care for the disabled during the day and that meet state and local laws and regulations;
- housekeepers whose services include the care of your dependent(s); and
- federal, state and local employment taxes you pay for someone you hire to provide child or eldercare for your eligible dependents.

Ineligible Dependent Care Spending Account Expenses
Among the expenses that do not qualify for reimbursement are but not limited to:
- expenses that are claimed as a tax credit on your income tax return;
- benefits provided to you through your spouse’s employer or a government program;
- expenses for services rendered by an individual you claim as a dependent and for whom you are entitled to a personal exemption on your income tax return;
- expenses for services rendered by a child of yours under age 19, even if you do not claim the child as a dependent on your income tax return;
- babysitting when you (and your spouse) aren’t at work or school;
- overnight camp;
- expense of a childcare center that provides for more than six non-resident children but does not comply with all applicable state and local laws; and
- expenses incurred while either you or your spouse, if you are married, are on a paid or unpaid leave of absence.

Flexible Spending Account Claims

Health Care Spending Account Claims
When you enroll in the Health Care Spending Account you automatically receive a Spending Account Debit card. This card can be used to pay for out of pocket eligible expenses.

How the Debit Card Works
All employees enrolled in the Health Care Spending Account receive a Your Spending Account (YSA) Debit Card. Below are important steps to follow:

- **Save your itemized receipts** – You will be asked to submit additional documentation. 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 online or via fax (Tip: the only time you may not need to submit documentation would be when you use your card for prescriptions, as long as it used in an approved pharmacy).

- **Choose “credit” when you swipe your card** – The YSA card is a signature-based debit card. This means you’ll be required to provide your signature, as you do when you use a credit card. If you choose the “debit” option, your transaction will not be processed.

- **Keep your account in good standing** – Only use the YSA card for eligible health care expenses at approved merchants listed on the Your Spending Account Website. Again, when requested, provide documentation to validate card purchases or services by the due date.

Log onto the Ryder BenefitsNow Portal at [www.Ryder.BenefitsNow.com](http://www.Ryder.BenefitsNow.com) to view your personalized Flexible Spending Account page. Go to the Health & Welfare Tab > click on Flexible Spending Accounts > scroll to the bottom of the page and click on “click here” > view your home page where you will find your balance/s, complete the reimbursement forms online or attach any receipts necessary to complete the process of any claims.

If you are unable to use your Health Care Spending Account debit card, you can submit the expense online or complete and submit a Health Care Flexible Spending Account Reimbursement Form along with
acceptable evidence of your expense to the FSA Administrator. Log onto the Ryder BenefitsNow Portal at www.Ryder.BenefitsNow.com to view your personalized Flexible Spending Account page. Go to the Health & Welfare Tab > click on Flexible Spending Accounts > scroll to the bottom of the page and click on “click here” > view your home page where you will find your balance/s, complete the reimbursement forms online or attach any receipts necessary to complete the process of any claims.

The FSA Administrator will process your request and mail you a check for the maximum amount of your allowable reimbursement, up to your annual election amount. Once you have received the full amount of your FSA account election for the year, no further expenses will be reimbursed.

To be reimbursed from your Health Care Account, you need to provide acceptable evidence of the expense. Acceptable evidence includes a copy of the Explanation of Benefits (EOB) form you receive from your medical or dental benefits administrator. The EOB will show how much of your covered medical, prescription or dental expenses were denied or partially paid. You can also submit itemized bills from providers for expenses not covered by you or your spouse’s Company-sponsored health care or dental care plans. Cancelled checks or copies of checks are not acceptable evidence of an eligible healthcare expense.

The invoice or bill you submit should include the type of service or product, the date the expense was incurred, the name of the patient, the name of the provider of care or services, and the amount of the expense.

**Dependent Care Spending Account Claims**
Once you have an eligible expense, you may submit it for reimbursement. Bills and receipts for dependent care expenses are acceptable evidence of your dependent care expense. Each bill or receipt should show the name and address of the day care provider, the name of the dependent receiving care, the total cost of the care, and the dates of service.

**How to File a Dependent Care Account Claim**
To receive reimbursement, you must complete and submit a Dependent Care Flexible Spending Account Reimbursement Form along with acceptable evidence of your expense to the FSA Administrator. To submit online you go to the Ryder BenefitsNow Service Center website at www.Ryder.BenefitsNow.com.

The FSA Administrator will process your request and mail you a check for the maximum amount of your allowable reimbursement, up to your current account balance. Once you have received the full amount of your FSA account election for the year, no further expenses will be reimbursed.

**Account Statements**
You will receive a yearly statement showing activity in your Flexible Spending accounts, including your account balance and reimbursements made.

**Deadline for Claim Requests**

**Health Care Spending Account**
The Health Care Spending Account provides for a two and a half month “grace period”, so that if you don’t use the entire amount by the end of the plan year, you can use the remaining funds in the first quarter of the next plan year. This means that if you participate in the Health Care Account, you will have until March 15 of the following year to incur expenses and until April 30, of the following year to submit claims for reimbursement. You can also decide whether expenses incurred during the grace period are applied to your current year or next year’s Health Care Spending Account.

**Dependent Care Spending Account**
You may file Dependent Care Account claims for reimbursement through April 15 of the following year. Expenses must have occurred on or before December 31 of the previous year. For example, if you have an eligible expense on December 20, but don’t receive or pay the bill until mid-January, you may still
submit the expense for reimbursement through the account. There is no grace period for the Dependent Care Spending Account.

Balances remaining in any of the spending accounts after the claim filing deadlines will be forfeited.

**When a Request for Reimbursement Is Denied**
If a request for reimbursement is denied, you will be notified in writing. If you are not satisfied with the reason the request was denied, you may ask to have your request reviewed by the benefits administrator. For more information, see the Administrative Information section of this book.
TABLE OF CONTENTS

Introduction ......................................................................................................................... 168

Definition of Disability ....................................................................................................... 168
   Regular Attendance and Appropriate Available Treatment ................................................. 168
   Pre-Existing Conditions ..................................................................................................... 168
   Benefit Contributions During Disability ........................................................................... 169
   Taxes ............................................................................................................................... 169

Short-Term Disability Plan for Non-Salaried Employees ................................................ 169
   For Hourly Employees ....................................................................................................... 169
   For Field Hourly/Driver/Warehouse Employees ............................................................... 169

The Salary Continuance Plan for Salaried Employees .................................................... 170

When Benefits Begin ......................................................................................................... 170
   For Non-salaried Employees ............................................................................................. 170
   For Salaried Employees .................................................................................................... 171
   Maternity .......................................................................................................................... 171
   Puerto Rico Employees (Hourly Employees Only) ................................................................ 171

Coordination with Other Payments .................................................................................. 171

Subrogation of Benefits ..................................................................................................... 172

Extended Disability ............................................................................................................ 174

Partial Disability ................................................................................................................. 174

Workers’ Compensation and Short-Term Disability ........................................................ 174

What the Short-Term Disability and Salary Continuance Plans Do Not Cover ............... 175

Ryder Short-Term Disability and Salary Continuance Plan Claims .................................. 175
   How to Apply for Benefits ............................................................................................... 175
   Benefit Payments ............................................................................................................ 176
   If A Claim For Benefits Is Denied .................................................................................... 176
   Overpayments .................................................................................................................. 176
   Pay Increases While Receiving Disability Benefits ....................................................... 176
   Vacation Accrual............................................................................................................... 176

When Your Benefits End ..................................................................................................... 176

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
**Introduction**
The Ryder System, Inc. Short-Term Disability (STD) Plan and the Salary Continuance Plan, provides income replacement if you become disabled due to a non-work-related sickness or injury. Generally, the provisions of the Short-Term Disability and the Salary Continuance Plans are the same, unless otherwise indicated.

**Plan Features**

<table>
<thead>
<tr>
<th>Benefits Administered by Liberty Mutual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of coverage</strong></td>
</tr>
</tbody>
</table>
| **Basic STD Pay** | Salaried employees: 100% or 60% of monthly base pay based on years of service (see grid in Salaried Employees section)  
Non-salaried employees*: 70% of weekly base pay up to $325 |
| **Basic STD Coverage** | Paid by the Company |
| **Additional STD Pay (applicable only to Non-salaried employees)** | 70% of weekly base pay (no maximum) |
| **Additional STD Coverage** | Paid by you, with pre-tax dollars |
| **Benefit elimination period** | 7 consecutive days of disability |
| **Maximum Benefit Period** | Salaried employees: 5 months  
All other employees: 26 weeks |

*Non-salaried employees are Hourly and Field Hourly/Driver/Warehouse employees.*

**Definition of Disability**

You are considered disabled if you have a non-occupational sickness or injury, while receiving care from a doctor on a continuing basis and you are unable to perform the material duties of your job and you have a 20% or more loss in weekly earnings due to the same sickness or injury. You must be considered actively at work the day prior to your date of disability. Actively at work means you were performing the duties of your job at your normal place of work. You will be considered actively at work while on vacation, an unrelated, approved Compensation Leave, approved Family Medical Leave of Absence or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday.

For purposes of the STD Plan, “sickness” means illness, disease, pregnancy or complications of pregnancy. “Injury” means bodily impairment resulting directly from an accident and independently of all other causes.

Maternity is treated like any other sickness. Short-Term disability benefits are provided for a disability related to maternity, pre and post-delivery. Pre-delivery benefits are based on the medical evidence provided to the plan from your treating physician. Under the plan, post-delivery benefits are provided for 6 weeks for a normal, vaginal delivery or a Cesarean section.

All benefit decisions are made on the basis of medical documentation and at the sole discretion of the short-term disability insurance administrator. Ryder System, Inc. makes no determination that an employee's sickness or injury qualifies for short-term disability or salary continuance benefits under the plan.

**Regular Attendance and Appropriate Available Treatment**

To receive benefits from the plan, you must be under the regular attendance of a physician and receiving appropriate available treatment. Regular attendance means personal visits to a physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your disability. Appropriate available treatment means care or services which are:
generally acknowledged by physicians to cure, correct, limit, treat or manage the disabling condition;
accessible within your geographical region;
provided by a physician who is licensed and qualified in a discipline suitable to treat the disabling injury or sickness; and
in accordance with generally accepted medical standards of practice.

**Pre-Existing Conditions**
A pre-existing condition is a condition resulting from an Injury or Sickness for which you were diagnosed or received Treatment within 3 months prior to your effective date of coverage. This plan will not cover any Disability or Partial Disability:

- which is caused or contributed to, by, or results from, a Pre-Existing Condition; and
- which begins in the first 12 months immediately after your effective date of coverage.

For Hourly/Driver/Warehouse employees, increases in Additional STD coverage are subject to pre-existing condition limitations. If benefits are not payable under newly elected Additional STD coverage, your claim will be administered as if you had not elected to increase your coverage. Your plan benefit payment would be based on the coverage level in effect before the increase in plan coverage.

**Benefit Contributions During Disability**
Your benefit coverage continues during an absence from work due to a disability. Your payroll contributions for all benefit elections, including 401(k) loan payments, but excluding any 401(k) contributions, will be taken from any disability payments you may be eligible to receive.

Your coverage will continue while you remain disabled, or until the end of the period for which you are entitled to receive STD benefits.

**Taxes**
The Company-provided Basic STD benefit is subject to all federal, state and local taxes and withholdings including Social Security and Medicare taxes.

If you pay for Additional STD coverage, you will do so with pre-tax dollars. Under the current tax laws you will have to pay federal, state and local taxes on any Additional STD benefits paid.

**Short-Term Disability Plan for Non-Salaried Employees**

**For Hourly Employees**
Basic short-term disability provides income replacement for up to 26 weeks of disability, including the first week of disability (the plan elimination period) in which no benefit payment is issued. Ryder provides coverage at no cost to you. Benefit payments are based on a percentage of your weekly base pay. Weekly base pay excludes any overtime pay, bonuses, incentive pay or any other incentive compensation or extra income. Disability payments are based on a percentage of your weekly base pay divided by 7 calendar days. Each day is paid at 1/7 of your weekly base pay and includes Saturdays and Sundays, regardless of your work schedule.

**For Field Hourly/Driver/Warehouse Employees**
Basic short-term disability provides income replacement for up to 26 weeks of disability, including the first week of disability (the plan elimination period) in which no benefit payment is issued. Benefit payments are based on a percentage of your weekly base pay. Weekly base pay is the average of the last 3 months (13 weeks) of earnings starting with the most recent completed full month of work prior to the date of your disability. Base pay includes overtime, bonuses, commissions, stops, starts, and mileage. Disability payments are based on a percentage of your weekly base pay divided by 7 calendar days.
Each day is paid at 1/7 of your weekly base pay and includes Saturdays and Sundays, regardless of your work schedule.

**If you are disabled, recover, and become disabled again**, benefits will be limited to a maximum duration of 26 weeks in any rolling 12-month period.

**To be considered a new period of disability**, 1 period of disability must be separated from another period of disability by a return to active full-time employment for a period of 30 consecutive days for a recurrent disability and 1 day for a new disabling condition. In the event of 2 or more periods of disability, benefits are limited to a maximum duration of 26 weeks.

Once you have received 26 weeks of STD benefits in a 12 consecutive month period, you will not be eligible to receive additional STD benefits until you have been actively at work for 6 consecutive months.

**To be considered a recurrent disability**, if you return to work as an active full-time employee for 30 consecutive days or more, any recurrence of a disability or a non-related disability or a disability due to the same causes as the prior disability will be treated as a new disability with respect to when benefits begin and the maximum duration of benefits provided by the plan. You will need to satisfy another 7-day elimination period before STD payments begin.

If 2 periods of the same or related disability are separated by less than 30 consecutive days of work, as an active full-time employee, the recurrent period of disability will be considered the same period of disability. A recurrent disability means a disability which is related or due to the same causes as the prior disability for which a benefit was payable.

Whether the disability is considered recurrent or a new disability, the maximum duration under the plan will still apply.

**The Salary Continuance Plan for Salaried Employees**
Salary Continuance provides income replacement for up to 5 months of disability. Ryder provides coverage at no cost to you. Benefits are based on your monthly base pay on the date of your disability, and are not subject to increases while you are receiving benefits. Monthly base pay excludes commissions, bonuses, incentive pay or any other incentive compensation or extra income.

**If you are disabled, recover, and become disabled again**, benefits will be limited to a maximum duration of 5 months (up to 150 days) in any rolling 12-month period.

**To be considered a new period of disability**, 1 period of disability must be separated from another period of disability by a return to active full-time employment for a period of 30 consecutive days for a recurrent disability and 1 day for a new disabling condition. In the event of 2 or more periods of disability, benefits are limited to a maximum of 5 months (up to 150 days), in any consecutive 12-month period.

Once you have received 5 months of STD benefits in a 12 consecutive month period, you will not be eligible to receive additional STD benefits until you have been actively at work for 6 consecutive months.

**When Benefits Begin**
**For Non-salaried Employees**
Short-Term Disability benefit payments begin after you have been disabled for 7 consecutive calendar days. The first 7 calendar days of disability (including Saturday and Sunday) are considered the elimination period, and no disability benefits are payable during this time. However, during the elimination period, pay can be made up from vacation or other paid time off programs available to you. You are limited to using only 5 days of paid time off during your elimination period.
The Basic STD plan replaces 70% of your weekly base pay to a maximum benefit payment of $325 per
week during which you are unable to perform the material duties of your job.

You may purchase additional coverage to increase your weekly maximum payment.

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Weekly Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic STD</td>
<td>70% of your weekly base pay up to a maximum of $325 a week</td>
</tr>
<tr>
<td>Additional STD</td>
<td>70% of base pay (no weekly maximum)</td>
</tr>
</tbody>
</table>

**For Salaried Employees**

Salaried employees must file for salary continuance benefits after they have been disabled for 7
consecutive calendar days, which includes Saturday and Sunday. Salary Continuance benefit payments
are paid retroactively to your date of disability once you have been disabled for 7 consecutive calendar
days.

The Salary Continuance plan replaces a percentage of your monthly base pay on the date of your
disability for up to 5 months for a non-occupational accidental injury, sickness, mental illness, pregnancy,
or substance abuse. The number of months you receive 100% income replacement or 60% income
replacement depends on your length of service with the Company.

The benefit you receive is based on your annual base salary.

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>Benefit Period at 100% of Salary</th>
<th>Benefit Period at 60% of Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>1 month</td>
<td>4 months</td>
</tr>
<tr>
<td>1-5 years</td>
<td>3 months</td>
<td>2 months</td>
</tr>
<tr>
<td>5 or more years</td>
<td>5 months</td>
<td>0 months</td>
</tr>
</tbody>
</table>

**Maternity**

Maternity is treated like any other illness. Disability benefits are provided for a disability related to
maternity, pre and post delivery. Pre-delivery benefits are based on the medical evidence provided to the
plan from your treating physician. Under the plan, post delivery benefits are provided for 6 weeks for a
normal, vaginal delivery or a Cesarean section.

**Puerto Rico Employees (Hourly Employees Only)**

Under the Puerto Rico Maternity Law, an employee is entitled to 8 weeks of full pay for maternity leave (4
prenatal and 4 postnatal), for the birth of a child. The employer is required to pay 100% of the
employee’s pay at the commencement of the maternity leave. Additionally, the employee is not eligible to
apply for Puerto Rico state disability.

If the employee returns to work before the 8-week period elapses, the employee waives the remaining
postpartum leave.

**Coordination with Other Payments**

While you are disabled, the amount of benefit you receive from the Ryder plan will be coordinated with
other income benefits that you, your spouse and/or children are eligible to receive from other sources.

This includes benefits to which you or your family is eligible or that are paid to you, or to your family or to
a third party on your behalf via any:

- disability benefits paid by the states of California, New York, New Jersey, Puerto Rico, Rhode
  Island, Hawaii, or other states as required by law;
- governmental law or program that provides disability or unemployment benefit as a result of your
  job with Ryder;
short-term disability

- plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with Ryder or as a result of membership or association with any group, association, union, or other organization;
- individual insurance policy where the premium is wholly or partially paid by Ryder;
- the Veteran’s Administration, or any other foreign or domestic governmental agency for the same disability;
- the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings;
- no fault insurance; or
- Ryder Pension Plan.

Ryder’s STD benefits will be coordinated with any state (New York, New Jersey, Rhode Island, California, Puerto Rico, Hawaii, or any other state as required by law) benefits you may receive. Your Ryder benefits will be reduced by the estimated amount of the state benefits initially, and adjusted after benefits are awarded, so that the total benefit you receive from both the state and Ryder does not exceed the plan’s maximum.

Disability income from any of the above sources will reduce the benefits payable from the Ryder STD plan so that your total benefit from Ryder and all other sources of disability income will equal the amount you are eligible for under this plan.

- You must inform the benefits administrator if you are entitled to, or eligible for any of these benefits. Failure to do so could cause an overpayment which will offset future benefits, until the overpayment is repaid in full.

Subrogation of Benefits

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Short Term Disability Plan and Salary Continuation Plan (STD Plans) shall be fully subrogated to and shall succeed to all rights of recovery and causes of action, under any legal theory of any type for the reasonable value of any services and benefits the Plans provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by the STD Plans and described in this Summary Plan Description, the STD Plans shall also have an independent right to be reimbursed by you for the reasonable value of any service and benefits the STD Plans provide to you, from any or all of the following listed below:

- third parties, including any person or tortfeasor alleged to have caused you to suffer injuries or damages;
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, and/or any other insurance program or from other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

These responsible or potentially responsible, third parties and persons or entities are collectively referred to as “Third Parties”.

By participating in the STD Plans, you agree as follows:

- that by accepting plan benefits, you consent to the plans’ right to subrogation or reimbursement and consent to hold any payment, amount or recovery received from a third Party in constructive trust, lien and/or equitable lien by agreement in favor of the STD Plans;
- that you will cooperate with the STD Plans in a timely manner in protecting the STD Plans’ legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan;
• signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
• responding to requests for information about any accident or injuries;
• appearing at depositions and in court;
• obtaining the consent of the STD Plans or its agents before releasing any party from liability or payment of medical expenses, and
• taking no action that might impair, prejudice or discharge your right to recovery or the STD Plans’ right to subrogation or reimbursement;
• that failure to cooperate in this manner shall be deemed a breach of contract and may result in the termination of plan benefits and/or the institution of legal action against you;
• that the STD Plans have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
• that no court costs or attorneys’ fees may be deducted from the STD Plans’ recovery without the STD Plans’ express written consent; any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall not defeat this right and the STD Plans’ are not required to participate in or pay court costs or attorneys’ fees to the attorney hired by you to pursue a damage/personal injury claim;
• that, regardless of whether you have been fully compensated or made whole, the STD Plans may collect from you the reasonable value of any services and benefits provided by the STD Plans, as well as collection costs, from the proceeds of any full or partial recovery that you or your legal representative obtains, whether before or after any determination of liability. The proceeds available for collection shall not be limited to only that recovery that is designated for medical costs and expenses, and shall include, but not be limited to any and all amounts earmarked as non-economic damages, settlement or judgment. The STD Plans’ right to recover the proceeds is not affected by the timing of the recovery (whether before or after any determination of liability), or the manner in which the recovery is structured or worded. The STD Plans’ ability to collect shall not be affected or reduced by the so-called “Make Whole Doctrine”, “Fund Doctrine”, “Common Fund doctrine”, “Collateral Source rule”, or any other equitable defenses that may affect the STD Plans’ right to subrogation or reimbursement;
• that benefits paid by the STD Plans may also be considered to be benefits advanced;
• that you agree that once STD Plans’ benefits are paid, a constructive trust, lien or equitable lien by agreement in favor of the plan exists with regard to any recovery, including by settlement (either before or after any determination of liability) or judgment, from a Third Party. As such, if you or your agent, including his attorney, receives any payment from any Third Party as a result of any injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you or your agent will serve as a constructive trustee and fiduciary over the funds, which will be held on behalf of the STD Plans and failure to hold such funds in trust will be deemed as a breach of your duties hereunder. Such breach may result in the termination of plan benefits or the institution of legal action against you or your agent;
• that you or an authorized agent, such as the your attorney, must hold any funds received from any Third Party that are due and owed to the STD Plans, as stated herein, separately and alone, and failure to hold funds as such will be deemed a breach of contract and may result in the termination of plan benefits or the institution of legal action against you or your authorized agent;
• that the STD Plans shall be entitled to recover reasonable attorney fees from you in collecting from you any funds held by you that were recovered from any Third Party;
• that the STD Plans may set off from any future benefits otherwise allowed by the STD Plans the value of benefits paid or advanced under this section to the extent not recovered by the STD Plans;
• that you will neither accept any settlement that does not fully compensate or reimburse the STD Plans without the STD Plans’ written approval, nor will you do anything to prejudice the STD Plans’ rights under this section;
that you will assign to the STD Plans all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the STD Plans provided, plus reasonable costs of collection;

that the STD Plans’ rights will be considered as a specific and first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid;

that the STD Plans’ rights will not be reduced due to your own negligence;

that the STD Plans may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name, which does not obligate the STD Plans in any way to pay you part of any recovery the STD Plans might obtain;

that the STD Plans shall not be obligated in any way to pursue this right independently or on your behalf;

that you will not assign your rights to settlement or recovery against a Third Party to any other party, including their attorneys, without the STD Plans’ express written consent; and

that if the injury or condition, giving rise to subrogation or reimbursement involves the wrongful death of a STD Plans’ beneficiary, this section applies to the personal representative of the deceased STD Plans’ beneficiary.

Extended Disability
If your disability is extended by a new cause while you are receiving benefits from the STD plan, benefits will continue while you remain disabled. However, benefits will end once you reach the maximum duration of benefits. The plan’s pre-existing limitation will apply to the new cause of disability.

Partial Disability
If you return to work on a part-time or limited basis because you are partially disabled, your benefits will be reduced by your weekly return to work earnings.

Benefits will not be reduced if your return-to-work wages are 20% or less than your adjusted pre-disability earnings. If your return-to-work wages are over 20% of your pre-disability earnings, the maximum amount you can receive in payments from work and disability benefits will not exceed 100% of your adjusted pre-disability earnings.

Workers’ Compensation and Short-Term Disability
Employees on approved Workers’ Compensation leave, are considered actively at work by the Plan. If, during an approved Workers’ Compensation leave, you incur a non-occupational sickness or injury unrelated to your Worker’ Compensation disability, which prevents you from returning to work once you are released to return to work, you may be eligible for benefits under the Ryder Short-Term Disability Plan or the Salary Continuance Plan.

If you have incurred a work-related injury or illness and have been approved for Workers’ Compensation, you are not eligible for benefits through the Ryder Short-Term Disability Plan or the Salary Continuance Plan even if Workers’ Compensation releases you to return to work or you have reached maximum medical improvement (MMI) and you are still unable to return to work.

Important Note: If your sickness or injury prevents you from returning to work after receiving the maximum benefits under the Short-Term Disability Plan or the Salary Continuance Plan, you will be administratively terminated by the Company. You may be eligible for Long-Term Disability Benefits. Contact the Long-Term Disability Insurance Company for details regarding the Long-Term Disability Benefits that may be available to you.
What the Short-Term Disability and Salary Continuance Plans Do Not Cover

The Ryder Short-Term Disability plan does not cover disabilities caused by or related to:

- sickness or injury not being regularly attended to by a physician and not received appropriate available care;
- pre-existing conditions;
- a disability due to war, declared or undeclared, or any act of war;
- intentionally self-inflicted injuries, while sane or insane;
- a work-related accident, injury, disease or sickness (Note: If a claim is, or may be filed as, work related, you must sign subrogation papers stipulating your agreement to pay back to the Ryder STD plan any future money that may be awarded from an occupational sickness or injury. This agreement applies even if the claim is denied as work related);
- failure to pass DOT requirements;
- loss of commercial driving license;
- the committing of, or attempting to commit, a felony or misdemeanor;
- injury sustained as a result of doing any work for pay or profit for another employer, including self-employment;
- active participation in a riot;
- cosmetic surgery unless such a surgery is in connection with an injury or sickness sustained while you are covered under this plan;
- a gender change including, but not limited to, any operation, drug therapy or any other procedure related to a gender change; and
- any period of disability during which you are incarcerated.

Ryder Short-Term Disability and Salary Continuance Plan Claims

How to Apply for Benefits

When you expect to be disabled for more than 7 consecutive days due to a non-occupational sickness or injury, you must call the benefits administrator. Your call will put you in touch with a customer service representative who will require the following information to establish your claim:

- name and social security number;
- employer’s name;
- supervisor’s name and telephone number;
- physician’s name, address and telephone number;
- description of your sickness or injury and your last day worked; and
- description of your job.

If your sickness or injury qualifies as a disability, the disability claim manager will call your physician to obtain medical information regarding your claim, and may call your supervisor to obtain more information about your job requirements.

When appropriate, the disability claim manager will certify the length of your disability -- the length of time you will be absent from work and receiving STD benefits. You must coordinate your disability absence with your supervisor.

As a follow-up to your phone call:

- you will receive a notification from the benefits administrator stating your approved length of disability or the reason for denial;
- the benefit administrator will inform your supervisor so that he or she will know when to expect you to return to work;
- you will begin receiving disability benefit payments once your claim is approved for payment, and the benefit payment amount is received by the Ryder Payroll Department (the following deductions will continue to be taken from your disability payment: all health and welfare contributions, 401(k) loan payments, garnishments, and payroll taxes);
**SHORT-TERM DISABILITY**

- a disability claims manager or physician will periodically speak with you and your physician to determine if you are progressing on schedule and, as necessary, to adjust your return-to-work date; and
- before the date on which you are expected to return to work, a disability claims manager will call you to check on your progress and confirm that you will be returning to work on the designated date.

You must coordinate safety and drug return-to-work testing with your supervisor if your disability lasts for a period of:
- 30 days or more for safety-sensitive positions; or
- 90 days or more for non-safety sensitive positions.

**Benefit Payments**

All benefits are paid to you, beginning with the first pay cycle, after the benefits administrator’s notification. Any payments owed in the event of your death may be paid to your estate.

**Important Note:** While you are collecting benefits from the Short-Term Disability Plan or the Salary Continuance Plan, you cannot receive pay for sick, holiday or vacation days. Hourly/Driver/Warehouse employees may, however, submit any available sick, holiday or vacation time for the first 7 days – the plan elimination period – of your disability.

**If A Claim For Benefits Is Denied**

You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed by the plan administrator. See the Administrative Information section for specific procedures to request a review of a denied claim.

**Overpayments**

The benefits administrator will notify you of any overpayment of a disability claim. In this case, you must repay Ryder the amount of overpayment. Any future Short-Term Disability payments or compensation will be offset by the overpayment amount until you have repaid the full amount owed to the Company.

Overpayments occur when:
- you do not notify or are late in notifying the benefits administrator of your return to work;
- you receive retroactive awards from other income benefits; or
- the benefits administrator has made an error in calculating your benefit.

**Pay Increases While Receiving Disability Benefits**

You cannot receive an increase in pay if you are receiving disability benefits. Disability benefit payments are calculated and based on the plan provisions and earnings in effect on the date your disability began. Any scheduled salary increases cannot be made until the date you return to work on a regular basis, and will not be made retroactive to the date your salary was scheduled to increase.

**Vacation Accrual**

FMLA (Family Medical Leave Act) runs concurrently with STD. If eligible for FMLA, you will accrue vacation benefits only for the FMLA portion (12 weeks) of your STD leave. If your STD leave is longer than 12 weeks, you will not continue to accrue vacation time until you return to work. For additional information on FMLA, please refer to your Employee Handbook.

**When Your Benefits End**

Benefits end on the earlier of the date:
- you are no longer disabled;
- you fail to furnish adequate proof of continuing disability;
- you refuse to be examined by a physician of the plan administrator’s choosing;
• you voluntarily terminate employment;
• you have received the maximum number of weeks of benefit payments;
• the plan is terminated or amended;
• your disability work earnings exceed the amounts allowed under the plan;
• you are able to return to work in a light-duty or part-time capacity and you refuse to do so;
• you are no longer under the care of a physician; or
• you are terminated for cause.

Note for employees that are terminated with severance: Termination of employment will not end approved STD benefit payments. Payments will continue even after termination of employment for as long as you remain disabled as defined by the STD Plan, but not beyond the maximum benefit period.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>179</td>
</tr>
<tr>
<td>LTD Summary</td>
<td>179</td>
</tr>
<tr>
<td>Definition of Disability</td>
<td>179</td>
</tr>
<tr>
<td>Regular Attendance and Appropriate Available Treatment</td>
<td>180</td>
</tr>
<tr>
<td>Pre-existing Conditions</td>
<td>180</td>
</tr>
<tr>
<td>Increases in Coverage</td>
<td>180</td>
</tr>
<tr>
<td>Cost of Coverage</td>
<td>180</td>
</tr>
<tr>
<td>Taxes</td>
<td>180</td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>180</td>
</tr>
<tr>
<td>Your Monthly LTD Benefit</td>
<td>180</td>
</tr>
<tr>
<td>Partial Disability Benefits</td>
<td>181</td>
</tr>
<tr>
<td>Benefit Maximum and Minimum</td>
<td>181</td>
</tr>
<tr>
<td>Recurrent Disability</td>
<td>181</td>
</tr>
<tr>
<td>Coordination with Other Payments</td>
<td>181</td>
</tr>
<tr>
<td>Social Security and LTD Benefits</td>
<td>182</td>
</tr>
<tr>
<td>Maximum Benefit Period</td>
<td>182</td>
</tr>
<tr>
<td>Basic LTD Coverage</td>
<td>182</td>
</tr>
<tr>
<td>Additional 50% and 60% LTD Coverage – Non-Salaried Employees</td>
<td>182</td>
</tr>
<tr>
<td>Additional 50% and 60% LTD Coverage – Salaried Employees</td>
<td>183</td>
</tr>
<tr>
<td>Combined Limit for Disabilities for Mental Illness, Substance Abuse or Non-Verifiable Symptoms</td>
<td>183</td>
</tr>
<tr>
<td>Rehabilitation Incentive Benefits</td>
<td>183</td>
</tr>
<tr>
<td>Workplace Modification Benefit</td>
<td>183</td>
</tr>
<tr>
<td>Conversion Privilege</td>
<td>184</td>
</tr>
<tr>
<td>Survivor Benefit</td>
<td>184</td>
</tr>
<tr>
<td>What the LTD Plan Does Not Cover</td>
<td>184</td>
</tr>
<tr>
<td>Long-Term Disability Plan Claims</td>
<td>185</td>
</tr>
<tr>
<td>How to Apply for LTD Benefits</td>
<td>185</td>
</tr>
<tr>
<td>Benefit Payments</td>
<td>185</td>
</tr>
<tr>
<td>If a Claim for Benefits is Denied</td>
<td>185</td>
</tr>
<tr>
<td>Overpayments</td>
<td>185</td>
</tr>
<tr>
<td>When Your LTD Benefits End</td>
<td>186</td>
</tr>
</tbody>
</table>

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.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
**Introduction**

The Ryder System, Inc. Long-Term Disability (LTD) Plan provides income replacement if you are unable to work because of an occupational or non-occupational sickness or injury.

**LTD Summary**

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Benefits Insured by Liberty Mutual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of coverage</td>
<td>Income protection due to long-term disability</td>
</tr>
<tr>
<td>Basic LTD Benefit</td>
<td>40% of pre-disability earnings</td>
</tr>
<tr>
<td>Basic LTD Coverage</td>
<td>Paid by the Company</td>
</tr>
<tr>
<td>Maximum Benefit Period</td>
<td>Up to 24 months</td>
</tr>
<tr>
<td>Additional LTD Benefit*</td>
<td>50% or 60% of pre-disability earnings</td>
</tr>
<tr>
<td>Additional LTD Coverage</td>
<td>Paid by you, with post-tax dollars</td>
</tr>
<tr>
<td>Benefit elimination period</td>
<td>Salaried employees: the greater of the end of your Short-Term Disability benefit or 150 days Non-salaried** employees: the greater of the end of your Short-Term Disability benefits or 180 days</td>
</tr>
<tr>
<td>Maximum Benefit Period</td>
<td>Salaried employees up to age 65 or refer to benefit duration chart Non-salaried employees up to 5 years</td>
</tr>
<tr>
<td>Minimum monthly benefits (all options)</td>
<td>$100 or 10% of your gross monthly benefits, whichever is greater</td>
</tr>
<tr>
<td>Maximum monthly benefit (all options)</td>
<td>$8,000. Your LTD benefits from Ryder may be reduced by disability income you are eligible to receive from other sources such as Social Security, state disability plans, or Workers’ Compensation plans.</td>
</tr>
<tr>
<td>You can take your coverage with you</td>
<td>You may be eligible to convert your policy to an individual policy when you leave the Company if you satisfy all of the Insurance Carrier’s requirements</td>
</tr>
</tbody>
</table>

*If you do not enroll on or before the date you first become eligible or you choose to increase your coverage due to a Qualified Life Event, you must complete and submit an Evidence of Insurability Form. After the insurance carrier has approved the increase, your new coverage amount will become effective on the first of the month following the approval. In addition to the Evidence of Insurability Form, proof of good health may also include a medical exam, if requested, and additional information such as physician’s statements. The Insurance carrier will pay for any additional information or tests needed to evaluate your application.**

**Non-salaried employees are Hourly and Field Hourly/Driver/Warehouse employees.**

**Definition of Disability**

You are disabled when the insurance carrier determines that:

- you are limited from performing the material and substantial duties of your own occupation due to your sickness or injury;
- if you are eligible for the 24 month Own Occupation benefit, "Disability" or "Disabled" means that during the Elimination Period and the next 24 months of Disability the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of his Own Occupation; and thereafter, the Covered Person is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.

"Own Occupation" means the occupation you were performing when your Disability or Partial Disability began. For the purposes of determining Disability under this policy, the insurance carrier will consider your occupation as it is normally performed in the national economy.
"Any Occupation" means any occupation that you are or become reasonably suited by training, education, experience, age, physical or mental capacity.

**Regular Attendance and Appropriate Available Treatment**
To receive benefits from the plan, you must be under the regular attendance of a physician and receiving appropriate available treatment. Regular attendance means personal visits to a physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your disability. Appropriate available treatment means care or services which are:
- generally acknowledged by physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within your geographical region;
- provided by a physician who is licensed and qualified in a discipline suitable to treat the disabling injury or sickness; and
- in accordance with generally accepted medical standards of practice.

**Pre-existing Conditions**
A pre-existing condition is a condition resulting from an Injury or Sickness for which you were diagnosed or received Treatment within three months prior to your effective date of coverage. This plan will not cover any Disability or Partial Disability:
- which is caused or contributed to by, or results from, a Pre-Existing Condition; and
- which begins in the first 12 months immediately after your effective date of coverage.

**Increases in Coverage**
All increases in plan coverage are subject to the pre-existing condition provision. The pre-existing condition limitation time period will be based on the effective date of your change in coverage. If benefits are not payable under the new coverage elected because of a pre-existing condition, your claim will be administered as if you had not elected to increase your coverage.

If you do not make any changes, the Company will continue the same coverage option that you elected for the previous year, unless the current plan is no longer available.

**Cost of Coverage**
Premium payments for Additional LTD coverage are made through payroll deductions. Your payments for this coverage are made with post-tax deductions from your pay. Monthly premiums are based on your attained age as of December 31 of the current plan year.

Earnings are based on your base pay or previous 2-year average earnings, whichever is greater. Prior 2-year average earnings are your total earnings for the 24-month period ending August 31 of the prior plan year.

**Taxes**
Basic LTD plan benefits are subject to all state, local and federal taxes. Because you pay for Additional LTD coverage with post-tax dollars, under current tax law you do not have to pay regular income taxes on any Additional LTD plan benefits.

**Waiver of Premium**
Once you begin receiving benefits from the plan, you are no longer required to pay premiums to continue your coverage.

**Your Monthly LTD Benefit**
LTD benefits are paid based on the number of months you are disabled. During the first 24 months, you are provided benefits based on the level of coverage you have elected, 40%, 50% or 60% of pre-disability
LONG-TERM DISABILITY

earnings. If you elected additional Long-Term Disability coverage, your benefit may be continued based on your additional coverage election and approval by the benefit administrator.

Pre-disability earnings are based on your base pay or previous 2-year average earnings, whichever is greater. Prior 2-year average earnings are your total annual earnings for the 24-month period ending August 31 of the prior plan year.

**Partial Disability Benefits**

You are eligible for Partial Disability Benefits if:

- you can perform one or more, but not all, of the material and substantial duties of your occupation on an active employment or part-time basis; or
- you can perform all of the material and substantial duties of your occupation on a part-time basis; and
- earn between 20% and 80% of your pre-disability earnings.

If you qualify for partial disability benefits, the plan will not offset return to work earnings for the first 12 months of partial disability benefits until the gross benefit combined with your return to work earnings exceeds 100% of your pre-disability earnings.

**Benefit Maximum and Minimum**

The maximum monthly benefit is $8,000. The minimum monthly benefit is the greater of $100 or 10% of your gross disability payment.

**Recurrent Disability**

You may attempt to return to work as an active full-time employee for up to 30 days during the benefit elimination period without interrupting the benefit elimination period. However, if your return to work lasts more than 30 days, it will interrupt the benefit elimination period and you will have to re-satisfy the benefit Elimination Period.

If you return to work after the benefit elimination period and are disabled again, your second disability will be considered a continuation of your first disability if:

- it has the same or related cause as your first disability, and
- it is separated by less than 6 months from your return to work.

If considered a continuation of your first disability, benefits are payable for the weeks remaining in your original benefit period. You will not have to satisfy a new elimination period.

If you return to work for 6 months or more, any recurrent disability will be treated as a new disability and is subject to the benefit elimination period and maximum period of benefits.

**Coordination with Other Payments**

While you are disabled, the amount of benefit you receive from the plan will be reduced by other income benefits you are eligible to receive from other sources. This includes benefits to which you or your family are eligible or that are paid to you, your family, or a third party on your behalf via any:

- Workers’ Compensation Law, the Jones Act, occupational disease law, Railroad Retirement act or similar governmental compulsory benefit act or law with similar intent;
- governmental law or program that provides disability or unemployment benefit as a result of your job;
- plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with Ryder or as a result of membership or association with any group, association, union, or other organization;
- individual insurance policy where the premium is wholly or partially paid by Ryder;
- group insurance benefits; or
• disability and/or retirement benefits you, your spouse and/or children are eligible to receive under:
  - the United States Social Security Act;
  - the Canada Pension Plan, the Quebec Pension Plan; or
  - any other similar plan or act;
• the amount of benefits you receive under the Sponsor’s Retirement Plan as follows:
  - the amount of any Disability Benefits under a Retirement Plan, or Retirement Benefits under a Retirement Plan you voluntarily elect to receive as retirement payment under Ryder’s Retirement Plan; and
  - the amount you receive as retirement payments when you reach the later of age 62, or normal retirement age as defined in Ryder’s plan;
  - the amount of earnings you earn or receive from any form of employment including severance; and
  - any amount you receive from any formal or informal sick leave or salary continuation plan(s).

Other Income Benefits, except retirement benefits, which may be payable as a result of the same Disability for which a benefit is paid.

The total benefit payable to you on a monthly basis (including all benefits provided under the plan) will not exceed 100% of your disability earnings.

**Social Security and LTD Benefits**
You are required to apply for Social Security disability benefits and any other disability income you may be eligible to receive as a result of your disability. If your initial application for Social Security is denied, you are required to follow the process established by the Social Security Administration to reconsider the denial and if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals. For information and assistance, contact the Insurance carrier. If you fail to apply for Social Security or complete the appeals process, your LTD benefits will be reduced by the estimated Social Security benefit that might have been available.

**Maximum Benefit Period**
The period of time LTD benefits are payable is called the maximum benefit period. Once you reach the maximum benefit period, no further LTD payments will be made. How long benefits continue generally depends on the plan you elect and your age when your disability begins.

**Basic LTD Coverage**
The maximum benefit under the Basic LTD Plan is 24 months.

**Additional 50% and 60% LTD Coverage – Non-Salaried Employees**

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Benefit Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 61</td>
<td>60 months</td>
</tr>
<tr>
<td>61</td>
<td>48 months</td>
</tr>
<tr>
<td>62</td>
<td>42 months</td>
</tr>
<tr>
<td>63</td>
<td>36 months</td>
</tr>
<tr>
<td>64</td>
<td>30 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>
**Additional 50% and 60% LTD Coverage – Salaried Employees**

The maximum period for LTD benefits depends on the age at which you become disabled and your normal retirement age:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Benefit Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 60</td>
<td>To age 65, but not less than 5 years</td>
</tr>
<tr>
<td>60</td>
<td>60 months</td>
</tr>
<tr>
<td>61</td>
<td>48 months</td>
</tr>
<tr>
<td>62</td>
<td>42 months</td>
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<td>63</td>
<td>36 months</td>
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<td>64</td>
<td>30 months</td>
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<td>24 months</td>
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<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

**Combined Limit for Disabilities for Mental Illness, Substance Abuse or Non-Verifiable Symptoms**

Disabilities due to sickness or injury, which are primarily due to mental illness, substance abuse, and non-verifiable symptoms, have a limited pay period of up to 24 months combined.

A mental illness means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) regardless of the underlying cause of the Mental Illness. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency.

**Rehabilitation Incentive Benefits**

The LTD plan supports disabled employees by providing an opportunity to be evaluated for rehabilitation. Rehabilitation is a process of working together to plan, adapt, and put into use options and services to meet your return-to-work needs. A rehabilitation program may include:

- physical therapy;
- occupational therapy;
- work hardening programs overseen by a physical therapist;
- functional capacity evaluations;
- psychological and vocational counseling;
- rehabilitative employment; and
- vocational rehabilitation services.

If you are eligible for a Rehabilitation Incentive Benefit, your monthly benefit percentage (40%, 50%, or 60%) will increase by 10%. The increased benefit will begin on the first day of the month after the insurance carrier receives written proof of your full participation in the Rehabilitation Program.

The Rehabilitation Incentive Benefit will cease, and your benefits will be reduced back to the elected coverage percentage, when you are no longer fully participating in the Rehabilitation Program approved by the insurance carrier or when the Rehabilitation Program ends.

**Workplace Modification Benefit**

Your rehabilitative employment may involve a change in your work environment or the way a job is performed. The insurance carrier will reimburse Ryder for reasonable modifications to accommodate your disability and enable you to return to active full-time employment. This benefit is available if:

- your disability is covered by the Ryder LTD plan;
- Ryder agrees to make modifications to your workplace to accommodate your return to work and performance of the essential duties of your job; and
- the insurance carrier approves the proposed modifications.
Conversion Privilege
When you become ineligible for LTD coverage or you leave the Company, you may convert your coverage to an individual policy if:

- your employment ends for a reason other than retirement;
- you are no longer eligible for coverage and you have been insured under this plan for at least 12 consecutive months; and
- a disability is not preventing you from performing the duties of your occupation.

You must elect to convert your policy within 31 days of your date of termination of coverage. Contact the insurance carrier noted in the Administrative Information section of this book for the appropriate conversion application.

You are not eligible to apply for coverage under this conversion policy if:

- you are or become insured under another group long-term disability plan within 31 days after your employment ends;
- you are disabled under the terms of the plan;
- you recover from a disability and do not return to work for your employer;
- you are on a leave of absence;
- your coverage under the plan ends for any of the following reasons:
  - the plan terminates;
  - the plan is changed to exclude the group of employees to which you belong;
  - you end your working career or retire and receive payment from any Employer’s retirement plan;
  - you fail to pay the required premiums under this plan; or
  - you die.

Survivor Benefit
When the insurance carrier receives proof that you have died, they will pay your eligible survivor a lump sum benefit equal to 3 months of your monthly benefit if, on the date of your death your disability had continued for 6 or more consecutive months if you were an hourly employee; or you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. If you do not have an estate no payment will be made.

What the LTD Plan Does Not Cover
The plan does not cover any disabilities caused by, contributed to, or resulting from:

- intentionally self-inflicted injuries, while sane or insane;
- active participation in a riot;
- loss of a professional license, occupational license, or certification;
- the committing of, or attempting to commit, a felony or misdemeanor;
- cosmetic surgery unless such a surgery is in connection with an injury or sickness sustained while you are covered under this plan;
- a gender change including, but not limited to, any operation, drug therapy or any other procedure related to a gender change;
- a pre-existing condition;
- a disability due to war, declared or undeclared, or any act of war; or
- any period of disability during which you are incarcerated.
Long-Term Disability Plan Claims
How to Apply for LTD Benefits
All employees are provided Basic LTD Coverage, so there is no “application” for LTD. The insurance carrier may contact you for additional medical information at the time you transition to LTD from Short-Term Disability.

The insurance carrier may require you to provide:
- your earnings or income, including copies of your federal and state income tax returns;
- evidence that you are under the ongoing care of a physician;
- medical information, including X-ray films and copies of medical records including physical, mental, or diagnostic exams and treatment notes;
- names and addresses for all medical providers you have seen or consulted during the last three years, including physicians, hospitals, other facilities, and pharmacists;
- authorization to obtain and release your medical, employment, financial, and other information pertinent to your claim; and
- proof that you have applied for all other income benefits that are available to you.

The above information must be sent to the insurance carrier within 90 days from the day benefit payments would begin.

If no proof of loss is received by the insurance carrier by the time it is due, it will not affect the claim if it was not possible to give proof within the required time and proof is given as soon as possible, but not later than one year after it is due, unless you are not legally competent.

Proof of loss may be required throughout the duration of the claim.

Benefit Payments
All payments are made to you at the end of the month in which you are approved for LTD benefits. The insurance carrier may make an advance benefit payment based on their estimated duration of your disability. If any claim payment is due after your claim is terminated, it will be paid after you provide proof of loss to the insurance carrier.

Any payments at your death may be paid to your estate. If payment is owed to a minor who is not legally competent, the insurance carrier may pay up to $3,000 to any relative who is entitled to receive the benefit.

If a monthly benefit is payable for a period of less than one month, you will be provided a benefit of 1/30 of each day you were disabled.

If a Claim for Benefits is Denied
You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section for specific procedures to request a review of a denied claim.

Overpayments
The insurance carrier will notify you of any overpayment of a disability claim. Overpayments may result from:
- retroactive awards from other income benefits;
- failure to report or late notification of other income benefits or earned income;
- misstatement; or
- an error made by the insurance carrier in calculating your benefit.
LONG-TERM DISABILITY

**When Your LTD Benefits End**

Your monthly benefit will end on the earliest of the following:

- the date you fail to provide proof of continued disability or partial disability and regular attendance of a physical;
- the date you fail to cooperate in the administration of the claim and such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
- the date you refuse to be examined or evaluated at a reasonable intervals;
- the date you refuse to receive appropriate available treatment;
- the date you refuse a job with Ryder where workplace modifications or accommodations were made to allow you to perform the materials and substantial duties of the job;
- the date you refuse to work in your own occupation on a part-time basis, but choose not to;
- the date your current partial disability earnings exceed 80% of your indexed basic monthly earnings (these earnings will be averaged over three consecutive months);
- the date you are no longer disabled according to this plan;
- the end of the maximum benefit period; or
- the date you die.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>188</td>
</tr>
<tr>
<td>The Ryder System, Inc. Life Insurance Program</td>
<td>188</td>
</tr>
<tr>
<td>The Ryder System, Inc. AD&amp;D Program</td>
<td>188</td>
</tr>
<tr>
<td>Variations in Plan Provisions</td>
<td>188</td>
</tr>
<tr>
<td>Dual Coverage</td>
<td>188</td>
</tr>
<tr>
<td>The Ryder System, Inc. Life and AD&amp;D Programs</td>
<td>188</td>
</tr>
<tr>
<td>Life Insurance Highlights</td>
<td>188</td>
</tr>
<tr>
<td>AD&amp;D Highlights</td>
<td>188</td>
</tr>
<tr>
<td>Age Reductions</td>
<td>189</td>
</tr>
<tr>
<td>Employee Life</td>
<td>189</td>
</tr>
<tr>
<td>Spouse Life</td>
<td>189</td>
</tr>
<tr>
<td>Proof of Good Health</td>
<td>189</td>
</tr>
<tr>
<td>Naming a Beneficiary</td>
<td>189</td>
</tr>
<tr>
<td>Cost of Coverage</td>
<td>189</td>
</tr>
<tr>
<td>Imputed Income</td>
<td>190</td>
</tr>
<tr>
<td>Coverage Continuation through Portability or Conversion</td>
<td>190</td>
</tr>
<tr>
<td>AD&amp;D Benefit Schedule</td>
<td>192</td>
</tr>
<tr>
<td>Coma Benefit</td>
<td>192</td>
</tr>
<tr>
<td>Brain Damage Benefit</td>
<td>192</td>
</tr>
<tr>
<td>Exposure</td>
<td>192</td>
</tr>
<tr>
<td>Disappearance</td>
<td>192</td>
</tr>
<tr>
<td>Spouse Education /Training Benefit</td>
<td>192</td>
</tr>
<tr>
<td>Child Education Benefit</td>
<td>193</td>
</tr>
<tr>
<td>Child Care Benefit</td>
<td>193</td>
</tr>
<tr>
<td>If You Become Terminally Ill</td>
<td>193</td>
</tr>
<tr>
<td>Seat Belt/Safety Net Benefit</td>
<td>194</td>
</tr>
<tr>
<td>Motorcycle Helmet Benefit</td>
<td>194</td>
</tr>
<tr>
<td>What the Basic and Additional Employee and Dependent Life Insurance</td>
<td></td>
</tr>
<tr>
<td>Program Does Not Cover</td>
<td>194</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>194</td>
</tr>
<tr>
<td>Additional Life Insurance and Spouse Life Insurance</td>
<td>194</td>
</tr>
<tr>
<td>What the Employee and Dependent AD&amp;D Program Does Not Cover</td>
<td>194</td>
</tr>
<tr>
<td>Ryder Life Insurance and AD&amp;D Claims</td>
<td>195</td>
</tr>
<tr>
<td>How to Apply for Life Insurance and AD&amp;D Benefits</td>
<td>195</td>
</tr>
<tr>
<td>If a Claim for Benefits is Denied</td>
<td>195</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>196</td>
</tr>
</tbody>
</table>

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LIFE INSURANCE

Introduction
This section of your Summary Plan Description describes the Ryder System, Inc. Life Insurance Program and the Ryder System, Inc. Accidental Death and Dismemberment (AD&D) Program.

The Ryder System, Inc. Life Insurance Program
This program provides you financial protection if you or one of your dependents dies. The program includes basic life coverage. You are not required to contribute to the cost of premiums for basic life insurance. You also have the option to purchase additional life insurance for you, and dependent life insurance for your spouse, domestic partner, and/or child(ren).

The Ryder System, Inc. AD&D Program
This program provides you the option to purchase financial protection if you or a dependent are injured or die as the result of an accident.

Variations in Plan Provisions
There are some variations in coverage for employees who are covered by a collective bargaining agreement or valid written customer contract. Please refer to your collective bargaining agreement or call the Ryder BenefitsNow Service Center for information about your specific life insurance coverage.

Dual Coverage
Dual coverage is not permitted under the plan. A spouse is not eligible for coverage as a dependent if he or she is eligible as an employee. If any child qualifies as an eligible employee under the plan, he or she is not eligible to be covered as a dependent child under the Life and AD&D plans.

The Ryder System, Inc. Life and AD&D Programs
Life Insurance and AD&D are insured by Minnesota Life.

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Coverage Amount</th>
<th>Coverage paid by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Basic Life*</td>
<td>1 x pay to a maximum of $200,000</td>
<td>Ryder - you are not required to contribute to the cost of premiums</td>
</tr>
<tr>
<td>Employee Additional Life</td>
<td>1 x pay to 7 x pay to a combined maximum, (basic and additional), of $1,500,000</td>
<td>You</td>
</tr>
<tr>
<td>Spouse Life</td>
<td>Increments of $10,000 to a maximum of $200,000</td>
<td>You</td>
</tr>
<tr>
<td>Child(ren) Life**</td>
<td>$2,500, $5,000, $10,000</td>
<td>You</td>
</tr>
</tbody>
</table>

* Life Insurance coverage amounts for Officers may vary
** Birth to 6 months $1,000

AD&D Highlights

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Coverage Amount</th>
<th>Coverage paid by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee AD&amp;D</td>
<td>1 x to 8 x pay to a maximum of $1,500,000</td>
<td>You</td>
</tr>
</tbody>
</table>
| Spouse & Child(ren) | Spouse and child(ren) are provided a percentage of the employee’s coverage as follows:  
  - Spouse only: 60% of the employee benefit  
  - Child(ren) only: 20% of the employee benefit  
  - Spouse & Child(ren): 50% spouse, 15% child(ren) of the employee benefit amount  
  - Maximum: a maximum of $600,000 for spouse and $100,000 for child(ren). | You              |
**Age Reductions**

**Employee Life**
Life Insurance coverage is reduced by 35% when you reach age 70 and by 50% when you reach age 75. The reduction is taken from the amount of life insurance in effect before you reach the specified ages. The reduction will apply on January 1 immediately following your birthday.

**Spouse Life**
The amount of spouse life insurance will reduce by the same percentage and at the same ages as the employee life insurance reduction. Spouse age reductions are based on the spouse’s age, if available. If spouse’s age is not available, spouse reductions will be based on the employee’s age.

**Proof of Good Health**
If you apply for an increase in coverage, you must complete and submit an Evidence of Insurability Form. After the insurance carrier has approved the increase, new coverage elected during a period of annual enrollment will become effective the later of the January 1 immediately following the enrollment period, or the date required evidence of insurability is found satisfactory, if later. Coverage elections made within 31 days of a qualified status change will become effective the later of the date of application, or the date required evidence of insurability is found satisfactory.

If you don’t enroll on or before the date you become eligible for coverage and you later choose to enroll, or if you apply for more than the guaranteed issue amount, you will have to provide a completed Evidence of Insurability Form to the insurance carrier. Your coverage will begin on the first of the month following the insurance carrier’s approval.

In addition to the Evidence of Insurability Form, proof of good health may also include:
- a medical exam, if requested, and
- additional information such as physician’s statements.

The insurance carrier will pay for any additional information or tests needed to evaluate your application.

**Naming a Beneficiary**
It is important that you designate a Beneficiary so benefits can be paid to your survivor(s) if you die. If you die, your beneficiary will receive the total amount of your Life Insurance benefits. You are the beneficiary for any dependent Life Insurance you purchase.

You can designate a beneficiary by going online to **www.Ryder.BenefitsNow.com** or by calling the Ryder BenefitsNow Service Center at 800-280-2999.
- to receive the death benefit, a beneficiary must be living on the date of the insured’s death;
- if there is no eligible beneficiary, or if the insured does not name one, the death benefit will be paid according to the following order of priority:
  - your lawful spouse or domestic partner (includes domestic partner only if the domestic partner is registered through an affidavit on file with the policyholder); otherwise,
  - your natural or legally adopted child(ren), if living; otherwise,
  - your parents, if living; otherwise,
  - your brothers and sisters, if living; otherwise,
  - the personal representative of the insured’s estate.

**Cost of Coverage**
You are not required to contribute toward the cost of Basic Life insurance. You have the option of purchasing, at your own expense, AD&D and Additional Life Insurance coverage as well as AD&D and Life Insurance coverage for your spouse and children. Premium payments are made through payroll deductions. Your payments for this coverage are made with post-tax deductions from your pay.
Monthly premiums for Employee Additional Life are based on the employee’s attained age as of December 31 of the current plan year and the employee’s frozen annual earnings or base pay, whichever is greater, as of August 31 of the previous year.

Monthly premiums for Spouse Life insurance are based on the spouse’s attained age as of December 31 of the current plan year and the employee’s frozen annual earnings or base pay, whichever is greater. If the spouse’s date of birth is not on file, the employee’s age will be used to determine the Spouse Life insurance premium.

Premiums for newly hired or newly eligible employees are based on the employee’s attained age as of December 31 of the current year and the employee’s base pay.

Monthly premiums for Employee AD&D and Family AD&D are based on the employee’s frozen annual earnings or base pay whichever is greater, as of August 31. Premiums for newly hired or newly eligible employees are based on the employee’s base pay.

**Imputed Income**
According to federal tax law, up to the first $50,000 of employee basic life insurance is available tax-free. You pay taxes on the value (as determined by the IRS) of basic life insurance coverage over $50,000. The IRS determined value of coverage over $50,000 is commonly called imputed income and is added to your taxable pay.

You must contact the Ryder BenefitsNow Service Center to drop Spouse Life, Child Life and Family AD&D insurance coverage on ineligible dependents, within 30 days of the date they became ineligible. Benefits under the Life and AD&D insurance plans are not payable to you, if your dependents are deemed ineligible, regardless if you were paying the monthly premiums.

**Coverage Continuation through Portability or Conversion**
If your coverage ends, you may be eligible to continue some or all of your insurance coverage on a direct-billed basis under either the portability or conversion options of the group policy. The chart below compares these options. Generally speaking, portability premiums are slightly higher than active premium rates, but less than conversion rates. Rates increase with age and are subject to change. In order to continue coverage, you must complete an election form and send it to Minnesota Life within 31 days of the date the coverage would otherwise have terminated. All coverage continued through portability or conversion is continued without proof of good health. Contact Minnesota Life at 866-293-6047 to learn more about the portability and conversion options. You will be provided with rate information and an application upon request.
### Portability

- Basic and Additional Term Life and Voluntary AD&D coverage can be ported.
- Dependent coverage can only be ported if employee coverage is ported.

### Conversion

- All Basic and Additional Term Life coverage can be converted.
- AD&D coverage cannot be converted.
- Dependent coverage can only be ported if employee coverage is ported.

### Events allowing portability/conversion

- Coverage is lost due to:
  - Retirement
  - Termination of employment
  - Layoff or non-medical leave
  - Other loss of eligibility

- Coverage is lost due to:
  - Retirement
  - Termination of employment
  - Layoff or leave
  - Loss of eligibility
  - Termination of group policy
  - Medical leave

### Maximum age to elect

<table>
<thead>
<tr>
<th></th>
<th>Employee:</th>
<th>Spouse/DP:</th>
<th>Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portability</td>
<td>Age 69</td>
<td>Employee's age 69</td>
<td>Qualifying age or employee's age 69</td>
</tr>
<tr>
<td>Conversion</td>
<td>No maximum age</td>
<td>No minimum</td>
<td>No minimum</td>
</tr>
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</table>

### Minimum amount allowed

<table>
<thead>
<tr>
<th></th>
<th>Employee:</th>
<th>Spouse/DP:</th>
<th>Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portability</td>
<td>$10,000</td>
<td>No minimum</td>
<td>No minimum</td>
</tr>
<tr>
<td>Conversion</td>
<td>No minimum</td>
<td>No minimum</td>
<td>No minimum</td>
</tr>
</tbody>
</table>

### Maximum amount allowed

<table>
<thead>
<tr>
<th></th>
<th>Employee:</th>
<th>Spouse/DP:</th>
<th>Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portability</td>
<td>Previous amount in force to maximum of $750,000 (65% of previous amount to maximum of $487,500 if 65 or older)</td>
<td>Previous amount in force</td>
<td>Previous amount in force</td>
</tr>
<tr>
<td>Conversion</td>
<td>Previous amount in force unless conversion is due to policy or class termination. If conversion is due to policy/class termination, maximum is the lesser of $10,000 or the existing coverage amount less the new coverage amount available under group replacement policy.</td>
<td>No maximum</td>
<td>No maximum</td>
</tr>
</tbody>
</table>

### Age reductions

- Employee coverage reduces to 65% at age 65.
- No age reductions

### Termination age

<table>
<thead>
<tr>
<th></th>
<th>Employee:</th>
<th>Spouse/DP:</th>
<th>Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portability</td>
<td>Age 70</td>
<td>Employee's age 70</td>
<td>Qualifying age limit or employee's age 70</td>
</tr>
<tr>
<td>Conversion</td>
<td>No termination age</td>
<td>No termination age</td>
<td>No termination age</td>
</tr>
</tbody>
</table>
AD&D Benefit Schedule

If You Lose:  | You or Your Beneficiary(ies) Will Receive:
---|---
Life | 100%
Both hands or both feet or sight of both eyes | 100%
One hand and one foot | 100%
One foot and sight of one eye | 100%
One hand and sight of one eye | 100%
Speech and hearing in both ears | 100%
Quadriplegia | 100%
Triplegia | 75%
Paraplegia & Hemiplegia | 50%
Uniplegia | 25%
One hand or one foot | 50%
Sight of one eye | 50%
Speech or hearing | 50%
Thumb and index finger of the same hand | 25%

No more than 100% of your AD&D coverage will be paid for all losses resulting from one accident.

**Coma Benefit**
The plan will pay a benefit if an insured sustains an injury which, independent of all other causes, directly results in the insured being in a coma. The benefit will be paid at the rate of 1% per month for a maximum of 100 months.

The waiting period for the Coma Benefit is 31 days from the date you become comatose during which time no Coma Benefits are payable. Payment of this benefit will reduce the insured’s total AD&D benefit.

**Brain Damage Benefit**
The plan will pay 50% of the coverage, limited to brain damage that lasts at least 12 consecutive months or more and is permanent and irreversible and began within 60 days of injury.

**Exposure**
The plan will provide coverage if you sustain an injury and you are unavoidably exposed to the elements and suffer a loss as a result of the exposure.

**Disappearance**
The plan will presume an insured suffered loss of life due to an accident if an insured’s body is not found within one year of the accident in which the conveyance an insured was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked.

**Spouse Education /Training Benefit**
If the insurance carrier approves your claim and receives proof that you have died as the result of an injury, the plan will pay the actual cost incurred by your spouse or domestic partner for full-time enrollment in and accredited professional institution or an institution of vocational training for the purpose of preparing for full-time employment. Enrollment must occur within 365 days from the date of the accident that caused the injury. The plan will pay a maximum benefit of the lesser of:
- 10% of the paid AD&D benefit; or
- $20,000; or
- the costs incurred within the 30-month period following the date of the accident.
Child Education Benefit
If the insurance carrier approves your claim, the plan will pay your authorized representative, on behalf of each of your Qualified Children, an Education Benefit if you die as a result of injury. Benefits will be paid for each dependent, provided that at the time of the death, the dependent child is enrolled as a full-time student at an accredited post-secondary educational institution and is under age 23. The annual benefit payable will be paid for up to four consecutive years, at the lesser of:
- 10% of the paid AD&D benefit;
- $20,000;
- actual education costs incurred.

Child Care Benefit
If the insurance carrier approves your claim, the plan will pay your authorized representative an additional benefit for childcare if you sustain an injury, which causes your death.

Childcare expenses are those expenses that are for a service or supply furnished by a licensed childcare provider or facility for a dependent child’s care. No payment will be made for expenses incurred more than four years after the date of your death.

Charges will be reimbursed for each eligible dependent child (birth to age 13) up to a maximum of the lesser of:
- 5% of the paid AD&D benefit; or
- $7,500; or
- Incurred childcare expenses per year.

The total maximum benefit amount payable is $30,000, regardless of the number of children who qualify.

If You Become Terminally Ill
If you have a life expectancy of 12 months or less, you can request an accelerated death benefit from your basic and additional life insurance plans. Similarly, if your insured dependent has a life expectancy of 12 months or less, you can request an accelerated death benefit from the dependent life insurance plan.

To qualify for an accelerated benefit, you or your covered dependent must:
- be insured for at least $10,000;
- have not assigned ownership rights under the coverage;
- not have an irrevocable beneficiary; and
- be terminally ill (life expectancy of 12 months or less).

If you qualify, you may choose a full or a partial accelerated benefit. A partial benefit can only be requested if the remaining amount after the early payout is at least $25,000. If a partial benefit is chosen, coverage will remain in force and the amount remaining will be the full amount prior to the early payout minus the amount that was accelerated. If a full benefit is paid, the coverage will end. If your employee life coverage ends due to taking a full benefit, then any coverage on your dependents will also end at that time, though they will have the right to convert life insurance coverage to an individual policy.

An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:
- is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
- is required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.
The maximum amount that can be accelerated is $1 million.

**Seat Belt/Safety Net Benefit**
If you die from injuries sustained in a motor vehicle accident, a seat belt/safety net benefit will be paid in addition to the life insurance benefit if:
- the injury occurs where you were a passenger in a private passenger car or tractor trailer, were not intoxicated, impaired or under the influence of alcohol or drugs and
- you were wearing a seat belt or safety net at the time of the accident (as verified by a police accident report).

The seat belt/safety net benefit payable is the lesser of:
- one times your annual base pay, or
- $25,000.

**Motorcycle Helmet Benefit**
If you die from injuries sustained while driving or riding on a motorcycle, a motorcycle helmet benefit will be paid in addition to the life insurance benefit if:
- the injury occurs where you were a passenger or driving a registered motorcycle, were not intoxicated, impaired or under the influence of alcohol or drugs and
- you were wearing a motorcycle helmet at the time of the accident (as verified by a police accident report).

The Motorcycle Helmet benefit payable is the lesser of one times your annual base pay or $25,000.

**What the Basic and Additional Employee and Dependent Life Insurance Program Does Not Cover**

**Basic Life Insurance**
There are no exclusions applicable to Basic Life Insurance.

**Additional Life Insurance and Spouse Life Insurance**
Additional Life Insurance and Spouse Life Insurance are subject to suicide exclusion. No benefit is payable if death results from suicide, whether the individual is sane or insane, within two years of the effective date of coverage. Additionally, if death does result from suicide, whether the individual is sane or insane, within two years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage effective before the increase.

**What the Employee and Dependent AD&D Program Does Not Cover**
The AD&D program will not pay for losses resulting from: (This list is not intended to be all inclusive)
- suicide or attempted suicide, whether sane or insane; or
- intentionally self-inflicted injury or any attempt at self-inflicted injury, whether sane or insane; or
- the covered person’s participation in, or attempt to commit, a crime, assault or felony; or
- bodily or mental infirmity, illness or disease; or
- medical or surgical treatment including diagnostic procedures; or
- alcohol, drugs, poisons, gases or fumes, voluntarily taken, administered, absorbed, inhaled, ingested or injected; or
- bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury; or
- travel or flight in or on any vehicle used for aerial navigation including getting in, out, on, or off such vehicle, if the covered person is:
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
  -
• acting as a pilot or a crew member of any aircraft, unless riding as a passenger; or
• riding as a passenger in a non-chartered aircraft which is owned, leased, operated, or controlled by Ryder; or
• a student taking a flying lesson, unless riding as a passenger; or
• hang gliding; or
• parachuting, except when the insured has to make a parachute jump for self-preservation; or
• war or any act of war, whether declared or undeclared; or
• riot or civil insurrection; or
• service in the military of any nation.

Ryder Life Insurance and AD&D Claims
How to Apply for Life Insurance and AD&D Benefits
To initiate a claim for life or AD&D insurance benefits, contact the Ryder BenefitsNow Service Center at 800-280-2999 to report the death or accident. The Ryder BenefitsNow Service Center will initiate the claim with Minnesota Life. Minnesota Life will contact the beneficiary(ies) or the executor of the estate to request the necessary documents (i.e., certified copy of the death certificate, accident report, etc.).

Benefits are paid in a lump sum to your designated beneficiary. If more than one beneficiary is named, each will be paid an equal share or as specified on your beneficiary form. If any named beneficiary dies before you, his or her share will be divided equally among the named surviving beneficiaries. Benefit payments should be exempt from federal income taxes.

If a minor does not have a legal guardian, payment may be made to the person caring for and supporting him or her until a legal guardian is appointed.

If a Claim for Benefits is Denied
You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section for specific procedures to request a review of a denied claim.
**Business Travel Accident**
The Business Travel Accident Plan provides added protection for active full-time employees traveling on Company business except for regular commuting to and from work. The plan provides a death benefit in the case of accidental death, an accidental dismemberment benefit for the loss of limb (or use of limb), sight, speech or hearing or a lump sum disability benefit if permanently disabled as a result of an accident.

All active full-time employees are eligible for this coverage on their date of hire as follows:
- hourly and salaried employees are eligible for up to 2x base pay to a maximum of $300,000;
- drivers are eligible for up to 1x base pay to a maximum of $100,000. Coverage is applicable to drivers traveling on business during a bonafide trip other than in the course of their regular employment; and
- employees MS Level 14 and above are eligible for up to 3x base pay to a maximum of $1,500,000.

The plan provides the following benefits for spouse/domestic partner and dependent child(ren) of the employee groups above, if invited to travel at Ryder’s expense:
- Spouse/Domestic Partner - $25,000;
- Child(ren) - $5,000.
TABLE OF CONTENTS

Introduction ................................................................................................................................. 198
How The Program Works .......................................................................................................... 198
    How to Enroll ...................................................................................................................... 198
Covered Services ..................................................................................................................... 198
    Advice and Consultation ..................................................................................................... 198
    Consumer Protection .......................................................................................................... 198
    Debt Matters ....................................................................................................................... 199
    Defense of Civil Lawsuits ................................................................................................. 199
    Document Preparation ....................................................................................................... 199
    Family Law ......................................................................................................................... 200
    Immigration Assistance .................................................................................................... 201
    Insurance Matters .............................................................................................................. 201
    Personal Injury .................................................................................................................. 201
    Real Estate Matters .......................................................................................................... 201
    Traffic and Criminal Matters ........................................................................................... 202
    Wills and Estate Matters ................................................................................................... 202
What Is Not Covered - Exclusions .......................................................................................... 202
How the Hyatt Legal Plan Works ............................................................................................ 203
    How Services Are Paid ...................................................................................................... 203

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Introduction
This section describes how the Hyatt Legal Plan works.

How The Program Works
The Hyatt Legal Plan offers a national network of attorneys to provide certain personal legal services and counsel at no cost or reduced cost. Attorney fees for representation covered by the Plan are fully paid by the Plan when you see a Plan Attorney. You may choose coverage for yourself only, or for your entire family. With family coverage, your spouse and dependents are also eligible for most services.

The Plan offers advice and consultation on certain personal legal matters, as well as representation for many other personal legal matters such as uncontested separation and divorce, custody issues, tax audits, boundary disputes, etc.

How to Enroll
If you are a U. S. based employee, you may elect coverage in the Hyatt Legal Program during your new hire enrollment or at Annual Enrollment each fall. There are two coverage categories: Employee Only or Family Coverage, which provides coverage for your spouse and dependents under age 26.

Once you enroll, you cannot change or cancel your coverage until the next Annual Enrollment period. If you experience a Qualified Life Event during the year that impacts your dependent situation, you may change your coverage in a manner consistent with the Qualified Life Event (for example, if you are enrolled in individual coverage and marry, you may change your coverage to family). However, you cannot cancel the coverage because of a Qualified Life Event.

Covered Services

Advice and Consultation
- Office Consultation and Telephone Advice. This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Consumer Protection
- Consumer Protection Matters. This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.
- Personal Property Protection. This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.
- Small Claims Assistance. This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the
Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

**Debt Matters**
- **Debt Collection Defense.** This service provides Participants with an attorney’s services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.
- **Identity Theft Defense.** This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.
- **Tax Audits.** This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

**Defense of Civil Lawsuits**
- **Administrative Hearing Representation.** This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.
- **Civil Litigation Defense.** This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.
- **Incompetency Defense.** This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

**Document Preparation**
- **Affidavits.** This service covers preparation of any affidavit in which the Participant is the person making the statement.
- **Deeds.** This service covers the preparation of any deed for which the Participant is either the grantor or grantee.
- **Demand Letters.** This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers
mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

- **Document Review.** This service covers the review of any personal legal document of the Participant such as letters, leases or purchase agreements.

- **Elder Law Matters.** This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds for the parents when the Participant is either the grantor or grantee; and preparing promissory notes for the parents when the Participant is the payor or payee.

- **Mortgages.** This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

- **Promissory Notes.** This service covers the preparation of any promissory note for which the Participant is the payor or payee.

**Family Law**

- **Adoption and Legitimization (Contested and Uncontested).** This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse. Legitimization of a child for the Plan Member and spouse, including reformation of a birth certificate, is also covered.

- **Divorce, Dissolution and Annulment (Uncontested).** This service is available to the Plan Member only, not to a spouse or dependents, and only applies as long as the spouse does not hire an attorney or file a responsive pleading that contests any portion of the case. This service includes preparing and filing all necessary pleadings and affidavits, drafting settlement or separation agreements and representation at an uncontested hearing. If a case is contested, the Plan Member must pay all legal fees. This service cannot be used as a “credit” toward a contested case. This service does not include disputes that arise after a decree is issued.

- **Name Change.** This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

- **Prenuptial Agreement.** This service covers representation of the Plan Member and includes negotiation, preparation, review and execution of a Prenuptial Agreement between the Plan Member and his or her fiancé/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiancé/partner must have separate counsel or waive his/her right to representation.

- **Protection from Domestic Violence.** This service covers the Plan Member only, not the spouse or dependents, as the victim of domestic violence. It provides the Plan Member with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action or representation for the offender.

- **Uncontested Change or Establishment of Custody Order.** This service is available to the Plan Member and spouse, and covers preparation of petitions, consent forms and waivers, and representation at any court hearings provided all parties are in agreement to establish or modify a child custody order.

- **Uncontested Guardianship or Conservatorship.** This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, the Plan Member or spouse must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, any
annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

**Immigration Assistance**

- This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

**Insurance Matters**

- Insurance Claims. This service provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided the carrier is not affiliated with the Plan Member's Sponsor or Employer. Litigation of coverage issues is included. Litigation of damages is not included.

**Personal Injury**

- Personal Injury (25% Network Maximum). Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

**Real Estate Matters**

- Boundary or Title Disputes (Primary Residence). This service covers negotiations and litigation arising from boundary or real property title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

- Eviction and Tenant Problems (Primary Residence - Tenant Only). This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

- Home Equity Loans (Primary Residence). This service covers the review or preparation of a home equity loan on the Participant's primary residence.

- Property Tax Assessment (Primary Residence). This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

- Refinancing of Home (Primary Residence). This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage, and deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, or property that is held for any rental, business, investment or income purpose.

- Sale or Purchase of Home (Primary Residence). This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.
Security Deposit Assistance (Primary Residence – Tenant only). This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant’s residential landlord for the Participant’s primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. This service does not include the Plan Attorney’s attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Zoning Applications. This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant’s primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

Expungement. Where permitted by law, this service covers the filing of a petition and appearance at any necessary hearing to expunge convictions from a Participant’s criminal record.

Juvenile Court Defense. This service covers the defense of a Participant and a Participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Plan Member only, including services for Parental Responsibility.

Restoration of Driving Privileges. This service covers the Participant with representation in proceedings to restore the Participant's driving license.

Traffic Ticket Defense (No DUI). This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Wills and Estate Matters

Living Wills. This service covers the preparation of a living will for the Participant.

Powers of Attorney. This service covers the preparation of any power of attorney when the Participant is granting the power.

Probate (10% Network Discount). Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney’s normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Trusts. This service covers the preparation of revocable and irrevocable trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Wills and Codicils. This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

What Is Not Covered - Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment related matters, including Company and statutory benefits;
- Matters involving Company, MetLife and affiliates, and Plan Attorneys;
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents;
- Appeals and class actions;
- Farm matters, business or investment matters, matters involving property held for investment or rentals, or issues when the Participant is the landlord;
- Patent, trademark and copyright matters;
- Costs or fines;
- Frivolous or unethical matters;
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits.

**How the Hyatt Legal Plan Works**

To use the plan, Participants should log on to [www.legalplans.com](http://www.legalplans.com) or call the Hyatt Legal Plans’ Client Service Center at 800-821-6400, Monday through Friday, from 8:00 a.m. to 7:00 p.m. Eastern time.

If you use Hyatt's web site at [www.legalplans.com](http://www.legalplans.com), click "Members Log In."

If you call the Client Service Center, the Client Service Representative who answers your call will:

- verify your eligibility for services;
- make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- give you a Case Number that is similar to a claim number (you will need a new Case Number for each new case you have);
- give you the telephone number of the Plan Attorney most convenient to you; and
- answer any questions you have about your Legal Plan.

Then call the Plan Attorney and identify yourself as a legal plan member referred to them by Hyatt Legal Plans. You should request an appointment for a consultation. You should be prepared to give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. Evening and Saturday appointments are available. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys’ fees based on a set fee schedule.

**How Services Are Paid**

The legal plan offers a national network of attorneys to provide certain services and counsel at little or no cost.

- **In-Network:** When you use a Hyatt Legal Plan attorney, attorney fees for covered services are paid in full, and there are no claim forms to file.
- **Out-of-Network:** You may choose an attorney who is not part of the Hyatt network. If you choose an out-of-network attorney, you may be reimbursed according to a set fee schedule.
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.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

THIS SECTION OF THE BENEFITS SUMMARY CONSTITUTES PART OF A PROSPECTUS COVERING SECURITIES THAT HAVE BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933.
Introduction
Ryder System, Inc. (also known as “Ryder” or the “Company”) established the Ryder System, Inc. 401(k) Savings Plan (the “401(k) Plan”) effective January 1, 1993. The 401(k) Plan offers you a valuable, tax-advantaged savings tool to invest for your future financial security. The combination of convenient pre-tax and post-tax contributions, Company contributions and a variety of investment choices makes the 401(k) Plan an excellent long-term savings vehicle.

Note: employees of Ryder Puerto Rico, Inc. are eligible to participate in the Ryder Puerto Rico, Inc. Employees’ Savings Plan. A summary of that plan will be sent under separate cover to employees working in Puerto Rico. The information contained in this section applies to employees working and residing in the United States only.

Eligibility
You are eligible to participate in the 401(k) Plan on your first day of employment with Ryder if you are an employee of Ryder System, Inc. or any of its subsidiaries or affiliates that have elected to offer the 401(k) Plan to certain employee groups.

You are eligible to receive Company contributions on the first of the month after you have completed one year of service in which you have:
- worked at least 1,000 hours, and
- attained age 21

You may not participate in the 401(k) Plan if you are (1) designated by Ryder as an independent contractor and not on Ryder’s U.S. payroll (regardless of your employment status under the law) at the time of any determination, or (2) being paid by or through an employee leasing company or other third party agency.

Union Employees
If you work under the provisions of a collective bargaining agreement, you are eligible to participate only if your agreement specifically provides for benefits under the 401(k) Plan.

Re-employment
If you leave the Company after meeting the eligibility requirements of the 401(k) Plan and are later rehired, you will be immediately eligible to re-enroll in the 401(k) Plan.

If you leave the Company before you are fully vested in the 401(k) Plan and you are re-employed by the Company within 5 years following the date of your termination, forfeited Company contributions will be restored to your account. You must notify the Ryder Retirement Service Center in writing of your re-employment.

If you were fully vested in the 401(k) Plan when you left Ryder, all future Company contributions will be fully vested as well.

Enrollment
You will receive an enrollment package shortly after your hire date. Once you receive 401(k) Plan materials, you may enroll in the 401(k) Plan at any time. Your contributions to the 401(k) Plan will begin as soon as administratively possible.

You can enroll in the 401(k) Plan:
- Online at http://netbenefits.fidelity.com, or
- By calling the Ryder Retirement Service Center at 800-373-7300.
When you enroll in the 401(k) Plan, you must decide:

- The percentage of your annual earnings you want to save or contribute to the 401(k), and
- How you want to invest your contributions.

**Break in Service**
You have a break in service if you don’t complete at least one hour of employment in a specific one-year period.

If your break in service is because of your pregnancy, the birth of your child, the placement of a child for adoption by you, or for you to care for the child right after the birth or placement for adoption, you will avoid a break in service:

- In the year in which your break begins, or in the following year, if needed to prevent a break in service, for purposes of determining your eligibility to receive Company contributions,
- In the two years beginning with the date your break begins, for purposes of determining your vested interest in company contributions.

If your break in service is due to an unpaid FMLA leave, you will receive credit for the period you are on leave, only for purposes of determining if you have a break in service.

If you have 5 consecutive breaks-in-service, then once again become eligible to participate in the 401(k) Plan, your service before the breaks will not be counted for purposes of determining your vested interest in Company contributions if (1) you had not made pre-tax contributions to the 401(k), and (2) you had no vested interest in any Company contributions that may have been made on your behalf prior to your breaks.

**Your Personal Identification Number (PIN)**
To access account information online or over the phone, you will need a personal identification number (PIN). To create your PIN:

- Go to [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com) and click on “Access My Benefits” in the NetBenefits box. Click on “New User Registration” and follow the instructions, or
- Call the Ryder Retirement Service Center at 800-373-7300 and follow the instructions.

**When Participation Begins**
You become a participant on the first day you meet eligibility requirements or enroll in the 401(k) Plan.

**Naming a Beneficiary**
When you enroll in the 401(k) Plan, you must name a beneficiary. Your beneficiary is the person who will receive any account balance remaining at the time of your death. Your beneficiary can be a trust, estate, charity, or a person.

- If you are married, according to IRS regulations, your spouse is the named beneficiary.
- To name a beneficiary other than your spouse, you and your spouse will have to complete a beneficiary designation form. A notary must witness your spouse’s signature consenting to the change.
- If you do not have a completed form on file or your beneficiary dies before you, your account balance will be paid to the beneficiary (or beneficiaries) you named under the Company’s group life insurance plan. If you did not name beneficiaries under that program or if he, she or they die before you, your account balance will be paid as follows:
  - to your spouse,
  - if no spouse exists, to your children,
  - if no children exist, to your estate.
Making Changes During the Year
You may increase, decrease or stop your contributions to the 401(k) Plan at any time. You may also change how your account is invested at any time. This includes changing the way future savings are invested or reallocating or transferring funds already in your account.

To change your contributions or change how your contributions are invested, call the Ryder Retirement Service Center at 800-373-7300 or go online to http://netbenefits.fidelity.com. Investment changes received by 4:00 p.m. Eastern Time will be effective at the closing price on that business day.

Changes you make to your contribution rate become effective as soon as administratively possible. You will receive a written confirmation statement within three to five business days of making a change to your contributions or investment mix.

Plan Highlights

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment</strong></td>
<td>Automatic once you are eligible.</td>
</tr>
<tr>
<td><strong>Your Contributions</strong></td>
<td>You are immediately eligible to contribute on either a pre-tax or post-tax basis, to a combined maximum of 50% of your annual earnings. The maximum the IRS allows you to contribute on a pre-tax basis is $17,500 in 2013. Employees defined by the IRS as “highly compensated employees” are limited to a combined pre-tax and post-tax contribution maximum of 6%.</td>
</tr>
<tr>
<td><strong>Catch-up Contributions</strong></td>
<td>If you are age 50 or over, you can contribute up to an additional $5,500 in pre-tax dollars after you have reached the IRS maximum of $17,500 in 2013.</td>
</tr>
<tr>
<td><strong>Investment options</strong></td>
<td>You can invest your account among the investment funds offered.</td>
</tr>
<tr>
<td><strong>Vesting</strong></td>
<td>You are always 100% vested in your contributions. You become 100% vested in any Company contributions when you complete 5 years of service with the Company</td>
</tr>
</tbody>
</table>
| **Loans**                      | You may have up to two outstanding loans limited to:  
  - One General Purpose Loan- maximum term up to 5 years, and/or  
  - One Home Purchase Loan- maximum term up to 15 years. |
| **Withdrawals**                | You may withdraw money from your account. Special rules apply. |

How the 401(k) Plan Works
- The 401(k) Plan lets you contribute part of your annual earnings (your pay) – from 1% to 50% on a combined pre-tax or post-tax basis into the 401(k) Plan. Pre-tax contributions are subject to annual IRS limits. The percentage of your pay you decide to contribute is automatically deducted from your pay each pay period. Highly compensated employees may be limited in the amount they can contribute to the 401(k) Plan and may receive a refund of a portion of their annual contribution election if the 401(k) Plan does not meet IRS discrimination testing guidelines.
• The amount of your pre-tax contributions to the 401(k) Plan is not taxed as income. Because your contribution is made before income taxes are calculated, your taxable pay is less, which reduces your taxes.
• The amount of your post-tax contributions is taxed as income. Because your contribution is made after taxes are calculated, your taxable pay is not reduced by the amount of your contribution, which does not reduce taxes the way that pre-tax contributions do.
• You won’t owe federal income tax on your pre-tax contributions or their earnings until they are withdrawn from the 401(k) Plan. Your earnings are allowed to remain in your account and grow on a tax-deferred basis until you take your money out of the 401(k) Plan.
• You won’t owe federal income tax on your post-tax contributions, even when they are withdrawn from the 401(k) Plan. However, any earnings made on your post-tax contributions are subject to federal income tax when they are withdrawn from the 401(k) Plan. Your earnings are allowed to remain in your account and grow on a tax-deferred basis until you withdraw them from the 401(k) Plan.
• You can borrow up to 50% of your vested account balance, up to a maximum of $50,000, reduced by the difference between your highest balance over the last 12 months of any outstanding loan against your account and the balance of any outstanding loan on the date you make this loan. The interest you pay goes back into your account, so you pay yourself back rather than a bank or credit company. Interest rates for loans are based on the prime rate in effect when you request a loan. You are limited to a maximum of two outstanding loans, a general-purpose loan and a loan to purchase or construct your primary residence. You may not have two general-purpose loans.
• You can tailor your investment strategy to meet your financial goals and risk preference. The 401(k) Plan has several investment options to help you build your retirement savings. These funds represent a range of investment categories – stocks, bonds and money market securities.
• Your investment earnings in the 401(k) Plan grow tax-free until your retirement. However, you must pay taxes when the earnings are paid out, unless you transfer your account to an eligible rollover plan (defined below under the section entitled “Rollovers”).

Saving With Tax-Deferred Contributions
Your pre-tax contributions are deducted from your pay before federal and most state and local income taxes are calculated. Your pre-tax contributions are subject to Social Security and certain other employment taxes.

Your post-tax contributions are deducted from your pay after federal, Social Security, and most state and local income taxes are calculated.

Limits on Contributions
Current federal laws limit the amount you can contribute on a pre-tax basis to the 401(k) Plan.

• Pre-tax contribution limit – This limit on your pre-tax contributions may be adjusted each year to keep pace with the cost of living. For 2013, the limit is $17,500, excluding catch-up contributions. This limit includes all pre-tax contributions that you make to all qualified plans in which you participate during any given taxable (usually calendar) year.
• Highly compensated employee limit – The IRS rules also limit the amount that highly compensated employees can contribute to the 401(k) Plan. These amounts are determined as a result of the application of IRS discrimination tests. If you earned $115,000 or more in 2012, you are considered a highly compensated employee for the 2013 plan year. As a result, the 401(k) Plan may return to you amounts you deferred that exceed the amounts permitted, as determined under these tests.
• The Section 415 limit – This is a limit on the total annual amount of employee contributions and Company contributions that may be made to the 401(k) Plan. The limit is $51,000, excluding
catch-up contributions. This limit may change periodically. If your combined contributions exceed this limit, you’ll be notified.

- **Compensation limit** – Under IRS rules, an employee may not make pre-tax contributions or receive Company contributions on pay over $255,000 in 2013. This limit may be adjusted from time to time to reflect changes in the cost of living.

- **Catch-up contribution limit** - If you are age 50 or over, you can contribute up to an additional $5,500 in pre-tax dollars after you have reached the IRS maximum of $17,500 (or if you have reached any applicable Plan limits, if lower). If your combined contributions exceed this limit, you’ll be notified.

**Impact on Your W-2**

Your pre-tax contributions to the 401(k) Plan reduce your taxable income and are not reported on your W-2 earnings statement. However, they are included when determining your Social Security taxes and other Ryder benefits.

**Company Contributions**

Any Company Contributions, Company Matching Contributions or Company Discretionary Contributions (collectively “Company contributions”) are subject to the 401(k) Plan’s eligibility provision of a one-year waiting period in which you have worked 1,000 hours and have attained age 21. Company contributions, when applicable, are deposited into the same investment options you select for your own contributions. Company contributions are made to individuals based on their assigned business segment, generally defined as either Hourly and Salaried Employees, or Field Hourly, Driver and Warehouse Employees.

**Company contributions: Hourly and Salaried Employees** (generally defined as all employees other than those specifically described below under Field Hourly, Driver and Warehouse Employees, and including employees who work under the provisions of a collective bargaining agreement which agreement specifically includes benefits under the 401(k) Plan).

- **Company Contribution**: whether or not you make your own pre-tax contributions to the 401(k) Plan, Ryder will contribute 3% of your eligible pay once you have met the eligibility requirements.

- **Company Matching Contribution**: if you contribute on a pre-tax basis to the 401(k) Plan, Ryder will match your contribution. Once you have met Ryder’s eligibility requirements, you are eligible for company match of 50% of your pre-tax contributions up to 5% of your eligible pay.

- **Discretionary Contribution**: Ryder, in its sole and absolute discretion, may make a discretionary contribution for a given year, based on a formula or other amount, that may be conditioned on the Company meeting certain specified performance goals, and are conditioned on the Participant contributing at least 2% of annual earnings on a pre-tax basis and being an active employee on the last day of the Plan Year.

The Employer contributions listed above shall apply exclusively to Hourly and Salaried Employees who were hired or re-employed on or after January 1, 2007, and those Hourly and Salaried Employees who were hired prior to January 1, 2007 and did not meet the eligibility requirements to be grandfathered in the Ryder System, Inc. Retirement Plan. Effective January 1, 2008, employees who were offered and made an irrevocable election in 2007 to continue to accrue benefits under the Ryder System, Inc. Retirement Plan are ineligible for Company Contributions and Company Matching Contributions, as described above. Eligible employees who elected to continue earning benefits under the Retirement Plan may be eligible for the Discretionary Contribution.

**Company contributions: Field Hourly, Driver and Warehouse Employees** (generally defined as hourly employees of Ryder’s Supply Chain business, including drivers, warehouse employees and hourly support service employees, and including employees who work under the provisions of a collective
bargaining agreement which agreement specifically includes benefits under the 401(k) Plan. The following describes the Company Contributions and Company Matching Contributions generally applicable to Field Hourly, Driver and Warehouse Employees. However, certain Field Hourly, Driver and Warehouse Employees who have joined Ryder as a result of an acquisition, or are employed at certain customer accounts described below, may not receive a Company Contribution and/or may receive a different Company Matching Contribution as specified below.

- **Company Contribution:** for each full year of employment, Ryder will contribute an amount equal to $400. The Company Contribution is credited to your account in monthly installments of $33, however, such monthly installment shall equal $35 for the months of November and December. Company contributions are credited whether or not you make your own pre-tax contributions to the 401(k) Plan. (Field Hourly, Driver and Warehouse employees who were employed with Total Logistic Control (TLC) and hired by Ryder on January 1, 2011 as part of the acquisition are not eligible to receive Company Contributions.)

- **Company Matching Contribution:** if you contribute on a pre-tax basis to the 401(k) Plan, Ryder will match your contribution. Once you have met Ryder’s eligibility requirements, you are eligible for company match of 100% of your pre-tax contributions that do not exceed $300, plus 50% of your pre-tax contributions that exceed $300 but do not exceed $1,100.

THE FOLLOWING FIELD HOURLY, DRIVER AND WAREHOUSE EMPLOYEES WILL RECEIVE AN ALTERNATE COMPANY MATCHING CONTRIBUTION AS FOLLOWS:

Field Hourly, Driver and Warehouse employees who were employed by Total Logistic Control (TLC), and hired by Ryder on January 1, 2011 as part of the acquisition will not receive a Company contribution. However, these employees will receive a Company matching contribution upon satisfaction of the eligibility requirements of 100% up to the first 4% of pre-tax contributions, plus 50% of the next 2% of pre-tax contributions. These employees will be deemed to have completed the one-year waiting period as of January 1, 2011 for purposes of receiving the Company matching contribution.

Field Hourly, Driver and Warehouse employees who were:

- employed by Scully Distribution Services and hired by Ryder on January 29, 2011 as part of the acquisition,

- hired by Ryder Integrated Logistics of California, LLC after this acquisition but before Ryder Integrated Logistics of California, LLC merged into its parent, Ryder Integrated Logistics, Inc. on July 1, 2011,


- hired into the Company’s Dedicated Contract Carriage (“DCC”) division on or after April 1, 2012, and who are employed to service a new customer account for a customer with a primary account location located in (i) Arizona, (ii) California, (iii) Washington, (iv) Oregon, (v) Utah, (vi) Idaho, or (vii) Nevada, or who were hired by the Company prior to April 1, 2012 and have been transferred on or after April 1, 2012 to service a customer account in any of the seven (7) the primary account locations noted above;
will not receive a Company Contribution. However, upon satisfaction of the eligibility waiting period, these employees will receive a Company Matching Contribution of 30% up to the first 5% of eligible pay.

**Vesting**

Vesting refers to the right to receive Company contributions credited to the 401(k) Plan. Once you are fully vested the Company contributions credited to your account are yours to keep, even if you leave Ryder. You are always 100% vested in your contributions as well as any rollover contributions. The vesting schedule is:

<table>
<thead>
<tr>
<th>Years of Vesting Service</th>
<th>Vested Interest in Company Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>0%</td>
</tr>
<tr>
<td>2 years</td>
<td>25%</td>
</tr>
<tr>
<td>3 years</td>
<td>50%</td>
</tr>
<tr>
<td>4 years</td>
<td>75%</td>
</tr>
<tr>
<td>5 years or more</td>
<td>100%</td>
</tr>
</tbody>
</table>

You have one year of vesting service for each year of employment you have with Ryder.

You are 100% vested in the Company contributions credited to your account when you:
- Complete at least 5 years of vesting service;
- Reach age 65 ("Normal Retirement Age");
- Become permanently disabled while employed by Ryder; or
- Die while employed by Ryder. If you die while absent from employment due to a qualified military leave, you will be considered to have died while employed.

If you leave the Company before retirement, you will forfeit any unvested portion of the Company’s contributions credited to your account. For example, if you leave the Company after 3 years of vesting service and your Company contributions and earnings are $800, you will receive $400 (50% of $800). However, if you return to employment within 5 years, the forfeited amount will be restored and you will be able to become vested in that amount through your re-employment.

If you separate from service and are later re-employed, the following rules apply:
- If you left with at least a partial vested interest in Company contributions or, if you had no vested interest in Company contributions but had made pre-tax contributions to the 401(k) Plan, the service you earned before the separation will be included in determining the vested interest in Company contributions made after you return.
- If you left with no vested interest in Company contributions, and you had not made pre-tax contributions to the 401(k) Plan, the service you earned before the separation will be included in determining the vested interest in Company contributions made after you return, only if you return within five years of your original separation.

All employees of Scully Transportation Services who were hired by Ryder Truck Rental, Inc. as of January 29, 2011 as part of the acquisition are credited with their service with Scully Transportation Services for vesting purposes. Similarly, all employees of Scully Distribution Services who were hired by Ryder Integrated Logistics of California as of January 29, 2011 as part of the acquisition are credited with their service with Scully Distribution Services for vesting purposes.

Field Hourly, Driver and Warehouse employees are always 100% vested in Company contributions and the first $300 of Company matching contributions.
All salaried and Field Hourly, Driver and Warehouse employees who were employed by Total Logistics Control and hired by Ryder on January 1, 2011 are fully vested in their accounts.

**Rollovers**

A rollover is a transfer of money from one eligible rollover plan to another. An “eligible rollover plan” is one that meets certain IRS requirements and is eligible for special tax advantages.

The 401(k) Plan both accepts, with the consent of the Retirement Committee, or its designee, rollovers from other eligible rollover plans and distributes amounts from the 401(k) Plan under the rollover rules.

Generally, an eligible rollover plan includes another qualified plan, an individual retirement account, an individual retirement annuity, an annuity plan described in section 403(a) of the Internal Revenue Code of 1986, as amended (the “Code”), an eligible deferred compensation plan described in section 457(b) of the Code or an annuity plan described in section 403(b) of the Code. You will continue to defer taxes on the amount you roll over. Also, rollover amounts are not subject to early withdrawal penalties.

Rollover contributions must be deposited to the 401(k) Plan within 60 days of the check date. If you miss this deadline, you will have to pay income tax and early withdrawal penalties on your distribution. Note that you may also have a rollover directly transferred from the eligible rollover plan into the 401(k) Plan.

**Plan Loans**

The purpose of the 401(k) Plan is to build a retirement fund. However, you may obtain a loan from your account balance. You pay a rate of interest equal to the prevailing prime rate at the time of your loan. You repay that interest back to your own account. As you repay the loan, the money is reinvested according to your most recent investment choices.

**Important Note:** You do not earn interest, dividends or capital gains on money outstanding on a loan you have taken from the 401(k) Plan.

**Loan terms include:**

- Only two loans may be outstanding at one time, one general-purpose and one loan for the purchase or construction of your primary residence. You may not have two general-purpose loans. You may borrow up to half of your vested balance to a maximum of the following: $50,000, minus the difference between your highest balance over the last 12 months of any outstanding loan against your account and the balance of any outstanding loan on the date you make this loan.
- The minimum amount you may borrow from your account is $1,000.
- Payments are made through regular post-tax payroll deductions.
- Your loan amount must be repaid within five years (or up to 15 years if the loan is used to buy or construct your primary residence).
- You may repay the entire loan balance in a single lump sum. There is no penalty for prepayment.
- Loans are not eligible for rollover.

**Loan Fees**

A one-time $50 processing fee will be charged to your account to cover costs for setting up and maintaining your loan. In addition, there is a $25 yearly maintenance fee for all existing loans. It is deducted quarterly, in the amount of $6.25 from your account. Fees are subject to change. Please review the Annual Fee Disclosure notice which summarizes all plan fees.

**Loan Payments**

Loan payments are usually made through payroll deductions on a post-tax basis. Deductions begin approximately 30 days after your loan is processed. If payroll deductions are not available to you, you will make monthly payments directly to the 401(k) Plan as instructed by the Ryder Retirement Service Center.
You must pay repayments by certified check, cashier’s check or money order. If you fail to make repayments when due, you will be deemed to have taken a distribution of your outstanding loan balance and will be taxed on such amount.

Loan payments are suspended during any unpaid FMLA or military leave.

**Loan Balance After Termination**
If you leave the Company before your loan is repaid, you may:
- Repay the outstanding loan balance in full;
- Take a distribution from the 401(k) Plan. Your distribution may be reduced by the amount of your outstanding loan, based on the decision of the Retirement Committee. Your outstanding loan balance will be reported as taxable income; or
- Defer your distribution and continue monthly payments using payment coupons provided by the Ryder Retirement Service Center or elect monthly electronic fund transfers from your financial institution until the loan is repaid.

**In-Service Withdrawals**
You may withdraw money from your account if:
- You are at least age 59½;
- You have an extreme financial hardship as defined by the IRS;
- You have made post-tax contributions to the 401(k) Plan; or
- You have rolled an account balance from an eligible rollover plan.

**Withdrawals After Age 59½**
Once you reach age 59½, you may withdraw all or part of the vested portion of your account balance – even if you continue to work for Ryder and make pre-tax contributions to the 401(k) Plan. Withdrawals after you reach age 59½ are taxed as ordinary income but are not subject to an early withdrawal penalty. You may make up to 2 withdrawals in any calendar year. To request a withdrawal, call the Ryder Retirement Service Center to obtain a distribution package.

**Hardship Withdrawals**
You may request a withdrawal in the event of a financial hardship. Employee pre-tax contributions and the vested portion of Company Contributions, Matching Contributions and Discretionary Contributions are available for withdrawal. Hardship withdrawals are permitted based on IRS safe harbor guidelines, including:
- Purchase of your primary residence;
- Preventing eviction from, or foreclosure on, your primary residence;
- Tuition and related fees for post-secondary education for you, your spouse, your children, or your other dependents;
- Extraordinary tax deductible medical expenses incurred by you, your spouse or your dependents, which are not covered by your medical insurance plan;
- Burial or funeral expenses for your deceased parent, spouse, child or your other dependents; and
- Repair of damage to your primary residence.

**Restrictions on Your Account**
If you receive a hardship withdrawal, you cannot make any contributions to the 401(k) Plan, the Ryder System, Inc. Employee Stock Purchase Plan (the “Stock Purchase Plan”), any deferred compensation plans and/or qualified or nonqualified stock options plans available to you for the 6-month period following the date of your hardship withdrawal.

**Evidence of Hardship**
If you are eligible for a loan under the 401(k) Plan, you must exhaust your loan options before any hardship withdrawal request can be granted. In addition, all in-service withdrawal options must be
exhausted. A hardship withdrawal must include a statement of need and evidence of the hardship. For example, medical bills or housing contracts can be accepted as evidence.

**Applying for a Hardship Withdrawal**
Call the Ryder Retirement Service Center to request a hardship withdrawal package. Return the completed package to the Ryder Retirement Service Center as directed.

The Ryder Retirement Service Center will review the information you submit and make a determination of a hardship withdrawal based on IRS guidelines. You will receive notification of the 401(k) Plan’s determination within 7-10 business days of receipt of your request.

**Tax Penalties on Hardship Withdrawals**
The Ryder Retirement Service Center is required to withhold 10% of your distribution for federal withholding tax. The money you receive from a hardship withdrawal is taxable income to you. Unless you are at least age 59½ or are making the withdrawal to pay tax-deductible medical expenses, you are also required to pay a 10% tax penalty in addition to other federal, state and local income taxes that may be due.

IRS rules also require a six-month suspension of your ability to save through all employer plans that require elective deferrals or employee contributions. This means you cannot save in the 401(k) Plan, the Stock Purchase Plan or any deferred compensation plan or any qualified or non-qualified stock option plan available to you. You can however, continue to contribute to the Health Care and Dependent Care Flexible Spending Accounts.

**Post-Tax Withdrawals**
You can withdraw any post-tax contributions that you may have made to the 401(k) Plan and any associated earnings for any reason at any time, without penalty. You do not have to pay income taxes on the post-tax contributions that you may have made. However, you will have to pay income tax on any earnings that are withdrawn.

**Rollover Withdrawals**
If you have previously rolled an account balance to the 401(k) Plan from an eligible rollover plan, you can withdraw the funds and any associated earnings for any reason at any time, without penalty. You will have to pay income taxes on the withdrawn amount (not including any post-tax contributions included in your account) at the time of distribution.

**Investment Options**
The 401(k) Plan has several investment options to help you build your retirement savings.

Descriptions of each of the funds are available in the 401(k) Plan enrollment materials, from the Ryder Retirement Service Center at 800-373-7300 or online at [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com). Fund prospectuses are also available through the Ryder Retirement Service Center.

**Accessing Account Information**
Your account is valued at the close of each business day. Keeping tabs on the performance of your investments is easy. Here are a few simple ways to access information about your account or to change your investment mix:

- After you enroll, you will receive quarterly statements showing account activity for the quarter. These statements include information about your account balance, contributions, investment changes, gains, and losses. The statements are mailed to your home address directly from the Ryder Retirement Service Center approximately 30 days after the close of the calendar quarter. Once you access your account activity online, the system will automatically set your online preference to suppress the mailed statements.
You can call the Ryder Retirement Service Center at 800-373-7300 to receive assistance with your account. You’ll need your Social Security number and Personal Identification Number (PIN) to access your account information.

To access information about your account 24-hours a day, 7 days a week, you can go online to http://netbenefits.fidelity.com. You may also make fund transfers, change payroll deductions, initiate a loan, and change your contribution election via this website. You’ll need your Social Security number and PIN to access your account. You may change your PIN whenever you want.

You Control Your Account
You should evaluate the investment options available under the 401(k) Plan in the same way you would evaluate any investment to determine whether you are comfortable with the investment risk and expected rate of return. The 401(k) Plan is intended to constitute a plan under Section 401 of the Employee Retirement Income Security Act of 1974 (“ERISA”) and Title 29 of the Code of Federal Regulations Sections 2550.404c-1, and the fiduciaries of the 401(k) Plan will be relieved of liability for any losses which are the direct and necessary result of investment instructions given by you or your beneficiaries.

You are urged to read the prospectus or other literature of each investment fund prior to making any investment decision.

To help protect the interests of all shareholders, the prospectus for Plan mutual funds states that the fund may temporarily or permanently terminate the exchange privilege of any investor who has a pattern of short-term or excessive trading or whose trading has been or may be disruptive to the fund. For these purposes, the Plan may consider an investor’s trading history in the future or other mutual funds, and accounts under common ownership or control. In addition, each prospectus states that the fund may refuse any exchange purchase (into the fund) for any reason. An exchange is defined in the prospectus as “the redemption of all or a portion of the shares of one fund and the purchase of shares of another fund.”

Confidentiality
Information regarding your account is subject to confidentiality requirements imposed on those who provide services to the 401(k) Plan. Fidelity is the recordkeeper and provides day-to-day administration for the 401(k) Plan.

Administrative Expenses
You are responsible for certain fees that are associated with the management of the 401(k) Plan, which are paid by the participants in the 401(k) Plan, including:

- Ryder Common Stock Fund trustee fee;
- Loan fees (if applicable to your account); and
- Other occasional administrative fees associated with satisfying fiduciary obligations of the 401(k) Plan, including 401(k) Plan communications.

These fees are deducted from your account and are reflected on your quarterly statement.

Distributions
The full value of your 401(k) Plan account is payable when:

- You retire at age 65;
- You become disabled, if you are approved for Social Security disability benefits;
- You die, and the distribution is payable to your surviving spouse or other beneficiary; or
- You terminate employment prior to age 65, death, or disability.

If, at the time you request a distribution, your vested account balance is:

- $1,000 or less – you are required to receive a single lump sum payment. You may roll over the distribution to another eligible rollover plan.
• **Greater than $1,000** – you may choose to receive payment from the 401(k) Plan immediately or wait and request payment at a later date. Your account will share in the investment gains or losses of the funds. You may change your investment mix at any time. However, 401(k) Plan payments must begin no later than April 1 following the calendar year that you reach age 70½.

**Non-Spouse Beneficiary Rollovers**
If a benefit from the 401(k) Plan becomes payable to a beneficiary of yours who is not your spouse, the beneficiary may roll over the benefit (through a direct rollover) to an individual retirement account or individual retirement annuity.

**Payment Options**
Your distribution will be in the form of a lump-sum distribution of your total account balance. Distributions from the Ryder Common Stock Fund can be made in shares instead of cash if your equity account has a balance greater than $500. Fractional shares of Ryder common stock will be paid in cash.

**When you Reach Age 70½**
Distributions from the 401(k) Plan must begin by April 1 following the calendar year in which you reach age 70½, or if later, the calendar year in which you retire from Ryder.

**Taxes**
The IRS has established guidelines for taxes on distributions from the 401(k) Plan. You may want to consult a tax advisor before receiving a distribution.

**Types of Taxes**
The following types of taxes can affect a distribution from the 401(k) Plan:
- Ordinary income tax;
- 10% penalty tax;
- 20% withholding tax; and
- 50% penalty tax.

**Ordinary Income Tax**
When you or your beneficiary receive a distribution from the 401(k) Plan, you will owe federal and, if applicable, state and local income taxes on the amount of your distribution unless you rollover to an eligible rollover plan.

**10% Penalty Tax**
The IRS imposes this early withdrawal tax on certain distributions and withdrawals. A 10% penalty tax will not apply if:
- A distribution is made to your beneficiary or estate upon your death.
- A distribution is made because you are totally and permanently disabled.
- A distribution to your spouse or dependent is required under the terms of a qualified domestic relations order (QDRO) issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the 401(k) Plan to your spouse, child, or other dependent. If a QDRO is received by the administrator, all or portions of your benefits may be used to satisfy the obligation. It is the plan administrator’s responsibility to determine the validity of a QDRO.
- The distribution is used for unreimbursed tax-deductible medical expenses that exceed 7.5% of your adjusted gross income.
- The distribution is made after you reach age 59½ or after you terminate employment at age 55 or older.
- The distribution is a “qualified reservist distribution”, that is, a distribution of your pre-tax contributions made upon your order or call to active duty for a period of more than 179 days (or
for an indefinite period). This applies only if you were ordered or called to active duty after September 11, 2001.

- A distribution is made due to an IRS levy under Internal Revenue Code Section 6331.

You can avoid the 10% penalty tax by arranging a rollover (direct or otherwise) of the amount withdrawn to an eligible rollover plan.

20% Withholding Tax
The IRS requires the 401(k) Plan to withhold 20% of the taxable portion of a withdrawal. This means that if the withdrawal check is made out to you, 20% will be withheld for taxes.

You can avoid the 20% withholding requirements by arranging a direct rollover of the amount withdrawn to an eligible rollover plan. Note that if you opt for a 60-day non-direct rollover, the 20% withholding requirements will apply.

Keep in mind that the withholding rate (20%) doesn’t necessarily determine the tax you will actually pay, which may vary depending on your personal circumstances.

50% Penalty Tax
Plan provisions state that payments from your 401(k) Plan must generally begin no later than April 1 of the year following the year in which you reach age 70½ or retire, if later. Subsequent distributions are required by December 31. So, for example, if your initial distribution is made on the April 1 following the year you reach age 70½, another distribution will have to be made by December 31 of that same calendar year.

You are required to withdraw no less than the required minimum distribution (“RMD”) from the 401(k) Plan, which is calculated according to certain IRS life expectancy tables. The Ryder Retirement Service Center will notify you of the amount of the RMD. You are responsible for ensuring that the distribution is made in a timely manner. If payment is not made by the required date or is less than the calculated RMD, a 50% penalty tax will be levied on the portion of your account that should have been paid to you.

Effect on Social Security
Saving with pre-tax dollars through the 401(k) Plan does not reduce your earnings for Social Security purposes. You pay Social Security (FICA) and Medicare taxes on your tax-deferred contributions to the 401(k) Plan, and these earnings are considered in your Social Security benefit.

Assignment of Benefits
A participant may not assign the benefit to which he is entitled, or any interest he may have in the assets of the 401(k) Plan (for example, to pay a debt). No lien may be created on any funds, securities or other property held under the 401(k) Plan, and a participant’s benefit or interest in the assets of the 401(k) Plan cannot be reached by any creditor, except as may be permitted by law. However, a participant’s interest may be subject to the terms of a Qualified Domestic Relations Order (“QDRO”) relating to provisions for divorce, child support, alimony or property agreements involving a spouse, former spouse or dependent, as required by ERISA and the Internal Revenue Code. A QDRO may allow payment to an alternate payee to commence regardless of the age or status of the participant.

You can obtain, without charge, a copy of the 401(k) Plan’s Qualified Domestic Relations Order procedures by contacting the Ryder Retirement Service Center.

No Insurance of Accounts
Because the plan is a defined contribution plan, your accounts are not insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. The PBGC does not insure benefits under defined contribution plans.
TABLE OF CONTENTS

Introduction ........................................................................................................... 220
How The Programs Work.......................................................................................... 220
  The Employee Assistance Program ................................................................. 220
    Eligibility ........................................................................................................ 220
  What the Program Covers ............................................................................... 220
  What Does the EAP Include? .......................................................................... 220
  How to Access the EAP ..................................................................................... 221
Tuition Reimbursement Program.......................................................................... 221
  How the Plan Works .......................................................................................... 221
  How to Apply for Reimbursement .................................................................. 221
  Undergraduate Tuition Reimbursement Request Form ................................... 222
  Graduate Degree Request Form and Graduate Tuition Reimbursement Request Form .......................................................... 222
  Undergraduate and Graduate Programs ......................................................... 222
Health Advocate........................................................................................................ 223
  How it Works ..................................................................................................... 223
  Services Provided ............................................................................................... 223
Consumer’s Medical Resource .............................................................................. 223
  How it Works ..................................................................................................... 224
  Services Provided ............................................................................................... 224
Adoption Assistance ............................................................................................... 224
  Covered Expenses Include ............................................................................. 224
  Expenses not covered by the Plan include ....................................................... 224
  How to File for Reimbursement ....................................................................... 224
  Claim Deadline .................................................................................................. 225
  Taxes .................................................................................................................. 225
YouDecide.com ........................................................................................................ 225
  How YouDecide.com Works ............................................................................ 225
Ryder System Federal Credit Union ..................................................................... 225
Direct Deposit and Pay Cards ............................................................................... 226

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
**Introduction**

This section of your Summary Plan Description (SPD) book reviews benefit programs offered by the Company and are available to active, regular full-time employees. Many of the programs are provided at no cost and do not require enrollment. Specific information about enrollment for certain programs is provided in the information listed about each program. The additional benefit programs include:

- Employee Assistance Program;
- Tuition Reimbursement Program;
- Health Advocate;
- Consumer’s Medical Resource;
- Adoption Assistance;
- YouDecide.com;
- Ryder System Federal Credit Union; and
- Direct Deposit and Pay Cards.

**How The Programs Work**

**The Employee Assistance Program**

To assist you in contributing your best at home and at work, the Company provides the Employee Assistance Program (EAP). The Employee Assistance Program makes available professional counseling for you and your family on a voluntary basis.

**Eligibility**

The Employee Assistance Program is available to all regular, full-time employees (eligible for medical coverage). Coverage becomes effective on the first of the month following 90 days of continuous full-time employment. Dependents of eligible employees, as described in the Eligibility Section, are eligible for coverage as well. You do not have to be enrolled in the Medical Plan to be eligible.

The following are not eligible to participate in the program:

- part-time, temporary and casual employees;
- employees covered under a medical plan provided by a collective bargaining agreement; and
- employees with less than one year of service with the Company.

**What the Program Covers**

The Employee Assistance Program (EAP) provides resources to help resolve personal concerns that may be affecting your health, well-being, family life or job performance. It provides confidential assistance to you and your family members 24/7.

In-person sessions are available with an EAP counselor in your area. The counselor will help you evaluate your concerns and suggest the next best steps. You may contact the EAP for any number of reasons, including:

- stress related to work, family and personal life;
- grief and bereavement counseling;
- marital, family and parent-child issues;
- anxiety or depression;
- coping with change and transition;
- financial and legal concerns; and
- problems with alcohol and/or drugs.

**What Does the EAP Include?**

- up to five counseling sessions per eligible person per year at no cost to you;
Other Benefits

- 24/7 phone access to live counselors, 365 days a year for assessment and referral;
- legal services: one-consultation per legal matter;
- financial services: one consultation per financial matter; and
- short-term counseling and/or referrals to community resources.

How to Access the EAP
Call 800-323-0751 to access services and plan to spend up to 15 minutes with an EAP counselor for an initial phone interview. You may also contact the program online at www.feibh.com and enter the user name: rsi.

Tuition Reimbursement Program
Ryder will reimburse up to 75% of eligible tuition costs for pre-approved, job-related courses or degree programs. To be eligible for reimbursement:

- you must complete the paperwork prior to the start of any class or Graduate Program.
- all required signatures must be obtained prior to the class begin date. Failure to comply with the application requirements and submission deadlines will result in reimbursement denial.
- you must complete the qualified course or program;
- courses must be taken at an accredited college or university. Workshops, seminars, preparation classes, and certification examinations are not eligible for reimbursement under the program;
- you must receive no less than a “C minus” grade (or its equivalent);
- you must be a regular, full-time employee of Ryder, actively employed by the Company on the first and last day of class to be eligible for reimbursement;
- you must submit for reimbursement no later than 90 days after the class end date; and
- you must be an employee in good standing at the beginning and end of the course.

How the Plan Works
If you are an active, regular full-time Ryder employee, you may receive reimbursement for the educational costs of qualified courses. Qualified courses are those deemed by your Manager and Human Resources Department as work-related or part of a work-related degree program. Courses that are not job-related are considered non-qualified and are not eligible for reimbursement.

You pay the cost of the course and request reimbursement after completing the course. You will be reimbursed for 75% of the tuition cost for each approved course for which you received a grade of C minus, its equivalent, or a higher grade.

The plan includes a maximum allowance of up to $250 for books/fees, which is included in the maximum annual reimbursement limit for undergraduate and graduate courses. The plan will reimburse 100% of the submitted expenses for books and fees, up to the $250 annual maximum.

The annual reimbursement maximum for undergraduate courses/degrees is $5,250. This conforms to the current IRS annual limit for tax-free reimbursement. The annual reimbursement maximum for graduate/doctorate courses/degrees is $10,000. Any reimbursements in excess of $5,250 toward graduate/doctorate courses/degrees will be taxable.

Reimbursements paid by Ryder are accumulated on a cash basis for the calendar year in which the reimbursement is paid, regardless if the course(s) associated with the reimbursement were completed in a prior year.

How to Apply for Reimbursement
Before enrolling in a course, you must complete a Tuition Reimbursement Request Form for each class. There are separate forms for the Undergraduate and Graduate Programs. Tuition reimbursement forms are available by logging on to www.Ryder.BenefitsNow.com. You can also contact your supervisor, manager or local Human Resources representative.
Undergraduate Tuition Reimbursement Request Form
The form must be approved by your Manager and your Human Resources Department prior to the beginning of each class.

Graduate Degree Request Form and Graduate Tuition Reimbursement Request Form
A Graduate Degree Request Form must be fully completed and approved by your Manager and the respective Executive Vice President of your division 30 days prior to enrolling in any Graduate Program or class. Once approved, the Graduate Tuition Reimbursement Request Form must also be completed for each class taken and approved by your Manager and your Human Resources Department prior to the beginning of each class.

How to Process the Reimbursement
After you have received the necessary approvals, keep the form until you have completed the course. Once you have satisfactorily completed the course, submit the original Tuition Reimbursement Request Form and copies of the following documentation within **90 days** following the completion of the course:
- an official grade report of C minus, or better grade;
- an itemized tuition bill or statement of account with charges; and
- proof of payment, such as a credit card receipt, the front and back of your cleared check, or a validated receipt from the school.

Reimbursement requests should be mailed or faxed directly to the Ryder BenefitsNow Service Center, P.O. Box 785001, Orlando, FL 32878-5001, Fax Number: 847-554-1734.

The Ryder BenefitsNow Service Center will process the reimbursement when administratively practicable. End of the year classes are generally reimbursed the following year due to third party administration end of year cutoff dates in December.

Undergraduate and Graduate Programs
No matter which degree you are seeking, you are expected to complete a one-year minimum service commitment to Ryder following the issuance of reimbursement for any coursework/degree. If you voluntarily terminate from Ryder System, Inc., within 12 months of completing any course(s), you will be required to reimburse the Company any applicable pro-rated payback amount. The prorated amount for all classes taken in a 12 month period is calculated based on the date of the last class taken prior to leaving the company. (Note: Each class is not pro-rated on its own.)

Example:
For termination date 04/06/13, 12 month look-back period = 04/06/13 to 04/06/12

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<thead>
<tr>
<th>Task</th>
<th>Description</th>
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<td>1</td>
<td>Calculate the amount of reimbursements received for the previous 12 months from the date of termination, 04/06/13:</td>
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<td>SW100 Intro to Social Work</td>
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<td><strong>TOTAL</strong></td>
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</table>
| 2    | Divide the total amount received by the number of pay periods in the previous 12 months to calculate the pro-rated amount.  
Example: $1,948.92 / 24 pay periods = $81.21 pro-rated amount |
| 3    | Multiply the pro-rated amount by the number of pay periods from the end date of the last class reimbursed until the date of termination to calculate the amount the company will pay.  
Last class ended on 07/27/12, terminating 04/06/13 - calculate the number of pay periods from 7/27/12 to 4/06/13 (using 4/15/13 as last paydate), which is 18 pay periods and multiply it by the pro-rated amount.  
$81.21 x 18 pay periods = $1,461.78 amount company will pay |
| 4    | Subtract that number from the total amount of reimbursement received for the previous 12 months, from date of termination.  
Example: $1,948.92 - $1,461.78 = $487.14 amount employee must pay back to the company |

**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. 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. This program is not a substitute for health insurance. Rather, it complements basic health coverage by providing a range of services as outlined below.

**How it Works**
If you need help with a health care or insurance issue, just call Health Advocate’s toll-free number at 866-695-8622. The first time you call, you will speak with a Personal Health Advocate (PHA). You will be asked to complete a short authorization form.

**Services Provided**
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; and
- prepare for health care appointments.

You or a covered family member may call as often as needed. Health Advocate can be accessed 24/7. Normal business hours are Monday - Friday between 8am-9pm Eastern Time. A message service is also available after hours and during weekends.

**Consumer’s Medical Resource**
Consumer’s Medical Resource (CMR) is an advocacy group that provides Medical Decision Support and Surgery Decision Support so that you and your covered dependents can make informed decisions about
your health. Employees and their families covered under a United Healthcare, Kaiser or Humana Plan are eligible for CMR.

**How it Works**
If you are faced with a difficult diagnosis or you need information on any medical condition, you can access either Medical Decision Support or Surgery Decision Support. You will then be able to set up a call with a Decision Support Specialist and research team made up of physicians and researchers who will work with you to identify and address any gaps in your understanding of your treatment options, as well as to provide relevant support resources for you and your family. You will also have 24/7 access to a personal password protected web portal where you can obtain general diagnosis and treatment information, medical research information and find additional resources.

**Services Provided**
Medical Decision Support® (MDS) is a decision-support program that offers you in-depth, objective, personalized and current information on all medical conditions. When you contact MDS, you will receive the information, tools and support you need to make the right medical choices for you and your family.

Surgery Decision Support (SDS) is a specialized advocacy program that services members who have been recommended for any of the following five surgical procedures: low back surgery, hip replacement, knee replacement, hysterectomy, obesity surgery. The SDS team will work with you to understand all of your options and help ensure you are making an informed decision about the course of action that is right for you.

You or a covered family member may call as often as needed. CMR can be reached at 888-644-1640.

**Adoption Assistance**
If you are a full-time employee enrolled in a Ryder Medical Plan at the time of initiating and at the time the adoption is finalized, you are eligible to receive up to $2,000 for qualified expenses related to the legally recognized adoption of a child. The benefit is limited to two adoptions per family, per lifetime. If both adoptive parents are employed by Ryder, the maximum number of adoptions allowed is two and the maximum benefit allowed is $4,000. To receive benefits, the child you adopt must be under the age of 18 at the time of the adoption and cannot be a relative or a stepchild of the adopting parents.

**Covered Expenses Include**
- state licensed adoption agency fees, including placement and parental counseling fees;
- legal costs, including attorney’s fees and court costs;
- state required pre- and post-placement home study program, if applicable;
- medical expenses of the natural mother associated with child birth (i.e. obstetrician fees, anesthesiologist);
- temporary foster care before placement of the child in your home; and
- reasonable and customary transportation and lodging expenses to obtain physical custody of the adopted child.

**Expenses not covered by the Plan include**
- temporary living expenses incurred by the natural mother;
- room and board expenses of the natural mother associated with the delivery of the child; and
- expenses incurred after the final date of adoption.

**How to File for Reimbursement**
Adoption Assistance Forms are available by contacting the Ryder BenefitsNow Service Center at 800-280-2999 or by visiting the website at www.Ryder.BenefitsNow.com. For expenses to be eligible for reimbursement, formal adoption proceedings must begin prior to the employee’s termination, either voluntary or involuntary, Retirement or Approval of Long-Term Disability benefits.
Your request for reimbursement must include:

- the completed Adoption Assistance Reimbursement Request Form;
- itemized bills or receipts which indicate the type of expense, date the expense was incurred and the amount of the expense (these expenses can only be submitted for reimbursement AFTER the effective date of the adoption); and
- a copy of the Adoption Certificate.

Reimbursement requests can be mailed or faxed to: Ryder BenefitsNow Service Center, P. O. Box 785001, Orlando, FL 32878-5001, Fax Number: 847-554-1734. Forms that are incomplete or missing proper documentation will not be processed until the missing information is provided.

Claim Deadline
Requests for reimbursement under Adoption Assistance MUST be submitted within 90 days of the effective date of the adoption or the request will not be considered for reimbursement.

Taxes
Ryder does not withhold income taxes on the reimbursement amount paid; you will be responsible for adjusting your Form 1040 to include in your gross income statement the taxable portion of the reimbursement. Please consult a tax advisor to find out if this benefit is taxable to you.

Important Note: Ryder is not responsible for and does not provide any of the adoption assistance or legal services described in the Adoption Assistance summary or Hyatt Legal Plan section of this book. The professional advice that you receive from the attorneys or other providers under these programs is not attributable to Ryder and you should not request advice or consultation on these matters from any Ryder employee. In the event that you are dissatisfied with the advice provided to you under these programs, please contact the provider of these services directly. Ryder shall not be liable for any malpractice, or other liability in connection with the provision of these services.

YouDecide.com
YouDecide.com is a free electronic financial comparison service made available to you and your family by the Company. Simply log on to www.youdecide.com/corporate and enter the Client ID: RS643 and identify the financial service for which you want to compare costs. YouDecide.com will gather information electronically among a nationwide network of vendors, compare the rates, and provide you with quotes that best match your personal profile.

You can use YouDecide.com to search and compare costs for the following services:
- auto financing and insurance;
- home financing and homeowner’s insurance;
- financial planning and online banking;
- credit cards;
- pet insurance; and
- tax preparation.

How YouDecide.com Works
- go to www.youdecide.com/corporate (Client ID: RS643) to register or call 800-585-2175.
- choose a product or service and fill out an application.
- your application will be sent to vendors who will immediately transmit quotes back to YouDecide.com.
- compare the information and make a purchasing decision.

Ryder System Federal Credit Union
The Ryder System Federal Credit Union offers a full range of services to Ryder employees, including:
OTHER BENEFITS

- savings accounts and checking accounts;
- Christmas and vacation club accounts;
- Individual Retirement Accounts (IRAs);
- ATM cards;
- direct deposit;
- financial counseling;
- “first mortgage”, home equity loans, auto loans; and
- credit cards.

For more information on the Credit Union you can call 800-97-RYDER or log on to www.RyderFCU.org.

**Direct Deposit and Pay Cards**
Direct deposit is a safe and convenient way to have your payroll check electronically deposited into the financial institution of your choice. Ryder makes direct deposit available to all employees. Ryder also provides Pay Cards which gives you access to your pay through a nationwide network of ATMs. To arrange for direct deposit of your paychecks or for further information about Pay Cards contact payroll at 305-500-3058, your location supervisor or your Human Resources representative.
TABLE OF CONTENTS

Introduction ........................................................................................................... 228
Eligibility ................................................................................................................ 228
Transfers ................................................................................................................ 228
Costs ...................................................................................................................... 229
How Your Retirement Benefits Are Calculated ................................................... 229
Minimum Annual Benefit ...................................................................................... 230
Vesting ................................................................................................................... 230
Early Retirement Benefit ....................................................................................... 231
Normal Retirement Benefit ................................................................................... 232
Disability Retirement Benefit ............................................................................... 232
Termination Benefits ............................................................................................. 233
Receiving Retirement Plan Benefits ...................................................................... 233
  Preparing for Retirement .................................................................................. 233
  Requesting a Plan Benefit ................................................................................ 233
  Death Benefits ................................................................................................ 233
  Payment Options ............................................................................................... 234
  Required Plan Distributions ............................................................................. 234
  Surviving Spouse Benefits ............................................................................... 235
Important Plan Information .................................................................................. 236
  Qualified Domestic Relations Order ............................................................... 236
  Variations in Retirement Plan Provisions ......................................................... 236
  Pension Benefit Guaranty Corporation ............................................................. 237
  Additional Information ...................................................................................... 237

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
Introduction
The Ryder System, Inc. Retirement Plan is a type of pension plan from which eligible participants receive a specified monthly benefit at retirement that is based on a formula generally taking into consideration annual earnings and years of service. The Retirement Plan is funded by the Company, and is intended to supplement retirement income that may be available from the Ryder System, Inc. 401(k) Savings Plan (the “401(k) Plan”), other personal savings, and Social Security.

For a list of participating employers in the Retirement Plan, please contact the Plan Administrator at 305-500-3595.

Eligibility

Employees
Participation in the Retirement Plan was frozen as of January 1, 2007 for new hires except for certain employees covered by a collective bargaining agreement that continued to provide for their participation in the Plan.

As a result, in general, if you were hired or re-hired on or after January 1, 2007, you are not eligible for the Retirement Plan. Instead, you are eligible for enrollment in the Ryder System, Inc. 401(k) Savings Plan.

Benefit accrual in the Retirement Plan for those participants who were hired prior to January 1, 2007 was generally frozen as of December 31, 2007 except for the following groups of employees:

- certain employees grandfathered into the Plan because they met specific tenure and age requirements and elected to remain in the Plan; and
- certain union employees whose terms and conditions of employment are covered by a collective bargaining agreement that continued to provide for their participation in the Plan (“grandfathered participants”).

If you are not in the grandfathered group and your benefits were frozen on December 31, 2007, the benefits you already earned remain in the Retirement Plan and cannot be taken from you.

Union Employees
If you work under the provisions of a collective bargaining agreement, you are eligible to participate in the Retirement Plan only if [the collective bargaining agreement provides for participation in the plan and] you do not participate in a separate plan providing retirement benefits, negotiated by Ryder, or you met the requirements to continue to earn benefits under the Retirement Plan as of January 1, 2007.

Re-Employment
Any former employee who is rehired on or after January 1, 2007 shall not be eligible to resume participation in the Plan unless covered by the terms of a collective bargaining agreement providing for participation in the Plan. If, at the time of separation you did not have a vested interest, but returned to work, within five years, then the service earned prior to the separation will be reinstated for purposes of meeting the Plan’s service vesting requirements.

Transfers
Employees who have been grandfathered into the Plan will retain their status in the Retirement Plan even if they transfer elsewhere in the Company, provided the new organizational assignment also participates in the Ryder Retirement Plan. However, benefits will be frozen on the effective date of transfer if the new organizational assignment is not eligible for participation in the plan or you transfer to a union group which participates in a separate plan providing retirement benefits.
Costs
Ryder pays the full cost of the Retirement Plan. You are not required nor permitted to make contributions to the Retirement Plan. Contributions to a special trust fund are made in accordance with yearly actuarial determinations.

How Your Retirement Benefits Are Calculated
The amount of your annual retirement benefit is based on your total annual earnings and years of service with the Company.

- **Total annual earnings** consist of your total pay received in a calendar year, including base pay, overtime pay, vacation pay, cost of living allowances, bonuses, pre-tax contributions to any Ryder plan involving IRS qualified salary reduction (like the 401(k) Plan), and commissions, up to the IRS limits.

- **A year of service** is a calendar year of participation in the plan in which you worked at least 1,000 hours.

- **Continuous service** is an uninterrupted period of time that you work for the company. Continuous service is used to determine if you qualify for early or disability retirement. Continuous service begins with your hire date and includes the time you are on an approved leave of absence (such as FMLA or military leave) or have a total and permanent disability.

You earn a portion of your benefit for each year of service that you are a participant in the Retirement Plan. Beginning January 1, 1989, the following formula is applied to your total annual earnings to determine the portion of benefits earned annually:

\[
\begin{align*}
1.45\% \text{ of total annual earnings of up to } & \15,600 \\
+ 1.85\% \text{ of total annual earnings over } & \15,600
\end{align*}
\]

\= \text{ Benefit amount for each year of service}

**Example:**
Jan’s hire date is November 1, 2001. She is eligible to enter the Retirement Plan on January 1, 2003, and earns $30,000 for that year of service. So in 2003, Jan will earn the following retirement benefit:

\[
\begin{align*}
1.45\% \times \15,600 &= \122.60 \\
+ 1.85\% \times \14,400 &= \166.40 \\
\text{Total 2003 benefit accrued} &= \189.00
\end{align*}
\]

For the purpose of this example, assume that Jan’s pay doesn’t increase. Here’s how her benefit would grow during her career with Ryder:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Annual Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 492.60</td>
</tr>
<tr>
<td>10</td>
<td>$ 4,926.00</td>
</tr>
<tr>
<td>20</td>
<td>$ 9,852.00</td>
</tr>
<tr>
<td>30</td>
<td>$14,778.00</td>
</tr>
</tbody>
</table>

When Jan retires at age 65 after 30 years of participation in the Retirement Plan, her annual benefit from the plan is \$14,778. This annual amount is divided by 12 and paid in monthly installments of \$1,231.50 as an individual life annuity.
Minimum Annual Benefit
There is a minimum annual benefit for any Participant who meets the following requirements as of January 1, 1996:

- The Participant is an employee of a participating or affiliated employer as of January 1, 1996, or is earning accruals while disabled in accordance with Plan provisions as of such date.
- The Participant is accruing benefits in accordance with the provisions of the Plan as of January 1, 1996, or is a transferred member as of January 1, 1996.
- The Participant had not transferred out of the Plan to an ineligible status as of January 1, 1996.

The minimum annual benefit payable at age 65 from the plan is $1,800, paid in 12 monthly installments of $150 as an individual life annuity.

Vesting
Vesting refers to your right of ownership to receive a benefit from the plan.

- If you leave Ryder System, Inc. or any of its subsidiaries or affiliates before you’ve earned a vested interest, you have no right to a benefit from the Retirement Plan.
- You will earn a vested interest in the plan when you:
  - Complete five years of service with Ryder System, Inc. or any of its subsidiaries or affiliates,
  - Reach age 65 while actively employed, even if you have fewer than five years of service with Ryder System, Inc. or any of its subsidiaries or affiliates.
- Years of service you complete with Ryder System, Inc. or any of its subsidiaries or affiliates before you become a participant in the retirement plan generally count toward your vested interest.
- Service with a company that was acquired by Ryder System, Inc. or one of its subsidiaries may also count toward your service for vesting purposes.
- In general, you earn a year of service for each plan year in which you are credited with at least 1,000 hours of service.

You continue to earn vesting service while employed by the Company. You will be credited with an hour of service for any hour for which you are paid or entitled to be paid by the Company, either because you worked or because you didn’t work but were entitled to be paid (e.g., vacation, holiday, illness, incapacity (including disability), layoff, jury duty, qualified military service or leave of absence). No more than 501 hours of service will be credited to you on account of any single continuous period during which you perform no duties for the Company except for military service or an approved leave of absence.

You will not receive credit for periods during which you receive payments made to comply with worker’s compensation, unemployment compensation or disability insurance laws, or payments that reimburse you for medical expenses. Unlike years of service for benefit accrual purposes, you begin earning vesting service on your date of employment with the Company or any affiliate of the Company as defined by the IRS.

After completing five or more years of service, you are 100% vested, which means you have a nonforfeitable right to a benefit in the future. If you have less than five years of vesting service, you are 0% vested, which means you have not earned the right to receive a benefit in the future.

Break in Service: You will incur a break in service if you are not credited with at least 501 hours of service in any calendar year. You will not have a break in service if you are absent from employment due to a family medical leave or military leave. For a family medical leave, you will be credited with up to 501 hours of service in the calendar year in which your absence begins however if you were already credited with at least 501 hours of service in the year in which the family medical leave begins, the hours will be credited to the next year if needed to avoid a break in service in that year.
Break in Service
The years of service you earn before a break in service will be restored when you return to work if:
- You had a vested interest before you left the Company, or
- You did not have a vested interest, but you are reemployed by the Company before you have five consecutive one year breaks in service.

However, you will lose whatever benefit and years of service you had earned before a break in service if:
- You did not have a vested interest before your break in service, and
- The time you were away from the Company exceeds a break in service of five years.

FMLA and Military Leaves
Your service will continue without a break for vesting purposes, if you are away from work due to an approved leave of absence including:
- A Family and Medical Leave (FMLA), which is limited to 12 weeks, or
- A military leave protected under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A qualified military service leave will be treated as service for vesting and benefit accrual. While on USERRA protected leave, your benefit accrual will be determined based on the total annual earnings you would have received during your military leave, or, if that isn’t certain, your total annual earnings in effect before the military leave will be used to calculate your benefit accrual.

Early Retirement Benefit
Early retirement benefits are available when you:
- Have a vested interest,
- Have 10 or more years of continuous service with the Company, and
- Leave the Company between the ages 55 and 65.

You can begin receiving a benefit from the plan the first of the month after you leave the Company, or payment can begin on the first of any month thereafter.

Retirement Before Age 62
If you retire before you reach age 62, your benefit from the plan will be reduced because you’ll receive a benefit over a longer period of time. If you retire between the ages of 62 and 65 there is no reduction in your benefit. The chart below shows how the benefit is reduced for each year that payment begins before age 62.

Reductions – Early Retirement
If you retire early and begin receiving a benefit from the plan before age 62, you’ll receive your benefit over a longer period of time. So, your monthly payment amount is reduced. The annual reduction is prorated for a period of less than 12 months.

<table>
<thead>
<tr>
<th>If payments begin at age:</th>
<th>You’ll receive this percentage of your age 65 retirement benefit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>91.66%</td>
</tr>
<tr>
<td>60</td>
<td>83.34%</td>
</tr>
<tr>
<td>59</td>
<td>79.16%</td>
</tr>
<tr>
<td>58</td>
<td>75.00%</td>
</tr>
<tr>
<td>57</td>
<td>70.84%</td>
</tr>
<tr>
<td>56</td>
<td>66.67%</td>
</tr>
<tr>
<td>55</td>
<td>62.50%</td>
</tr>
</tbody>
</table>
Example: You retire at age 55 with an annual retirement benefit of $12,000. If payment begins at age 55, your annual benefit would be $12,000 \times 62.50\% = $7,500.

**Normal Retirement Benefit**

Normal retirement age is 65. Normal retirement benefits begin on the first of the month on or after your 65th birthday.

If you work beyond age 65, and are a member of the grandfathered group, you will continue to earn retirement benefits pursuant to the benefit formula. Your benefit from the plan will normally begin on the first of the month on or after your retirement date. You must begin receiving payment from the plan by April 1st of the year following the calendar year in which you reach age 70\(\frac{1}{2}\), or retire from Ryder. If you are a 5% owner of Ryder or one of its subsidiaries or affiliates, you must begin receiving payments from the plan by April 1st of the year following the calendar year in which you reach age 70\(\frac{1}{2}\).

**Disability Retirement Benefit**

Disability retirement benefits are available from the plan if you are 100% vested and you reach age 45 with 15 years of continuous service at the time you suffer a total and permanent disability while actively employed by Ryder. You must also have been approved to receive Social Security disability benefits. This means you may start payment of your benefits at this time even if you have not reached your early retirement date under the Plan.

Your disability retirement benefit will equal the benefit you earned up to the date of your disability. You can begin receiving disability retirement benefits from the plan the first of the month after the later of the date you have met the above eligibility requirements and your pay from Ryder has ceased, or five months after the date you stopped working due to disability. The benefit will be unreduced for early commencement.

If you are grandfathered in the pension plan, are 100% vested and have at least 10 years of continuous service and become disabled, or if you are grandfathered and meet the requirements above to start payment of your disability retirement benefit, but do not want to commence right away, you will to continue to earn benefits under the plan. If so, you will earn benefits until whichever is earliest:

- the date you reach age 65, or, if later, 5 years after the date your disability began,
- the date you elect early retirement,
- the date you recover, or
- the date you die.

The benefits you earn in this way will be based on the greater of your annualized pay rate at the time you become disabled or your total annual earnings for the last complete year you worked. If you elect early retirement, your benefit will be reduced if payment begins before age 62.

Certain causes of disability may not qualify you for benefits from the plan. The plan administrator reserves the right to select a physician to examine you periodically to verify that your total and permanent disability continues to qualify you for disability retirement benefits.

**Suspension of Benefit Payments**

Effective January 1, 2009, if you are reemployed by the Company while receiving your pension benefits, your benefit will continue. If you are reemployed by one of the unions for which continued participation and benefit accrual has been bargained, any additional benefits that you earn will be added to the benefit that you are already receiving. If you are a grandfathered participant, you will not earn additional benefits if you are reemployed.
**Termination Benefits**

If you leave Ryder for a reason other than retirement, death or total and permanent disability, you are entitled to receive the amount of your vested interest in the plan. Your vested interest is payable at age 65. This table applies to you if you terminate employment prior to age 55, but after you have completed at least ten continuous years of service. You may commence payment of your benefit when you reach 55 or at any later date you choose. If you commence payment before age 65, your benefit will be reduced based on the following chart.

Benefits for each year that payments are made before age 65 are reduced as follows:

<table>
<thead>
<tr>
<th>If payments begin at age:</th>
<th>You'll receive this percentage of your age 65 retirement benefit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td>93.33%</td>
</tr>
<tr>
<td>63</td>
<td>86.67%</td>
</tr>
<tr>
<td>62</td>
<td>80.00%</td>
</tr>
<tr>
<td>61</td>
<td>73.33%</td>
</tr>
<tr>
<td>60</td>
<td>66.67%</td>
</tr>
<tr>
<td>59</td>
<td>63.33%</td>
</tr>
<tr>
<td>58</td>
<td>60.00%</td>
</tr>
<tr>
<td>57</td>
<td>56.67%</td>
</tr>
<tr>
<td>56</td>
<td>53.33%</td>
</tr>
<tr>
<td>55</td>
<td>50.00%</td>
</tr>
</tbody>
</table>

If at the time you leave Ryder, you already met the requirements for an early retirement (that is, you already reached age 55 and had 10 years of continuous service) but did not choose to receive payment, benefits, when they become payable to you, will be reduced according to the chart shown under “Reductions - Early Retirement”, and not the "Termination Benefits" table above.

**Receiving Retirement Plan Benefits**

**Preparing for Retirement**

You should contact the Ryder Retirement Service Center approximately 6 months before your desired retirement date. They will send you a retirement package that includes:

- An estimate of your benefit available under a number of different payment forms,
- Details about all the information and forms you must submit to receive benefits from the plan, and
- A request for copies of certain documents including your birth certificate, the birth certificate of your spouse or other beneficiary, and your marriage certificate. (If a beneficiary is initiating a survivor benefit request, proof of death will also be requested.)

**Requesting a Plan Benefit**

To receive a benefit from the plan, you or your beneficiary must submit the signed required forms to the Ryder Retirement Service Center for payment. If you are married, you must obtain your spouse's written, notarized consent to elect a form of payment that does not provide a survivor annuity to your spouse on your death. Forms are included in the package you receive from the Ryder Retirement Service Center.

**Death Benefits**

If you are receiving benefits from the plan and die, death benefits payable are determined by the payment option you selected.
Retirement Plan

Payment Options
The Ryder Retirement Plan provides several forms of payment. Each payment option distributes benefits from the plan differently. You can select the form that best suits your retirement income needs. Payment options for plan benefits include:

- Individual Life Annuity,
- Joint and Survivor Annuity,
- Life with 10-year Certain Benefit, or
- Level Payment.

Individual Life Annuity
This option provides the full benefit amount in equal monthly payments for as long as you live. Survivor benefits are not payable with this option. If you are single when payments are to begin, your benefit will be paid in this form unless you elect otherwise.

Joint and Survivor Annuity
If you are married, you must select this option with your spouse as your contingent annuitant unless you elect otherwise with spousal consent. You may choose another payment option if you are married and have written notarized consent from your spouse to elect a different payment option or to choose someone other than your spouse as your contingent annuitant. If you are not married you may choose a contingent annuitant for this option.

With this payment option, you receive a monthly payment during your lifetime. After your death, your beneficiary will receive a percentage of your reduced monthly benefit. The percentage your beneficiary receives is determined by the option you select – 50%, 66 2/3%, 75% or 100%. The percentage you elect will affect the monthly amount you receive during your lifetime. The greater the percentage you select for your beneficiary, the lower the monthly payment paid during your lifetime.

Life and 10-Year Certain Annuity
If you elect this option, you will receive a monthly benefit for your lifetime. Payments are guaranteed for 10 years (120 months). If you die within the 10-year period, your benefit will continue to be paid to your beneficiary until the full 10 years of payments are made.

Level Payment
This payment option is only available if you elect to start payments from the plan before Social Security benefits begin. You will receive a larger monthly payment beginning with the date you retire and ending with the leveling age you elected (either age 62 or 65). Once you start receiving Social Security benefits, payment from the plan will be reduced to offset the amount you are receiving from Social Security. The net effect is to provide a level income throughout your retirement years. However, if payments from the plan will not at least equal $50 per month after you begin receiving Social Security benefits, this option will not be available to you. You are responsible to apply for Social Security benefits at attainment of age 62 or 65 to coordinate with this payment option. Payments from the retirement plan end when you die. No survivor benefits are payable with this option.

Required Plan Distributions

Vested Balance $5,000 or Less
If the present value of your vested interest in the plan is greater than $1,000, but less than $5,000 and the required forms are not submitted to the Ryder Retirement Service Center in the required time, the distribution will be paid automatically and will be rolled over into a Fidelity IRA, which will be established in the name of the participant at the time.

If the present value of your vested interest in the plan is less than or equal to $1,000 and the required forms are not submitted to the Ryder Retirement Service Center in the required time, the distribution will
be paid automatically and will be subject to the mandatory 20% federal tax withholding rate and any applicable state tax withholding.

If your distribution qualifies as an eligible rollover distribution, you may elect to have all or a portion of your benefit transferred directly into an eligible retirement plan, or an IRA. By doing so, you may delay taxes on your distribution.

**At Age 70½**
Distributions from the plan must begin by April 1st of the year following the calendar year in which you reach age 70½, or calendar year in which you retire from Ryder.

**Surviving Spouse Benefits**

**Death Before You Begin Payment**
Your spouse will be eligible for a plan benefit if you die after you are vested but before you begin receiving payments from the plan (whether you already left employment or not), and your benefit at retirement is valued at over $5,000. Your spouse will receive a lifetime income benefit based on the benefit you earned up to the time of your death.

If your total benefit is valued at $5,000 or less, your spouse will receive the full amount in a single lump sum payment.

**If You Die Before You Leave Ryder**
The amount of benefit your spouse receives is equal to the survivor’s portion of the 50% joint and survivor annuity benefit. This will be calculated as if you had left Ryder on the day of your death, survived to age 65, and then retired.

If you have at least 10 years of continuous service when you die, your spouse may elect payment as early as:
- The month after you would have attained age 55, or
- If you are over age 55, the month following your death. The benefit will be subject to early retirement reductions.

**Former Employees and Retirees**
Your surviving spouse will receive a lifetime income based on the benefit you earned up to the time of your death if you are:
- Already retired, or
- Are no longer an employee, and
- Have a vested interest in the plan when you die, but have not yet received a benefit from the plan.

**Amount of Spouse’s Benefit**
The amount of benefit payable to your spouse is equal to the survivor’s portion of a 50% joint and survivor annuity, calculated as if you survived to age 65. Payment normally starts when you would have turned age 65. However, if you were age 65 or older at your death, payments can begin the month following your death.

If you have 10 years of continuous service at the time you leave the company, your spouse will receive the survivor’s portion of the 50% joint and survivor annuity (subject to early retirement reductions). Benefits may begin on the month after you would have attained age 55 or the first of the month after your death, whichever is later.

If you are over age 55 and have 10 years of continuous service at the time you leave the company, your
spouse will receive the survivor’s portion of a 50% joint and survivor annuity (subject to early retirement reductions). Benefit payments can begin as early as the first of the month after your death.

Important Plan Information

IRS Limits
The IRS imposes a limit on the amount of annual earnings on which a benefit from the Retirement Plan can be based.

There is also an IRS limit on the amount of benefit you can receive from the plan. These limits change periodically as required by law. If you are affected by these limits, you will be notified. You may also be eligible for a benefit through the company's Benefit Restoration Plan.

Social Security
Both you and the Company contribute to the cost of your Social Security benefits over the course of your career. Social Security benefits normally begin at 65. Under the new Social Security guidelines, benefits may not begin until age 66 or later depending on your date of birth. In addition, your spouse may be eligible for Social Security benefits based on your earnings history.

Taxes
You are not required to pay current federal income taxes on your Plan benefits until you receive them. When you receive your Plan benefits in annuity form, you will owe current federal taxes. Federal income taxes will be withheld from your payments based on a form that you will complete prior to the commencement of your Plan payments. You may also choose to have no federal income tax withheld from your payments. If you fail to return such form to the Plan, federal income tax will be withheld automatically using similar wage withholding elections previously made by you. Note that if you elect not to have withholding apply, or even if you do elect withholding, you may still owe additional taxes on the payments when you file your income tax return. You are responsible for payment of any taxes associated with the payments, and are advised to consult with your income tax advisor regarding the income tax consequences of the payments being made to you.

If you receive a lump sum payment from the Plan and roll this money over into an IRA or eligible retirement plan, you will not owe federal income taxes on the amount that you roll over at the time of the roll over. You may owe a 10% excise tax if your Plan benefits are paid to you in a lump sum before age 59 1/2, you do not make a rollover and you terminate employment before the beginning of the year in which you reach age 55.

Qualified Domestic Relations Order
Benefits payable under the Retirement Plan are for the sole purpose of providing benefits to Retirement Plan participants and their beneficiaries. Except as otherwise required by law or by the Retirement Plan document, no one has the right to anticipate, withdraw or assign the benefits payable to any other individual(s).

However, benefits will be paid according to a valid Qualified Domestic Relations Order (QDRO), if it is properly served. A QDRO is an order or judgment that meets certain specific requirements from a state court directing the plan administrator to pay all or a portion of a participant's Retirement Plan benefits to a former spouse or dependent.

The plan administrator has no discretion in these matters. However, every effort will be made to notify you as soon as it appears that an attempt is being made to assign your benefits through a court order.

Variations in Retirement Plan Provisions
There are some variations in coverage for certain employees of Ryder.
Non-exempt employees of the former named Ryder Dedicated Logistics, Inc. and Ryder Driver Leasing, Inc. who began participation in the RDL field variation of the Ryder System, Inc. Employee Savings Plan effective January 1, 1991, will not earn additional benefits in the Retirement Plan after December 31, 1990. Benefits accumulated before that date will be maintained in the Ryder System, Inc. Retirement Plan. Future service with the company will continue to count toward vesting and eligibility for early retirement.

**Pension Benefit Guaranty Corporation**

Your benefits under the Ryder System, Inc. Retirement Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay retirement benefits you would have received under their retirement plan, but some people may lose certain benefits.

**What the PBGC Covers**

The PBGC guarantee generally covers:
- Normal and early retirement benefits,
- Disability benefits if you become disabled before the plan terminates, and
- Certain benefits for your survivors.

**What the PBGC Does Not Cover**

The PBGC guarantee generally does not cover:
- Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- Some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan’s normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if a portion of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and how much the PBGC collects from employers.

**Additional Information**

For more information about the PBGC, talk with your plan administrator or contact:
- The PBGC’s Technical Assistance Division, 1200 K Street, N.W. Suite 930, Washington, DC 20005-4026, or
- Call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000, or
- Connect online to the PBGC’s Internet web site at [www.pbgc.gov](http://www.pbgc.gov).

**Benefit Accrual Restrictions**

Benefits under the Plan may be restricted if the Plan becomes underfunded, meaning in general that the funding percentage of the Plan using methodology required by the IRS falls beneath 60%. If this occurs, benefit accrual under the Plan will cease entirely until the funding percentage improves. In addition the Level Payment Option may not be available if the funding level drops beneath 80%. If this occurs, you will be notified.
Receiving Information About Your Plan and Benefits:
You are entitled to:

- Receive a summary of the Retirement Plan’s funded status. The Plan Administrator is required by law to furnish each participant with a copy of this annual funding notice.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. If you have a right to a pension, you will receive a statement at least once every three years if you are employed by the Company. You may also make a written request for a statement, but the Plan Administrator is not required to provide such a statement more than once a year. The Plan must provide the statement free of charge.
TABLE OF CONTENTS

Introduction ........................................................................................................... 240
Who Is Eligible ....................................................................................................... 240
When to Enroll ....................................................................................................... 240
How To Enroll ........................................................................................................ 240
Shares Are Purchased at a Discount ................................................................... 240
To Get More Information About RyderShares ..................................................... 241

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.
**Introduction**

As an employee of Ryder System, Inc., you have a unique opportunity to buy stock in Ryder at discounted prices through RyderShares, the Stock Purchase Plan for employees. The following summary of RyderShares is not complete and does not include all the information you should consider in deciding whether to participate. Before deciding whether to enroll, you should review the Prospectus and other plan documents at www.benefitaccess.com.

**Who Is Eligible**

In general, any full-time or part-time employee of Ryder in the U.S. or Canada is eligible to participate. You must also be an active employee for 90 days prior to the 1st day of the quarter.

You are not eligible to participate if:

- you are customarily employed 20 hours or less per week;
- you own or would own 5 percent or more of the total combined voting power or value of all classes of stock of the Company, calculated under certain Internal Revenue Code rules, were you to participate in such offering period; or
- you are subject to the reporting requirements of Section 16 of the Securities Exchange Act of 1934, as amended.

**When to Enroll**

An eligible employee may only enroll during a quarterly enrollment period. The following table shows the four quarterly enrollment periods and when contributions (payroll deductions) begin:

<table>
<thead>
<tr>
<th>When you enroll between</th>
<th>Contributions begin</th>
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<tbody>
<tr>
<td>November 15 through January 1</td>
<td>January 1</td>
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<tr>
<td>February 15 through April 1</td>
<td>April 1</td>
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<tr>
<td>May 15 through July 1</td>
<td>July 1</td>
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<tr>
<td>August 15 through October 1</td>
<td>October 1</td>
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</tbody>
</table>

Once you enroll, contributions continue until you cancel or change your elections.

**How To Enroll**

Decide on the amount you want to contribute. You may elect to contribute one of two ways:

- elect between one percent and 15 percent of your base pay per pay period; or
- elect a specific dollar amount (There is a minimum election of $5.00 per pay period).

There are three ways to enroll in RyderShares: 1) access the Morgan Stanley website at www.benefitaccess.com and click on the icon to enroll or adjust your contributions; 2) use the voice response system by calling 888-301-0681, or 3) call Morgan Stanley and speak with a customer service representative.

When you enroll in RyderShares, each paycheck will be reduced by the amount you elect to contribute. Your payroll contributions are taken from base salary only on an after-tax basis.

Regardless of the option you elect, you may not purchase more than 2,500 shares on any one purchase date or stock with an aggregate fair market value of more than $25,000 in any calendar year.

**Shares Are Purchased at a Discount**

You will receive a discount of 15% on the price of Ryder common stock; therefore, 100% of your contributions are used to purchase shares of common stock.
The price you pay for Ryder common stock will be the lesser of:
- 85% of the closing market price per share of Ryder common stock on the first trading day of the quarter; or
- 85% of the closing market price per share of Ryder common stock on the last trading day of the quarter.

Once the shares purchased for you are in your account, you are subject to a three-month holding period (12-month holding period for Vice Presidents and Senior Vice Presidents (MS 14-16)). During the applicable holding period, you may not sell or transfer your shares. After the applicable holding period, you may sell or transfer your stock without restriction either on-line or by calling Morgan Stanley at 800-301-0681.

To Get More Information About RyderShares

For more information about RyderShares, please see the Prospectus and other plan documents at www.benefitaccess.com.

If you have questions about your account, want to sell shares, change or stop contributions or request other services, you should call Morgan Stanley at 888-301-0681.

Ryder System, Inc. Determines the Rules Administering RyderShares

RyderShares is administered by the Compensation Committee of the Ryder System, Inc. Board of Directors. RyderShares is intended to qualify under the provisions of Section 421 and Section 423 of the Internal Revenue Code. RyderShares is not subject to the Employee Retirement Income Security Act of 1974, as amended, and is not a qualified plan under Section 401(a) of the Internal Revenue Code.
DEFINITIONS

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Definitions

A number of words and phrases have a specific meaning when used to describe your Ryder Benefits Package. The following definitions are superseded to the extent a specific definition is provided in a particular section of this benefit summary.

Accelerated Death Benefit: advance payment of basic and/or additional life insurance.

Accident: for the purposes of the seat belt/safety net benefit, means the unintentional collision of a motor vehicle (four-wheel, private passenger car, pickup truck, station wagon, van, or jeep-type vehicle) not being used for the transportation of passengers for hire.

Accident: for the purposes of the Medical Plan, a sudden unexpected occurrence traceable within reasonable limits to a defined time, plan and cause.

Actively at work: performing the duties of your job at your normal place of work. You will be considered actively at work while on vacation, on an unrelated approved leave or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation, Workers’ Compensation leave or holiday.

Active full-time employee: an employee classified as full-time who works 30 hours per week or more for Ryder System, Inc. or one of its subsidiaries or affiliates on a regular basis in the usual course of Company business.

Annual enrollment: the designated period of time when an employee may elect to change or continue certain benefit plan participation for the coming year.

Any occupation: for the LTD plan, an occupation for which education, training or experience qualifies you, and that has as earnings potential greater than an amount equal to:
- the lesser of the product of your indexed pre-disability earnings and the benefit percentage for which you are enrolled; and
- the maximum monthly benefit of $8,000.

Assets: the property and resources (such as cash and investments) of a person or company. A mutual fund’s assets are whatever securities (stocks, bonds, treasury bills, etc.) that it owns, plus any cash.

Autism Spectrum Disorders – a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Beneficiary: the person or persons designated to receive 401(k) Savings Plan payments, AD&D death benefits or Life Insurance benefits payments if you die.

Benefit elimination period: the period of time you must be continuously disabled before STD or LTD benefits begin. For Non-salaried employees, the benefit elimination period for the STD plan is one week (7 continuous days) and the benefit elimination period for LTD is 26 weeks or the first 180 consecutive
days of any period of disability. For Salaried employees, the elimination period for the STD plan is one week (7 continuous days) and the benefit elimination period for the LTD plan is 5 months or the first 150 consecutive days of any period of disability.

**Birthday rule:** if your children are covered under two parent’s plans, the plan of the parent whose birthday falls earlier in the calendar year pays benefits first. If both parents have the same birthday, the plan that has covered the family for a longer period of time pays benefits first.

**Bonds:** loans or debt issued by corporations, governments or municipalities to raise money. A bond is like an IOU. It shows the amount loaned (principal), the rate of interest to be paid on the loan, and the date that the principal will be paid back (maturity date). Bonds pay periodic payments that create a fixed source of income. Mutual funds that invest primarily in bonds are called income funds.

**Cancer Resource Services (CRS):** a program administered by UnitedHealthcare or its affiliates. The CRS program provides:
- specialized consulting services, on a limited basis, to you and your eligible dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

**Certificate of creditable coverage:** a document that provides proof of prior health coverage by a previous employer or insurer.

**Child(ren):** your children up to age 26, including, generally, natural children, step-children, legally adopted children, children placed in your home for whom adoption proceedings have begun, and children for whom you are the legal guardian. Each benefit plan may provide a slightly different definition, thus, notwithstanding the preceding, “Child(ren)” for any benefit plan shall be as defined under the portion of the SPD describing that plan.

**Coinsurance:** the percentage portion of covered charges paid by the plan and the percentage portion of covered charges paid by the plan participant.

**Common stocks:** shares, usually represented by stock certificates. If you own stock, you own a part of the Company. Your ownership gives you the right to share in dividends and to vote on corporate matters that affect shareholders.

**Company:** Ryder System, Inc. and any of its subsidiaries or affiliates that provide benefits. Also referred to as Ryder.

**Company Contributions and Company Matching Contributions:** contributions to a Participant’s 401(k) Savings Plan account made by Ryder.

**Continuing benefit period:** the period of disability that extends beyond the initial benefit period.

**Continued claim:** a period of short-term disability separated from another period of disability by a return of employment for less than or equal to 30 consecutive days, regardless of diagnosis.

**Continuation coverage:** when health care coverage ends for you and/or your dependents, you may be able to buy continuing coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). The number of months you can continue coverage depends on the reason coverage ended.

**Copay:** the amount that the participant must pay directly to a medical, dental, pharmacy or vision network provider for specific covered charges.
DEFINITIONS

Covered charge(s): the usual and prevailing charge for a medical or dental service or supply that is:
- medically necessary for the treatment of illness or injury; and
- provided by a qualified, licensed and accredited hospital, health care facility, physician, or other health care professional operating within the scope of a professional license.

Covered health service: those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse or their symptoms. A covered health service is a health care service or supply described in this booklet as a covered health service, which is not listed as an exclusion, including experimental, investigational or unproven services.

Deductible: the amount of covered charges you must pay each year before the Medical, Dental, or Prescription Plan will pay benefits.

Deductible income: for the purposes of the LTD plan, any amount you receive or are eligible to receive because of your disability under any Workers’ Compensation law or similar law, including amounts for permanent, temporary or vocational partial or total disability. This also includes any Social Security Disability or retirement benefits you, your spouse or your children under age 18 receive or are eligible to receive.

Dental specialist: a licensed dentist who has signed an agreement with a dental provider organization under which he/she agrees to provide specialized dental care service with an approved referral. Dental specialists include: Endodontists, Oral surgeons, Orthodontists, Pedodontists, and Periodontists.

Dentist: any doctor of dental surgery (D.D.S. or D.M.D.), oral surgeon, or orthodontist licensed to render dental services within the scope of their practice. This includes any other dental doctors furnishing any dental services, which such doctor is licensed to perform.

Dependent(s): each benefit plan provides a slightly different definition, thus “Dependent(s)” for any given benefit plan shall be as defined under the portion of the SPD describing that plan.

Designated Facility: A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the plan to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Disability/disabled: for the purposes of the STD program, you are considered to be disabled if, as a result of a non-occupational illness or injury, you are unable to perform the material duties of your occupation.

Disability claims manager/administrator: the agent assigned by the plan administrator to perform all duties related to or concerning the payment of LTD or STD benefits or the delivery of services.

Domestic partner: a person of the same or opposite sex, if he or she has met all of the following criteria for at least 12 months before the coverage effective date:
- the individual and you are each other’s sole domestic partner and intend to remain so indefinitely;
- the individual and you are not married to or legally separated from each other or anyone else;
- the individual and you are not related by blood or adoption to a degree of closeness that would prohibit legal marriage in the state in which he or she resides;
- the individual is at least eighteen (18) years of age and mentally competent to consent to a contract;
- the individual and you are living together in the same residence and intend to do so indefinitely; and
DEFINITIONS

- the individual and you are engaged in a committed relationship of mutual caring and support and are jointly responsible for each other's common welfare and living expenses.

Earnings: each benefit plan provides a slightly different definition, thus “Earnings” for any given benefit plan shall be as defined under the portion of the SPD describing that plan. Examples:

**Base pay:** for purposes of the STD plan, this is the amount of regular salary or wages paid by your employer just prior to the date of disability. Your base pay will not be reduced by deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. Commissions, bonuses, overtime, incentive pay or any other extra compensation are not included in base pay.

**Weekly base pay:** for the purposes of the STD plan, for field hourly, driver and warehouse employees, is the average of the last 3 months (13 weeks) of earnings starting with the most recent completed full month of work prior to the date of your disability date. Weekly base pay includes overtime, bonuses, commissions, stops, starts, trips, mileage and other applicable wages.

**Weekly base pay:** for the purposes of the STD plan, for hourly employees, this is the number of hours you are normally scheduled to work each week, up to a maximum of 40 hours, multiplied by your base hourly rate of pay. Usually your annual base pay divided by 52 weeks. Weekly base pay excludes commissions, any overtime pay, bonuses, other fringe benefits or extra income.

**Monthly base pay:** for purposes of the STD plan, for salaried employees, this is your monthly salary, not including overtime, commissions, or compensation other than base pay.

**Pre-disability earnings:** for the purposes of the LTD plan, your monthly rate of average earnings in effect on the day before you became disabled. Average earnings means the greater of your base pay or the average of the previous 2 years of total earnings as of August 31, rounded to the next higher thousand.

**Indexed pre-disability earnings:** means your monthly earnings in effect just prior to the date disability or partial disability began adjusted on the first anniversary of benefit payments and each anniversary thereafter. Your monthly earnings are increased annually by 7%, or the current annual percentage increase in the Consumer Price index, whichever is less.

**Total Annual Earnings:** the portion of earnings subject to withholding for purposes of Federal Income Taxes paid to the employee by the Company during the plan year, including: regular pay, overtime pay, vacation pay, cost-of-living allowances, bonuses, commissions, before tax contributions by an employee to a 401(k) plan or other plan involving IRS qualified salary reductions (such as section 125 cafeteria plan). All forms of imputed income, dividends paid on Restricted Stock rights and disqualifying dispositions of stock options under the Ryder System, Inc. stock plans, all types of company prerequisites and beginning with the 2002 plan cycle, cash awards and payments made under the Ryder System, Inc. Long Term Incentive Plan, are excluded.

**Life Insurance:** the amount of pay which your life insurance coverage is based on. For the purposes of the program, earnings are:

- the greater of your total earnings or base pay, determined at your date of hire and updated once per year at annual enrollment. Total earnings are based upon the 12 months prior to September 1 of the previous plan year and include base pay, commissions, bonuses, overtime pay, trips, miles and stops, vacation, holiday, and sick pay, but not disability pay.

**Eligible expenses:** the amount the Plan covers for covered health services. For network benefits, the eligible expenses are the contracted fee(s) with that provider. Reimbursement for non-network treatment is based primarily on a percentage of the published rates allowed by Medicare. The Ryder plans
reimburse non-network care at either 50% or 60% of eligible charges up to 110% of the Medicare reimbursement rate. When using non-network providers, you pay higher deductibles, higher coinsurance and you pay for any charges billed in excess of 110% of the Medicare reimbursement rate. If there is no published Medicare rate, a gap methodology will be used by the Claim Administrator to determine the eligible reimbursement.

**Emergency:** a sudden, serious, and unexpected illness, injury, or condition that requires immediate medical attention due to severe pain, or to prevent the loss of life, permanent disfigurement or impairment of a bodily function or organ, or to prevent the loss of a tooth.

**Equities:** another term for stocks. When you own a part of something, you have “equity” in it. Investments in stocks are called “equities” and mutual funds that invest in stocks are often called “equity funds.”

**Essential function:** a function that is substantial, not incidental, is fundamental or inherent to the job, and cannot be easily omitted or changed.

**Experimental or investigational services:** medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the determination is made regarding coverage in a particular case, are not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. Services subject to review and approval by any institutional review board for the proposed use or are the subject of ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial; set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight are also experimental or investigational. The claim administrator may determine that an experimental or investigational service meets the definition of a covered health service for that sickness or condition.

**Evidence of Insurability:** also known as proof of good health as required by the life and disability claims administrator when increases in coverage are requested at annual enrollment.

**Highly Compensated Employee:** an employee whose previous year’s total annual earnings are equal to or exceed the amount determined by the IRS. The IRS rules limit the percentage that higher-paid employees can contribute to the plan. As a result, the total amount you may contribute to the Dependent Day Care Flexible Spending Account and 401(k) plans may be limited to a lower percentage or the maximum allowable by law.

**Home Health Care Agency:** an organization that has been licensed or certified as a home health care agency in a state where home health care is given, or is a home health care agency as defined by Medicare and has been approved by the benefits administrator.

**Hospice:** a facility that provides short periods of stay for a terminally ill person in a homelike setting for either direct care or respite care. This facility may be either freestanding or affiliated with a hospital.

**Hospital:** an institution that meets one of the following tests:

- it is accredited as a hospital:
  - by the American Osteopathic Association;
  - by the Commission on the Accreditation of Rehabilitative Facilities; or
  - under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Healthcare Organizations.
- it is legally operated, has 24-hour-a-day supervision by a staff of doctors, has 24-hour-a-day nursing service by registered graduate nurses, and complies with either of the following:
DEFINITIONS

• It mainly provides general in-patient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities. All such facilities are under its control;
• It mainly provides specialized in-patient medical care and treatment of sick or injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All such facilities are in it, under its control, or available to it under written agreement with a hospital (as defined above) or with a specialized provider of those facilities;
• it is licensed, certified or approved as a freestanding surgical facility by the appropriate agency of the state in which it is located;
• the State Department of Health licenses it as a birth center.

A hospital is not a nursing home, institution, or part of one, which:
• is used mainly as a place for convalescence, rest, nursing care or care for the aged;
• furnishes mainly homelike (custodial) care or training in the routines of daily living; or
• is mainly a school.

Hours of service: each hour you are paid or are entitled to receive pay (such as vacation, holiday, illness, disability leave, layoff, jury duty, FMLA, military duty or military leave) for performing the duties of your job.

Ineligible status: for the purpose of eligibility, includes but is not limited to part-time status, transferring to a collective bargaining unit with no Ryder benefits and any leave of absence with no benefits.

Injury: bodily damage other than Sickness, including all related conditions and recurrent symptoms.

In-network: for the Dental and Vision Plans, treatment or services provided by network providers or provided by non-network provider but authorized by the applicable benefits administrator.

In-network provider: for the Dental and Vision Plans, a health care provider who has contracted with a provider network to provide treatment or services under the plan and to accept negotiated rates. Also, a health care provider authorized by the benefits administrator. An in-network provider is also referred to as a “participating provider.”

Investment mix: the combination of investment options that you choose.

Material duties: for the purposes of the STD and LTD programs, the essential tasks, functions and operations, and the skills, abilities, knowledge, training, and experience generally required by employers from those engaged in a particular occupation.

Maturity: the date on which a debt (bond) must be paid.

Medically necessary: service or supply required to diagnose or to treat an illness or injury in accordance with standards of good medical practice. It includes both the frequency and duration of treatment, and it must be ordered by a physician and not be educational or experimental.

Medically and psychologically necessary: medically and psychologically necessary services which:
• are adequate and essential for the evaluation and/or treatment of a disease condition or illness, as defined by standard diagnostic nomenclatures [Diagnostic and Statistical Manual of Mental Disorders [Fourth Edition] DSM-IV-R];
• can reasonably be expected to improve an individual's condition or level of functioning; and
• are in keeping with national standards of mental health professional practice (psychiatry, clinical psychology, psychiatric social work, psychiatric nursing), as defined by standard clinical references, statistical validity of the effectiveness of psychotherapy(ies), and national professional
standards referred to in your Medical Plan and its exhibits, and promulgated by National Mental Health Professional Associations.

**Medical Plan**: The Ryder System, Inc. Medical Plan, also referred to as the plan.

**Mental illness**: for the purposes of the STD plan, any psychological, behavioral, or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorder, but excluding demonstrable structural brain damage.

**Monthly LTD benefit**: a monthly sum payable to you while you are disabled. The maximum monthly benefit is $8,000. The minimum monthly benefit is $100.

**Monthly income loss**: the difference of your pre-disability earning minus your current monthly earnings.

**Mutual fund**: an investment in which your money is pooled with money from other investors and a professional money manager buys and sells securities with the money to earn a profit for investors.

**Net Asset Value (NAV)**: the price or market value of an individual share of a mutual fund. NAV is calculated at the end of every business day by adding the value of all the securities and cash in the mutual fund’s portfolio, subtracting the fund’s liabilities, and dividing that amount by the number of shares the fund has issued.

**Network**:  
- **for the Dental and Vision Plans**, a provider of health care services who has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide covered health services to covered persons.
- **For the UnitedHealthcare Medical Plan**, when used to describe a provider of health care services, Network means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator’s affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator’s ultimate corporate parent, including direct and indirect subsidiaries. A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network benefits**: **for the Dental, Vision and UnitedHealthcare Medical Plans**, benefits for covered health services that are provided by a network physician or a network provider’s office or at a network facility, also known as In-Network benefits.

**Network general dentist**: for participants in the Cigna Managed Dental Plan, a dentist whom you select from a list of providers in the Cigna Managed Dental Plan network as your primary provider and who coordinates all your dental care.

**Non-duplication of benefits**: in situations where both you and your spouse have health care coverage, your coverage is coordinated with the other insurance plan so that benefits are not duplicated. The combined benefit will not be more than the total expenses recognized under these plans. If children are covered under both parents’ health plans, the birthday rule is used to prevent duplication of benefits.
Non-network benefits: for the Dental, Vision and UnitedHealthcare Medical Plans, benefits for covered health services that are provided by or directed by a non-network physician either at a network facility or at a non-network facility, also known as Out-of-Network benefits.

Non-network provider: for the Medical and Dental Plans, a health care professional who has not contracted with a network to render treatment or services under the plan.

Orthodontia treatment lifetime maximum: the lifetime maximum the plan will pay for orthodontia treatment per participant. Benefits paid are included in the annual maximum.

Other income benefit: the amount of any benefit for loss of income, provided to you or your family, as a result of the period of disability for which you are claiming benefits from the Ryder LTD plan.

Out-of-Network provider: for the Vision Plan, a health care professional who has not contracted with a network to render services under the vision plan.

Out-of-pocket maximum: the limit on your cost for covered charges each calendar year. The amounts vary for in-network and non-network options. The out-of-pocket maximum includes the annual deductible, but does not include copays. The out-of-pocket maximum is the most an individual or family will pay in a given calendar year for deductibles and coinsurance under the Medical Plan.

Important Note: One of the most expensive decisions you can make is to seek care from non-network providers. Only when non-network expenses are charged at the Medicare reimbursement rate will the maximum annual member cost be limited to $10,000. But providers typically charge far in excess of Medicare reimbursement rates, in which case the difference is not applied to the annual non-network out-of-pocket maximum. Therefore, the maximum annual out-of-pocket expense for non-network care can exceed $10,000 per person on an unlimited basis.

Own occupation: under the LTD plan, any employment, business, trade, profession, calling, or vocation that involves material duties of the same general character as your regular ordinary employment with Ryder. Your own occupation is not limited to your job with Ryder.

Partial disability/partially disabled: under the STD plan, you are considered partially disabled if, immediately following a period of total disability for which you were eligible to receive a weekly benefit, you are:
- still prevented by the same disabling condition from performing essential duties of your occupation; but
- you have recovered to the extent you are:
  - able to perform some, but not all, of the essential duties of your or any occupation; and
  - as a result, you are earning more than 20% but no more than 80% of your pre-disability weekly earnings.

Participating provider: for the Dental Plan, a licensed general practitioner who has signed an agreement with the Cigna Dental plan under which they agree to provide dental care services.

Patient charge schedule: a list of covered benefits and charges applicable under the Cigna Managed Dental Plan.

Physical disease: an entity or process that produces structural or functional changes in your body as diagnosed by a physician.
DEFINITIONS

Physician: for the purposes of the medical, STD and LTD plans, a licensed practitioner of the healing arts acting within the scope of his or her license. Covered physicians include: (This list is all inclusive.)
- a medical doctor (MD) or surgeon;
- an osteopath, podiatrist, or chiropodist;
- a chiropractor, except that services are limited to the correction and treatment of the extremities and/or a subluxation of the spine;
- a nurse midwife under the supervision of a physician;
- physical therapist;
- psychologist or psychiatrist;
- dentist or oral surgeon; or
- acupuncturist.

Note: Specifically excluded from this definition are naturopaths, religion-affiliated practitioners, optometrists, and opticians, whether or not licensed under any legal authority.

Plan administrator: the named fiduciary within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) appointed under the plan with the authority to control and manage the operation and administration of the plan. The Plan Administrator for the Ryder System, Inc. employee benefit plans is the Vice President of the Compensation and Benefits, except that the Plan Administrator of the 401(k) Savings Plan and the Retirement Plan is the Ryder Retirement Committee.

Plan payment: the amount the plan pays for covered services. The amount depends on the type of service received and the benefit option you elect.

Post-tax: money that is deducted from your paycheck after Social Security, federal and most state income taxes are deducted.

Predetermination of benefits: an estimate supplied by the benefits administrator of the amount of benefit the dental plan will pay toward a specified course of treatment.

Pre-existing condition: for the purposes of the STD and LTD plans, a pre-existing condition is a mental or physical condition for which you have consulted a physician, received medical treatment or services, or taken prescribed drugs or medications at any time during the 3-month period just before the date your STD and/or LTD coverage becomes effective. You are not covered for a disability caused or contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition unless, on the date you become disabled, you:
- have been continuously insured under the plan for at least 12 months; and
- have been actively at work for at least one full day after the end of those 12 months.

Preferred Provider Organization (PPO): a group of hospitals and physicians who contract with the benefits administrator to provide health care services under the laws of the state where its service areas are located.

Pre-tax: money deducted from your paycheck before Social Security, federal and most state income taxes are deducted except that, in the 401(k) Savings Plan, your pre-tax contributions are subject to Social Security and certain other employment taxes.

Proof of good health: also known as evidence of insurability as required by the life and disability claims administrator when increases in coverage are requested at annual enrollment or at other times as appropriate.

Prospectus: provides investors with a thorough description of a mutual fund or stock, including an explanation of the fund’s objective, how money is invested, and the fees and expenses associated with the fund.
**Qualified Life Event:** any of the following events that affect both the need for benefits and the participant's financial ability to provide those benefits. The Internal Revenue Service defines Qualified Life Event. They include, but are not limited to, the following:

- marriage or divorce of the employee;
- birth or adoption of a child;
- death of a spouse or other dependent;
- spouse's gain or loss of employment;
- employee's or spouse's change in employment status from full-time to part-time (or vice versa);
- employee or spouse taking an unpaid leave of absence;
- a significant change in health care coverage or cost of coverage for employee and/or spouse that is attributable to spouse's employment; and
- other events that are approved by the plan administrator and are consistent with IRS statutes or regulations.

**Qualified Domestic Relations Order (QDRO):** a court order or judgment that meets specific requirements to pay all or a portion of your savings plan benefits to a former spouse or dependent.

**Rollover:** a transfer of money from one tax-qualified savings or 401(k) plan to another.

**S&P 500:** a market value-weighted index created by Standard & Poor’s covering the stock of 500 utility, industrial, transportation, and financial companies.

**Savings plan:** The Ryder System, Inc. 401(k) Savings Plan. Also referred to as the 401(k) plan or the plan.

**Securities:** refers to all investments, including stocks, bonds, short-term securities, and shares of mutual funds.

**Sickness:** disability is deemed to be caused by sickness, rather than accident, if it is caused or contributed by: any condition, disease, or disorder of the body or mind; any infection, except a pus-forming infection of an accidental cut or wound; hernia of any type; any disease of the heart; mental illness; substance abuse; or pregnancy.

**Stock (equity):** a unit of ownership sold by a company that sells stock to raise money. When you buy stocks, you become an owner of a piece of the company.

**Substance abuse:** for the purposes of the STD and LTD plans, a pattern of pathological use of alcohol, other psychoactive drugs, and substances characterized by:

- impairments in social and/or occupational functioning;
- debilitating physical condition;
- inability to abstain from or reduce consumption of the substance; or
- the need for daily substance use to maintain adequate functioning.

**Tax-deferred contributions:** the before-tax amount a participant elects to contribute to the 401(k) Savings Plan. Tax-deferred contributions are not subject to federal income taxes when deposited into the 401(k) Savings Plan. However, these contributions are subject to federal income tax when withdrawn from the plan.

**Tax-qualified plan:** one that meets certain IRS requirements and is eligible for special tax advantages, such as tax-deferred contributions and earnings.

**Terminally ill/terminal illness:** an individual who has a life expectancy of 12 months or less.
**Total disability/totally disabled:** for the purposes of the LTD plan, means that you are prevented by: accidental bodily injury; sickness; mental illness; substance abuse; or pregnancy, from performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability weekly earnings.

**Usual and prevailing charge:** the charge for services, treatments, supplies, or medications essential to the care of the covered individual, which are the lesser of:
- the actual charges for such services, treatments, supplies or medications; or
- the amount normally charged for comparable services, treatments, supplies or medications by most providers in the locality where the charges were incurred when furnished to an individual of the same sex and age for a similar sickness or injury.

The benefits administrator determines the allowable amount for each service, treatment, supply or medication.

**Vesting (Vested):** the process by which you gain ownership of Company contributions to the 401(k) Savings Plan. You are vested after you have completed 60 or more months of service with Ryder. You are always 100% vested in your contributions to the plan.

**Year of service:** a calendar year of employment in which you work at least 1,000 hours. An employee’s first year of service shall be the one-year period beginning on his first date of employment, for purposes of determining eligibility for participation in the 401(k) Savings and Retirement plans.
RYDER SEVERANCE PLAN

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

I. ARTICLE - INTRODUCTION

Ryder System, Inc. (the “Company”) established the Ryder Severance Plan (the “Plan”), effective as of January 1, 2007 and as amended and restated as of June 1, 2010, to provide temporary and short-term unemployment type benefits to certain employees of the Company and its participating affiliates who suffer a loss of employment under the terms and conditions set forth in the Plan. The Plan is hereby amended and restated effective as of January 1, 2013. The Plan replaces and supersedes any and all severance plans, policies, guidelines and/or practices of the Company and its participating affiliates in effect for their employees prior to January 1, 2013, and such other plans, policies, guidelines and/or practices are amended to effectuate the foregoing, with the exception of any individual written agreement between an employee and the Company regarding severance benefits. The Plan is intended to fall within the definition of an “employee welfare benefit plan” under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan may not be amended except in accordance with the terms set forth below.

Please note that the existence of this Plan in no way alters or modifies any other terms of an individual’s employment with the Employer.

II. ARTICLE - DEFINITIONS AND INTERPRETATIONS

The following definitions and interpretations of important terms apply to the Plan.

1. **Base Pay.** For purposes hereof, Base Pay shall mean such person’s basic hourly rate from his or her Employer as of the date of his or her Termination of Employment multiplied by the normal hours the Employee was regularly scheduled to work. Base Pay shall be determined as reflected on the applicable Employer’s payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation or other additional compensation. For purposes hereof, an Employee’s Base Pay shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended.

2. **Base Salary.** For purposes hereof, Base Salary shall mean such person’s base salary or wages from his or her Employer as of the date of his or her Termination of Employment. Base Salary shall be determined as reflected on the applicable Employer’s payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation, COLA, hardship pay, assignment premiums (if not included in base pay), or other additional compensation. For purposes hereof, an Employee’s Base Salary shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended (the “Code”).

3. **Company.** Ryder System, Inc.

4. **Effective Date.** January 1, 2013.
5. **Employee.** Any regular full-time employee of the Employer who works in the United States (including eligible expatriates, and excluding employees based in Puerto Rico) other than: (i) an individual who is entitled to similar severance-type or termination benefits or has entered into a written agreement with the Company or an affiliate, predecessor or successor of the Company that provides the individual with severance, termination, or any similar benefits payable in the event of his or her termination of employment; (ii) any designated employee represented by a union or covered by a collective bargaining agreement; (iii) any non-officer eligible for severance-like compensation; (iv) any driver or warehouse worker; (v) any supply chain worker hired or rehired on or after January 1, 2013 and covered under the Ryder Severance Plan for Eligible Supply Chain Employees (as such Plan may be amended from time to time) or (vi) any employees hired on the Company's General Motors Lead Logistics Provider account on or after May 31, 2010. The term “Employee” shall also not include any individual (i) designated by the Employer as an independent contractor and not as an employee at the time of any determination, (ii) being paid by or through an employee leasing company or other third party agency, (iii) designated by the Employer as a freelance worker and not as an employee at the time of any determination, (iv) designated by the Employer as a seasonal, occasional, casual, limited duration, or temporary employee, during the period the individual is so paid or designated, or (v) designated by the Employer as a leased employee, during the period the individual is so paid or designated; and any such individual listed in (i), (ii), (iii), (iv) or (v) shall not be an Employee even if he or she is later retroactively reclassified as a common-law employee of the Employer during all or any part of such period pursuant to applicable law or otherwise.

6. **Employer.** The Company and each affiliate or subsidiary of the Company that participates in the Plan with the approval of the Company’s Board of Directors.

7. **Just Cause.** Any one of the following reasons for the discharge or other separation of an Employee from employment with an Employer:

(i) any act or omission by the Employee resulting or intended to result in personal gain at the expense of any Employer;

(ii) the improper disclosure by the Employee of proprietary or confidential information, or trade secrets of any Employer, including, without limitation, pricing information, client lists, or business processes;

(iii) misconduct by the Employee, including, but not limited to:

- fraud,
- intentional violation of or negligent disregard for the rules and procedures of the Employer or actions or inactions resulting in harm to the Employer (including a violation of the Employer's Principles of Business Conduct, the Employer's Employee Handbook, or any other policy or practice of the Employer),
- insubordination,
- theft,
- violent acts or threats of violence,
- conviction of a felony,
- conviction of a misdemeanor with a nexus to the Employee’s employment,
- breach of trust or dishonesty, or
- unauthorized possession or use of alcohol or controlled substances on the property of the Employer or unauthorized use of alcohol or controlled substances while on business for the Employer. The determination of whether an Employee has engaged in unauthorized use of alcohol while on business for the Employer will be determined by the Plan Administrator in its sole and absolute discretion;
(iv) excessive absenteeism or lateness which does not qualify as legitimate time off pursuant to any rights under federal or state law;

(v) poor job performance;

(vi) any other act that the Employer shall deem detrimental to the Company.

The determination of whether a discharge or other separation from employment is for Just Cause shall be made by the Plan Administrator, in its sole and absolute discretion, and such determination shall be conclusive and binding on the affected Employee.

8. **Participant.** An Employee who meets the requirements for eligibility under the Plan, as set forth in Article III of the Plan. An individual shall cease being a Participant once all benefits payable to such individual under the Plan have been completed (or earlier upon the death of the Participant) and no person shall have any further rights under this Plan with respect to such former Participant.

9. **Plan Administrator.** The Plan Administrator shall be the Chief Administrative Officer.

10. **Termination of Employment.**

A. The termination by the Employer of an Employee’s employment relationship with the Employer as the result of a bona fide job elimination. Notwithstanding the foregoing, a bona fide job elimination will not be considered a Termination of Employment if:

(i) an Employee is offered, but refuses, employment with the Employer, its businesses or its affiliated companies (or a joint venture owned by any such entity) in a position that provides the Employee with substantially equivalent base pay and job responsibilities (unless the position requires the Employee to unreasonably relocate), as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence, including but not limited to job descriptions, offer letters, and pay records.

(ii) an Employee works in a business (or the portion of such business) of the Employer (a) which is sold in whole or in part to another corporation or company, whether by sale of stock or assets, (b) which is merged or consolidated with another corporation or company or is part of a similar corporate transaction or (c) which is outsourced, insourced or otherwise transferred or lost to another corporation or company including, but not limited to, the customer, a purchaser, surviving business, competitor, vendor, supplier, or temporary agency, (the “New Employer”), and the Employee is offered employment, whether temporary, part time or full time with the New Employer whether or not s/he accepts any such position and whether or not the offer occurs prior to or during the term of the severance period in a position that provides the Employee with substantially equivalent base pay and job responsibilities and does not require the Employee to unreasonably relocate, as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence, including but not limited to job descriptions, offer letters, and pay records. Decisions by the Plan Administrator are final. For the avoidance of doubt, any short term or temporary assignment with the New Employer during the transition period will disqualify the Employee from receiving severance benefits.
B. Termination of Employment shall not include any discharge or other separation of employment other than for those reasons enumerated in section 11.A. Nor, by way of example, will a Termination of Employment occur under any of the following circumstances:

(i) for Just Cause;

(ii) an Employee’s voluntary resignation, job abandonment, or retirement;

(iii) death or disability of the Employee; or

(iv) the Employee fails to return to active employment after a cessation of disability or following a termination of an approved leave of absence.

An indefinite or temporary layoff or reduction in force does not constitute a Termination of Employment unless the layoff or reduction in force is permanent. The determination as to whether a layoff or reduction in force is permanent shall be made by the Plan Administrator at the time of such layoff or reduction in force, in its sole and absolute discretion, and such determination shall be final and binding on all affected Employees. An Employee’s Termination of Employment shall occur on the last day of his or her employment with the Employer.

11. Years of Service. A Year of Service shall be measured as a full 12 month consecutive period. No credit shall be provided for any fraction of a Year of Service. The Years of Service shall be based upon the Employee’s adjusted hire date, as indicated in the Employer’s records. If an Employee is rehired after having received any severance benefits under this Plan or any other plan or program, the Years of Service shall be based upon his or her latest date of hire.

III. ARTICLE - ELIGIBILITY FOR SEVERANCE BENEFITS

An Employee becomes eligible for severance under the Plan (i.e., becomes a “Participant”) if such Employee: (i) either (A) experiences a Termination of Employment, or (B) is notified in writing that the Plan Administrator, in its sole and absolute discretion, has decided to grant the Employee eligibility hereunder, and (ii) satisfies the conditions of Article IV.

IV. ARTICLE - CONDITIONS TO RECEIVE SEVERANCE BENEFITS

Notwithstanding anything herein to the contrary, severance benefits shall be paid under the Plan in consideration of the Employee executing an agreement and general release in such form acceptable to the Company, in its sole discretion, under which, among other things, the Employee releases and discharges the Employer from all claims and liabilities relating to the Employee’s employment with the Employer and/or the termination of the Employee’s employment, including without limitation, any claims under any federal, state or local statute or ordinance, including but not limited to those under the Age Discrimination in Employment Act of 1967. An Employee shall become a Participant and payment of severance under the Plan will be paid only after the agreement and general release has been signed and the time for the Employee to revoke the agreement and general release, if any, has expired (the “Release Effective Date”).

V. ARTICLE - THE AMOUNT OF SEVERANCE BENEFITS

1. Severance Pay. A Participant will be entitled to receive severance pay under the Plan based on the Participant’s position with the Employer immediately prior to the Termination of Employment.
and the Participant’s Years of Service with the Employer as set forth in Schedule A. The Employer has no obligation to re-hire any Participant who received severance. If a Participant is rehired by the Employer while still receiving severance benefits under this Plan, any severance benefits then payable to the Participant shall cease upon the date of rehire. The Employer reserves the right to deduct from the severance pay any salary or incentive overpayments or other amounts improperly or inadvertently paid to the Participant during the course of employment, unless such deduction is otherwise prohibited by law or in violation of Section 409A of the Code.

2. **Extension of Benefits.** In connection with a termination of employment, Participants (and their eligible dependents) may be entitled to elect to continue coverage under the Company’s group medical, prescription, vision and dental insurance plans and the Company’s Health Care Reimbursement Account on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”) if the Participant was a participant in such plans as of his or her termination date. If an Employee becomes a Participant and elects COBRA coverage for him or herself and/or his or her eligible dependents, the Company will pay a portion of the COBRA premiums for the number of weeks the Participant is entitled to severance pay under the Plan, except that the Company will not pay any portion of the COBRA premiums for drivers or warehouse workers. Specifically, for such period, the Company will reduce the COBRA premiums by the amount it pays at such time for active employees’ insurance premiums. The Participant will be responsible for the remaining amount of the COBRA premium. All other provisions of Participants’ COBRA coverage will be in accordance with the applicable plan in effect for active employees of the Company (including any applicable copayments, deductibles and other out-of-pocket expenses). Participants should refer to the Company’s group medical, prescription and dental plans and Health Care Reimbursement Account Plan for additional information regarding their rights and obligations under COBRA.

3. **No Continuation of Non-COBRA Benefits.** Participation in any Company short-term disability plan, long-term disability plan, employee stock purchase plan, accidental death and dismemberment plan, life insurance and/or additional life insurance plan, Dependent Care Reimbursement Account or business travel accident plan will end as of the Termination of Employment date. Participants should refer to the plan documents for the life insurance plan to determine applicable conversion rights. Coverage under the Company’s legal plan will end as of the last day of the month in which the Termination of Employment date occurs. Participation in any other benefits under the Company’s health, welfare or retirement benefits plans will end as of the Termination of Employment date.

4. **Non-Duplications of Benefits.** If a Participant receives severance benefits under the Plan, such Participant shall not be entitled to receive any other severance, separation, notice or termination payments on account of his or her employment with the Employer under any other plan, policy, program or agreement, except as provided in the agreement and general release referenced in Article IV of the Plan or otherwise prohibited by Section 409A of the Code. If, for any reason, a Participant becomes entitled to or receives any other severance, separation, notice or termination payments on account of his or her employment or Termination of Employment with the Employer, including, for example, any payments required to be paid to the Participant under any Federal, State or local law or pursuant to any agreement (except unemployment benefits payable in accordance with state law and payment for accrued but unused vacation and benefits as described in the release), his or her severance under the Plan will be reduced by the amount of such other payments paid or payable, to the extent permitted by Section 409A of the Code. A Participant must notify the Plan Administrator if he or she receives or is claiming to be entitled to receive any such payment(s).
VI. ARTICLE - HOW AND WHEN SEVERANCE WILL BE PAID

Severance pay under the Plan will be paid to a Participant in the form of periodic installments in accordance with Schedule A hereto; provided that, the Plan Administrator, in its sole and absolute discretion, may provide severance pay to a Participant in the form of a single lump sum payment to the extent permitted under Section 409A of the Internal Revenue Code. Notwithstanding anything in the Plan to the contrary, no severance payments will be made to a Participant after December 31 of the second calendar year following the calendar year in which the Termination of Employment occurs.

VII. ARTICLE - MISCELLANEOUS PROVISIONS

1. Amendment and Termination. The Company reserves the right, in its sole and absolute discretion, to terminate, amend or modify the Plan, in whole or in part, at any time and for any reason. If the Plan is terminated, amended or modified, an individual’s right to participate in, or to receive severance benefits under, the Plan may be changed; provided, however, that severance payable to a Participant who has incurred a Termination of Employment prior to such termination, amendment or modification of the Plan, shall not be reduced by the termination, amendment or modification.

2. No Additional Rights Created. Neither the establishment of this Plan, nor any modification thereof, nor the payment of any severance benefits hereunder, shall be construed as giving to any Participant, Employee (or any beneficiary of either), or other person any legal or equitable right against the Employer or any officer, director or employee thereof; and in no event shall the terms and conditions of employment by the Employer of any Employee be modified or in any way affected by this Plan.

3. Records. The records of the Employer with respect to Years of Service, employment history, base pay, absences, and all other relevant matters shall be conclusive for all purposes of this Plan.

4. Construction. The respective terms and provisions of the Plan shall be construed, whenever possible, to be in conformity with the requirements of ERISA, or any subsequent laws or amendments thereto. To the extent not in conflict with the preceding sentence or another provision in the Plan, the construction and administration of the Plan shall be in accordance with the laws of the State of Florida applicable to contracts made and to be performed within the State of Florida (without reference to its conflicts of law provisions).

5. Severability. Should any provisions of the Plan be deemed or held to be unlawful or invalid for any reason, such fact shall not adversely affect the other provisions of the Plan unless such determination shall render impossible or impracticable the functioning of the Plan, and in such case, an appropriate provision or provisions shall be adopted so that the Plan may continue to function properly.

6. Incompetency. In the event that the Plan Administrator finds that a Participant is unable to care for his or her affairs because of illness or accident, then the severance benefits payable hereunder, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, may be paid in such manner as the Plan Administrator shall determine, to the extent permitted by Section 409A of the Code, and the application thereof shall be a complete discharge of all liability for any payments or severance benefits to which such Participant (or designated beneficiary) was or would have been otherwise entitled under this Plan.

7. Plan Not a Contract of Employment. Nothing contained in this Plan shall be held or construed to create any liability upon the Employer to retain any Employee in its service. All Employees shall
remain subject to discharge or discipline to the same extent as if the Plan had not been put into effect. An individual who is receiving severance under this Plan shall not be considered an Employee immediately upon his or her Termination of Employment.

8. **Financing.** The severance benefits payable under this Plan shall be paid out of the general assets of the Company. No Participant or any other person shall have any interest whatsoever in any specific asset of any Employer. To the extent that any person acquires a right to receive payments under this Plan, such right shall not be secured by any assets of any Employer.

9. **Nontransferability.** In no event shall the Company (or any other Employer) make any payment under this Plan to any assignee or creditor of a Participant, except as otherwise required by law. Prior to the time of a payment hereunder, a Participant shall have no rights by way of anticipation or otherwise to assign or otherwise dispose of any interest under this Plan, nor shall rights be assigned or transferred by operation of law.

10. **Tax Matters.** All payments made hereunder shall be subject to applicable tax and other withholding as determined by the Company.

11. **Section 409A of the Code.** Notwithstanding anything herein to the contrary, the Company shall have the right to defer a payment hereunder so as to avoid negative tax consequences under Section 409A of the Code, and such payment shall be made on the first day on which no negative tax consequences will be imposed on the Participant under Section 409A. No payments shall be made hereunder unless a Participant’s Termination of Employment constitutes a “separation from service” as defined by Section 409A of the Code and the regulations issued thereunder. For purposes of determining whether a “separation from service” has occurred, pursuant to Treas. Reg. §1.409A-1(h)(3), the Company has elected to use “at least 80 percent” each place it appears in Sections 1563(a)(1), (2), and (3) of the Code and in Treas. Reg. §1.414(c)-2. Severance payments hereunder are intended to constitute separation pay due to an involuntary separation from service under Section 409A.

### VIII. ARTICLE - WHAT ELSE A PARTICIPANT NEEDS TO KNOW ABOUT THE PLAN

1. **Claim Procedure.** An individual or his or her beneficiary (if applicable) may file a written claim with the Plan Administrator with respect to his or her rights to receive a benefit from the Plan. The claimant will be informed of the decision of the Plan Administrator with respect to the claim within 90 days after it is filed. Under special circumstances, the Plan Administrator may require an additional period of not more than 90 days to review a claim. If this occurs, the claimant will be notified in writing as to the length of the extension, the reason for the extension, and any other information needed in order to process the claim. If the claimant is not notified within the 90-day (or 180-day, if so extended) period, he or she may consider the claim to be denied.

   If a claim is denied, in whole or in part, the claimant will be notified in writing of the specific reason(s) for the denial, the exact plan provision(s) on which the decision was based, what additional material or information is relevant to his or her case, and what procedure the claimant should follow to get the claim reviewed again. The claimant then has sixty (60) days to appeal the decision to the Plan Administrator.

   The appeal must be submitted in writing to the Plan Administrator. A claimant may request to review pertinent documents, and may submit a written statement of issues and comments.

   A decision as to a claimant's appeal will be made within sixty (60) days after the appeal is received. Under special circumstances, the Plan Administrator may require an additional period of not more than 60 days to review an appeal. If this occurs, the claimant will be notified in writing.
as to the length of the extension, not to exceed 120 days from the day on which the appeal was
received.

If a claimant's appeal is denied, in whole or in part, he or she will be notified in writing of the
specific reason(s) for the denial and the exact plan provision(s) on which the decision was based.
The decision on an appeal of the Plan Administrator will be final and binding on all parties and
persons affected thereby. If a claimant is not notified within the 60-day (or 120-day, if so
extended) period, he or she may consider the appeal as denied.

2. Plan Interpretation and Benefit Determination. The Plan is administered and operated by the
Plan Administrator who has complete authority, with respect to matters within its jurisdiction, in its
sole and absolute discretion, to construe the terms of the Plan (and any related or underlying
documents or policies), and to determine the eligibility for, and amount of, severance benefits due
under this Plan to Participants and their beneficiaries. All such interpretations and determinations
(including factual determinations) of the Plan Administrator shall be final and binding upon all
parties and persons affected thereby. The Plan Administrator may appoint one or more
individuals and delegate such of its powers and duties as it deems desirable to any such
individual(s), in which case every reference herein made to the Plan Administrator shall be
deemed to mean or include the appointed individual(s) as to matters within their jurisdiction.

3. Participants’ Rights Under ERISA. Participants of the Plan are entitled to certain rights and
protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator’s office, all Plan documents, and copies of all
documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports
and Plan descriptions.

Obtain copies of Plan documents and other Plan information upon written request to the Plan
Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report if the Plan covers 100 or more people.
The Plan Administrator is required by law to furnish each Participant with a copy of this summary
annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are
responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of
the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.
No one, including the Company or any other person, may fire an employee or otherwise
discriminate against an employee in any way to prevent him/her from obtaining a benefit or
exercising his/her rights under ERISA. If a Participant’s claim for a benefit is denied in whole or in
part, he/she must receive a written explanation of the reason for the denial. Participants have the
right to have the Plan Administrator review and reconsider their claims. Under ERISA, there are
steps that Participants can take to enforce the above rights.

For instance, if a Participant requests materials from the Plan Administrator and does not receive
them within 30 days, he/she may file suit in a federal court. In such a case, the court may require
the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the
Participant receives the materials, unless the materials were not sent because of reasons beyond
the control of the Plan Administrator.

If a Participant has a claim for severance benefits which is denied or ignored, in whole or in part,
he/she may file suit in a state or federal court. If he/she is discriminated against for asserting
his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit in
a federal court. The court will decide who should pay court costs and legal fees. If the
Participant is successful, the court may order the person the Participant has sued to pay these costs and fees. If the Participant loses, the court may order him/her to pay these costs and fees, for example, if it finds the claim is frivolous. If a Participant has any questions about the Plan, he/she should contact the Plan Administrator. Any questions about this statement or about any rights under ERISA should be directed to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

4. **Plan Document.** This document shall constitute the plan document and summary plan description of the Plan.

5. **Other Important Facts:**

   OFFICIAL NAME OF THE PLAN: Ryder Severance Plan

   SPONSOR: Ryder System, Inc.
   11690 NW 105 St.
   Miami, FL 33178-1103
   305.500.3726

   EMPLOYER IDENTIFICATION NUMBER (EIN): 59-0739250

   PLAN NUMBER: 526

   TYPE OF PLAN: Employee Welfare Severance Benefit Plan

   END OF PLAN YEAR: December 31st

   TYPE OF ADMINISTRATION: Employer Administered

   PLAN ADMINISTRATOR: Chief Administrative Officer
   11690 NW 105 St.
   Miami, Florida 33178-1103
   305.500.4743

   AGENT FOR SERVICE OF LEGAL PROCESS: Executive Vice President -- General Counsel
   11690 NW 105 St.
   Miami, Florida 33178-1103
   305.500.7797

   RESTATEMENT EFFECTIVE DATE: January 1, 2013

The Plan Administrator keeps records of the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions that an individual may have about the Plan.

Service of legal process may be made upon the Plan Administrator.
No individual may, in any case, become entitled to additional severance benefits or other rights under this Plan after the Plan is terminated. Under no circumstances, will any benefit under this Plan ever vest or become nonforfeitable, except as provided in Section 1 of Article VII.

Severance pay is subject to Federal and state income and Social Security tax withholdings and any other withholdings mandated by law.

For All Participants

Vacation. All Participants receive earned but unused vacation in accordance with the Company’s vacation policy.

Outplacement. Outplacement services will be paid by the Company on a Participant’s behalf in an amount to be determined at the Plan Administrator’s sole discretion.

These are the only Severance Benefits to which a Participant is entitled except as provided in Sections 2 and 3 of Article V. No other fringe benefits, including, but not limited to, car allowances, outplacement incidentals, cell phones allowances, or other perquisites are to be paid as severance.
SCHEDULE A
Eligible Non-Exempt and Hourly Employees
One week Base Pay per Year of Service for first 10 years, plus
Two weeks Base Pay per Years of Service over 10 years
Minimum: 2 weeks Base Pay
Maximum: 36 weeks Base Pay

Participants with less than one (1) Year of Service receive two (2) weeks of Base Pay.

Eligible Exempt Employees

MS 01-07, SA 10, 63, 64, 65, 66, 67, 72, 75, 77, IT 30-31 and AA01, 02
One week Base Salary per Year of Service for first 10 years, plus
Two weeks Base Salary per Years of Service over 10 years
Minimum: 4 weeks base salary
Maximum: 36 weeks base salary

MS 08-09, IT-32 and SA 12, 13, 18, 43, 68, 70, 79
One week Base Salary per Year of Service for first 10 years, plus
Two weeks Base Salary per Years of Service over 10 years
Minimum: 8 weeks base salary
Maximum: 36 weeks base salary

MS 10, IT-33 and SA44
One week Base Salary per Year of Service for first 10 years, plus
Two weeks Base Salary per Years of Service over 10 years
Minimum: 12 weeks base salary
Maximum: 36 weeks base salary

MS 11-13, and SA16, 17, 19, 38, 46, 47, 48, 49, 89
One week Base Salary per Year of Service for first 10 years, plus
Two weeks Base Salary per Years of Service over 10 years
Minimum: 26 weeks base salary
Maximum: 39 weeks base salary
Directors must be employed by the Company for one year to be eligible for severance.

Revised: January 1, 2013
RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

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.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

I. ARTICLE - INTRODUCTION

Ryder System, Inc. (the “Company”) established the Ryder Severance Plan for Eligible Supply Chain Employees (the “Plan”), effective as of January 1, 2013, to provide temporary and short-term unemployment type benefits to certain supply chain employees of the Company and its participating affiliates who are hired or rehired on or after January 1, 2013 and who suffer a loss of employment under the terms and conditions set forth in the Plan. The Plan replaces and supersedes any and all severance plans, policies, guidelines and/or practices of the Company and its participating affiliates in effect for their applicable supply chain employees prior to the effective date of this Plan, and such other plans, policies, guidelines and/or practices are amended to effectuate the foregoing, with the exception of any individual written agreement between an employee and the Company regarding severance benefits. The Plan is intended to fall within the definition of an “employee welfare benefit plan” under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan may not be amended except in accordance with the terms set forth below.

Please note that the existence of this Plan in no way alters or modifies any other terms of an individual’s employment with the Employer.

II. ARTICLE - DEFINITIONS AND INTERPRETATIONS

The following definitions and interpretations of important terms apply to the Plan.

1. **Base Pay.** For purposes hereof, Base Pay shall mean such person’s basic hourly rate from his or her Employer as of the date of his or her Termination of Employment multiplied by the normal hours the Employee was regularly scheduled to work. Base Pay shall be determined as reflected on the applicable Employer’s payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation or other additional compensation. For purposes hereof, an Employee’s Base Pay shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended.

2. **Base Salary.** For purposes hereof, Base Salary shall mean such person’s base salary or wages from his or her Employer as of the date of his or her Termination of Employment. Base Salary shall be determined as reflected on the applicable Employer’s payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation, COLA, hardship pay, assignment premiums (if not included in base pay), or other additional compensation. For purposes hereof, an Employee’s Base Salary shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended (the “Code”).

3. **Company.** Ryder System, Inc.

4. **Effective Date.** January 1, 2013.
5. **Employee.** Any regular full-time employee of the Employer (whether exempt, non-exempt or hourly) who works in the United States (including eligible expatriates and excluding employees based in Puerto Rico) and who: (i) was hired or rehired on or after January 1, 2013; (ii) works within the supply chain business of the Employer; and (iii) is designated to be within management levels MS01 - MS07 or equivalent SA, IT and AA positions as outlined on Schedule A or is a non-exempt or hourly worker. The term “Employee” shall exclude (a) all other employees of the Employer, (b) drivers and warehouse workers, and (c) employees hired on the Company’s General Motors Lead Logistics Provider account on or after May 31, 2010. The term “Employee” shall also exclude any individual (i) designated by the Employer as an independent contractor and not as an employee at the time of any determination, (ii) being paid by or through an employee leasing company or other third party agency, (iii) designated by the Employer as a freelance worker and not as an employee at the time of any determination, (iv) designated by the Employer as a seasonal, occasional, casual, limited duration, or temporary employee, during the period the individual is so paid or designated, or (v) designated by the Employer as a leased employee, during the period the individual is so paid or designated; and any such individual listed in (i), (ii), (iii), (iv) or (v) shall not be an Employee even if he or she is later retroactively reclassified as a common-law employee of the Employer during all or any part of such period pursuant to applicable law or otherwise.

6. **Employer.** The Company and each affiliate or subsidiary of the Company that participates in the Plan with the approval of the Company’s Board of Directors.

7. **Just Cause.** Any one of the following reasons for the discharge or other separation of an Employee from employment with an Employer:

   (i) any act or omission by the Employee resulting or intended to result in personal gain at the expense of any Employer;

   (ii) the improper disclosure by the Employee of proprietary or confidential information, or trade secrets of any Employer, including, without limitation, pricing information, client lists, or business processes;

   (iii) misconduct by the Employee, including, but not limited to:
      - fraud,
      - intentional violation of or negligent disregard for the rules and procedures of the Employer or actions or inactions resulting in harm to the Employer (including a violation of the Employer’s Principles of Business Conduct, the Employer’s Employee Handbook, or any other policy or practice of the Employer),
      - insubordination,
      - theft,
      - violent acts or threats of violence,
      - conviction of a felony,
      - conviction of a misdemeanor with a nexus to the Employee’s employment,
      - breach of trust or dishonesty, or
      - unauthorized possession or use of alcohol or controlled substances on the property of the Employer or unauthorized use of alcohol or controlled substances while on business for the Employer. The determination of whether an Employee has engaged in unauthorized use of alcohol while on business for the Employer will be determined by the Plan Administrator in its sole and absolute discretion;

   (iv) excessive absenteeism or lateness which does not qualify as legitimate time off pursuant to any rights under federal or state law;

   (v) poor job performance;
(vi) any other act that the Employer shall deem detrimental to the Company.

The determination of whether a discharge or other separation from employment is for Just Cause shall be made by the Plan Administrator, in its sole and absolute discretion, and such determination shall be conclusive and binding on the affected Employee.

8. Participant. An Employee who meets the requirements for eligibility under the Plan, as set forth in Article III of the Plan. An individual shall cease being a Participant once all benefits payable to such individual under the Plan have been completed (or earlier upon the death of the Participant) and no person shall have any further rights under this Plan with respect to such former Participant.

9. Plan Administrator. The Plan Administrator shall be the Chief Administrative Officer.

10. Termination of Employment.

A. The termination by the Employer of an Employee’s employment relationship with the Employer as the result of a bona fide job elimination. Notwithstanding the foregoing, a bona fide job elimination will not be considered a Termination of Employment if:

(i) an Employee is offered, but refuses, employment with the Employer, its businesses or its affiliated companies (or a joint venture owned by any such entity) in a position that provides the Employee with substantially equivalent base pay and job responsibilities (unless the position requires the Employee to unreasonably relocate), as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence including but not limited to job descriptions, offer letters, and pay records.

(ii) an Employee works in a business (or the portion of such business) of the Employer (a) which is sold in whole or in part to another corporation or company, whether by sale of stock or assets, (b) which is merged or consolidated with another corporation or company or is part of a similar corporate transaction or (c) which is outsourced, insourced or otherwise transferred or lost to another corporation or company including, but not limited to, the customer, a purchaser, surviving business, competitor, vendor, supplier, or temporary agency, (the “New Employer”), and the Employee is offered employment, whether temporary, part time or full time with the New Employer whether or not s/he accepts any such position and whether or not the offer occurs prior to or during the term of the severance period in a position that provides the Employee with substantially equivalent base pay and job responsibilities and does not require the Employee to unreasonably relocate, as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence, including but not limited to job descriptions, offer letters, and pay records. Decisions by the Plan Administrator are final. For the avoidance of doubt, any short term or temporary assignment with the New Employer during the transition period will disqualify the Employee from receiving severance benefits.

B. Termination of Employment shall not include any discharge or other separation of employment other than for those reasons enumerated in section 11.A. Nor, by way of example, will a Termination of Employment occur under any of the following circumstances:

(i) for Just Cause;
(ii) an Employee’s voluntary resignation, job abandonment, or retirement;
(iii) death or disability of the Employee; or
(iv) the Employee fails to return to active employment after a cessation of disability or following a termination of an approved leave of absence.

An indefinite or temporary layoff or reduction in force does not constitute a Termination of Employment unless the layoff or reduction in force is permanent. The determination as to whether a layoff or reduction in force is permanent shall be made by the Plan Administrator at the time of such layoff or reduction in force, in its sole and absolute discretion, and such determination shall be final and binding on all affected Employees. An Employee’s Termination of Employment shall occur on the last day of his or her employment with the Employer.

11. Years of Service. A Year of Service shall be measured as a full 12 month consecutive period. No credit shall be provided for any fraction of a Year of Service. The Years of Service shall be based upon the Employee’s adjusted hire date, as indicated in the Employer’s records. If an Employee is rehired after having received any severance benefits under this Plan or any other plan or program, the Years of Service shall be based upon his or her latest date of hire.

III. ARTICLE - ELIGIBILITY FOR SEVERANCE BENEFITS

An Employee becomes eligible for severance under the Plan (i.e., becomes a “Participant”) if such Employee: (i) either (A) experiences a Termination of Employment, or (B) is notified in writing that the Plan Administrator, in its sole and absolute discretion, has decided to grant the Employee eligibility hereunder, and (ii) satisfies the conditions of Article IV.

IV. ARTICLE - CONDITIONS TO RECEIVE SEVERANCE BENEFITS

Notwithstanding anything herein to the contrary, severance benefits shall be paid under the Plan in consideration of the Employee executing an agreement and general release in such form acceptable to the Company, in its sole discretion, under which, among other things, the Employee releases and discharges the Employer from all claims and liabilities relating to the Employee’s employment with the Employer and/or the termination of the Employee’s employment, including without limitation, any claims under any federal, state or local statute or ordinance, including but not limited to those under the Age Discrimination in Employment Act of 1967. An Employee shall become a Participant and payment of severance under the Plan will be paid only after the agreement and general release has been signed and the time for the Employee to revoke the agreement and general release, if any, has expired (the “Release Effective Date”).

V. ARTICLE – THE AMOUNT OF SEVERANCE BENEFITS

1. Severance Pay. A Participant will be entitled to receive severance pay under the Plan based on the Participant’s position with the Employer immediately prior to the Termination of Employment and the Participant’s Years of Service with the Employer as set forth on Schedule A. The Employer has no obligation to re-hire any Participant who received severance. If a Participant is rehired by the Employer while still receiving severance benefits under this Plan, any severance benefits then payable to the Participant shall cease upon the date of rehire. The Employer reserves the right to deduct from the severance pay any salary or incentive overpayments or other amounts improperly or inadvertently paid to the Participant during the course of employment, unless such deduction is otherwise prohibited by law or in violation of Section 409A of the Code.
2. **Extension of Benefits.** In connection with a termination of employment, Participants (and their eligible dependents) may be entitled to elect to continue coverage under the Company’s group medical, prescription, vision and dental insurance plans and the Company’s Health Care Reimbursement Account on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”) if the Participant was a participant in such plans as of his or her termination date. If an Employee becomes a Participant and elects COBRA coverage for him or herself and/or his or her eligible dependents, the Participant will be responsible for the full amount of the COBRA premium. All provisions of Participants’ COBRA coverage will be in accordance with the applicable plan in effect for active employees of the Company (including any applicable copayments, deductibles and other out-of-pocket expenses). Participants should refer to the Company’s group medical, prescription and dental plans and Health Care Reimbursement Account Plan for additional information regarding their rights and obligations under COBRA.

3. **No Continuation of Non-COBRA Benefits.** Participation in any Company short-term disability plan, long-term disability plan, employee stock purchase plan, accidental death and dismemberment plan, life insurance and/or additional life insurance plan, Dependent Care Reimbursement Account or business travel accident plan will end as of the Termination of Employment date. Participants should refer to the plan documents for the life insurance plan to determine applicable conversion rights. Coverage under the Company’s legal plan will end as of the last day of the month in which the Termination of Employment date occurs. Participation in any other benefits under the Company’s health, welfare or retirement benefits plans will end as of the Termination of Employment date.

4. **Non-Duplications of Benefits.** If a Participant receives severance benefits under the Plan, such Participant shall not be entitled to receive any other severance, separation, notice or termination payments on account of his or her employment with the Employer under any other plan, policy, program or agreement, except as provided in the agreement and general release referenced in Article IV of the Plan or otherwise prohibited by Section 409A of the Code. If, for any reason, a Participant becomes entitled to or receives any other severance, separation, notice or termination payments on account of his or her employment or Termination of Employment with the Employer, including, for example, any payments required to be paid to the Participant under any Federal, State or local law or pursuant to any agreement (except unemployment benefits payable in accordance with state law and payment for accrued but unused vacation and benefits as described in the release), his or her severance under the Plan will be reduced by the amount of such other payments paid or payable, to the extent permitted by Section 409A of the Code. A Participant must notify the Plan Administrator if he or she receives or is claiming to be entitled to receive any such payment(s).

VI. **ARTICLE - HOW AND WHEN SEVERANCE WILL BE PAID**

Severance pay under the Plan will be paid to a Participant in the form of periodic installments in accordance with Schedule A hereto; provided that, the Plan Administrator, in its sole and absolute discretion, may provide severance pay to a Participant in the form of a single lump sum payment to the extent permitted under Section 409A of the Internal Revenue Code. Notwithstanding anything in the Plan to the contrary, no severance payments will be made to a Participant after December 31 of the second calendar year following the calendar year in which the Termination of Employment occurs.
VII. ARTICLE - MISCELLANEOUS PROVISIONS

1. **Amendment and Termination.** The Company reserves the right, in its sole and absolute discretion, to terminate, amend or modify the Plan, in whole or in part, at any time and for any reason. If the Plan is terminated, amended or modified, an individual’s right to participate in, or to receive severance benefits under, the Plan may be changed; provided, however, that severance payable to a Participant who has incurred a Termination of Employment prior to such termination, amendment or modification of the Plan, shall not be reduced by the termination, amendment or modification.

2. **No Additional Rights Created.** Neither the establishment of this Plan, nor any modification thereof, nor the payment of any severance benefits hereunder, shall be construed as giving to any Participant, Employee (or any beneficiary of either), or other person any legal or equitable right against the Employer or any officer, director or employee thereof; and in no event shall the terms and conditions of employment by the Employer of any Employee be modified or in any way affected by this Plan.

3. **Records.** The records of the Employer with respect to Years of Service, employment history, base pay, absences, and all other relevant matters shall be conclusive for all purposes of this Plan.

4. **Construction.** The respective terms and provisions of the Plan shall be construed, whenever possible, to be in conformity with the requirements of ERISA, or any subsequent laws or amendments thereto. To the extent not in conflict with the preceding sentence or another provision in the Plan, the construction and administration of the Plan shall be in accordance with the laws of the State of Florida applicable to contracts made and to be performed within the State of Florida (without reference to its conflicts of law provisions).

5. **Severability.** Should any provisions of the Plan be deemed or held to be unlawful or invalid for any reason, such fact shall not adversely affect the other provisions of the Plan unless such determination shall render impossible or impracticable the functioning of the Plan, and in such case, an appropriate provision or provisions shall be adopted so that the Plan may continue to function properly.

6. **Incompetency.** In the event that the Plan Administrator finds that a Participant is unable to care for his or her affairs because of illness or accident, then the severance benefits payable hereunder, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, may be paid in such manner as the Plan Administrator shall determine, to the extent permitted by Section 409A of the Code, and the application thereof shall be a complete discharge of all liability for any payments or severance benefits to which such Participant (or designated beneficiary) was or would have been otherwise entitled under this Plan.

7. **Plan Not a Contract of Employment.** Nothing contained in this Plan shall be held or construed to create any liability upon the Employer to retain any Employee in its service. All Employees shall remain subject to discharge or discipline to the same extent as if the Plan had not been put into effect. An individual who is receiving severance under this Plan shall not be considered an Employee immediately upon his or her Termination of Employment.

8. **Financing.** The severance benefits payable under this Plan shall be paid out of the general assets of the Company. No Participant or any other person shall have any interest whatsoever in any specific asset of any Employer. To the extent that any person acquires a right to receive payments under this Plan, such right shall not be secured by any assets of any Employer.
9. **Nontransferability.** In no event shall the Company (or any other Employer) make any payment under this Plan to any assignee or creditor of a Participant, except as otherwise required by law. Prior to the time of a payment hereunder, a Participant shall have no rights by way of anticipation or otherwise to assign or otherwise dispose of any interest under this Plan, nor shall rights be assigned or transferred by operation of law.

10. **Tax Matters.** All payments made hereunder shall be subject to applicable tax and other withholding as determined by the Company.

11. **Section 409A of the Code.** Notwithstanding anything herein to the contrary, the Company shall have the right to defer a payment hereunder so as to avoid negative tax consequences under Section 409A of the Code, and such payment shall be made on the first day on which no negative tax consequences will be imposed on the Participant under Section 409A. No payments shall be made hereunder unless a Participant’s Termination of Employment constitutes a “separation from service” as defined by Section 409A of the Code and the regulations issued thereunder. For purposes of determining whether a “separation from service” has occurred, pursuant to Treas. Reg. §1.409A-1(h)(3), the Company has elected to use “at least 80 percent” each place it appears in Sections 1563(a)(1), (2), and (3) of the Code and in Treas. Reg. §1.414(c)-2. Severance payments hereunder are intended to constitute separation pay due to an involuntary separation from service under Section 409A.

## VIII. ARTICLE - WHAT ELSE A PARTICIPANT NEEDS TO KNOW ABOUT THE PLAN

1. **Claim Procedure.** An individual or his or her beneficiary (if applicable) may file a written claim with the Plan Administrator with respect to his or her rights to receive a benefit from the Plan. The claimant will be informed of the decision of the Plan Administrator with respect to the claim within 90 days after it is filed. Under special circumstances, the Plan Administrator may require an additional period of not more than 90 days to review a claim. If this occurs, the claimant will be notified in writing as to the length of the extension, the reason for the extension, and any other information needed in order to process the claim. If the claimant is not notified within the 90-day (or 180-day, if so extended) period, he or she may consider the claim to be denied.

   If a claim is denied, in whole or in part, the claimant will be notified in writing of the specific reason(s) for the denial, the exact plan provision(s) on which the decision was based, what additional material or information is relevant to his or her case, and what procedure the claimant should follow to get the claim reviewed again. The claimant then has sixty (60) days to appeal the decision to the Plan Administrator.

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   A decision as to a claimant’s appeal will be made within sixty (60) days after the appeal is received. Under special circumstances, the Plan Administrator may require an additional period of not more than 60 days to review an appeal. If this occurs, the claimant will be notified in writing as to the length of the extension, not to exceed 120 days from the day on which the appeal was received.

   If a claimant's appeal is denied, in whole or in part, he or she will be notified in writing of the specific reason(s) for the denial and the exact plan provision(s) on which the decision was based. The decision on an appeal of the Plan Administrator will be final and binding on all parties and persons affected thereby. If a claimant is not notified within the 60-day (or 120-day, if so extended) period, he or she may consider the appeal as denied.
2. **Plan Interpretation and Benefit Determination.** The Plan is administered and operated by the Plan Administrator who has complete authority, with respect to matters within its jurisdiction, in its sole and absolute discretion, to construe the terms of the Plan (and any related or underlying documents or policies), and to determine the eligibility for, and amount of, severance benefits due under this Plan to Participants and their beneficiaries. All such interpretations and determinations (including factual determinations) of the Plan Administrator shall be final and binding upon all parties and persons affected thereby. The Plan Administrator may appoint one or more individuals and delegate such of its powers and duties as it deems desirable to any such individual(s), in which case every reference herein made to the Plan Administrator shall be deemed to mean or include the appointed individual(s) as to matters within their jurisdiction.

3. **Participants’ Rights Under ERISA.** Participants of the Plan are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report if the Plan covers 100 or more people. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including the Company or any other person, may fire an employee or otherwise discriminate against an employee in any way to prevent him/her from obtaining a benefit or exercising his/her rights under ERISA. If a Participant’s claim for a benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. Participants have the right to have the Plan Administrator review and reconsider their claims. Under ERISA, there are steps that Participants can take to enforce the above rights.

For instance, if a Participant requests materials from the Plan Administrator and does not receive them within 30 days, he/she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a Participant has a claim for severance benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or federal court. If he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant has sued to pay these costs and fees. If the Participant loses, the court may order him/her to pay these costs and fees, for example, if it finds the claim is frivolous. If a Participant has any questions about the Plan, he/she should contact the Plan Administrator. Any questions about this statement or about any rights under ERISA should be directed to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.
4. **Plan Document**: This document shall constitute the plan document and summary plan description of the Plan.

5. **Other Important Facts**:

   **OFFICIAL NAME OF THE PLAN**: Ryder Severance Plan for Eligible Supply Chain Employees

   **SPONSOR**: Ryder System, Inc.
   11690 NW 105 St.
   Miami, FL 33178-1103
   305.500.3726

   **EMPLOYER IDENTIFICATION NUMBER (EIN)**: 59-0739250

   **PLAN NUMBER**: 529

   **TYPE OF PLAN**: Employee Welfare Severance Benefit Plan

   **END OF PLAN YEAR**: December 31st

   **TYPE OF ADMINISTRATION**: Employer Administered

   **PLAN ADMINISTRATOR**: Chief Administrative Officer
   11690 NW 105 St.
   Miami, Florida 33178-1103
   305.500.4743

   **AGENT FOR SERVICE OF LEGAL PROCESS**: Executive Vice President -- General Counsel
   11690 NW 105 St.
   Miami, Florida 33178-1103
   305.500.7797

   **EFFECTIVE DATE**: January 1, 2013

The Plan Administrator keeps records of the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions that an individual may have about the Plan.

Service of legal process may be made upon the Plan Administrator.

No individual may, in any case, become entitled to additional severance benefits or other rights under this Plan after the Plan is terminated. Under no circumstances, will any benefit under this Plan ever vest or become nonforfeitable, except as provided in Section 1 of Article VII.

Severance pay is subject to Federal and state income and Social Security tax withholdings and any other withholdings mandated by law.

**For All Participants**

**Vacation**: All Participants receive earned but unused vacation in accordance with the Company’s vacation policy.
These are the only severance benefits to which a Participant is entitled except as provided in Sections 2 and 3 of Article V. No other fringe benefits, including, but not limited to, car allowances, outplacement incidentals, cell phones allowances, or other perquisites are to be paid as severance.
SCHEDULE A
SCS Plan Employees
Eligible Non-Exempt and Hourly Employees
One week Base Pay per Year of Service
Minimum: 2 weeks Base Pay
Maximum: 4 weeks Base Pay

Participants with less than one (1) Year of Service receive two (2) weeks of Base Pay.

Eligible Exempt Employees
MS 01-07, SA 10, 63, 64, 65, 66, 67, 72, 75, 77, IT 30-31 and AA01-02
One week Base Salary per Year of Service
Minimum: 2 weeks Base Pay
Maximum: 4 weeks Base Pay

Participants with less than one (1) Year of Service receive two (2) weeks of Base Salary.