New Hire Benefits
2021 Enrollment Guide
Welcome To Ryder

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

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

This brochure is designed to outline the general features of each of your benefit choices. Your Summary Plan Description (SPD) is available online and fully details the coverage and provisions of the benefit programs. To review the SPD, log on to Ryder.BenefitsNow.com.

Summary of Benefits and Coverage (SBC)

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

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

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

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

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

Your enrollment deadline is indicated on your Personalized Enrollment Worksheet that is included in the kit you received at your home address of record. Please be sure to enroll by the deadline date stated on your Personalized Worksheet. You must complete the audit process on all dependents you enroll to avoid cancellation of their coverage.

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

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

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

Getting it done with BenefitsNow

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

1. Go to Ryder.BenefitsNow.com. Follow the instructions on the Login page to register as a first time user. Make sure to save your username and password for future access.
2. View the Benefit Videos to understand what Ryder offers!
3. Review the Benefits Enrollment Guide.
4. Select the “Enroll Now” button to enroll in your benefits.
3. After you make your enrollment elections, make sure to hit the “Complete” button at the bottom of the page and print your Confirmation Statement for your records.

Enrollment can also be done by calling the Ryder BenefitsNow Service Center at 1-800-280-2999.

Benefit Videos

We want you to understand your benefit plans! To help you with that go to Ryder.BenefitsNow.com to view different videos that explain our benefits in detail.
Review the Rules

Ryder Dependent Eligibility Rules

Definition of Eligible Dependents

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

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

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

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

4. Your natural or adopted children, those of your spouse/domestic partner and children of whom you have legal custody or guardianship, age 26 and older, if due to a physical or mental disability, they are unable to support and maintain themselves financially. The Medical plan carrier you elect solely determines eligibility for coverage. You may apply when you first become eligible to enroll for coverage, or if already enrolled, you must request continued coverage before the dependent’s coverage would otherwise end.

**Working Spouse/Domestic Partner Coverage Rule**

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

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

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

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

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

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

If your working spouse/domestic partner... then your spouse/domestic partner CAN be covered under Ryder’s...

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

If your working spouse/domestic partner... then your spouse/domestic partner CANNOT be covered under Ryder’s...

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>is eligible for comprehensive medical and prescription coverage through his/her employer regardless of a restricted provider network, cost of coverage or a higher deductible for physician services, hospitalization or surgery</td>
<td>Medical and Prescription plans</td>
</tr>
<tr>
<td>is eligible for comprehensive dental coverage through his/her employer</td>
<td>Dental plan</td>
</tr>
</tbody>
</table>

Q&A

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

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

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

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

### Acceptable Required Documents For You Enrolled Dependants

<table>
<thead>
<tr>
<th>Eligible Dependent</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your legal spouse</td>
<td>‣ Government-Issued Marriage Certificate AND&lt;br&gt; ‣ Federal Tax Return Within Last Two Years Listing Spouse* (black out any Social Security Numbers and financial information). &lt;br&gt; If married within the last 12 months, the Federal Tax Return is not required</td>
</tr>
<tr>
<td>Your domestic partner or common law spouse who is a tax qualified dependent as defined by the Internal Revenue Service – Section 152**</td>
<td>‣ Completed and notarized Affidavit of Domestic Partnership/Common Law Spouse (form will be included in the correspondence that will be sent to you a few weeks after you add your dependent(s) to coverage). AND&lt;br&gt; ‣ Federal Tax Return Within Last Two Years Listing Domestic Partner/Common Law Spouse* (black out any Social Security Numbers and financial information).</td>
</tr>
<tr>
<td>Your domestic partner or common law spouse who is NOT a tax qualified dependent defined by the Internal Revenue Service – Section 152</td>
<td>‣ Completed and notarized Affidavit of Domestic Partnership/Common Law Spouse (form will be included in the correspondence that will be sent to you a few weeks after you add your dependent(s) to coverage).</td>
</tr>
<tr>
<td>Your children up to age 26</td>
<td><strong>This includes you, your spouse’s, your domestic partner’s/common law spouse’s unmarried, natural or adopted children for whom you have legal custody or legal guardianship.</strong>&lt;br&gt; Your Child: Government-Issued Birth Certificate (including parents’ names)&lt;br&gt; Child of adoption/Legal Guardianship: Adoption Certificate (including child’s date of birth) OR&lt;br&gt; Adoption Placement Agreement (including child’s date of birth)&lt;br&gt; Step Child: Government-Issued Birth Certificate (including parents’ names), Government-Issued Marriage Certificate, and a Federal Tax Return Within Last Two Years Listing Spouse* (black out any Social Security Numbers and financial information). OR&lt;br&gt; Government-Issued Birth Certificate (including parents’ names), Government-Issued Marriage Certificate (if married within the last 12 months)&lt;br&gt; Tax Qualified Child of Domestic Partner/Common Law Spouse: Government-Issued Birth Certificate (including parents’ names), Affidavit of Domestic Partnership/Common Law Spouse (form will be included in the correspondence that will be sent to you a few weeks after you add your dependent(s) to coverage), and Federal Tax Return Within Last Two Years Listing Spouse* (black out any Social Security Numbers and financial information)&lt;br&gt; Non Tax Qualified Child of Domestic Partner/Common Law Spouse: Government-Issued Birth Certificate (including parents’ names), Affidavit of Domestic Partnership/Common Law Spouse (form will be included in the correspondence that will be sent to you a few weeks after you add your dependent(s) to coverage)</td>
</tr>
<tr>
<td>Your unmarried children who are mentally or physically disabled and depend on you for support and care.</td>
<td>The information listed in the “Your children up to age 26 section” AND Federal Tax Return Within Last Two Years Claiming Child</td>
</tr>
</tbody>
</table>
To maintain a healthy workforce, we are encouraging tobacco users to improve their health and rewarding tobacco-free employees with a credit toward monthly medical premium costs. Medical research data confirms that tobacco use is one of the leading causes of heart-related conditions and premature death in the country.

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

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

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

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

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

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

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

Q. I am trying to quit smoking, but have not stopped completely. If I stop smoking during the middle of the year, can I get the Non-Tobacco User credit at that time?
A. Yes. If you successfully complete the UHC QuitPower tobacco cessation program during the plan year, you may elect the Non-Tobacco at that time provided that your enrolled spouse/domestic partner is also tobacco free. Please see page 25 of this guide for more information on QuitPower.

*Tobacco Usage Plan Rules
Ryder expects all employees to comply with the Working Spouse Policy summarized as follows:

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

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

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

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*Some employees covered under a collective bargaining agreement may have a credit included in their premium rate, therefore the option to enroll in the non-tobacco user credit would not be available.
**UnitedHealthcare (UHC) Medical Plans**

**UHC Option 1 Plan**

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

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

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

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

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

**For In-Network Expenses**

<table>
<thead>
<tr>
<th>FIRST, You Pay</th>
<th>THEN, Plan Pays</th>
<th>LAST, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong>*</td>
<td>Ryder pays 80%</td>
<td>Ryder pays 100% after reaching Out-Of-Pocket Maximum of</td>
</tr>
<tr>
<td>$750 Employee</td>
<td>You pay 20% up to out-of-pocket maximum</td>
<td>$5,400 Employee</td>
</tr>
<tr>
<td>$1,500 Employee +1</td>
<td></td>
<td>$10,800 Employee +1 &amp; Family</td>
</tr>
<tr>
<td>$2,250 Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Individual deductible of $750 each

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

** Preventive care is covered according to the guidelines of the U.S. Preventive Task Force (USPSTF) and the requirements of the Affordable Care Act.
UHC Health Savings Account (HSA) Medical Plan

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

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

Ryder contributes money into your HSA and you can contribute money as well. Ryder’s contributions are intended to offset the higher deductible. (For more information on Ryder’s contribution, refer to page 9).

Then, once you meet your annual deductible, Ryder pays 80% for eligible in-network medical expenses and you pay 20% up to the out-of-pocket maximum. Once you meet the deductible, your prescriptions are covered based on the prescription plan described on page 15.

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

In-Network Expenses

<table>
<thead>
<tr>
<th>FIRST, You Pay</th>
<th>Your HSA Account</th>
<th>THEN, Plan Pays</th>
<th>LAST, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Ryder contributes up to:</td>
<td>Ryder pays</td>
<td>Ryder pays 100% after reaching Out-Of-Pocket Maximum of</td>
</tr>
<tr>
<td>$1,400</td>
<td>$250 Single coverage</td>
<td>80%</td>
<td>$6,650 Employee</td>
</tr>
<tr>
<td>Employee</td>
<td>$500 Employee +1 and Family coverage</td>
<td></td>
<td>$13,300 Employee +1 (1) &amp; Family</td>
</tr>
<tr>
<td>$2,800</td>
<td>You may contribute on a pretax basis up to:**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee +1(1)</td>
<td>$3,600 Single coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4,200</td>
<td>$7,200 Employee +1 and Family coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family(1)</td>
<td>$1,000 Additional if age 55 or older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

To help with funding your Health Savings Account, you (and your enrolled spouse/domestic partner) can each earn $100 that will be deposited into your Health Savings Account if you complete an annual preventive care physical exam.

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* Approved preventive drugs are covered at 100% without having to meet the deductible. Approved preventive therapy medications bypass the deductible.
** See page 9 for details on how much you can contribute.
*** Preventive care is covered according to the guidelines of the U.S. Preventive Task Force (USPSTF) and the requirements of the Affordable Care Act.
(1) Any election including covered dependents means the higher tier deductible and out-of-pocket maximum must be met before benefits are paid under the plan.
Ryder makes it easy to enroll in the Health Savings Account. When you enroll in the UHC HSA Medical Plan online or via phone, you are automatically agreeing to the terms of opening the savings account (no different than a typical savings account).

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

If you choose to contribute to your HSA account (in addition to Ryder’s contribution), you can make convenient pre-tax contributions through payroll deductions. You have the option to change your contribution amount throughout the calendar year. You can contribute up to $3,600 per year for single coverage or $7,200 per year for employee +1 or family coverage. If you are 55 years of age or older you can contribute an additional $1,000. This maximum amount includes Ryder contributions and any earned reward money as a result of completing an annual preventive care physical exam.

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

**Limits on HSA Contributions**

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

- If you are a new hire with a prior High Deductible Health Plan/HSA Enrollment, and you have continual 12-month enrollment, you may elect up to the maximum amount regardless of the benefit effective date.
- If you are a new hire with NO prior High Deductible Health Plan/HSA Enrollment, below is a guide of amounts you may elect through payroll deduction for the rest of the calendar year.

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

<table>
<thead>
<tr>
<th>Benefit Effective Date</th>
<th>Maximum Employee Annual Pre-Tax HSA Contribution Single*</th>
<th>Maximum Employee Annual Pre-Tax HSA Contribution Family*</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>$3,600</td>
<td>$7,200</td>
</tr>
<tr>
<td>February 1</td>
<td>$3,300</td>
<td>$6,600</td>
</tr>
<tr>
<td>March 1</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>April 1</td>
<td>$2,700</td>
<td>$5,400</td>
</tr>
<tr>
<td>May 1</td>
<td>$2,400</td>
<td>$4,800</td>
</tr>
<tr>
<td>June 1</td>
<td>$2,100</td>
<td>$4,200</td>
</tr>
<tr>
<td>July 1</td>
<td>$1,800</td>
<td>$3,600</td>
</tr>
<tr>
<td>August 1</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>September 1</td>
<td>$1,200</td>
<td>$2,400</td>
</tr>
<tr>
<td>October 1</td>
<td>$900</td>
<td>$1,800</td>
</tr>
<tr>
<td>November 1</td>
<td>$600</td>
<td>$1,200</td>
</tr>
<tr>
<td>December 1</td>
<td>$300</td>
<td>$600</td>
</tr>
</tbody>
</table>

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

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

Family Example:

Ryder contributes up to $500 annually.

You have the option of contributing up to $7,200* (family maximum) of your own money to your HSA tax-free. If you are age 55 or older and not eligible for Medicare, you can make additional catch-up contributions of up to $1,000.

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

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

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

Ryder makes no representations about future contributions.

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

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

You are certifying that you are eligible to contribute to an HSA under Internal Revenue Code Section 223. You understand that you may access the Custodial and Deposit Agreement governing your HSA at www.optumbank.com or by calling 1-866-234-8913, and that a copy of said agreement will be sent to you in a “Welcome Kit” after your HSA is opened.

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

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

HSA Q&A

Can dependent children who are no longer full-time students and/or are no longer tax dependent on their parents taxes still enroll in Ryder’s HSA plan?
Yes, the eligible dependent child can still enroll in the Ryder HSA Medical plan and utilize the High Deductible Health Plan (HDHP) portion of the benefit. However, the employee cannot utilize pre-tax HSA dollars to reimburse expenses for a child that is not a tax dependent.

Can someone enrolled in Medicare or Medicaid use any HSA funds they had contributed prior to their enrollment in Medicare/Medicaid?
Yes, those funds can be used to reimburse for any qualified expenses, but you cannot contribute any additional pre-tax funds. Note, if you are eligible for Medicare, but have not yet enrolled, you can still contribute to the HSA.

How do HSA contributions work if you are married, but enrolled in separate plans?
When an employee and their spouse enroll separately in employer provided coverage, then:
• If you each enroll in “self-only” coverage, you can each contribute up to the self-only limit in your respective HSA.
• If either or both of you enroll in any type of “family” coverage (employee + spouse, family, etc.) then you are able to contribute up to the family limit – on a combined basis. You will want to be careful that both of your combined HSA contributions do NOT exceed the maximum allowed under family coverage.

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

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

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

What happens if my Spouse enrolls in Medicare?
If your spouse enrolls in Medicare, but you are still enrolled in Family HDHP, you may contribute up to the family limit. Your spouse would not be able to contribute to an HSA.
How the UHC Standard Medical Plan works.
The UHC Standard Medical Plan is a PPO type plan with a high deductible, copays and co-insurance.

This plan only has in-network benefits. If you choose doctors, facilities, hospitals or services outside of the network, there is NO reimbursement under the plan. Go to www.myuhc.com to look for in-network providers under the Choice Plus Network.

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

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

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

For In-Network Expenses Only

<table>
<thead>
<tr>
<th>FIRST, You Pay</th>
<th>THEN, Plan Pays</th>
<th>LAST, Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays*</td>
<td>Deductible</td>
<td>Ryder pays 100% after reaching Out-Of-Pocket Maximum of</td>
</tr>
<tr>
<td>$25** PCP</td>
<td>$2,600 Employee</td>
<td>$6,850 Employee</td>
</tr>
<tr>
<td>$75** Urgent Care</td>
<td>$5,200 Employee +1</td>
<td>$13,700 Employee +1 &amp; Family</td>
</tr>
<tr>
<td>$15 Generic Prescriptions</td>
<td>$7,800 Family</td>
<td></td>
</tr>
</tbody>
</table>

* Copays and generics not subject to deductibles.
** Additional costs for lab, xray, etc. may apply.
*** For maintenance medications you can only pick up two 30-day supplies of any retail requirement. Otherwise, you will be charged almost the full cost of the prescription. All 90-day supply prescriptions can be filled through mail order or at a CVS retail pharmacy.

Plan Pays 100% of Preventive Care (Deductible does not apply)
## UHC Medical Plans Overview

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

<table>
<thead>
<tr>
<th></th>
<th>UHC OPTION 1</th>
<th>UHC HSA</th>
<th>UHC Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All services from providers in network</td>
<td>Your Choice of provider</td>
<td>All services from providers in network</td>
<td>Your Choice of provider</td>
</tr>
<tr>
<td><strong>Per Person</strong></td>
<td>$750</td>
<td>$1,400</td>
<td>$2,800</td>
</tr>
<tr>
<td><strong>Employee + One</strong></td>
<td>$1,500</td>
<td>$2,800</td>
<td>$5,600</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$2,250</td>
<td>$4,200</td>
<td>$8,400</td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td>Not Included**</td>
<td>Included as part of Medical Plan you pay the full cost of the prescription until you meet the deductible***</td>
<td>Included as part of Medical Plan $15 copay for generics. All other drugs you pay full cost until the deductible is met.***</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td>Plan pays 80% Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td><strong>Per Person</strong></td>
<td>$5,400</td>
<td>$6,650</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$10,800</td>
<td>$13,300</td>
<td>$13,700</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td><strong>Primary Care Specialist</strong></td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
</tr>
<tr>
<td><strong>Virtual Visits</strong></td>
<td>$20(1) Co-pay</td>
<td>$50 Co-pay</td>
<td>$20(1) Co-pay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Plan pays 100% no deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 100% no deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 100% no deductible</td>
</tr>
<tr>
<td><strong>Laboratory &amp; X-Ray</strong></td>
<td>(Free-standing or hospital-based) In-Office In Specialist’s Office</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care/ Outpatient Hospital or Facility</strong></td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$300 co-pay after annual deductible</td>
<td>Plan pays 80% after in-network annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Plan pays 80% after annual deductible</td>
<td>Plan pays 80% after annual deductible</td>
<td>$75 copay no deductible</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse EAP (through FEI Behavioral Health)</strong></td>
<td>Up to 5 office visits no cost</td>
<td>Up to 5 office visits no cost</td>
<td>Up to 5 office visits no cost</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Inpatient Hospital or Facility/Outpatient Office Visits</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td>Inpatient Hospital or Facility/Outpatient Office Visits</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
<td>Plan pays 80% after annual deductible Medicare Reimbursement Rate (MRR)*</td>
</tr>
</tbody>
</table>

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

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

*** Some drugs under the ACA are covered at 100%; chronic medications may bypass the deductible.

(1) Co-pays do not count toward annual deductible, only towards out-of-pocket maximum.

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

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

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

<table>
<thead>
<tr>
<th>Kaiser CA*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All services from providers in network</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$600</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$1,200</td>
</tr>
<tr>
<td>Family</td>
<td>$1,200</td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>25% coinsurance ($100 max)</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>covered at preferred cost share when medically necessary</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after annual deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$50 co-pay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Plan pays 100% no deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory &amp; X-Ray</strong></td>
<td></td>
</tr>
<tr>
<td>(Free-standing or hospital-based)</td>
<td>$10 copay after annual deductible is met</td>
</tr>
<tr>
<td>In-Office</td>
<td></td>
</tr>
<tr>
<td>In Specialists Office</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care/ Outpatient Hospital or Facility</strong></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after annual deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after annual deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td></td>
</tr>
<tr>
<td>Convenience Care</td>
<td>$30 copay per visit</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>EAP (through FEI Behavioral Health)</td>
<td>Up to 5 office visits no cost</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital or Facility/Outpatient Office Visits</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td></td>
<td>$30 co-pay for individual visit; $15 co-pay for group visit</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility/Outpatient Office Visits</td>
<td>Plan pays 80% after annual deductible</td>
</tr>
<tr>
<td></td>
<td>$30 co-pay for individual visit; $5 co-pay for group visit</td>
</tr>
</tbody>
</table>

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

**Note:** During the calendar year, you can add or drop coverage or any dependents within 30 days if you experience a life changing event, you cannot change plans in the middle of the year.
Prescription drug coverage is managed by CVS Caremark. Your Prescription ID Card is accepted at all CVS Caremark pharmacies or at any of the participating retail pharmacies. For a complete list of participating pharmacies near you, go to www.caremark.com, Group Code: RX7397, or call 1-844-278-5699.

**CVS Caremark Prescription Plan**

<table>
<thead>
<tr>
<th></th>
<th>CVS Caremark Prescription Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail</strong></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$100 - does not apply to generics, the HSA or the Standard Plan</td>
</tr>
<tr>
<td>Generic Co-pay</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Preferred Drug List - Brand Name* Co-insurance</td>
<td>You pay 25% after annual deductible ($25 min. $100 max. co-pay)</td>
</tr>
<tr>
<td>Non-Preferred Drug List - Brand Name* Co-insurance</td>
<td>You pay 45% after annual deductible ($50 min. - $150 max. co-pay)</td>
</tr>
<tr>
<td>Biotech Medication</td>
<td>$125 co-pay 30-day supply, subject to pre-authorization</td>
</tr>
<tr>
<td><strong>Mail Service Program</strong></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>or CVS Retail Store Limited to a 90-day supply</td>
</tr>
<tr>
<td>Generic Co-pay</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td>Preferred Drug List - Brand Name* Co-insurance</td>
<td>You pay 25% after annual deductible ($62.50 min. $250 max. co-pay)</td>
</tr>
<tr>
<td>Non-Preferred Drug List - Brand Name* Co-insurance</td>
<td>You pay 45% after annual deductible ($125 min. - $375 max. co-pay)</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

** or the UHC Option 1 Passive PPO Plan

If you enroll in the UHC HSA Medical Plan

1. The prescription coverage is included in the Medical Plan. You pay the full cost of your prescription until you meet the UHC HSA medical plan deductible. When you use a network pharmacy, you pay a discounted rate for prescriptions.
2. Once you meet the UHC HSA medical plan deductible ($1,400/$2,800/$4,200), you will have prescription drug coverage according to the prescription plan design summarized on the chart above.
3. You have the option to use your HSA dollars to pay for prescriptions.

If you enroll in the UHC Standard Medical Plan

1. The prescription coverage is included in the Medical Plan. Generics have a $15 copay. For all other drugs, you pay the full cost of your prescription until you meet the deductible. You must use a network pharmacy or the plan will not pay anything towards prescription.
2. Once you meet the UHC Standard Medical Plan deductible ($2,600/$5,200/$7,800), if you are using a brand name drug, you will have prescription coverage according to the prescription plan design summarized on the chart above.
3. If you fund the Health Care Spending Account, you can use your YSA card to pay for your prescriptions.

Please note that we do not apply any drug card value to the deductible or the out-of-pocket accumulators.
A Health Benefit at No Cost that Helps Make Living with Diabetes Easier

Testing and tracking your blood glucose levels is critical to successfully managing your diabetes, but it can be a time-consuming, manual process.

Now, there’s a better way with the Livongo connected meter. With this meter, every time you test your blood glucose levels, your numbers will be automatically sent to a secure online account.

With Livongo, you can easily:
• Track your levels, see trends and share your data with whomever you choose*
• Get unlimited test strips and lancets delivered to your door with no out-of-pocket cost
• Get personalized tips in real-time to help you stay on track and make informed choices.

You can get started by calling 1-800-945-4355 and provide the code: RYDER. Or you can enroll online at: join.livongo.com/RYDER/begin

This program is voluntary, however, it is highly encouraged for eligible members to enroll. The program offers advanced technology and a personal coaching team to answer questions and help with goal setting, all at no cost to you.

Diabetes management is an urgent challenge in the U.S. due to the continuing increase and remarkable magnitude diabetes has on our health care system. Ryder is committed to providing the best resources to help those with diabetes manage their health to live their best life.

*By participating in this program, you are consenting to Livongo sharing your glucose readings with your health care provider.
Virtual Visits – Your access to care online, any time.

When you don’t feel well or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. A virtual visit lets you see or talk to a doctor from your mobile device, computer or tablet without an appointment. After registering and requesting a visit you will pay your portion of the service costs according to your medical plan, and then you will enter a virtual waiting room. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. And, it’s part of your health benefits with UnitedHealthcare. (See page 13 for UHC member cost).

You have access to a network of virtual visit provider groups. To learn more about virtual visits and the network you can please log into myuhc.com® or the UnitedHealthcare app. Once you choose a virtual visit provider group you will be directed to their website from myuhc.com.

You also have the option of going directly to the website for AmWell, Doctor on Demand, Teledoc or their app to access care. You can download their app directly from Google Play™ or Apple® App Store®.

Frequently Asked Questions

Q: What type of conditions are commonly treated through a virtual visit?
A: Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Cold/flu
- Bronchitis
- Sore throat
- Bladder infection/Urinary tract infection
- Diarrhea
- Fever
- Pink eye
- Minor rashes
- Sinus problems
- Stomach ache
- Migraine/headaches
- Earaches

Q: How safe is the information being shared during a virtual visit appointment?
A: UnitedHealthcare requires all network providers, including virtual visit providers, to comply with all applicable laws, including laws relating to the security and confidentiality of patient information. Virtual visit providers are covered entities under HIPAA and its regulations. Therefore, these providers have direct legal requirements to protect and secure confidential patient information.

Q: Can my child or underage dependent use virtual visits?
A: Yes. Virtual care can be a great alternative to a pediatric visit. In general, a parent or legal guardian must be present when the virtual visit is conducted with a minor dependent who is covered under your plan.
Cigna Dental Plan

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

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

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

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

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

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

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

* Dentists listed on Cigna.com that are not noted as DPPO Advantage providers, have agreed to discount their fees, however, claims are paid at the out-of-network coverage level seen in the chart.
** Dentists that have no affiliation with Cigna. These claims are reimbursed based on usual and prevailing (U & P) charges. Any charges in excess of U & P are the responsibility of the patient.

(1) See Fee schedule located on the benefits website Ryder.BenefitsNow.com
Standard contact lenses are spherical clear contacts in conventional wear and planned replacements, such as disposable lenses.

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

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

Eye Wear Discount Program

If you do not elect to enroll in the Vision Plan, you are still eligible for eyewear discounts through EyeMed. The Vision Discount Plan does not require enrollment and has no cost. It offers discounts of 20% to 60% off the retail cost of eyewear, including eyeglass frames, lenses and conventional contact lenses. The plan also provides discounts of 15% on the usual and prevailing fee for LASIK and PRK surgery when services are provided by U.S. Laser Network.

If you would like to take advantage of the discount simply state that you are part of Ryder System and present the plan number 9238411.

EyeMed Vision Plan

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

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

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

*** Contact lenses are considered medically necessary when standard eyeglass lenses will not correct a member’s vision.
Flexible Spending Accounts (FSA)

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

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

By planning ahead, you’ll be able to contribute enough to cover the expenses you are sure of, and maximize your health care and/or dependent care dollars. Under the HCSA you have until March 15th of the following year to incur eligible expenses. All expenses must be submitted for reimbursement by April 30, 2022. You also have the flexibility to decide whether services incurred during the “grace period” between January 1st and March 15th, 2022 are applied to your 2021 or 2022 account.

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

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

<table>
<thead>
<tr>
<th>Health Care Spending Account (HCSA):</th>
<th>Dependent Care Spending Account (DCSA):</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can contribute from $250 up to $2,750 annually.</td>
<td>You can contribute from $250 up to $5,000 annually.</td>
</tr>
<tr>
<td>HCSA reimbursements cannot be made for your domestic partners nor his/her children unless they are claimed as a tax dependent on your federal tax form.</td>
<td>A dependent care spending account is used to pay for eligible, work-related expenses that are necessary for you and your spouse or domestic partner to work or attend school.</td>
</tr>
<tr>
<td>Eligible expenses include, but not are limited to: medical co-pays and deductibles, dental work including orthodontia, prescriptions, prescription glasses, contacts and LASIK surgery. For a full list of eligible expenses, go to <a href="http://www.irs.gov">www.irs.gov</a> and search under Publication 502.</td>
<td>Your dependent care expenses must be for qualified individuals including your dependent child under the age of 13 who lives with you for more than half the year, or your spouse or other tax dependent who is physically or mentally incapable of self-care and lives with you more than half the year.</td>
</tr>
<tr>
<td>Eligible expenses include, but are not limited to:</td>
<td>Eligible expenses include, but are not limited to certified day care or day camp, before and after-school programs, baby-sitting services by qualified individuals and elder care services.</td>
</tr>
</tbody>
</table>
Disability Benefits

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

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

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

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

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

<table>
<thead>
<tr>
<th>Company Provided</th>
<th>Optional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Short-Term Disability (STD)*</td>
<td>Basic Long-Term Disability (LTD)</td>
</tr>
<tr>
<td>Portion of Pay</td>
<td>70%</td>
</tr>
<tr>
<td>Payment Maximum</td>
<td>$325 per week</td>
</tr>
<tr>
<td>Benefit Payment Period</td>
<td>Up to 25 weeks</td>
</tr>
<tr>
<td>Subject to Withholding</td>
<td>Yes</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>7 consecutive calendar days</td>
</tr>
<tr>
<td>The period of time you must wait before benefits are paid</td>
<td>During this period of time you may receive Short-Term Disability benefits</td>
</tr>
<tr>
<td>Why Choose This Plan?</td>
<td>Company provides this at no cost to you.</td>
</tr>
</tbody>
</table>

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

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

Pre-Existing Condition Limitation

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

Information on how to report a disability claim can be found on the Ryder Benefits portal. Go to www.Ryder.BenefitsNow.com under the Health & Welfare tab > Short Term Disability > Reporting your disability claim.
Life Insurance

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

### Employee Life Insurance

<table>
<thead>
<tr>
<th>Company Pays</th>
<th>Optional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Life Insurance</strong></td>
<td>1x pay</td>
</tr>
<tr>
<td><strong>Seat Belt Insurance</strong></td>
<td>1x pay</td>
</tr>
<tr>
<td><strong>Additional Life Insurance</strong></td>
<td>1x to 7x pay</td>
</tr>
<tr>
<td><strong>Employee Accidental Death and Dismemberment</strong></td>
<td>1x to 8x pay*</td>
</tr>
<tr>
<td><strong>Benefit Maximum</strong></td>
<td>$200,000</td>
</tr>
<tr>
<td><strong>Subject to insurance carrier approval</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Why Choose Coverage?</strong></td>
<td>Company provides this at no cost to you.</td>
</tr>
</tbody>
</table>

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

### Optional Coverage

<table>
<thead>
<tr>
<th>Spouse Life Insurance</th>
<th>Child Life Insurance</th>
<th>Family Accidental Death and Dismemberment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit</strong></td>
<td>Increments of $10,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Benefit Maximum</strong></td>
<td>$200,000</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Subject to insurance carrier approval</strong></td>
<td>Only required for over $30,000</td>
<td>No</td>
</tr>
<tr>
<td><strong>Why Choose Coverage?</strong></td>
<td>Provides life insurance for your spouse/domestic partner.</td>
<td>Provides life insurance for your dependent children.</td>
</tr>
</tbody>
</table>

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

### Submitting a Medical Questionnaire

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

...should my child get a flu shot?

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

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

Once eligible, you can contribute on either a pre-tax, or post-tax basis, a combined maximum of 50% of your annual earnings. You have 3 options: pre-tax, post-tax or Roth (company match is only for pre-tax and Roth) there is no company match on post-tax contributions. The maximum the IRS allows you to contribute on a pre-tax basis is $19,500. If you are age 50 or over, you can contribute up to an additional $6,000 in pre-tax dollars after your contributions have reached the allowable maximum.

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

Employee Assistance Plan (EAP)
The EAP program makes professional counseling available for you and your family on a voluntary basis. The program is designed to assist you and your family with personal or family problems before they become overwhelming. This includes (but is not limited to):
- family or marital conflicts
- parent-child relationships
- financial budgeting
- crisis and substance abuse problems.

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

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

Hyatt Legal Plan
The Hyatt Legal Plan offers you and your family value, convenience and peace of mind, providing easy and low-cost access to a wide variety of personal legal services. Covered services include:
- Wills
- Trusts
- Adoption
- Wills
- Trusts
- Identity theft
- Real Estate transactions
- Contested guardianship

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

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

To be eligible, the adoptive child may not be related to either adopting parent. Log on to Ryder.BenefitsNow.com to print the Adoption Assistance Request Form. The form is located under the “Other Benefits” tab > Adoption Assistance.

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

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

Bisk Education
Ryder works with leading non-profit, regionally accredited universities through Bisk Education to offer a wide selection of online degrees and certificates designed for busy, working professionals. For more information, visit Ryder.com/employees and click on Career & Education - Education & Self Development. Discounts are provided if you enroll.

QuitPower®. You can break free from tobacco.
Are you ready to quit?
If you’re thinking of breaking free from your nicotine addiction, QuitPower® can help. QuitPower® is a comprehensive tobacco cessation program that can help you live a healthier life. As a member of a UHC medical plan, you have access to:
- A personal coach for ongoing information and support;
- A quit plan that’s customized for your needs; and
- Nicotine patches or gum, delivered to your home at no cost to you.

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

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

Once you have completed the QuitPower® Program you can enroll in Ryder’s Non-Tobacco User Credit for a savings on your monthly medical premiums, provided that your enrolled spouse/domestic partner is also tobacco free.

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

Real Appeal
Real Appeal is an online weight loss and healthy lifestyle program that can help you take small steps that lead to big results.

If you’ve been struggling to lose weight, Real Appeal’s personalized approach can help you look great and feel your best without turning your life upside-down. By implementing small changes over time, you’ll gradually shift to a healthier, happier lifestyle and begin to see results that last.

If you or your spouse/domestic partner are enrolled in one of the UnitedHealthcare Medical plans and you meet the requirement of a body mass index (BMI) of 25 or higher, you may be eligible to join Real Appeal at no cost, not even a co-pay or deductible!

Once you enroll, you will meet with a Transformation Coach from your smart phone, tablet or personal computer – who customizes a program that suits your lifestyle and targets your desired weight loss goals. Note: it will not be possible to participate in the program using a Ryder issued computer, as the security firewall and bandwidth space will limit or deny user access. Accordingly, you must use your smart phone, tablet, or home computer to take part in the program. You will receive 52 weeks of access to this coach who will offer continual support and help you stay on track. After your goals are set and your coaching support network is intact, you’ll need all the right tools and resources to kick start your weight loss. The Real Appeal Success Kit is delivered right to your door at no cost.

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

To sign up for the Real Appeal program go to ryder.realappeal.com.
COBRA Rights Notice

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

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

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

COBRA Qualifying Events

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

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

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

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

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

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

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

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

Responsibilities Regarding COBRA Continuation Coverage

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

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

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

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

**ELECTING COBRA CONTINUATION COVERAGE**

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

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

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

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

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

**LENGTH OF THE COBRA CONTINUATION PERIOD**

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

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

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

**SECOND QUALIFYING EVENT EXTENSION**

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

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

**DISABILITY EXTENSION**

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

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

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

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

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

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

**Cost of COBRA Continuation Coverage**

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

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

**Address Changes**

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

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

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

**COBRA Contact Information**

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

Ryder BenefitsNow Service Center  
P.O. Box 1484  
Lincolnshire, IL 60069-1484  
or Fax to 1-844-212-8557

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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

For further information on states where you may be eligible for assistance paying your employer health plan premiums, go to www.RyderBenefitsNow.com and look under the compliance tab.

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. 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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.
Contact Information:

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

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

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

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

Prescription Plan
Caremark Rx Plan
1-844-278-5699
www.caremark.com
Group Code: RX7397

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

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

Short-Term and
Long-Term Disability Plans
Lincoln Financial
1-888-481-2423

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

Life Insurance Plans
Securian
1-866-293-6047

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

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

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

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

Ryder Retirement Service Center
401(k)
1-800-373-7300
www.netbenefits.Fidelity.com

RyderShares
www.StockPlanConnect.com
1-888-301-0681

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

Direct questions to the Ryder BenefitsNow Service Center at 1-800-280-2999. Representatives are available Monday - Friday from 8:00 a.m. – 8:00 p.m. ET.