



To: Participants and beneficiaries under the following Ryder-sponsored benefit plans:

- Certain Medical, Dental, Prescription and Mental Health/Substance Abuse Plans
- Health Care Flexible Spending Account
- Ryder System, Inc. 401(k) Savings Plans
- Ryder System, Inc. Retirement Plans

From: Ryder Benefits Department

Date: June 2011

Attached you will find a "Summary of Material Modifications" ("SMM") which, together with this notice, supplements or modifies the information presented in your 2008 Summary Plan Description (the "SPD"). The SMM below describes changes made to the above-referenced Plans for the 2011 Plan Year including changes required by recent legislation. The SMM also incorporates notices required by law to be provided annually. **Please keep this notice and the attached SMM with your copy of the 2008 SPD.**

Unless otherwise stated, all defined terms used in this SMM have the same meaning as used in the SPD. Official plan documents control the actual payment of benefits and the administration of the plans. This SMM merely highlights the changes and does not replace those documents. In case of any discrepancy between this SMM, the SPD, or plan documents, the terms of the plan documents will control.

An electronic version of this SMM is available on the www.ryder.com website under "Employees", "Benefits", then "Summary Plan Description and other Documents". Only active employees have access, and your employee personnel number is required to access this document online. If you have any questions about this notice, the SMM or your Ryder benefits, please contact the Ryder BenefitsNow Service Center at 800-280-2999. Service Representatives are available from 8:00 am to 8:00 pm EST, Monday through Friday.

Administrative Changes:

Children's Coverage Age Expanded to 26

Effective January 1, 2011, your Ryder health plan is required to offer dependent coverage to eligible children until the attainment of age 26. To be eligible, your child is **no longer** required to be a full-time student, to live with you in your home, to be unemployed, financially dependent upon you, or be unmarried (although your child's spouse and/or children are ineligible for coverage).

Required Data for Spouses and Domestic Partners

All covered spouses and domestic partners must have their social security number on file with the BenefitsNow Service Center. This is necessary to comply with the Medicare Coordination of Benefit provision. Additionally, for employees who have Spouse Life insurance, your spouse or domestic partner's date of birth is **required** to be on file with the BenefitsNow Service Center. Date of birth is needed to correctly calculate Spouse Life insurance premiums based upon your spouse or domestic partner's age. **Any spouse or domestic partner without a social security number or date of birth on file at the end of 2010 was dropped from coverage.**

Update Beneficiaries Online

On Ryder's BenefitsNow web site, you can make beneficiary designations for life insurance coverage online rather than completing a paper form. This way, your beneficiary designation can be reviewed or updated at any time. If you do not have access to the Internet, you can contact the BenefitsNow Service Center by phone to update your beneficiary at 800-280-2999.

Life Insurance – Child Life Insurance

- Under the Child Life Insurance plan, dependent children will be covered up to age 26 beginning January 1, 2011.

Mental Health Parity

Due to Mental Health Parity legislation that took effect in January 2011, your Ryder health plan is required to ensure that financial requirements and treatment limitations for mental health and substance abuse disorder benefits are no more restrictive than the requirements and limitations applied to medical or surgical benefits. Therefore, beginning January 1, 2011, mental health and substance abuse claims will be subject to the same financial requirements and treatment limitations applied to medical or surgical benefits.

Effective January 1, 2011, the Value Options mental health benefits will be terminated. If you are enrolled in a United Healthcare medical plan, you will now have mental health and substance abuse benefits through United Behavioral Health (UBH). If you are enrolled in an HMO, your mental health coverage is provided through your HMO plan, not UBH. Each HMO is required to comply with this new law.

Medical Plans – Terminations

Effective January 1, 2011, the following medical plans have been eliminated:

- Aetna
- Avmed
- Blue Cross Blue Shield of Alabama
- Blue Cross Blue Shield of Michigan (East, West, Mid)*
- Blue Cross Blue Shield of Mississippi
- Blue Cross Blue Shield of Tennessee
- Capital Health Plan
- Capital District PHP
- Health Assurance Coordinated Care
- Health Assurance Pittsburgh**
- Humana Kentucky PPO
- Humana Louisville HMO
- MVP Rochester
- Patient Choice (administered by UMR)
- Tufts
- Wellmark (Blue Cross Blue Shield of Iowa)

**non-union plans only*

***union plan terminated January 31, 2011*

Medical Plans - Coverage Updates Effective January 1, 2011

Plan design changes have also been made to some of the Ryder sponsored hl plans. (Note: the changes below reflect summary information only. Please contact your insurance company for complete plan details)

- Effective January 1, 2011, the Ryder health plans may no longer impose a lifetime benefit maximum.
- Effective January 1, 2011, there will be a \$750,000 Annual Limit on Essential Benefits. This will impact all United Healthcare plans*.
- All Kaiser HMO plans will cover preventive care at 100% with no deductible.
- The Starbridge Sickness & Accident plan will cover preventive care at 100% with no deductible.
- The Blue Cross Blue Shield of Michigan plans will cover preventive care at 100% with no deductible.
- The Humana Puerto Rico plan will cover preventive care at 100% with no deductible.
- The UHC Passive Plan will cover preventive care at 100% no deductible for both in-network and out-of-network services.

- Effective January 1, 2011 the health plans shall not impose a pre-existing conditions exclusions for enrollees age 19 or younger.

Under the Starbridge Sickness & Accident Plan, coverage for Emergency Room care differs based upon whether the visit is due to an accident or illness. In the case of an accident, there is a \$50 deductible per accident, and then the plan pays 80% up to \$2,500 per accident (maximum of 2 accidents per year). In the case of an illness, the plan covers 80% after the annual deductible up to the \$1,500 outpatient annual maximum.

*non-union plans only

Rescission of Health Coverage

Effective January 1, 2011, a group health plan may not rescind a participant's coverage (that is, terminate that coverage retroactively) except in the case of fraud or the individual's intentional misrepresentation of a material fact, as prohibited by the plan terms.

Ryder continues to reserve the right to terminate the health coverage for you and your dependents prospectively without notice for cause (as determined by the Plan Administrator), of if you and/or your dependents are otherwise determined to be ineligible for coverage under the plan. In addition, if you and/or your dependents commit fraud or intentional misrepresentation in an application for health coverage, in connection with a benefit claim or appeal, or in response to any request for information, Ryder may terminate your coverage retroactively upon 30 day notice.

Caremark Prescription Drug Plans

Effective January 1, 2011, the following Caremark Prescription Drug Programs will go into effect:

Generics First

Members enrolled in the Caremark Prescription Drug Plan will be required to try a generic or preferred medication before utilizing a brand name drug. If the member tries (or has already tried) the generic or preferred medication without success, they may subsequently receive coverage for a non-preferred medication by obtaining approval from Caremark. Members who choose to continue their brand-name medication in 2011 without trying the generic or preferred medication, or without getting prior approval, risk having to pay the full cost of their medication. The Generic First Program requirements will apply to the following drug classes:

- ACE Inhibitors/ARBs – prescribed for high blood pressure;
- Statins – prescribed for high cholesterol; and
- Proton Pump Inhibitors (PPIs) – prescribed for gastric reflux or ulcers.

The program will also target Preferred Specialty Drugs for:

- rheumatoid arthritis; and
- growth hormone deficiency

Note: Additional drug classes may be added to the list at any time.

Important Changes to the Health Care Flexible Spending Account

Reimbursement for Over-the-Counter Medications and Drugs

Under recent health care reform legislation, over-the-counter (OTC) medications and drugs (*e.g., Advil, Claritin, Robitussin*) can no longer be reimbursed through the health care flexible spending account unless a prescription is written by a doctor for that item.

Children Up to Age 26 Health care reform permits reimbursements under the health care flexible spending account for your eligible children up to age 26.

Pension Plan

Changes Under the HEART Act: Effective January 1, 2007, if you are absent from employment due to qualified military service and die while performing this service, you will be credited with the years of your qualified military service for vesting purposes (but not for benefit accrual). Your period of qualified military service will also count towards years of continuous service for purposes of determining eligibility for an early retirement benefit. This service will be credited up to the day following your date of death.

Savings Plan

STS/FMS Employees: If you became employed by Ryder Truck Rental, Inc. as a result of its January 29, 2011 acquisition of the stock of Scully Companies, Inc., you are eligible to participate in the Plan. Your period of employment with Scully Transportation Services, Inc. as of that date will count for vesting purposes.

Total Logistic Control: Total Logistic Control (“TLC”) became a participating employer in the Plan effective as of January 1, 2011. If you are an employee of TLC, you become eligible to participate in the Plan according to the same provisions that apply to any other employee. However, if you were employed with TLC as of December 31, 2010, you will be deemed to have completed the required year of service as of January 1, 2011 for purposes of receiving the Matching Contribution.

The general Plan terms apply to you, except as follows:

If you are an hourly employee who was employed by TLC as of December 31, 2010, you will receive a Matching Contribution as of the end of each pay cycle once you meet the Matching Contribution eligibility requirements. Instead of the Plan’s general Matching Contribution, however, your match will equal 100% of the first 4% of your pre-tax contributions in that pay cycle, plus 50% of the next 2% of your pre-tax contributions in that pay cycle. You are not eligible to receive the \$400 Company Contribution that other Field Hourly, Driver and Warehouse Employees may receive.

Any employee who was employed by Total Logistic Control as of December 31, 2010 shall be fully vested in his account.

Distributions: Effective as of January 1, 2011, if you terminate employment with Ryder (or a related employer) without receiving a distribution, your account balance will be reviewed quarterly to determine if it has fallen below \$1,000. If it has, you will receive a distribution of your full benefit.

NOTICES

Women's Health and Cancer Rights Act of 1998

Your Medical Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. For more information, call Member Services on the number listed on the back of your medical ID card.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any length of hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under Federal law, require that a provider obtain authorization from the group health plan or the health insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

HIPPA Privacy Notice

On or about April 14, 2003, the Ryder System, Inc. health plan ("Plan") circulated its HIPAA Notice of Privacy Practices (the "Notice") together with the company's 2003 Summary Plan Description (SPD) booklet. Since that time, the Notice has been included in each annual SPD booklet and is still applicable and available for your review, and review by your dependents (family members who also participate in the Plan). You and your dependents can obtain copies of the Notice as follows:

If you would like a hard copy of the Notice, please submit a written request to:

VP, Global Compliance and Business Standards

Ryder System, Inc.

11690 NW 105th St.

Miami, FL 33178

Designation of a Primary Care Provider (PCP)

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

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care

professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Grandfathered Health Plans

Ryder operates the Health Assurance Pittsburgh (grandfathered union*) plan as a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that the Health Assurance Pittsburgh plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Ryder's plan administrator at 1-800-280-2999.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

* On January 31, 2011, the Health Assurance Pittsburgh union plan was eliminated.

Early Retiree Reinsurance Program Notice

You may be a plan participant, or may be offered the opportunity to enroll as a plan participant in an employment-based health plan through Ryder that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Patient Protection and Affordable Care Act ("the Affordable Care Act").

Under the Early Retiree Reinsurance Program, the Federal government reimburses Ryder for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, Ryder may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If Ryder chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and Ryder chooses to use the reimbursements for this purpose. Ryder may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits

coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

Member Appeals Notice

On July 23, 2010, Interim Final Regulations (IFR) related to the Patient Protection and Affordable Care Act, otherwise known as Health Care Reform, were released specifying required changes related to an enhanced claims and appeals process impacting non-grandfathered health plans. These regulations may require changes to the current claims and appeals processes.

The new claims and appeals processes described below do not apply to the Health Assurance Pittsburg plan.

Plans affected by the Patient Protection and Affordable Care Act must provide an internal and external process for appeal of coverage determinations. This requirement applies to new group plans, including self-funded, who have until July 1, 2011 to comply with the new requirements.

As a result of the Affordable Care Act:

Members are allowed to appeal a determination of an individual's eligibility for coverage.

The claimant must be notified of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account medical exigencies, but not later than 24 hours after the receipt of the claim. This is a change from DOL regulations of 72 hours.

The claimant must be provided, free of charge, with any "new or additional evidence considered, relied upon, or generated" in connection with the claim. This must be provided in advance of the date of the notice of adverse benefit determination.

Enrollees must also be offered an external appeals process (Note: The external review requirements for plans not subject to State law (ASO ERISA plans governed by the Federal requirements) are not yet defined.)

Appeal Process:

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

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and

- any documentation or other written information to support your request.

Federal External Review Program:

The *Departments of Health and Human Services, Labor and Treasury* (Departments) will establish a Federal external review process. Where applicable, once the process has been established by the *Departments*, you will be provided with additional information concerning the process.

Contact UnitedHealthcare at the telephone number shown on your ID card for more information on the Federal external review program.

Voluntary External Review

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the voluntary external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for Experimental or Investigational Services or Unproven Services.

The voluntary external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact the Claims Administrator at the toll-free number on your ID card for more information.

Urgent Care Appeal Timeframe:

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Request for Benefits *	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	24 hours
If the Claims Administrator denies your request for Benefits, you must appeal the adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.

Concurrent Care Claims:

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

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To take advantage of special enrollment rights, you must experience a qualifying event and provide your health plan with timely notice of the event and your enrollment request. If you have any questions regarding your HIPAA special enrollment rights contact: BenefitsNow Service Center at 1-800-280-2999.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for the Plan.

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

If you live in one of the following States, you may be eligible for assistance paying your Plan premiums. The following list of States is current as of November 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
<p>Website: http://www.medicaid.alabama.gov</p> <p>Phone: 1-800-362-1504</p>	<p>Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</p> <p>Phone: 1-866-298-8443</p>
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
<p>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/</p> <p>Phone (Outside of Anchorage): 1-888-318-8890</p> <p>Phone (Anchorage): 907-269-6529</p>	<p>Medicaid Website: http://www.colorado.gov/</p> <p>Medicaid Phone (In state): 1-800-866-3513</p> <p>Medicaid Phone (Out of state): 1-800-221-3943</p> <p>CHIP Website: http:// www.CHPplus.org</p> <p>CHIP Phone: 303-866-3243</p>
ARIZONA – CHIP	
<p>Website: http://www.azahcccs.gov/applicants/default.aspx</p> <p>Phone (In state): 1-877-764-5437</p>	
ARKANSAS – CHIP	FLORIDA – Medicaid
<p>Website: http://www.arkidsfirst.com/</p> <p>Phone: 1-888-474-8275</p>	<p>Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml</p> <p>Phone: 1-866-762-2237</p>

GEORGIA – Medicaid	MONTANA – Medicaid
<p>Website: http://dch.georgia.gov/</p> <p>Click on Programs, then Medicaid</p> <p>Phone: 1-800-869-1150</p>	<p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</p> <p>Telephone: 1-800-694-3084</p>
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
<p>Medicaid Website: www.accesstohealthinsurance.idaho.gov</p> <p>Medicaid Phone: 1-800-926-2588</p> <p>CHIP Website: www.medicaid.idaho.gov</p> <p>CHIP Phone: 1-800-926-2588</p>	<p>Website: http://www.dhhs.ne.gov/med/medindex.htm</p> <p>Phone: 1-877-255-3092</p>
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
<p>Website: http://www.in.gov/fssa/2408.htm</p> <p>Phone: 1-877-438-4479</p>	<p>Medicaid Website: http://dwss.nv.gov/</p> <p>Medicaid Phone: 1-800-992-0900</p>
IOWA – Medicaid	CHIP Website: http://www.nevadacheckup.nv.org/
<p>Website: www.dhs.state.ia.us/hipp/</p> <p>Phone: 1-888-346-9562</p>	CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid

<p>Website: https://www.khpa.ks.gov</p> <p>Phone: 800-766-9012</p>	<p>Website: www.dhhs.nh.gov/ombp/index.htm</p> <p>Phone: 603-271-4238</p>
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://chfs.ky.gov/dms/default.htm</p> <p>Phone: 1-800-635-2570</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: 1-800-356-1561</p>
LOUISIANA – Medicaid	<p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: 1-800-701-0710</p>
<p>Website: http://www.lahipp.dhh.louisiana.gov</p> <p>Phone: 1-888-342-6207</p>	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
<p>Website: http://www.maine.gov/dhhs/oms/</p> <p>Phone: 1-800-321-5557</p>	<p>Medicaid Website: http://www.hsd.state.nm.us/mad/index.html</p> <p>Medicaid Phone: 1-888-997-2583</p>
MASSACHUSETTS – Medicaid and CHIP	<p>CHIP Website: http://www.hsd.state.nm.us/mad/index.html</p> <p>Click on Insure New Mexico</p> <p>CHIP Phone: 1-888-997-2583</p>
<p>Medicaid & CHIP Website: http://www.mass.gov/MassHealth</p> <p>Medicaid & CHIP Phone: 1-800-462-1120</p>	
MINNESOTA – Medicaid	NEW YORK – Medicaid

<p>Website: http://www.dhs.state.mn.us/</p> <p>Click on Health Care, then Medical Assistance</p> <p>Phone (Outside of Twin City area): 800-657-3739</p> <p>Phone (Twin City area): 651-431-2670</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/</p> <p>Phone: 1-800-541-2831</p>
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/index.htm</p> <p>Phone: 573-751-6944</p>	<p>Website: http://www.nc.gov</p> <p>Phone: 919-855-4100</p>
NORTH DAKOTA – Medicaid	UTAH – Medicaid
<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/</p> <p>Phone: 1-800-755-2604</p>	<p>Website: http://health.utah.gov/medicaid/</p> <p>Phone: 1-866-435-7414</p>
OKLAHOMA – Medicaid	VERMONT– Medicaid
<p>Website: http://www.insureoklahoma.org</p> <p>Phone: 1-888-365-3742</p>	<p>Website: http://ovha.vermont.gov/</p> <p>Telephone: 1-800-250-8427</p>

OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
<p>Medicaid & CHIP Website: http://www.oregonhealthykids.gov</p> <p>Medicaid & CHIP Phone: 1-877-314-5678</p>	<p>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm</p> <p>Medicaid Phone: 1-800-432-5924</p> <p>CHIP Website: http://www.famis.org/</p> <p>CHIP Phone: 1-866-873-2647</p>
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
<p>Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</p> <p>Phone: 1-800-644-7730</p>	<p>Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</p> <p>Phone: 1-800-562-3022 ext. 15473</p>
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
<p>Website: www.dhs.ri.gov</p> <p>Phone: 401-462-5300</p>	<p>Website: http://www.wvrecovery.com/hipp.htm</p> <p>Phone: 304-342-1604</p>
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
<p>Website: http://www.scdhhs.gov</p> <p>Phone: 1-888-549-0820</p>	<p>Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm</p> <p>Phone: 1-800-362-3002</p>

TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethiptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

Note: Employees who work under the provisions of certain collective bargaining agreements may be covered under different plan provisions than those described in this Summary of Material Modifications.