The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit benefitsadministration@rubytuesday.com or call **800-325-0755**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call **800-325-0755** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan covers certain preventive services without cost-sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses because all eligible expenses are covered at 100%.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses because all eligible expenses are covered at 100%.
Will you pay less if you use a network provider?	Yes. See **www.multiplan.com/symetra** or call **1-800-280-9297** for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered		Not applicable.
	Specialist visit	Not covered		Not applicable.
	Preventive care/screening/immunization	No charge	Not covered	Limited to preventive services for adults, including pregnant women, and children as required by ACA. The services include counseling and screening for alcohol misuse, blood pressure, cholesterol, colorectal cancer, depression, type 2 Diabetes, HIV, obesity, STI prevention, tobacco use, anemia, breast cancer, cervical cancer, domestic and interpersonal violence, osteoporosis, syphilis, autism, immunizations, well-woman visits, vision and hearing screenings for children. A complete list of the ACA preventive recommendations and guidelines can be found at http://www.uspreventiveservicestaskforce.org
If you have a test	Diagnostic test (x-ray, blood work)	Not covered		Not applicable.
	Imaging (CT/PET scans, MRIs)	Not covered		Not applicable.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com/mycatamaranrx to optumrx.com or 1-800-248-1062.**	Generic drugs	No charge	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). The following services are covered at 100% if FDA-approved and prescribed by a doctor: • Contraceptive methods for women, including OTC (such as contraceptive sponges and spermicides); • Aspirin to prevent Cardiovascular Disease (OTC); • Iron Supplementation (OTC) (for Children at increased risk for iron-deficiency anemia); • Folic Acid Supplementation (for women planning or capable of pregnancy);
	Brand Name drugs			
	Non-Preferred Brand Name drugs			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				• Oral Fluoride Supplementation (where water source does not contain fluoride); • Smoking deterrents. A description of these services can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/
	Specialty drugs	Not covered		Not applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered		Not applicable.
	Physician/surgeon fees	Not covered		Not applicable.
If you need immediate medical attention	Emergency room care	Not covered		Not applicable.
	Emergency medical transportation	Not covered		Not applicable.
	Urgent care	Not covered		Not applicable.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered		Not applicable.
	Physician/surgeon fee	Not covered		Not applicable.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered		Not applicable.
	Inpatient services	Not covered		Not applicable.
If you are pregnant	Office visits	Not covered		Not applicable.
	Childbirth/delivery professional services	Not covered		Not applicable.
	Childbirth/delivery facility services	Not covered		Not applicable.
If you need help recovering or have other special health needs	Home health care	Not covered		Not applicable.
	Rehabilitation services	Not covered		Not applicable.
	Habilitation services	Not covered		Not applicable.
	Skilled nursing care	Not covered		Not applicable.
	Durable medical equipment	Not covered		Not applicable.
	Hospice services	Not covered		Not applicable.
If your child needs dental or eye care	Children's eye exam	Not covered		Not applicable.
	Children's glasses	Not covered		Not applicable.
	Children's dental check-up	Not covered		Not applicable.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery • Dental care • Diagnostic testing and imaging, other than preventive • Emergency room visits and treatment	• Eye wear (glasses and contacts) • Hearing aids • Infertility treatment • Inpatient hospital stays • Long-term care • Mental health and substance abuse treatment • Non-emergency care when traveling outside the U.S.	• Prescription drugs other than the required preventive medications • Physician visits for illness or injury • Private-duty nursing • Routine eye care (Adult) • Routine foot care • Urgent care visits and treatment • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
• Preventive care covered under ACA

For more information about limitations and exceptions, see plan or policy document at **benefits.rubytuesday.com** **or call 800-325-0755.**

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at **800-325-0755.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at **800-325-0755**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? No
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: 1-888-482-6765.
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助，请拨打这个号码
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist** **N/A**
- **Hospital (facility)** **N/A**
- **Other** **N/A**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay: This condition is not covered, so patient pays 100 percent.

Cost Sharing	
Deductibles	**$0**
Copayments	**$0**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$12,694**
The total Peg would pay is	**$12,694**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist** **N/A**
- **Hospital (facility)** **N/A**
- **Other** **N/A**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay: This condition is not covered, so patient pays 100 percent.

Cost Sharing	
Deductibles	**$0**
Copayments	**$0**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$7,239**
The total Joe would pay is	**$7,239**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist** **N/A**
- **Hospital (facility)** **N/A**
- **Other** **N/A**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay: This condition is not covered, so patient pays 100 percent.

Cost Sharing	
Deductibles	**N/A**
Copayments	**N/A**
Coinsurance	**N/A**
What isn't covered	
Limits or exclusions	**$1,900**
The total Mia would pay is	**$1,900**

For more information about limitations and exceptions, see plan or policy document at **benefits.rubytuesday.com** **or call 800-325-0755.**