Ruby Tuesday

2023 OPEN ENROLLMENT
Full-Time Employees

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A Message from Ruby Tuesday

At Ruby Tuesday we recognize our ultimate success depends on our talented and dedicated workforce. Our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access, and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

You can also access overviews of our benefit plans at http://benefits.rubytuesday.com/

Eligibility

Eligible Employees:

You may enroll in the Ruby Tuesday Employee Benefits Program if you are an exempt employee or a non-exempt, full-time employee who averages at least 30 hours worked per week for the past 12 months.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. See the legal notices for more information.

When Coverage Begins:

Newly hired employees and dependents will be effective in Ruby Tuesday's benefits programs on the first day of the month following the date of hire beginning January 1, 2023.

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status
- Change in number of dependents
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation will be required. Failure to request a change of status within 30 days of the event may result in loss of coverage.

Medical Insurance Options

As a Ruby Tuesday employee, you have the choice of the following medical plans through Blue Cross Blue Shield. BCBS partners with more than 95% of hospitals, doctors, and specialists nationwide.

HRA PREMIER CARE PLAN

This plan has a Health Reimbursement Account (HRA) provided by Ruby Tuesday. It provides $2000 for Employee Only and $4000 for Employees covering dependents. These dollars can be used up front to cover expenses that would typically be subject to the deductible. In other words, the first $2000/$4000 is covered by the HRA. Office visits, lab work, Urgent Care, Emergency Room and other expense subject to the deductible can be paid for 100% with your HRA until you've exhausted the funds. For most employees this means you will never have to use your own money to pay for medical treatment. The HRA will be administered by Blue Cross Blue Shield and will help offset the costs for qualified in-network deductible expenses incurred by you or a covered family member. The money spent in your HRA counts toward meeting your deductible; prescription drug copays are not reimbursable through your HRA.

While this is the highest premium plan with a $2800 annual deductible you can use the HRA to meet the majority of your deductible. Once your HRA funds have been exhausted, you will be responsible for meeting the remainder of your calendar year deductible. After the deductible has been satisfied, the medical plan will pay 80% of the allowable charges, and you will be responsible for 20% up to the out-of-pocket maximum. After that, the plan will pay 100% of covered expenses for the remainder of the calendar year. Your HRA balance will reset each year on January 1.
Your network accessibility is not limited, so you are able to work with providers In-and-Out of Network, and you pay co-pays for doctor visits and Rx.

HSA HIGH DEDUCTIBLE (High-D)

This plan has the lowest premium and a $3,000 (Individual) annual deductible. Your network accessibility is limited to In-Network Providers, and you pay the full cost of your Medical/Rx expenses until the deductible is met.

HSA LOW DEDUCTIBLE (Low-D)

This is the average premium plan, and your annual deductible is $1,750 (Individual). Your network accessibility is not limited, so you are able to work with providers In-and-Out of Network. You pay the full cost of your Medical/Rx expenses until the deductible is met.

Ruby Tuesday is contributing up to a $500 HSA match per employee enrolled in the High-D and Low-D HSA qualified plans. So, whether you are enrolled in individual coverage, employee + spouse coverage, employee + child(ren) coverage, or family coverage, you get up to a $500 match per year deposited tax free into the HSA divided into two deposits - one in the first half of the year and one in the second half of the year.
PLEASE NOTE: The match amount counts toward your total IRS limit for the year.

SYMETRA MEC PLAN

This plan covers **preventive services only**. There is no deductible, and you are responsible for all non-preventive Medical/Rx expenses.

Members using providers in Tennessee are restricted to Network S. Members using providers outside of Tennessee, will use the BlueCard PPO Network. All members may visit bcbst.com or call 1-800-565-9140 for a list of in-network providers.

Medical Plan Comparison

Ruby Tuesday offers the choice between two HSA medical plans and a Medical PPO through BlueCross BlueShield of Tennessee, Inc., or a Minimum Essential Coverage Plan option through Symetra Life Insurance. Company Highlights of the medical plans are listed below. The grid below outlines the member share.

	HRA Premier Care Plan - PPO		High D – EPO HSA		Low D – PPO HSA		Symetra MEC Plan
Benefit Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	Schedule of Benefits
Annual Deductible							
Individual	*$2,800	$6,450	$3,000	N/A	$1,750	$3,500	$0
Family	*$8,400	$19,350	$6,000	N/A	$3,500	$7,000	$0
Coinsurance	20%	40%	30%	N/A	20%	50%	100%
Spending Account							
Type	HRA		HSA		HSA		N/A
Amount	$2,000		$500		$500		N/A
Maximum Out-of-Pocket							
Individual	$6,450	$9,600	$6,450	N/A	$6,450	$7,000	N/A
Family	$12,900	$19,200	$12,900	N/A	$12,900	$14,000	N/A
Physician Office Visit							
Primary Care	Deductible + Coinsurance	40% of the Maximum Allowable Charge after Deductible	30% after deductible	N/A	20% after deductible	50% of the Maximum Allowable Charge after deductible	**Preventive Care Only**
Specialty Care				N/A			
Preventive Care	100%		100%	Not covered	100%		
Diagnostic Services							
X-ray and Lab Tests	20% after deductible	40% of the Maximum Allowable Charge after deductible	30% after deductible	Not Covered	20% after deductible	50% of the Maximum Allowable Charge after deductible	
Complex Radiology							
Inpatient Facility Charges							
Outpatient Facility and Surgical Charges							
Urgent Care Facility							
Emergency Room Facility Charges	100% after $300 copay per visit, then 20% after deductible		30% after deductible		20% after deductible		
Mental Health / Substance Abuse							
Inpatient	20% after deductible	40% of the Maximum Allowable Charge after deductible	30% after deductible	Not covered	20% after deductible	50% of the Maximum Allowable Charge after deductible	
Outpatient							
Other Services							
Chiropractic	20% after deductible	50% of the Maximum Allowable Charge after deductible	30% after deductible	Not covered	20% after deductible	50% of the Maximum Allowable Charge after deductible	

*Note: HRA Premier Plan includes access to Health Reimbursement Account (HRA) fully funded by Ruby Tuesday and administered by Blue Cross Blue Shield. Ruby Tuesday will fund $2,000 toward your HRA; if you have a covered family member on your plan, Ruby Tuesday will fund $4,000 upon enrollment in the HRA Premier medical plan. You will receive ID cards once enrolled in the BCBS plans.

Prescription Drug Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Elixir. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred or Specialty Drugs. After you are enrolled, you will receive a separate card for pharmacy benefits, you can register to receive them here.

	HRA Premier Care Plan - PPO		High D – EPO HSA		Low D – PPO HSA		Symetra MEC Plan
Benefit Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	Schedule of Benefits
Retail Pharmacy (30 Day Supply)							
Generic (Tier 1)	$15 copay	50% of the Maximum Allowable Charge after Deductible	$10 copay after deductible	50% of the Maximum Allowable Charge after Deductible	$10 copay after deductible	50% of the Maximum Allowable Charge after Deductible	**
Preferred (Tier 2)	$40 copay		75% after deductible		75% after deductible		
Non-Preferred (Tier 3)	$75 copay		Greater of 75% or $400 deductible		Greater of 75% or $400 deductible		
Preferred Specialty (Tier 4)	Greater of 75% or $400 deductible						
Mail Order Pharmacy (90 Day Supply)							
Generic (Tier 1)	$40 copay		$30 copay after deductible		$30 copay after deductible		**
Preferred (Tier 2)	$120 copay		75% after deductible		75% after deductible		**
Non-Preferred (Tier 3)	Greater of 75% or $1,200		Greater of 75% or $1,200		Greater of 75% or $1,200		**
Preferred Specialty (Tier 4)	Not Covered		Not Covered		Not Covered		Not Covered

**Covers up to a 30-day supply (retail prescription) or 90-day supply (mail order).

**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
- Oral Fluoride Supplementation (where water source does not contain fluoride)
- Smoking deterrents

Medical Insurance Info

At the Doctor's Office

It's recommended that you choose an in-network primary care physician (PCP) for your medical coverage, even though it is not required for plans that include out of network benefits. A PCP can be your Family Practitioner, Internist, General Medicine, Pediatrician, or an OB/GYN (Obstetrician & Gynecologist). Each member of your family may have a different PCP.

If you are newly enrolling in medical benefits, make an appointment with your PCP, even if you're NOT sick once the plan year has begun. This relationship will set the foundation for staying healthy—today and well into the future.

Network Provide/Facility Search

Make sure that your provider or facility is in-network. To locate a network provider, call **800-565-9140 or** visit **bcbst.com/get-care/find-care**

- Find doctors, dentists, hospitals, and other health care providers
- Get cost estimates for over 1,600 common medical procedures

Member Service Portal

Your medical carrier's member portal is your access to secure, personalized services with interactive health tools built around you, your benefits, and your health. Access the BCBST portal at **www.bcbst.com/log-in/member/** Once you are registered your personal health information will be available to you 24/7, including:

- Finding care
- Managing prescriptions
- Managing claims
- Staying healthy
- Getting coverage and cost details

Need your health data on the run? Download your free carrier app from the App Store or Google Play. Use your mobile device to search for doctors, hospitals and more! Just search for BCBS Tennessee.

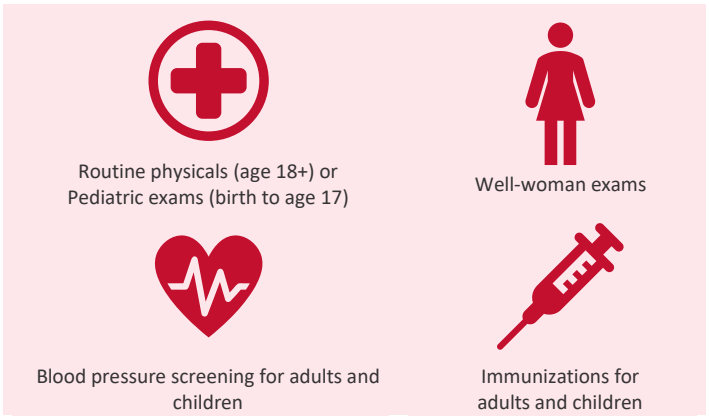
Blue Cross Blue Shield Health Concierge

Your Blue Cross Blue Shield Concierge is ready to speak with you at our toll-free number from 8 a.m. to 6 p.m., Monday through Friday. Simply call the number on your Blue Cross Blue Shield member ID card.

Preventive Care

You and your family have access to a wide range of preventive services under the Affordable Care Act. These services are 100% covered by your medical plan when using in-network providers. For more details about the covered services please visit www.healthcare.gov/coverage/preventive-care-benefits.

Common preventive services include:



Medical Weekly Rates

	HRA Premier Care Plan - PPO	High D Plan – EPO HSA	Low D – PPO HSA	Symetra MEC Plan
Non Tobacco				
Employee	$49.22	$21.93	$40.33	$7.08
Employee + Spouse	$145.24	$58.38	$108.33	$7.98
Employee + Child(ren)	$133.82	$50.08	$98.76	$7.61
Employee + Family	$188.22	$79.85	$144.39	$8.63
Tobacco				
Employee	$92.99	$57.62	$106.07	$7.08
Employee + Spouse	$192.77	$94.07	$174.06	$7.98
Employee + Child(ren)	$181.16	$85.76	$164.49	$7.61
Employee + Family	$237.89	$115.53	$210.12	$8.63

Ruby Tuesday is contributing up to a $500 HSA match per employee enrolled in the High-D and Low-D HSA qualified plans. So, whether you are enrolled in individual coverage, employee + spouse coverage, employee + child(ren) coverage, or family coverage, you get up to a $500 match per year deposited tax free into the HSA divided into two deposits - one in the first half of the year and one in the second half of the year.
PLEASE NOTE: The match amount counts toward your total IRS limit for the year.

The HRA will be administered by Blue Cross Blue Shield and will help offset the costs for qualified in-network deductible expenses incurred by you or a covered family member. The money spent in your HRA counts toward meeting your deductible; prescription drug copays are not reimbursable through your HRA. Ruby Tuesday will fund $2,000 toward your HRA; if you have a covered family member on your plan, Ruby Tuesday will fund $4,000 upon enrollment in the HRA Premier medical plan. Once your HRA funds have been exhausted, you will be responsible for meeting the remainder of your calendar year deductible. After the deductible has been satisfied, the medical plan will pay 80% of the allowable charges, and you will be responsible for 20% up to the out-of-pocket maximum. After that, the plan will pay 100% of covered expenses for the remainder of the calendar year. Your HRA balance will reset each year on January 1.

The MEC plan covers preventive services only. There is no deductible, and you are responsible for all non-preventive services.

Employee Out-of-Pocket Cost Calculation Exercise

Summarized below are four scenarios outlining various claimant utilization examples.

Claim Example: Claimant #1

	Count	Allowed Cost per	Total
Doctor office visits	3	$93.00	$279.00
Lab Charges (subj to Ded & Coins except in PPO)	3	$50.00	$150.00
RX Generic cost AVG $25 per script	5	$25.00	$125.00
RX Top Used brand AVG $75 per script	0	$35.00	$0.00
MRI (subj to Ded & Coins except in 1000 PPO)	0	$700.00	$0.00
Hospital days inpatient (subj to Ded & Coins)	0	$1,900.00	$0.00
Total Claims			$554.00

Claimant #1	HRA Premier	Low D HSA	High D HSA
HRA / H.S.A. payment	$ 286	$ 500	$ 500
OV Copays (2 PCP)	$ -	$ -	$ -
RX Copays	$ 75	$ -	$ -
Deductible (less HRA and H.S.A)	$ -	$ 54	$ 54
Coinsurance	$ -	$ -	$ -
Employee Pays/Total OOP	**$ 75**	**$ 54**	**$ 54**

Claim Example: Claimant #2

	Count	Allowed Cost per	Total
Doctor office visits	15	$93.00	$1,395.00
Lab Charges (subj to Ded & Coins in PPO)	6	$50.00	$300.00
RX Generic cost AVG $25 per script	7	$25.00	$175.00
RX Top Used brand AVG $75 per script	3	$75.00	$225.00
MRI (subj to Ded & Coins except in 1000 PPO)	0	$700.00	$0.00
Hospital days inpatient (subj to Ded & Coins)	0	$1,900.00	$0.00
Total Claims			$2,095.00

Claimant #2	HRA Premier	Low D HSA	High D HSA
HRA / H.S.A. payment	$ 1,695	$ 500	$ 500
OV Copays (2 PCP)	$ -	$ -	$ -
RX Copays	$ 225	$ -	$ -
Deductible (less HRA and H.S.A)	$ -	$ 1,250	$ 1,595
Coinsurance	$ -	$ 69	$ (2,095)
Employee Pays/Total OOP	**$ 225**	**$ 1,319**	**$ 1,595**

Claim Example: Claimant #3

	Count	Allowed Cost per	Total
Doctor office visits	12	$93.00	$1,116.00
Lab Charges (subj to Ded & Coins in PPO)	4	$50.00	$200.00
RX Generic cost AVG $25 per script	7	$25.00	$175.00
RX Top Used brand AVG $75 per script	8	$75.00	$600.00
MRI (subj to Ded & Coins except in 1000 PPO)	1	$700.00	$700.00
Hospital days inpatient (subj to Ded & Coins)	3	$2,000.00	$6,000.00
Total Claims			$8,791.00

Claimant #3	HRA Premier	Low D HSA	High D HSA
HRA / H.S.A. payment	$ 2,000	$ 500	$ 500
OV Copays (2 PCP)	$ -	$ -	$ -
RX Copays	$ 425	$ -	$ -
Deductible (less HRA and H.S.A)	$ 800	$ 1,250	$ 2,500
Coinsurance	$ 1,043	$ 1,408	$ 1,737
Employee Pays/Total OOP	**$ 2,268**	**$ 2,658**	**$ 4,237**

Claim Example: Claimant #4

	Count	Allowed Cost per	Total
Doctor office visits	20	$93.00	$1,860.00
Lab Charges (subj to Ded & Coins in PPO)	4	$50.00	$200.00
RX Generic cost AVG $25 per script	20	$25.00	$500.00
RX Top Used brand AVG $75 per script	10	$75.00	$750.00
MRI (subj to Ded & Coins except in 1000 PPO)	2	$700.00	$1,400.00
Hospital days inpatient (subj to Ded & Coins)	13	$2,000.00	$26,000.00
Total Claims			$30,710.00

Claimant #4	HRA Premier	Low D HSA	High D HSA
HRA / H.S.A. payment	$ 2,000	$ 500	$ 500
OV Copays (2 PCP)	$ -	$ -	$ -
RX Copays	$ 700	$ -	$ -
Deductible (less HRA and H.S.A)	$ 800	$ 1,250	$ 2,500
Coinsurance	$ 5,332	$ 5,792	$ 8,313
Employee Pays/Total OOP	**$ 6,450**	**$ 6,450**	**$ 6,450**

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Teladoc is dedicated to making health care better, faster and easier

Your access to Teladoc lets you **talk with a doctor anytime**, anywhere, through phone or online video consults. Teladoc is dedicated to improving member experiences by continually offering more health options and easier ways to access care.

More health care options

DERMATOLOGY

Millions of Americans suffer from common skin problems, many of which are easily treatable. Get the skin care you need.

BEHAVIORAL HEALTH

Teladoc doctors can provide advice, recommendations and referrals for whatever is on your mind.

Easier and better service

MOBILE APP

The Teladoc member app gives you 24/7/365 access to a doctor through the convenience of your mobile devices.

ADVANCED SCHEDULING

Now you have the choice to talk with the first available doctor or to schedule a consult at a time that fits your schedule.

$40 Co-pay

Talk to a doctor anytime

Teladoc.com

Facebook.com/Teladoc

1-800-Teladoc

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Teladoc® Member Frequently Asked Questions

What is Teladoc?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving you 24/7/365 access to quality medical care through phone and video consults.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, or Pediatrics. They average 15 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Does Teladoc replace my doctor?

No. Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

What kind of medical care does Teladoc provide?

When requesting a consult, you can choose between general medical, behavioral health or dermatology.

What consult methods are available?

You can talk with a Teladoc doctor via a phone consult, video consult within the secure member portal, or video consult within the Teladoc mobile app.

How do I set up my Teladoc account?

Setting up your account is a quick and easy process online. Visit the Teladoc website and click "Set Up Account". Follow the online instructions.

How do I request a consult to talk to a doctor?

Visit the Teladoc website, log into your account and click "Request a Consult". You can also call Teladoc to request a consult by phone.

How quickly can I talk to the doctor?

A doctor will call you back in 16 min, on average. If you miss the doctor's call, whether you are away from the phone or you have anonymous call blocker on, you will be returned to the bottom of the waiting list. The consult request is cancelled if you miss three calls.

Is there a time limit when talking with a doctor?

There is no time limit for consults.

Can Teladoc doctors write a prescription?

Yes, Teladoc doctors can prescribe short-term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, non-therapeutic and/or certain other drugs which may be harmful because of their potential abuse.

How do I pay for a prescription called in by Teladoc?

When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.

Can I provide consult information to my doctor?

Yes. You have access to your electronic medical record at anytime. Download a copy online from your account or call Teladoc and ask to have your medical record mailed or faxed to you.

Talk to a doctor anytime

Teladoc.com

1-800-Teladoc

Facebook.com/Teladoc

Teladoc.com/mobile

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Health Savings Account (HSA)

When you are enrolled in the BCBST High-D or Low-D plan, and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone is able to enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

HSA Contributions

You are able to contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions for 2023:

- $3,850 Individual or $7,750 Family
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.
- Ruby Tuesday HSA Contribution: $500

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes.

Select the image below to see a brief video for ways you can optimize your HSA.

Dental Insurance

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! Ruby Tuesday offers affordable plan options for routine care and beyond. Coverage is available from Blue Cross Blue Shield.

Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

Please refer to the summary plan description for complete plan details. Please note that you will receive a dental ID card.

	BlueCross BlueShield of Tennessee, Inc. Dental	
Benefit Coverage	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$0	$0
Family	$0	$0
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Person/Family (indicate calendar/benefit year)	$2,000	$2,000
Preventive Oral exams X-rays & diagnostic Teeth cleanings (1 every 6 months) Fluoride treatment Topical sealant Emergency treatment	100%	100%
Basic Minor Restorative Services Fillings Space maintainers Oral surgery Extractions, Periodontics Endodontics Stainless Steel Crowns Repairs to crowns & bridgework Occlusion adjustment Local anesthesia	50%	50%
Major Restorative Services Porcelain crowns Fixed & removable bridgework Full & partial dentures	50%	50%
Orthodontia		
Benefit Percentage	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Covered	Covered
Dependent Children	Covered	Covered
Lifetime Maximum	$2,000	$2,000
Benefit Waiting Periods	0 months	0 months

Dental Premium Rates	
Per Week	
Employee	$6.57
Employee + Spouse	$12.50
Employee + Child(ren)	$11.41
Employee + Family	$15.99

Vision Insurance

BlueCross BlueShield of Tennessee, Inc. has a large network of Eye Care Providers. By seeing a preferred provider, you have the benefit of a low copayment for a vision exam and materials. You may also go to out-of-network providers, but you will need to pay for services and then submit a claim form for the reimbursed allowances.

You will not receive a Vision ID card. You can give your provider your ID Number or SSN and they will be able to locate your policy and benefits.

	BlueCross BlueShield of Tennessee, Inc. Vision – Base Plan	BlueCross BlueShield of Tennessee, Inc. Vision – Premier Plan
Benefit Coverage	In-Network Benefits	In-Network Benefits
Copay		
Routine Exams	$10 copay	$10 copay
Lenses		
Single Vision Lenses	$25 copay	$25 copay
Bifocal Lenses	$25 copay	$25 copay
Trifocal Lenses	$25 copay	$25 copay
Frames		
Retail Equivalent	$0 copayment up to $150 allowance	up to $200 allowance
Contact Lenses		
Necessary / Prescribed	100%	100%
Elective	$0 copayment up to $125 allowance	$0 copayment up to $175 allowance
Other Services		
Laser Corrective Surgery	Not covered	Not Covered
Frequency		
Routine Exams	12 months	12 months
Lenses	12 months	12 months
Frames	24 months	12 months
Contact Lenses (Elective)	12 months	12 months

Vision Rates		
Per Week	**Base Plan**	**Premier Plan**
Employee	$1.09	$1.88
Employee + Spouse	$2.07	$3.56
Employee + Child(ren)	$2.18	$3.75
Employee + Family	$3.20	$5.51

Life and AD&D

Basic Life and Accidental Death & Dismemberment

Ruby Tuesday provides you with Basic Life and AD&D coverage at no cost to you through Lincoln! For newly eligible employees, coverage is effective on the 1st of the month following the date of hire. Basic Life does not apply to full-time hourly employees.

- Area Coaches, receive two times your covered annual salary up to $250,000. Managers and Managers in Training, Support Center Team Members and Full-Time Hourly Employees receive $25,000 for both Basic Life and AD&D.
- No medical underwriting is required. You are automatically covered for this benefit but be sure to designate a beneficiary during the enrollment process.

Voluntary Life and Accidental Death & Dismemberment

You may purchase additional Life and AD&D coverage for yourself and your dependents. When unexpected events occur, our Accidental Death & Personal Loss plans can help provide much-needed financial support and stability. Covered events include accidental death, paralysis, third-degree burns, comas, and loss of speech, hearing, sight or limbs. We expedite claims processing.

For newly eligible employees, coverage is effective on the 1st of the month following the date of hire. If you do not enroll when you are first eligible to do so, you and your spouse will be subject to medical underwriting for any amount of coverage if you decide to enroll at a later date.

Voluntary Life and AD&D	
You	**Managers, Area Coaches, Support Center Team Members**
Benefit Maximum	1x, 2x, 3x, 4x, or 5x your salary, up to $500,000 (Full Time Hourly 1x, 2x, 3x,4x, or 5x your salary up to $250,000).
Guaranteed Issue	$250,000
Your Spouse	
Benefit Maximum	**Life:** Choice of $10,000 or $25,000, then increments of $25,000 up to a maximum of $250,000. (Not to exceed 100% of the employee's Supplemental Life benefit) **AD&D:** Spouse: Only 50% of your amount
Guaranteed Issue	$25,000
Your Child	
Benefit Maximum	**Life:**$2,500 increments, up to $10,000 **AD&D Child(ren) Only:** Each child: 15% of your amount **AD&D Spouse and Child(ren):** Spouse: 40% of your amount; Each Child: 10% of your amount
Guaranteed Issue	$10,000

Plan options include:

- **Childcare benefit** — to help pay for state-licensed childcare centers
- **Educational benefit** — to help ensure higher education for dependent children & training for spouses or domestic partners
- **Passenger restraint and airbag benefit** — for proper use of restraint devices during an accident
- **Repatriation of remains benefit** — if a covered employee or dependent dies while at least 200 miles from home

Disability Insurance

Short Term Disability (STD)

In the event you are unable to work as a result of an illness or injury, Ruby Tuesday provides disability insurance through Lincoln. The plans offer income protection and may replace a portion of your earnings while you are unable to work. If your disability extends beyond 26 weeks, you may be eligible to receive Long Term Disability benefits. For newly eligible employees, coverage is effective on the 1st of the month following the date of hire.

Short Term Disability	
Benefit Coverages	**Managers, Area Coaches, Support Center, Full-Time Hourly Restaurant Team Members**
Elimination Period	Covered Injury / Illness on the first day | 7 days accident / 7 days sickness
Benefit Percentage	60% of your weekly salary
Maximum Weekly Benefit	$2,000
Maximum Period of Payment	26 weeks

Employees who work in NY, NJ, CA, RI or HI are not eligible to purchase this coverage. NY employees are automatically covered by Ruby Tuesday for statutory benefits that cover 50% of your salary up to a maximum benefit amount of $170 per week.

Long Term Disability (LTD)

You may purchase long-term disability insurance, which provides you with monthly income protection for covered disabilities that last longer than 26 weeks.

Long Term Disability		
Benefit Coverages	**Managers, Area Coaches, Support Center Team Members**	**Full-Time Hourly Restaurant Team Members**
Elimination Period	After 180 days of disability or the end of short-term disability benefits, whichever occurs later	After 180 days of disability or the end of short-term disability benefits, whichever occurs later
Benefit Percentage	60% of your weekly salary	60% of your weekly salary
Maximum Monthly Benefit	$10,000	$900
Maximum Period of Payment	Social Security normal retirement age	Social Security normal retirement age

LTD benefits received are reduced by State Disability Income (SDI) for employees residing in states with a State Disability Program (CA, NY, NJ, HI, and RI), Workers Compensation and Social Security.

Helpful Terminology

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs
- **Calendar Year Maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80 percent coinsurance means the plan covers 80 percent of the cost of service after a deductible is met. You will be responsible for the remaining 20 percent of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- **Deductible** – The amount you must pay for covered services before your health plan begins to pay.
- **Elimination Period** – The time between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Health Spending Accounts (HSA)** – HSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account stays in the account and can build year over year if it is not spent. This means you do not need to spend the money in the account before the end of the plan year.
- **Generic drugs** – A drug that offers equivalent uses, doses, strength, quality, and performance as a brand-name drug, but is not trademarked.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail Order Pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Health care providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Additional deductibles and higher coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Primary Care Provider (PCP)** – A doctor (generally a family practitioner, internist, or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Reasonable & Customary Charges (R&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist, or neurologist).
- **Specialty drugs** – A drug that requires special handling, administration, or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Employee Assistance Program (EAP)

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices, or locating further help.

Contact the EAP today!
Services available 24 hours a day, 7 days a week.

- Call: **1-888-238-6232**
- Email: eap@email.com
- Online: **www.resourcesforliving.com**

It's free... Your employer covers the cost of initial assessment, additional problem-solving sessions, and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.

It's confidential... Your EAP has been set up with Aetna's Resource for Living, an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

- Members can call 24/7 for free emotional support and daily life assistance, including:
- Contact Aetna's Resource for Living at **1-888-238-6232** or **www.resourcesforliving.com** (username: Ruby Tuesday, password: EAP)

401(k) Retirement Program

Whether you're just starting out in your career, or you've been in the workforce for years, it's always a good time to plan for retirement. Contributing to a 401(k) account now can help keep you financially secure later in life. The Ruby Tuesday 401(k) plan provides you with the tools and flexibility you need to prepare.

What is a 401(k)? This employer-sponsored retirement account can help build and create choices for your future self by saving money — tax free — from your paycheck. Due to the value of compounding interest, the sooner you participate in a 401(k), the better. Eligible employees can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by Principal. You may start making pre-tax contributions into the plan after six months of service.

The plan offers a convenient, tax-deferred way to save.

- **Who Can Join?** Any employee age 21 or older who has worked for Ruby Tuesday 6 months and makes less than $150,000 per year.
- **How Much Can You Contribute?** On a pre-tax basis: 1% to 50% of your pay up to $22,500 in 2023. This limit is adjusted annually each year by the IRS. You can also contribute on after-tax basis up to 10% of your gross pay or Roth after-tax basis.
- **Does Ruby Tuesday Contribute?** 50% match of contributions, up to 6% of salary. Total match, up to 3% of salary.
- **How Can You Join?** Call Principal at **1-800-547-7754** or via internet at **www.principal.com.**

Pre-tax vs. Roth 401(k): What's the difference? If you contribute to your 401(k) pre-tax, your contributions will be taken out before taxes each pay period. However, you'll have to pay taxes on the funds when you withdraw them during retirement. If you choose the available Roth 401(k), contributions will be deducted from your paycheck after taxes — so you won't pay taxes when you withdraw during retirement. Once you retire, you might be in a higher tax bracket, so contributing after taxes now could save you money in the long run.

Voluntary Benefits

You have the option to purchase additional voluntary benefits via post-tax payroll deductions. Benefits you may purchase include:

Critical Illness

The Lincoln Critical Illness plan is designed to help employees and their families with the out-of-pocket costs associated with a critical illness. Critical illnesses include Heart Attack, Stroke, Major Organ Transplant, End-Stage Renal Failure, Cancer, and additional conditions.

- Employees select an Initial Benefit of $5,000 increments up to $30,000. A Spouse/Domestic Partner can select an initial benefit up to $2,500 increments up to $15,000 (not to exceed 50% of employee's benefit), and children's elections are $2,500 increments up to $7,500.
- No medical questions as long as the employee is actively at work and has medical coverage.
- Benefits are paid directly to the insured on a post-tax basis.
- This plan is portable, so you may continue coverage if you leave the company for any reason.

Accident Insurance Plan

The Lincoln Accident Insurance plan provides employees with a choice of two comprehensive plans (Option 1 or Option 2) which provide payments for covered accidents.

- With over 150 covered events, including hospitalization resulting from an accident as well as accidental death or dismemberment, the Lincoln Accident Insurance plan will pay for covered accidents in addition to any other insurance payments you may receive.
- Coverage is Guaranteed Issue, no medical questions are asked.
- Spouse and Dependent Child(ren) coverage is also available. This plan is portable, so you may continue coverage if you leave the company for any reason.

Hospital Indemnity

There are two plans to choose from (Option 1 & Option 2).

- The Option 1 plan pays $850 for the first day of a hospital stay per year and $300 per day for up to 3 days.
- The Option 2 plan pays $1,500 for the first day of a hospital stay per plan year and $500 per day for up to 3 days.

Allstate Identity Theft Protection

Every 2 seconds there is a new victim of identity fraud and 1 in 4 people have already experienced identity theft.

Commuter Benefit

The Commuter Benefit Plan is available to New York, New Jersey, & Philadelphia employees only

- This benefit makes it easy to order transit and parking passes, vouchers, or a Commuter Check online through PayFlexDirect.com.

Chubb Term Life

This coverage pays a benefit up to $250,000 that can be used as your beneficiary sees fit. It can help cover funeral expenses, medical expenses, debts and more. This is electable in increments of 1 time to 5 times your basic annual earnings up to $100,000 with no medical questions.

Group Legal Plan

MetLife is a voluntary group legal plan which provides fully covered legal advice and representation for most personal legal matters (employment and business-related matters are excluded from coverage). Once enrolled, employees have access to an attorney, as if on retainer, through Hyatt's nationwide network of 12,000 pre-qualified attorneys. Employees may contact an attorney for representation for a wide range of legal services, in addition to telephone advice and office consultations on an unlimited number of personal legal matters.

Customer Service Information

Type of Coverage	Carrier	Phone Number	Website / e-mail
Medical EPO/PPO	BlueCross BlueShield of Tennessee, Inc.	800-565-9140	www.BCBST.com/member
Medical Indemnity	Symetra Life Insurance Company	800-796-3872	
Pharmacy	Elixir	800-361-4542	https://www.elixirsolutions.com/
Dental PPO	BlueCross BlueShield of Tennessee, Inc.	800-565-9140	www.BCBST.com/member
Vision	BlueCross BlueShield of Tennessee, Inc.	877-342-0737	www.BCBST.com
Accident, Hospitalization, Critical Illness	Lincoln	877-275-5462	https://www.lincolnfinancial.com/public/individuals
Life, Short and Long-Term Disability	Lincoln	877-275-5462	https://www.lincolnfinancial.com/public/individuals
Employee Assistance Program (EAP)	Aetna Inc	888-238-6232	www.resourcesforliving.com Username: RubyTuesday Password: EAP
Qualified Life Events	Ruby Tuesday	800-325-0755, Opt. 4	benefitsadministration@rubytuesday.com
401(k) Retirement	Principal	1-800-547-7754	www.principal.com
Identity Theft	Allstate	855-821-2331	Allstate.com
Term Life	Chubb	866-324-8222	Chubb.com
Legal Services	MetLife	800-821-6400	Info.legalplans.com and enter **6090862**

Ruby Tuesday

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance apply.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, 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 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 this 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 30 days after your 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 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

MICHELLE'S LAW DISCLOSURE

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. Ruby Tuesday group health plan extends dependent coverage beyond the ACA requirements, to age 26, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

To obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting

your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Benefits Administration
216 E. Church Street
Maryville, TN 37804
benefitsadministration@rubytuesday.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date 01/01/2023
- Benefits Administration
  216 E. Church Street
  Maryville, TN 37804
  benefitsadministration@rubytuesday.com

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Ruby Tuesday About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ruby Tuesday and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. **Ruby Tuesday has determined that the prescription drug coverage offered by the Ruby Tuesday health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ruby Tuesday coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Ruby Tuesday coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ruby Tuesday and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ruby Tuesday changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	01/01/2023
Name of Entity/Sender:	Ruby Tuesday
Contact--Position/Office:	Benefits Administration
Address:	216 E. Church Street, Maryville, TN 37804
Phone Number:	N/A

CMS Form 10182-CC **Updated April 1, 2011**

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
Ruby Tuesday	63-0475239	
5. Employer address	6. Employer phone number	
216 E. Church Street	N/A	
7. City	8. State	9. ZIP code
Maryville	TN	37804
10. Who can we contact about employee health coverage at this job?		
Benefits Administration		
11. Phone number (if different from above)	12. Email address	
N/A	benefitsadministration@rubytuesday.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full Time & Part Time employees

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Spouse, Domestic Partners, Children up to age 26, Children who are mentally or physically unable to care for themselves.

[x] If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Ruby Tuesday

216 E Church Street
Maryville, Tennessee 37804

This brochure summarizes the benefit plans that are available to Client Name eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.