Ruby Tuesday

2024 WELLNESS AND BENEFITS GUIDE

FULL TIME EMPLOYEES

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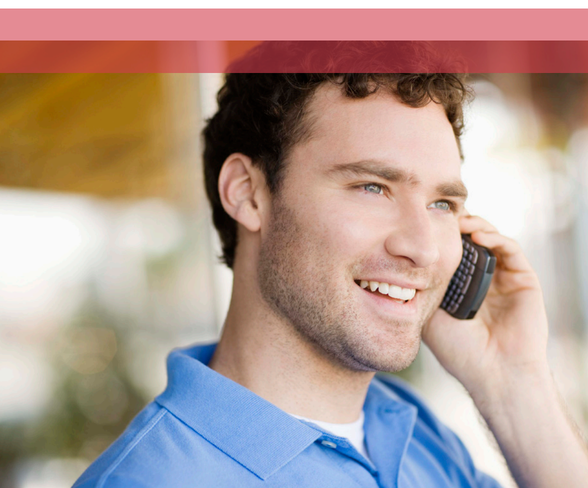
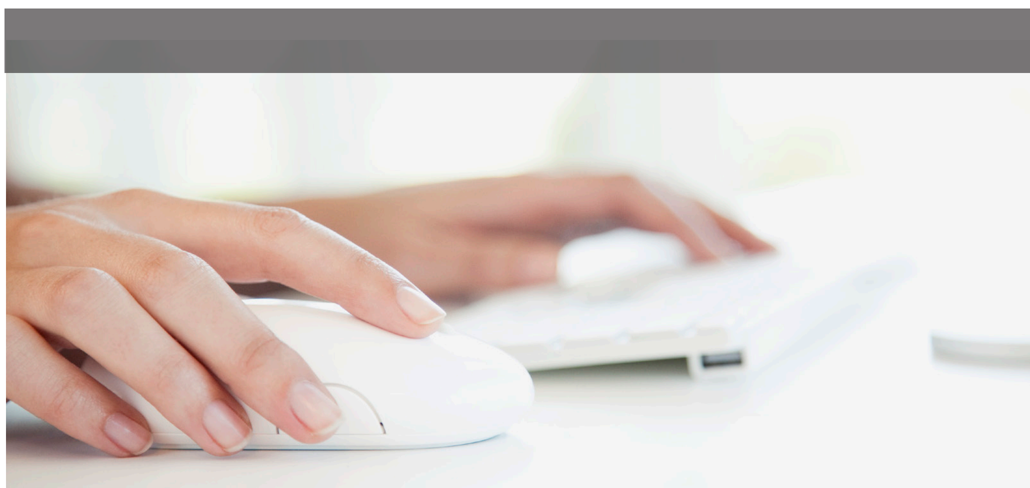
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 43 for more details.

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 EPO/PPO Pharmacy	Elixir	800-361-4542	**www.elixirsolutions.com/**
Medical Indemnity	Pan-American	800-999-5382	**mypalic.com**
Medical Indemnity Pharmacy	RxEDO	888-879-7336	**www.RxEDO.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 and Critical Illness	Lincoln	877-275-5462	**www.lincolnfinancial.com/public/individuals**
Life, Short and Long-Term Disability	Lincoln	877-275-5462	**www.lincolnfinancial.com/public/individuals**
Employee Assistance Program (EAP)	Lincoln	833-475-0980	**GuidanceResources.com** Username: LFGNY Password: LFGNY1
Savings Accounts	PayFlex	844-729-3539	**www.mypayflex.com**
Qualified Life Events	Ruby Tuesday	800-325-0755, Opt. 4	**benefitsadministration@rubytuesday.com**
401(k) Retirement	Principal	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	**www.legalplans.com**
Pet Insurance	Nationwide	877-738-7874	**benefits.petinsurance.com/rubytuesday**





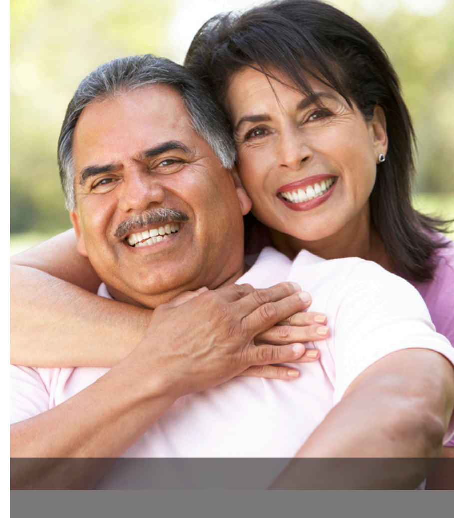
A MESSAGE FROM RUBY TUESDAY

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 guide 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/**

All benefit elections made during the annual open enrollment are effective January 1, 2024 through December 31, 2024. Changes to your benefit elections cannot be made during the plan year, unless you experience a qualifying life event.

See next page for examples of qualifying life events.



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, 2024.

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

QUALIFYING LIFE EVENTS

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 BlueCross BlueShield of Tennessee, Inc. BCBST 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 $3,200 (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.

PAN-AMERICAN MEC PLANS*

There are two MEC plan options with Pan-American. These plans cover preventative services with limited hospital indemnity coverage. With either plan, there is no deductible or coinsurance. Members using providers are restricted to the First Health PPO network.

All members may visit **providerlocator.com/palicfh** or call **888-561-5759** for a list of in-network providers. **See page 14 for additional information.**

*Employees residing in Maine are offered an alternative MEC plan. Please see page 35 for Maine-Only MEC coverage.

BCBST MEDICAL PLAN COMPARISON

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

<table>
<tr><th></th><th colspan="6">BCBST PLANS</th></tr>
<tr><th>BENEFIT COVERAGE</th><th colspan="2">HRA PREMIER CARE PLAN - PPO</th><th colspan="2">HIGH D – EPO HSA</th><th colspan="2">LOW D – PPO HSA</th></tr>
<tr><th></th><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td colspan="7">ANNUAL DEDUCTIBLE</td></tr>
<tr><td>Individual</td><td>$2,800</td><td>$6,450</td><td>$3,200</td><td>N/A</td><td>$1,750</td><td>$3,500</td></tr>
<tr><td>Family</td><td>$8,400</td><td>$19,350</td><td>$6,400</td><td>N/A</td><td>$3,500</td><td>$7,000</td></tr>
<tr><td>Coinsurance</td><td>20%</td><td>40%</td><td>30%</td><td>N/A</td><td>20%</td><td>50%</td></tr>
<tr><td colspan="7">SPENDING ACCOUNT</td></tr>
<tr><td>Type</td><td colspan="2">HRA</td><td colspan="2">HSA</td><td colspan="2">HSA</td></tr>
<tr><td>Amount</td><td colspan="2">$2,000</td><td colspan="2">$500</td><td colspan="2">$500</td></tr>
<tr><td colspan="7">MAXIMUM OUT-OF-POCKET</td></tr>
<tr><td>Individual</td><td>$6,450</td><td>$9,600</td><td>$6,450</td><td>N/A</td><td>$6,450</td><td>$7,000</td></tr>
<tr><td>Family</td><td>$12,900</td><td>$19,200</td><td>$12,900</td><td>N/A</td><td>$12,900</td><td>$14,000</td></tr>
<tr><td colspan="7">PHYSICIAN OFFICE VISIT</td></tr>
<tr><td>Primary Care</td><td rowspan="2">Deductible + Coinsurance</td><td rowspan="3">40% of the Maximum Allowable Charge*</td><td>30%*</td><td>N/A</td><td rowspan="2">20%*</td><td rowspan="3">50% of the Maximum Allowable Charge*</td></tr>
<tr><td>Specialty Care</td><td rowspan="2">100%</td><td>N/A</td></tr>
<tr><td>Preventive Care</td><td>100%</td><td>Not Covered</td><td>100%</td></tr>
<tr><td colspan="7">DIAGNOSTIC SERVICES</td></tr>
<tr><td>X-ray & Lab Tests</td><td rowspan="5">20%*</td><td rowspan="5">40% of the Maximum Allowable Charge*</td><td rowspan="5">30%*</td><td rowspan="5">Not Covered</td><td rowspan="5">20%*</td><td rowspan="5">50% of the Maximum Allowable Charge*</td></tr>
<tr><td>Complex Radiology</td></tr>
<tr><td>Inpatient Facility Charges</td></tr>
<tr><td>Outpatient Facility & Surgical Charges</td></tr>
<tr><td>Urgent Care Facility</td></tr>
<tr><td>Emergency Room Facility Charges</td><td colspan="2">100% after $300 copay per visit, then 20%*</td><td colspan="2">30%*</td><td colspan="2">20%*</td></tr>
<tr><td colspan="7">MENTAL HEALTH / SUBSTANCE ABUSE</td></tr>
<tr><td>Inpatient</td><td rowspan="2">20%*</td><td rowspan="2">40% of the Maximum Allowable Charge*</td><td rowspan="2">30%*</td><td rowspan="2">Not covered</td><td rowspan="2">20%*</td><td rowspan="2">50% of the Maximum Allowable Charge*</td></tr>
<tr><td>Outpatient</td></tr>
<tr><td colspan="7">OTHER SERVICES</td></tr>
<tr><td>Chiropractic</td><td>20%*</td><td>50% of the Maximum Allowable Charge*</td><td>30%*</td><td>Not covered</td><td>20%*</td><td>50% of the Maximum Allowable Charge*</td></tr>
</table>

* After deductible

Note: HRA Premier Plan includes access to Health Reimbursement Account (HRA) fully funded by Ruby Tuesday and administered by BCBST. 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 BCBST plans.

BCBST 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

To locate a network provider, call **1-800-565-9140** 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

Make sure that your provider or facility is in-network.

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/login/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.

BLUECROSS BLUESHIELD HEALTH CONCIERGE

Your BlueCross BlueShield 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 BlueCross BlueShield 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:

Routine physicals (age 18+) or pediatric exams (birth to age 17)

Well-woman exams

Blood pressure screening for adults and children

Immunizations for adults and children

TELADOC

TELADOC IS DEDICATED TO MAKING HEALTHCARE BETTER, FASTER AND EASIER

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

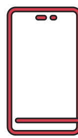
DERMATOLOGY

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

BEHAVIORAL HEALTH

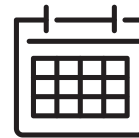
Teladoc doctors can provide advice, recommendations and referrals for whatever is on your mind.

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 COPAY

TALK TO A DOCTOR ANYTIME

Teladoc.com

Facebook.com/Teladoc

800-Teladoc

Teladoc.com/mobile

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.

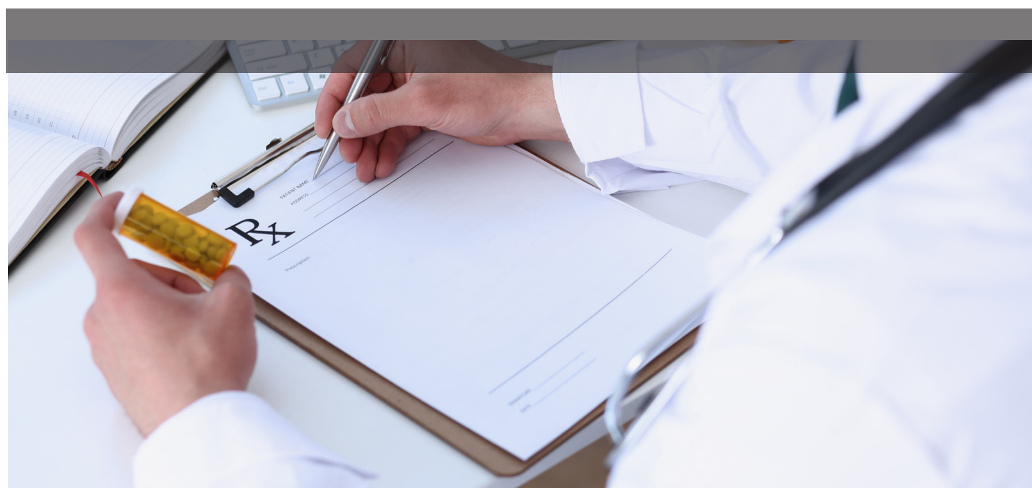
PRESCRIPTION DRUG COVERAGE FOR MEDICAL PLANS

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**.

Ruby Tuesday Rx Bin Number: 009893

	BCBST PLANS					
BENEFIT COVERAGE	**HRA PREMIER CARE PLAN – PPO**		**HIGH D – EPO HSA**		**LOW D – PPO HSA**	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
RETAIL PHARMACY (30 DAY SUPPLY)						
Generic (Tier 1)	$15 copay	50% of the Maximum Allowable Charge*	$10 copay*	50% of the Maximum Allowable Charge*	$10 copay*	50% of the Maximum Allowable Charge*
Preferred (Tier 2)	$40 copay		75%*		75%*	
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*		$30 copay*	
Preferred (Tier 2)	$120 copay		75%*		75%*	
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	

* After deductible



ELIXIR PHARMACY – PAYER MATRIX

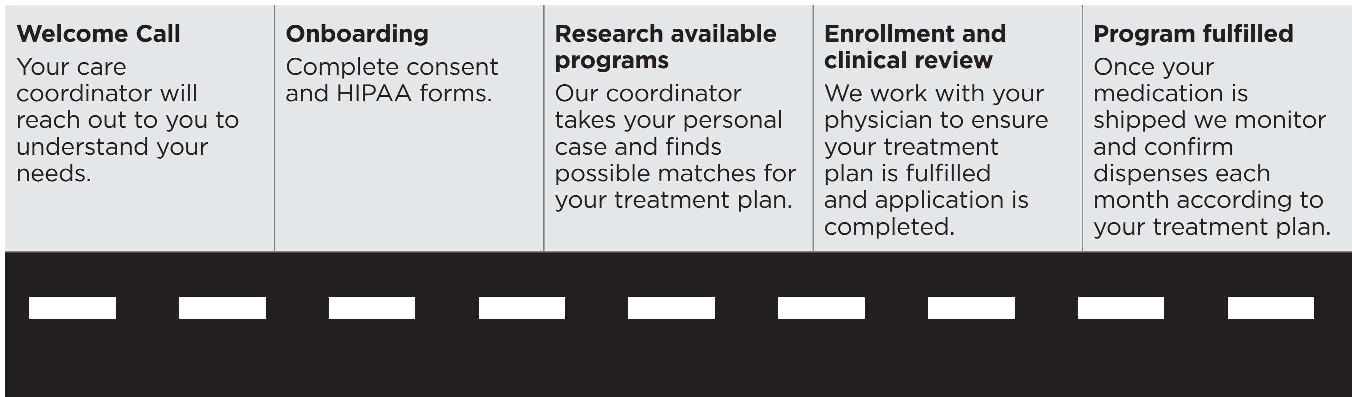
We are here to be your trusted patient advocate!

Payer Matrix is part of the pharmacy plan, Elixir Pharmacy. Payer Matrix is a patient advocacy group that wants to help you save money on your specialty medications. If eligible for a discount on your prescription medications, your personalized care coordinator will guide you through every step and will be there if you have any questions along the way!

WHAT YOUR CARE COORDINATOR DOES FOR YOU

- Patient assistance program guidance
- Keep everything on-time
- Hands-on paperwork
- Dispense notifications
- Scheduling assistance
- Program research
- Personalized custom care
- Your own dedicated care coordinator

PAYER MATRIX ROAD MAP



Welcome Call	Onboarding	Research available programs	Enrollment and clinical review	Program fulfilled
Your care coordinator will reach out to you to understand your needs.	Complete consent and HIPAA forms.	Our coordinator takes your personal case and finds possible matches for your treatment plan.	We work with your physician to ensure your treatment plan is fulfilled and application is completed.	Once your medication is shipped we monitor and confirm dispenses each month according to your treatment plan.

LEARN MORE ABOUT US TODAY.

Visit our website at

www.payermatrix.com

EMPLOYEE OUT-OF-POCKET COST CALCULATION EXERCISE

Summarized below are four scenarios outlining various claimant utilization examples when enrolled in one of the BCBST medical plans.

	CLAIM EXAMPLE: CLAIMANT #1			CLAIM EXAMPLE: CLAIMANT #2		
EXAMPLE COSTS	COUNT	ALLOWED COST PER	TOTAL	COUNT	ALLOWED COST PER	TOTAL
Doctor office visits	3	$93.00	$279.00	15	$93.00	$1,395.00
Lab Charges (subj to Deductible & Coinsurance except in PPO)	3	$50.00	$150.00	6	$50.00	$300.00
RX Generic cost AVG $25 per script	5	$25.00	$125.00	7	$25.00	$175.00
RX Top Used brand AVG $75 per script	0	$35.00	$0.00	3	$75.00	$225.00
MRI (subj to Deductible & Coinsurance except in 1000 PPO)	0	$700.00	$0.00	0	$700.00	$0.00
Hospital days inpatient (subj to Deductible & Coinsurance)	0	$1,900.00	$0.00	0	$1,900.00	$0.00
Total Claims			$554.00			$2,095.00

	CLAIMANT #1			CLAIMANT #2		
	HRA PREMIER	LOW D HSA	HIGH D HSA	HRA PREMIER	LOW D HSA	HIGH D HSA
HRA / HSA Payment	$ 286	$ 500	$ 500	$ 1,695	$ 500	$ 500
OV Copays (2 PCP)	$ –	$ –	$ –	$ –	$ –	$ –
RX Copays	$ 75	$ –	$ –	$ 225	$ –	$ –
Deductible (less HRA and HSA)	$ –	$ 54	$ 54	$ –	$ 1,250	$ 1,795
Coinsurance	$ –	$ –	$ –	$ –	$ 69	($ 2,095)
Employee Pays/Total OOP	$ 75	$ 54	$ 54	$ 225	$ 1,319	$ 1,795

	CLAIM EXAMPLE: CLAIMANT #3			CLAIM EXAMPLE: CLAIMANT #4		
	COUNT	ALLOWED COST PER	TOTAL	COUNT	ALLOWED COST PER	TOTAL
Doctor office visits	12	$93.00	$1,116.00	20	$93.00	$1,860.00
Lab Charges (subj to Deductible & Coinsurance in PPO)	4	$50.00	$200.00	4	$50.00	$200.00
RX Generic cost AVG $25 per script	7	$25.00	$175.00	20	$25.00	$500.00
RX Top Used brand AVG $75 per script	8	$75.00	$600.00	10	$75.00	$750.00
MRI (subj to Deductible & Coinsurance except in 1000 PPO)	1	$700.00	$700.00	2	$700.00	$1,400.00
Hospital days inpatient (subj to Deductible & Coinsurance)	3	$2,000.00	$6,000.00	13	$2,000.00	$26,000.00
Total Claims			$8,791.00			$30,710.00

	CLAIMANT #3			CLAIMANT #4		
	HRA PREMIER	LOW D HSA	HIGH D HSA	HRA PREMIER	LOW D HSA	HIGH D HSA
HRA / HSA Payment	$ 2,000	$ 500	$ 500	$ 2,000	$ 500	$ 500
OV Copays (2 PCP)	$ –	$ –	$ –	$ –	$ –	$ –
RX Copays	$ 425	$ –	$ –	$ 700	$ –	$ –
Deductible (less HRA and HSA)	$ 800	$ 1,250	$ 2,500	$ 800	$ 1,250	$ 2,700
Coinsurance	$ 1,043	$ 1,408	$ 1,737	$ 5,332	$ 5,792	$ 8,313
Employee Pays/Total OOP	$ 2,268	$ 2,658	$ 4,237	$ 6,450	$ 6,450	$ 6,650

MEC MEDICAL INSURANCE INFO

PanaBridge Advantage Plans provide a combination of Minimum Essential Coverage (MEC) and a limited hospital indemnity plan. *Employees residing in Maine are offered an alternative MEC plan. Please see page 35 for Maine-Only MEC coverage.*

BENEFIT DESCRIPTION	PLAN 1	PLAN 2
HOSPITAL ADMISSION INDEMNITY BENEFIT • Pays in addition to hospital indemnity • Once per admission, once per diagnosis • Benefit will not be payable for the same or related injury or illness	$1,000 first day when admitted as an inpatient into a hospital room	$1,500 first day when admitted as an inpatient into a hospital room
HOSPITAL INDEMNITY BENEFIT • Must be admitted as an inpatient into a hospital room • If hospital confinement falls into a category below a different maximum applies	$400 per day Overall calendar year max subject to 10 day(s) total for any inpatient stay in a hospital	$600 per day Overall calendar year max subject to 10 day(s) total for any inpatient stay in a hospital
Intensive Care If the participant is confined in a hospital intensive care unit	$800 per day Up to 5 day(s) calendar year max (applied to overall calendar year max)	$1,200 per day Up to 5 day(s) calendar year max (applied to overall calendar year max)
Substance Abuse Must be diagnosed and admitted as an inpatient in a substance abuse unit	$200 per day Up to 5 day(s) calendar year max (applied to overall calendar year max)	$300 per day Up to 5 day(s) calendar year max (applied to overall calendar year max)
Mental Illness Must be diagnosed and admitted as an inpatient into a mental illness unit	$200 per day Up to 10 day(s) calendar year max (applied to overall calendar year max)	$300 per day Up to 10 day(s) calendar year max (applied to overall calendar year max)
Skilled Nursing Facility Must be admitted in skilled nursing facility following a covered hospital stay of at least 3 days	$200 per day Up to 7 day(s) calendar year max (applied to overall calendar year max)	$300 per day Up to 7 day(s) calendar year max (applied to overall calendar year max)
DOCTOR'S OFFICE BENEFIT Benefit pays one benefit per day if the patient is seen by a doctor for an illness or injury	$80 per day 4 day(s) per calendar year	$100 per day 4 day(s) per calendar year
OUTPATIENT DIAGNOSTIC LABS • Includes glucose test, urinalysis, CBC, and others • When hospital confinement is not required and the test is ordered or performed by a doctor	$20 per day 3 day(s) per calendar year	$20 per day 3 day(s) per calendar year
OUTPATIENT DIAGNOSTIC RADIOLOGY • Includes chest, broken bones, and others • When hospital confinement is not required and the test is ordered or performed by a doctor	$70 per day 2 day(s) per calendar year	$70 per day 2 day(s) per calendar year
OUTPATIENT ADVANCED STUDIES • Includes CT Scan, MRI, and others • When hospital confinement is not required and the test is ordered or performed by a doctor	$250 per day 2 day(s) per calendar year	$250 per day 2 day(s) per calendar year
INPATIENT SURGICAL BENEFIT • Surgery must be performed due to an illness or injury as an inpatient stay in a hospital • Minor surgical procedures are excluded	$225 per day 1 day(s) per calendar year	$300 per day 1 day(s) per calendar year
INPATIENT ANESTHESIA BENEFIT 25% of the amount paid under the inpatient surgical benefit	$56.25 per day 1 day(s) per calendar year	$75.00 per day 1 day(s) per calendar year
OUTPATIENT SURGICAL BENEFIT • Surgery must be performed due to an illness or injury at an outpatient surgical facility center or hospital outpatient surgical facility • Minor surgical procedures are excluded	$112.50 per day 1 day(s) per calendar year	$150 per day 1 day(s) per calendar year
OUTPATIENT ANESTHESIA BENEFIT 25% of the amount paid under the outpatient surgical benefit	$28.13 per day 1 day(s) per calendar year	$37.50 per day 1 day(s) per calendar year
AMBULANCE SERVICES Pays one benefit per day for emergency ground, air, and water ambulance transportation	$200 per day 1 day(s) per calendar year	$250 per day 1 day(s) per calendar year

THE LIMITED BENEFIT INDEMNITY PLAN ALONE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE (MAJOR MEDICAL COVERAGE) AND DOES NOT SATISFY THE REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. HOWEVER, THE PREVENTIVE CARE PLAN OFFERED AS PART OF PANABRIDGE ADVANTAGE DOES MEET THE REQUIREMENT UNDER THE AFFORDABLE CARE ACT AS IT PROVIDES MINIMUM ESSENTIAL COVERAGE.

MEC MEDICAL INSURANCE INFO*

MEMBER ADVOCACY

WHAT IS A MEMBER ADVOCATE?

A member advocate is an in-house representative that works exclusively on behalf of our members to reduce medical costs and stressful billing situations. They can help members find community programs, hospitals, pharmaceutical companies, and provider offices who have affordable treatment costs. Also, they serve as a single point-of-contact to help resolve on-going or challenging billing issues. They're even available to speak with members individually, as well as their physicians and medical facilities, so everyone has a full understanding of how the benefits work and can make the most informed choices regarding planning medical treatment.

ADVOCATES CAN ASSIST WITH:

- Medical bills & Prescription costs
- Lab work & X-rays
- CAT Scans / MRIs
- Scheduling surgical procedures
- Durable medical equipment
- Diabetic supplies
- Complicated claims and billing issues

THEY HELP LOWER COSTS BY:

- Finding providers that offer sliding-scale treatment pricing
- Arranging payment plans for previously incurred bills
- Requesting discounted lump-sum payments to settle balances
- Locating community programs for specialized services or frequently recurring expenses due to chronic conditions
- Contacting discount pharmacies

*Employees residing in Maine are offered an alternative MEC plan. Please see page 35 for Maine-Only MEC coverage.

MEMBER SERVICES

Our member service representatives are responsible for ensuring that customers receive the best assistance with their questions and concerns. Pan-American Life's customer service representatives interact with customers to provide information in response to inquiries about products and services. They communicate with administrators and members through a variety of means; by telephone, by e-mail, fax or mail.

We can assist members, companies and providers with:

- Member Advocacy
- ID Cards
- Policy Information
- Member Eligibility
- Verification of Benefits
- Prescription Benefits
- PPO Network Information
- Account Management
- Claims
- And more!

Monday through Friday,
7:30 AM-5:00 PM, Central Time
1-800-999-5382
Full bilingual (English-Spanish) services

PPO PROVIDER NETWORK

USING IN-NETWORK PROVIDERS CAN STRETCH YOUR BENEFIT DOLLARS

Your plan includes access to the First Health Network, which is more than a PPO Network, it is a full service Managed Care Organization offering savings opportunities on a national, directly contracted basis. It provides access to more than 5,000 hospitals and 695,000 physicians and health care professionals nationwide. First Health is committed to patient safety at a high level by exercising care in the selection and evaluation of providers for our network. Thorough credentialing and re-credentialing processes minimize unfavorable risks, which in turn, impacts clinical and cost outcomes. In addition to the First Health Network, our members also have access to a secondary, or Wrap Network that provides them and their covered dependents a broader access to Physicians and health care professionals in urban, suburban, and rural areas.

PAN-AMERICAN MEC BENEFITS*

GLOBAL REPATRIATION

HELPING TO PROVIDE PEACE OF MIND DURING YOUR TIME OF NEED

The passing of a loved one is a difficult and emotional experience. When it occurs during travel, you or your loved ones may feel that help is no longer within reach.

Global Repatriation is a worldwide benefit designed to help your family when you or a covered dependent suffers a loss of life due to a covered accident or illness while traveling 100 miles or more away from their permanent residence. The benefit provides transportation of a covered member's remains to his/her primary place of residence in the United States and repatriation of foreign nationals to their home countries.

Benefit Includes:

- Expenses for preparations; embalming or cremation
- Transport casket or air tray
- Transportation of remains to place of residence or place of burial

All services must be authorized and arranged by AXA Assistance designated personnel and the maximum benefit per person is $20,000 USD per occurrence. No claims for reimbursement will be accepted.

To Activate Assistance Call: **1-888-558-2703** / **1-312-356-5963**

Global Repatriation benefits are independently offered and administered by AXA Assistance USA, Inc. **www.axa-assistance.us**.

Pan-American Life and AXA Assistance USA, Inc. are not affiliated. See policy for exclusions and limitations.

HEALTHIEST YOU

With HealthiestYou, you can connect to a doctor, get treatment, and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more sitting around in waiting rooms. And best of all, it's FREE!

24X7 UNLIMITED DOCTOR ACCESS Are you sick? Call HealthiestYou first! Our physician network can diagnose, treat, and prescribe with no consult fees, anytime, anywhere. Really!	PRESCRIPTION SAVINGS Need a prescription? Our geo-based Prescription search engine can save you up to 85% on your prescription and will often beat your co-pay.
SHOP & PRICE PROCEDURES Do you need an MRI or an Ultrasound? Our app puts you in the driver's seat by providing a vehicle to search and price procedures in your direct area. Happy shopping!	HEALTH MANAGEMENT CONTENT Are you stressed? Let HealthiestYou guide you to improved health and happiness with relevant health content delivered at your time of need.
REGISTER AND ACCESS YOUR ACCOUNT **member.healthiestyou.com** No internet? Call a doctor **1-855-894-9627**	To learn how to connect with a doctor 24/7, shop and price procedures, prescription savings and more. Watch our video: **www.mypalic.com/videohy**

Don't forget to download the app

*Employees residing in Maine are offered an alternative MEC plan. Please see page 35 for Maine-Only MEC coverage.

PAN-AMERICAN MEC BENEFITS*

PRESCRIPTION DRUG INDEMNITY BENEFITS

Your prescription drug indemnity benefit will pay a maximum amount per day, per insured person, with a maximum amount either per month or per calendar year (check your plan below). There are no copayments, deductibles, or coinsurance.

PRESCRIPTION DRUG INDEMNITY PAYS	PLAN 1	PLAN 2
Generic	$10 per day	$10 per day
Brand	Discount Only	$50 per day
CALENDAR YEAR MAXIMUM LIMIT		
Generic	12 days per insured	12 days per insured
Brand	-	12 days per insured

*Employees residing in Maine are offered an alternative MEC plan. Please see page 35 for Maine-Only MEC coverage.

MEDICAL WEEKLY RATES*

	BCBST PLANS			PAN-AM MEC PLANS	
	HRA PREMIER CARE PLAN - PPO	HIGH D - EPO HSA	LOW D - PPO HSA	PLAN 1	PLAN 2
NON-TOBACCO					
Employee	$49.22	$21.93	$40.33	$22.11	$28.79
Employee + Spouse	$145.24	$58.38	$108.33	$42.48	$57.02
Employee + Child(ren)	$133.82	$50.08	$98.76	$33.55	$44.63
Employee + Family	$188.22	$79.85	$144.39	$56.84	$76.99
TOBACCO					
Employee	$92.99	$57.62	$106.07	$22.11	$28.79
Employee + Spouse	$192.77	$94.07	$174.06	$42.48	$57.02
Employee + Child(ren)	$181.16	$85.76	$164.49	$33.55	$44.63
Employee + Family	$237.89	$115.53	$210.12	$56.84	$76.99

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 BlueCross BlueShield 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 Plans cover preventative services only, with limited hospital indemnity coverage. There is no deductible or coinsurance and you are responsible for all non-preventative services.

*Employees residing in Maine are offered an alternative MEC plan. Please see page 35 for Maine-Only MEC coverage.

HEALTH SAVINGS ACCOUNT

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.

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 2024:

- $4,150 Individual or $8,300 Family
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.
- Ruby Tuesday HSA Contribution: $500

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

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).

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.

DEPENDENT CARE FSA

WHAT IS A DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)?

A Dependent Care FSA lets members set aside money from their paycheck on a pretax basis to use for eligible out-of-pocket expenses. Members can use this FSA to pay for eligible child and adult care expenses like day care, before and after school care, nursery school, preschool and summer day camp.

HOW MUCH CAN I CONTRIBUTE TO MY DEPENDENT CARE FSA?

Generally, the maximum amount that may be contributed to the Dependent Care FSA is $5,000 and determined on a calendar year basis.

Amounts contributed to the Dependent Care FSA are subject to the "use or lose" rule. This means any unused contributions remaining at the end of the plan year are lost, unless the plan includes a grace period (which provides up to 2.5 months to access unused contributions following the end of the plan year). Review your plan documents to understand whether a grace period is available.

THE PAYFLEX® DEPENDENT CARE FSA

PAY THE PAYFLEX WAY

PayFlex makes it easy to pay for your eligible expenses.

- **Use the PayFlex Card®, your account debit card:** When you use the PayFlex debit card (if offered), your expense is automatically paid from your FSA.
- **Pay yourself back:** Pay for eligible expenses with cash, check or your personal credit card. Then submit a claim to pay yourself back. You can even have your claim payment deposited directly into your checking or savings account.
- **Pay your provider:** Use PayFlex's online feature (if offered) to pay your provider directly from your account.

Note: Some PayFlex cards are used for certain expenses. Check your plan details to confirm.

Quick tip: Save your itemized statements and detailed receipts of your expenses, as well as your Explanation of Benefits from your insurance carrier.

PAYFLEX MOBILE® APP

PLAN, SAVE AND PAY ON THE GO

With our free PayFlex Mobile app, you can easily access your account information in the palm of your hand.

SIMPLY "TAP" TO:

- Check your account balance and view account activity
- View your account alerts
- Access the Eligible Expense Scanner to verify if an item is an eligible health care expense
- Review a list of common eligible expense items
- Pay your providers directly from your account
- Take pictures of receipts and pay yourself back for eligible expenses

WHAT'S NEW WITH THE PAYFLEX MOBILE APP?

- PayFlex's Eligible Expense Scanner makes it easy for you to scan an item barcode to determine if it's an eligible health care expense.
- Enhanced security and complimentary fraud protection.

HOW DO I GET THE PAYFLEX MOBILE APP? AND IS THERE A FEE TO USE IT?

- You can download the app from your mobile device's app store.
- The app is supported by the following devices:
- iOS version 10 or above on iPhone® 5S, iPad Air®, iPad Mini® 2 or newer models
- Android version 4.4 (Kitkat) or above on phones or tablets
- There's no fee to download the app. Anyone with a PayFlex account can use it for free.

CAN I SUBMIT A CLAIM USING THE APP?

Yes, you can submit a claim through the app if you want to reimburse yourself for an expense.

- After you log in, select Manage Funds to get started.
- When sending documents with your claim, simply take a picture and upload it through the app.

HOW DO I ACCESS THE ELIGIBLE EXPENSE SCANNER?

After you log in to the app, you can find it on the home page or tap HELP to access the Eligible Expense Scanner.

HOW DO I GET STARTED WITH THE APP?

It's easy. Just use the same username and password you use for the PayFlex member website. If you haven't set up your online account with PayFlex, go to **payflex.com** to get started.

Note: Standard text messaging rates and other rates from your wireless carrier may apply when using the PayFlex Mobile® app. PayFlex Systems USA, Inc. This material is for informational purposes only and is not an offer of coverage. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. It does not contain legal or tax advice. You should contact your legal counsel if you have any questions or if you need additional information. In case of a conflict between your plan documents and the information in this material, the plan documents will govern. Eligible expenses may vary from employer to employer. Please refer to your employer's Summary Plan Description ("SPD") for more information about your covered benefits. Information is believed to be accurate as of the production date; however, it is subject to change. PayFlex cannot and shall not provide any payment or service in violation of any United States (U.S.) economic or trade sanctions. For more information about PayFlex, go to PayFlex.com. PayFlex Mobile® is a registered trademark of PayFlex Systems USA, Inc. Apple, the Apple logo, iPad and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. Android is a trademark of Google LLC.

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 BlueCross BlueShield of Tennessee, Inc.

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		
	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR PLAN MAXIMUM		
Per Individual	$2,000 per individual (Basic and Major Services combined)	
ANNUAL DEDUCTIBLE		
Individual	$0	$0
Family	$0	$0
Waived for Preventive Care?	Yes	Yes
PREVENTIVE CARE		
Oral exams, X-rays & diagnostic, teeth cleanings (1 every 6 months), fluoride treatment, topical sealant, emergency treatment	0%	0%
BASIC SERVICES		
Minor Restorative Services, Fillings, Space Maintainers, Oral Surgery, Extractions, Periodontics, Endodontics, Stainless Steel Crowns, Repairs to Crowns and Bridgework, Occlusion Adjustment, Local Anesthesia	50%	50%
MAJOR PROCEDURES		
Porcelain Crowns, Fixed and Removable Bridgework, Full and Partial Dentures	50%	50%
ORTHODONTIA		
Adults	50% up to a lifetime maximum benefit of $2,000 per individual; deductible waived; No waiting period	
Children (up to 19th birthday)		

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		
BENEFIT COVERAGE	**BASE PLAN**	**PREMIER PLAN**
	IN-NETWORK BENEFITS	**IN-NETWORK BENEFITS**
	YOU PAY	
Exam	$10 copay	$10 copay
Single Vision Lenses	$25 copay	$25 copay
Bifocals Lenses	$25 copay	$25 copay
Trifocals Lenses	$25 copay	$25 copay
Frames – Retail Equivalent	$0 copayment up to $150 allowance	up to $200 allowance
Contacts • Necessary/Prescribed • Elective	100% $0 copayment up to $125 allowance	100% $0 copayment up to $175 allowance
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 12 Months
Contacts (Elective)	Once every 12 Months	Once every 12 Months

VISION PREMIUM RATES		
PER WEEK	**BASE PLAN**	**PREMIER PLAN**
Employee	$1.09	$1.87
Employee + Spouse	$2.07	$3.56
Employee + Child(ren)	$2.18	$3.75
Employee + Family	$3.20	$5.51

LINCOLN EMPLOYEE ASSISTANCE PROGRAM

THE RESOURCES YOU NEED TO MEET LIFE'S CHALLENGES

*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.

IN-PERSON GUIDANCE	UNLIMITED 24/7 ASSISTANCE	ONLINE RESOURCES
Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get: • In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)	You and your family can access the following services anytime — online, on the mobile app, or with a toll-free call: • Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more	*EmployeeConnect* offers a wide range of information and resources you can access on your own. Expert advice and support tools are just a click away when you visit **GuidanceResources.com** or download the GuidanceNowSM mobile app. You'll find: • Articles and tutorials • Videos

*EMPLOYEECONNECT*SM COUNSELORS ARE EXPERIENCED AND CREDENTIALED.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized support for each work-life service you use.

*EMPLOYEECONNECT*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Depression
- Relationships
- Stress

EMPLOYEECONNECTSM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To learn more:

- Visit **GuidanceResources.com**
- (username: LFGNY | password: LFGNY1)
- Download the GuidanceNowSM mobile app
- Call **833-475-0980**

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.

- Regional Director of Operations, receive two times your covered annual salary up to $250,000. Managers, Managers in Training, and Support Center Team Members 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.

IMPORTANT REMINDER!

You MUST designate a beneficiary for your Life and AD&D insurance when you become eligible for coverage or upon enrollment. This will ensure your assets are distributed according to your wishes.

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, REGIONAL DIRECTOR OF OPERATIONS, SUPPORT CENTER, FULL-TIME HOURLY RESTAURANT TEAM MEMBERS**
Elimination Period	Covered Injury / Illness on the first day | 0 days accident / 0 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.

VOLUNTARY LIFE AND AD&D

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

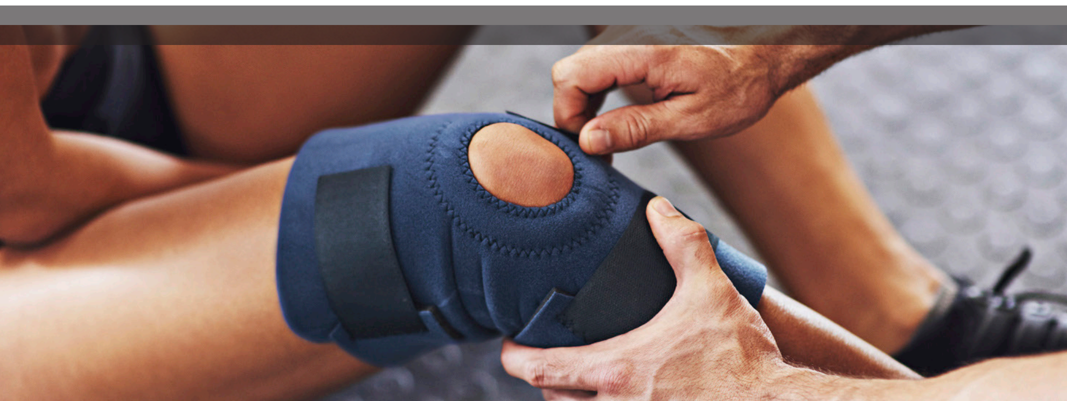
You may purchase additional Life and AD&D coverage for yourself and your dependents. When unexpected events occur, our Accidental Death & Personal Loss plans can help provide much-needed financial support and stability. Covered events include accidental death, paralysis, third-degree burns, comas, and 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 providing evidence of insurability (medical underwriting) for any amount of coverage if you decide to enroll at a later date.**

VOLUNTARY LIFE AND AD&D	
YOU	**MANAGERS, REGIONAL DIRECTOR OF OPERATIONS, SUPPORT CENTER TEAM MEMBERS**
Benefit Maximum	**Life:** up to 5x your wage, up to $500,000 ($250,000 for Managers and Managers in Training) **AD&D:** up to 5x your wage, up to $500,000 ($250,000 for Managers and Managers in Training)
Guaranteed Issue	3x annual earnings or $100,000
YOUR SPOUSE	
Benefit Maximum	**Life:** Increments of $10,000, up to a maximum of $250,000. (Not to exceed 100% of the employee's Supplemental Life benefit) **AD&D:** Amount equal to 50% of employee's voluntary AD&D amount, not to exceed $250,000 (with or without children)
Guaranteed Issue	$50,000
YOUR CHILD	
Benefit Maximum	**Life:** $2,500 increments, up to $10,000 **AD&D:** Amount equal to 15% of employee's voluntary AD&D, up to $75,000
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



EVIDENCE OF INSURABILITY

Note: If enrolled, you are not covered until EOI is approved (if it was required).

WHAT IS EOI AND WHEN IS IT NEEDED?

EOI is the information we use to verify your good health when you're purchasing life,cdisability, or critical illness insurance. We require EOI if you are:

- Buying an insurance amount higher than the guaranteed amount for your plan
- Already enrolled and want to increase coverage

GET STARTED NOW

1. Log in to my MyLincolnPortal.com. First time user? Register using : LF1071RUB
2. Click "Complete Evidence of Insurability."
3. Answer the questions about you and other applicants. You'll be asked:
   - General applicant information, such as date of birth, height, and weight
   - Qualifying questions, including if you or other applicants have been diagnosed with a disease or are prescribed medications for a condition
   - Medical questions—if you or other applicants have a condition, we may need to know a little more about it, such as the name, diagnosis date, and treatments
4. Review your responses, then electronically sign and submit your application.
5. Save your confirmation report.

WHAT HAPPENS NEXT?

In some cases, you may be auto-approved for coverage. If not, we'll review your application and contact you if more information is required. In all cases, we'll notify you of your application outcome.

QUESTIONS?

For more information, contact your human resources department.

SUBMITTING EOI MADE EASY

☑MINIMAL QUESTIONS

The online questionnaire adjusts to your responses, so you only answer questions that are relevant to you.

☑GUIDED SUPPORT

Quick tips and search as-you-type features help you provide quick and appropriate responses.

☑INSTANT CONFIRMATION

You'll receive email acknowledgment that we've received your application. In some cases, you may be automatically approved.

VOLUNTARY DISABILITY

VOLUNTARY 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, REGIONAL DIRECTOR OF OPERATIONS, 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.

VOLUNTARY 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.

ATTAINED AGE*^	MONTHLY PREMIUM RATE PER $1,000 OF INSURED'S CRITICAL ILLNESS INSURANCE
17-24	$0.515
25-29	$0.653
30-34	$0.785
35-39	$0.964
40-44	$1.294
45-49	$1.673
50-54	$2.263
55-59	$3.026
60-64	$4.187
65-69	$5.665
70+	$5.752

* The Insured's age will determine Insured's Premium rate

^ Premium will be calculated as of the Insured's age on each Policy Anniversary.

ATTAINED AGE*^	MONTHLY PREMIUM RATE PER S1.000 OF DEPENDENT SPOUSE OR LIFE PARTNER CRITICAL ILLNESS INSURANCE
17-24	$0.515
25-29	$0.653
30-34	$0.785
35-39	$0. 964
40-44	$1.294
45-49	$1.673
50-54	$2.263
55-59	$3.026
60-64	$4.187
65-69	$5.665
70+	$5.752

* The Insured Dependent Spouse's or Life Partner's age will determine the applicable Dependent Spouse or Life Partner Premium rate

^ Premium will be calculated as of the Insured Dependent Spouse's or Life Partner's age on each Policy Anniversary.

Monthly Premium rate per $1,000 of Dependent Child(ren) Critical Illness Insurance: $0.685

VOLUNTARY ACCIDENT COVERAGE

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.

ACCIDENTAL INJURY BENEFITS	PLAN 1 - ACCIDENT LOW PLAN		PLAN 2 - ACCIDENT HIGH PLAN	
TYPE OF INJURY	BENEFIT AMOUNT		BENEFIT AMOUNT	
	NON-SURGICAL	SURGICAL	NON-SURGICAL	SURGICAL
FRACTURES				
Ankle	$450	$900	$575	$1,150
Arm (shoulder to elbow)	$875	$1,750	$1,125	$2,250
Arm (elbow to wrist)	$450	$900	$575	$1,150
Collarbone	$525	$1,050	$675	$1,350
Elbow	$450	$900	$575	$1,150
Finger	$100	$200	$125	$250
Foot (except toes)	$450	$900	$575	$1,150
Hand (except fingers)	$450	$900	$575	$1,150
Leg (hip to knee)	$2,625	$5,250	$3,375	$6,750
Leg (knee to ankle)	$1,750	$3,500	$2,250	$4,500
Nose	$875	$1,750	$1,125	$2,250
Rib	$450	$900	$575	$1,150
Toe	$100	$200	$125	$250
Wrist	$450	$900	$575	$1,150
Chip Fracture	25% of the amount payable for full Fracture			
DISLOCATIONS				
Ankle	$875	$1,750	$1,125	$2,250
Elbow	$450	$900	$575	$1,150
Finger	$100	$200	$125	$250
Foot (except toes)	$875	$1,750	$1,125	$2,250
Hand (except fingers)	$450	$900	$575	$1,150
Toe	$100	$200	$125	$250
Wrist	$450	$900	$575	$1,150
Partial Dislocation	25% of benefit payable for Dislocation			
SPECIFIC INJURY BENEFITS				
Concussion	$150		$200	
Eye Injury Surgical Repair Removal of foreign body	$300 $150		$400 $200	
Lacerations No Sutures Required	$35		$50	
Lacerations Sutures Required (Total Length of all Sutured Lacerations)	5cm or less $75 5.1-15.5cm $200 15.6cm or more $400		5cm or less $100 5.1-15.5cm $300 15.6cm or more $600	

LINCOLN ACCIDENT INSURANCE PLAN RATES		
PER WEEK	**OPTION 1**	**OPTION 2**
Employee	$2.14	$2.82
Employee + Spouse	$3.60	$4.69
Employee + Child(ren)	$4.03	$5.20
Employee + Family	$5.45	$7.03

VOLUNTARY LEGAL PLAN

MetLife's Legal Plans, Inc. 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 a Plan 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.

FIND A PLAN ATTORNEY

Visit: **www.legalplans.com**

Call: **800-821-6400**

Legal Services Policy Number: 990-4330

WEEKLY RATE

METLIFE LEGAL	WEEKLY RATE
Employee	$4.85

Includes coverage for eligible dependents

LEGAL SERVICES*			
Advice and Consultation	Office Consultations	**Will and Estate Planning**	Trusts
	Telephone Advice		Living Wills
Consumer Protection Matters	Small Claims Assistance	**Real Estate Matters**	Eviction and Tenant Problems (Tenant Only)
	Personal Property Protection		Home Equity Loans (Primary Residence)
	Review personal legal documents		Property Tax Assessment
Traffic Infractions	Restoration of Driving Privelages	**Juvenile Matters**	Juvenile Court Defense
Financial Matters	Debt Collection Defense	**Family Law**	Name Change
	Identity Management Services		Prenuptial Agreement
	Identity Theft Defense		Protection from Domestic Violence
	Personal Bankruptcy		Adoption and Legitimization
	Tax Audits		Divorce, Dissolution, Annulment (up to 20 hrs)
	Financial Education		Guardianship or Conservatorship
Defense of Civil Lawsuits	Administrative Hearing Representation	**Document Preparation**	Affidavits
	Civil Litigation		Demand Letters
	Incompetency Defense		Mortgages

*With MetLife Plan Attorney; exclusions and Limitations apply

VOLUNTARY PET INSURANCE

MY PET PROTECTION®

My Pet Protection pet insurance from Nationwide is a reimbursement indemnity plan. That means we reimburse members for a portion of eligible veterinary expenses related to accidents, injuries and illnesses.*

HOW TO ENROLL:

Call 877-738-7874 to speak with a Nationwide representative and mention you are an employee of Ruby Tuesday or visit **benefits.petinsurance.com/rubytuesday**. **Note:** You can enroll or drop anytime.

Premium is based on:

- Species of pet
- Employee ZIP code
- Age of pet
- Breed of pet
- Reimbursement level selected: 50% or 70%

*Premium calculation, rating variables and/or rates are subject to change based on approval by the Department of Insurance in each individual state. Rates are guaranteed for one year from the policy effective date based on information provided at the time of enrollment.

	MY PET PROTECTION®	MY PET PROTECTION® WELLNESS500
Annual deductible	$250	$250
Reimbursement	Up to 70%	Up to 70%
Maximum annual benefit	$7,500	$7,500
Pre-existing conditions	Not included	Not included
Accidents and illnesses	Included	Included
Hereditary and congenital	Included	Included
Cancer	Included	Included
Dental disease	Included	Included
Hospitalization or treatment	Included	Included
Behavioral treatments	Included	Included
Rx therapeutic supplements	Included	Included
Dental cleanings	Not included	Included up to $500
Wellness exams	Not included	Included up to $500
Vaccinations	Not included	Included up to $500
Flea prevention	Not included	Included up to $500
Spay/neuter	Not included	Included up to $500
24/7 vethelpline® ($110 value)	Included	Included
PetRxExpressSM	Included	Included
Advertising and reward	Included	Included
Emergency boarding	Included	Included
Loss due to theft	Included	Included
Mortality benefit	Included	Included

MULTI-PET DISCOUNT	
2-3 Pets	5%
4+ Pets	10%

Avian and exotic pet coverage

Nationwide is the only pet insurer in the United States to offer coverage for birds and exotic pets like reptiles and small mammals. Avian and exotic pet plans are available only by phone. Benefits include:

- Veterinary exams, including specialty and emergency visits
- Hospitalization and surgeries

ADDITIONAL VOLUNTARY BENEFITS

HOSPITAL INDEMNITY

There are two options for voluntary Hospital Indemnity plans offered through Lincoln Financial.

LINCOLN HOSPITAL INDEMNITY WEEKLY RATES		
PER WEEK	**OPTION 1**	**OPTION 2**
Employee	$3.19	$5.47
Employee + Spouse	$7.07	$12.12
Employee + Child(ren)	$6.02	$10.33
Employee + Family	$9.70	$16.62

PLAN BENEFITS		
TYPE OF BENEFIT	**OPTION 1 - LOW PLAN**	**OPTION 2 - HIGH PLAN**
	BENEFIT AMOUNT	
Hospital Admission (1 per year)	$850 per day	$1,500 per day
Hospital Confinement (up to 3 per year)	$300 per day	$500 per day

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.
Note: Coverage may require EOI.

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**.

ALLSTATE IDENTITY PROTECTION PRO
$2.30 per person / weekly
$4.14 per family / weekly

[1]2021 Identity Fraud Study, Javelin Strategy & Research

Get identity protection for real life.

Sign up during open enrollment.

Questions? 1-800-789-2720

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. Identity crime can happen to anyone — 1 in 6 Americans have been impacted by an identity crime[1] no matter how careful you are. That's why your company offers **Allstate Identity Protection Pro+** as a benefit. Allstate Identity Protection is proud to have a broad, inclusive definition of "family" that covers everyone under your roof (or under your wallet) — no matter their age. Get comprehensive identity monitoring and fraud resolution designed to help you protect yourself and your family against today's digital threats.

For over 90 years, Allstate has been protecting what matters most. Prepare for what's next with:

- Identity, financial account, and credit monitoring
- 24/7 alerts and fraud recovery
- Up to $1 million in identity theft expense reimbursement

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 $23,000 in 2024. 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.

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.

MAINE-ONLY MEC MEDICAL PLAN

This plan is available to residents of Maine only. Offered through Pan-American, this plan covers preventative services only.

Preventive care coverage now covers 100% of eligible preventive service costs when performed in-network. That means that you pay nothing out of pocket for access to a variety of medical screenings, exams, and immunizations which may help reduce your risk of developing health conditions in the future and avoid expensive treatment down the road.

Preventive care includes screenings, tests, medicines and counseling performed or prescribed by your doctor or other health care provider to test for conditions which may develop even when you don't have signs or symptoms of an injury or illness.

MAINE-ONLY MEC MEDICAL PLAN RATES	
PER WEEK	
Employee	$6.10
Employee + Spouse	$8.55
Employee + Child(ren)	$7.76
Employee + Family	$10.92

PPO PROVIDER NETWORK

Your plan includes access to the First Health Network.

To locate in-network Physicians or Hospitals call **1-888-561-5759** or visit **www.providerlocator.com/palicfh** to search online

MEMBER SERVICES

We can assist members, companies and providers with:

- Member Advocacy
- ID Cards
- Policy Information
- Member Eligibility
- Verification of Benefits
- PPO Network Information
- Account Management
- Claims
- And more!

Monday through Friday, 7:30 AM – 5:00 PM, Central Time call **1-800-999-5382**.

AFTER YOU ENROLL

Once you enroll in the plan, you will receive your ID Card(s) by mail. The information in your card will help you register to our online member portal at mypalic.com, where you will have 24-hour access to:

- Review claims
- Access plan documents
- See your benefits
- Find in-network providers
- Print ID cards
- Download forms
- Frequently Asked Questions
- And much more

EXAMPLE OF COVERED PREVENTIVE SERVICES FOR ADULTS:

Screenings for:

- Blood pressure
- Cholesterol (for adults of certain ages or at higher risk)
- Colorectal cancer (for adults over 50)
- Depression
- Type 2 diabetes (for adults with high blood pressure)

EXAMPLE OF COVERED PREVENTIVE SERVICES FOR ADULTS: (CONTINUED)

Immunizations:

- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza (Flu)
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chicken pox)

Counseling for:

- Alcohol misuse
- Obesity
- Sexually transmitted infection (STI) prevention (for adults at higher risk)
- Tobacco use (including programs to help you stop using tobacco)

ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN

- Contraception (FDA approved and ACA required contraceptive methods, sterilization procedures, and patient education and counseling)
- Well-woman visits (to obtain recommended preventive services for women under 65)

Screenings for:

- Breast cancer (mammography every 1 to 2 years for women over 40)
- Cervical cancer (for sexually active women)
- Chlamydia infection (for younger women and other women at higher risk)
- Domestic and interpersonal violence
- Gestational diabetes (for those at high risk)
- Gonorrhea (for all women at higher risk)
- Human Immunodeficiency Virus (HIV) (for sexually active women)

Additional services for pregnant women:

- Anemia screenings
- Bacteriuria urinary tract or other infection screenings
- Breast feeding interventions to support and promote breast feeding after delivery
- Expanded counseling on tobacco use
- Gestational diabetes (screening for women 24 to 28 weeks pregnant)
- Hepatitis B counseling (at the first prenatal visit)

COVERED PREVENTIVE SERVICES FOR CHILDREN

Screenings and assessments for:

- Alcohol and drug use (for adolescents)
- Autism (for children at 18 and 24 months)
- Behavioral issues
- Blood pressure (screening for children)
- Cervical dysplasia (for sexually active females)
- Congenital hypothyroidism (for newborns)
- Depression (screening for adolescents)
- Developmental (screening for children under age 3, and surveillance throughout childhood)
- Dyslipidemia (screening for children at higher risk of lipid disorders)
- Hearing (for all newborns)
- Height, weight and body mass index measurements
- Hematocrit or hemoglobin
- Hemoglobinopathies or sickle cell (for newborns)
- HIV (for adolescents at higher risk)
- Lead (for children at risk of exposure)
- Medical history
- Obesity
- Oral health risk assessment (for young children)
- Phenylketonuria (PKU) (newborns)
- Tuberculin testing (for children at higher risk of tuberculosis)
- Vision (screening as part of physical exam, not separate eye exam)

Immunizations:

From birth to age 18. Doses, recommended ages, and recommended populations vary.

- Diphtheria, pertussis, tetanus (DPT)
- Hæmophilus influenzæ type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Inactivated poliovirus
- Influenza (Flu)
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Rotavirus
- Varicella (chicken pox)

PRESCRIPTION DRUG COVERAGE

The following chart shows categories of pharmaceuticals available to you at no cost. As lists may change, please note that in order to determine which specific drugs or brands within each of the below categories are covered under your prescription benefits, you will need to contact RxEDO at **1-888-879-7336** or go online to **rxedo.com** for more information.

ITEM	AVAILABILITY	COVERAGE
Aspirin	Adult men and women 45 years or more	Generic, OTC
Folic Acid supplements	Adult women Up to 55 years	Generic, OTC
Fluoridated drugs	6 months – 5 years	Brand, generic
Tobacco Cessation	Adult men and women	• Generic or OTC only on nicotine replacement products • Limit to Generic Zyban
ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN		
Oral Contraceptives	Adult women	Generic, single source brands
Emergency contraception		Generic, OTC, single source brands
Injectable contraceptives		Generic, single source brands
Transdermal patch		Generic, single source brands
Diaphragm and cervical cap		Generic, single source brands

SAVE ON DISCOUNT PRESCRIPTIONS

Eligible medications will be available to all members at RxEDO's pharmacy's contracted rate

HELPFUL HINTS

- Show the pharmacist your identification card. It includes the BIN # and PCN #, as well as any other information they will need to process your claim through RxEDO.
- If your pharmacy has any questions concerning the process, please have them call the RxEDO Pharmacy Help Desk at For questions or drug look-up go to **www.rxedo.com** or call **1-888-879-7336**.

For questions or drug look-up go to www.rxedo.com or call 1-888-879-7336.

REQUIRED NOTICES

IMPORTANT LEGAL NOTICES AFFECTING YOUR 2024 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 following in-network deductibles and coinsurance apply:

	IN-NETWORK DEDUCTIBLE		IN-NETWORK COINSURANCE
	INDIVIDUAL	FAMILY	
BCBST HRA Premier Care - PPO	$2,800	$8,400	80%
BCBST High Deductible – EPO HSA	$3,200	$6,400	70%
BCBST Low Deductible – PPO HSA	$1,750	$3,500	80%

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 from 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.

PATIENT PROTECTION MODEL DISCLOSURE

The Ruby Tuesday Operations LLC Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BlueCross BlueShield of Tennessee at (800)565-9140.

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

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. The Ruby Tuesday Operations LLC 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 the 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

Questions regarding any of this information can be directed to:
Benefits Administration
210 Simmons Street
Maryville, TN 37801
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 01/01/2024
- Benefits Administration

210 Simmons Street

Maryville, TN 37801

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 Cigna and Kaiser CA plan(s) 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 15th to 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.

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.

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: 01/01/2024
Name of Entity/Sender: Ruby Tuesday
Contact--Position/Office: Benefits Administration
Address: 210 Simmons Street, Maryville, TN 37801
Phone Number: N/A

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)**.

ALABAMA-MEDICAID
Website: **http://myalhipp.com/** Phone: **1-855-692-5447**
ALASKA-MEDICAID
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**
ARKANSAS-MEDICAID
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA-MEDICAID
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**
COLORADO-HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **https://hcpf.colorado.gov/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/** HIBI Customer Service: 1-855-692-6442
FLORIDA-MEDICAID
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268

GEORGIA-MEDICAID

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

INDIANA-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

IOWA-MEDICAID AND CHIP (HAWKI)

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

KANSAS-MEDICAID

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY-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/agencies/dms

LOUISIANA-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)

MAINE-MEDICAID

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
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

MASSACHUSETTS-MEDICAID AND CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA-MEDICAID

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

MISSOURI-MEDICAID

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA-MEDICAID

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA-MEDICAID

Website: **http://www.ACCESSNebraska.ne.gov**
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA-MEDICAID

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE-MEDICAID

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

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

NEW YORK-MEDICAID

Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: 1-800-541-2831

NORTH CAROLINA-MEDICAID

Website: **https://medicaid.ncdhhs.gov/**
Phone: 919-855-4100

NORTH DAKOTA-MEDICAID

Website: **https://www.hhs.nd.gov/healthcare**
Phone: 1-844-854-4825

OKLAHOMA-MEDICAID AND CHIP
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742

OREGON-MEDICAID
Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 1-800-699-9075

PENNSYLVANIA-MEDICAID
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** Phone: 1-800-692-7462 CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx** CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND-MEDICAID AND CHIP
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA-MEDICAID
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820

SOUTH DAKOTA-MEDICAID
Website: **http://dss.sd.gov** Phone: 1-888-828-0059

TEXAS-MEDICAID
Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program** Phone: 1-800-440-0493

UTAH-MEDICAID AND CHIP
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669

VERMONT-MEDICAID
Website: **https://dvha.vermont.gov/members/medicaid/hipp-program** Phone: 1-800-250-8427

VIRGINIA-MEDICAID AND CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON-MEDICAID
Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022

WEST VIRGINIA-MEDICAID AND CHIP
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)

WISCONSIN-MEDICAID AND CHIP
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm** Phone: 1-800-362-3002

WYOMING-MEDICAID
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 January 31, 2023, 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 1/31/2026)

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
OMBNo.1210-0149
(expires 6-30-2024)

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.

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 Ruby Tuesday	4. Employer Identification Number (EIN) 63-0475239	
5. Employer address 210 Simmons Street	6. Employer phone number N/A	
7. City Maryville	8. State TN	9. Zip code 37801
10. Who can we contact about employee health coverage at this job? Benefits Administration		
11. Phone number (if different from above) N/A	12. Email address benefitsadministration@rubytuesday.com	

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

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

    Full Time & Part Time employees

- With respect to dependents:
  - ☒ 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.

  - ☒ 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)

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210 SIMMONS STREET
MARYVILLE, TENNESSEE 37801

This brochure summarizes the benefit plans that are available to Ruby Tuesday 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.

Ruby Tuesday