RYMAN
RYMAN HOSPITALITY PROPERTIES, INC.

January 2025 Health Plan Offerings

PARTICIPANT OUT-OF-POCKET EXPENSES	Traditional PPO Plan		High Deductible with Copays		High Deductilbe with H.S.A	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible						
Individual Coverage	**$750**	**$1,500**	**$2,750**	**$5,500**	**$3,250**	**$6,000**
Family Coverage	**$1,500**	**$3,000**	**$5,500**	**$11,000**	**$6,500**	**$12,000**
Maximum Out of Pocket (Medical + Rx)						
Individual Coverage	**$4,000**	**$8,000**	**$6,500**	**$13,000**	**$4,000**	**$10,000**
Family Coverage	**$8,000**	**$16,000**	**$13,000**	**$26,000**	**$8,000**	**$20,000**
Coinsurance Amounts by Type of Service	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Coinsurance Amounts below are the Amount Paid by Insurance and Applied After Deductible					
Routine Well Adult Care **Includes: Office Visits, pap smear, mammogram (1 annually), gynecological exam, routine physical exam, x-ray, laboratory, colon cancer screening, colonoscopy, prostate exam, sigmoidoscopy, blood*	Covered at 100% deductible waived	Not Covered	Covered at 100% deductible waived	Not Covered	Covered at 100% deductible waived	Not Covered
Routine Child Care & Well Baby Care **Includes: Office visits, routine physical exams, and age appropriate vaccinations*	Covered at 100% deductible waived	Not Covered	Covered at 100% deductible waived	Not Covered	Covered at 100% deductible waived	Not Covered
Primary Care Physician (PCP) Office Visit **General Practioner, Family Practice, Internal Medicine, OB/GYN, Pediatrician & Mental Health Provider*	$25	60%	$25	60%	Subject to Deductible - then paid at 90%	50%
Specialist Office Visit	$40	60%	$40	60%		50%
Mental Health Substance Abuse Office Visit	$25	60%	$25	60%		50%
Teladoc Virtual Visit	$10	N/A	$10	Not Covered	$49 - until OOP is met	Not Covered
Teladoc Virtual Behavioral Health Visit	$10	N/A	$10	60%		50%
In Office Surgery & Diagnostic	80%	60%	80%	60%	Subject to Deductible - then paid at 90%	50%
Outpatient Surgery and Outpatient Hospital Services	80%	60%	80%	60%		50%
Inpatient Surgery/Hospital Services	80%	60%	80%	60%		50%
Urgent Care	$50	60%	$75	60%		50%
Emergency Room	$500		$500			50%
Ambulance	80%	60%	80%	60%		50%
Therapy Services - Speech, Occupational, Physical Therapies	$25	60%	$25	60%		50%
Optum Rx Prescription Drug Program						
Generic (Tier 1)	$10 Copay		$10 Copay		90% after deductible	
Preferred Brand (Tier 2)	$35 Copay		$35 Copay			
Non-Preferred Brand (Tier 3)	$70 Copay		$70 Copay			
Specialty Rx (Tier 4)	$140 Copay		$140 Copay			
Mail Order Rx 90 Day Supply						
Generic (Tier 1)	$25 Copay		$25 Copay		90% after deductible	
Preferred Brand (Tier 2)	$87.50 Copay		$87.50 Copay			
Non-Preferred Brand (Tier 3)	$175 Copay		$175 Copay			

This document is for comparison purposes only, please see your full benefit document for plan details. The full Plan Document shall supersede this benefit summary. Any Errors or Ommissions are unintentional.

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