OEG Employee Health and Welfare Plan

Plan Overview and Administration Information

a part of the

Summary Plan Description (SPD)

(Updated effective as of January 1, 2026)

OPRY ENTERTAINMENT

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Introduction

The RHP Corporate Properties, LLC (the Company) benefits are designed to assist you in protecting your financial security. They provide for certain kinds of expenses such as if you become ill or injured, or provide for your family's health and well-being.

The Company's benefits can provide real value to you and your family. However, to get the most out of them, you need to understand how the benefits work, when you can receive benefits, and what steps you must follow. This Summary Plan Description (SPD) can help.

The Company maintains the OEG Employee Health and Welfare Plan (the Health and Welfare Plan, or the Plan) for the exclusive benefit of eligible employees of the Company and other participating employers (each, the Employer) and their eligible family members. The Plan provides various health and welfare benefits, or "coverages." These coverages include the following:

- **Medical (including Prescription Drug and other associated benefits and services)**
- **Dental**
- **Vision**
- **Life Insurance**
- **Accidental Death and Dismemberment (AD&D)**
- **Short Term Disability**
- **Long Term Disability**
- **Flexible Spending Accounts (Health Care FSA or Limited Use FSA, and Dependent Care FSA)**
- **Business Travel Accident**
- **Employee Assistance Program (EAP)**
- **Identity, Financial and Privacy Protection**

Some of these coverages may be automatically provided if you are benefits eligible (EAP coverage, for example) or if you enroll in certain coverage (for example, if you enroll in medical coverage, prescription drug coverage is automatically provided to you), while you must elect to participate in others.

You will be asked to make a decision about your benefits once a year. That means you need to evaluate your needs, learn about your options, and choose benefit levels that will protect you (and, in some cases your eligible family members) for a full year (the plan year for the Plan is the calendar year).

About this Material

This **Plan Overview and Administration Information** booklet, along with the coverage booklets described in the **"SPD Quick Reference Guide"** section, serve as the summary plan description required by the Employee Retirement Income Security Act of 1974 (ERISA). Together, these materials summarize the major features of the Plan available to eligible employees as of January 1, 2026. The **"Participation in the Plan"** section of this booklet outlines the eligiblity requirements for the benefits described in the SPD.

The SPD is intended to provide easy-to-understand, general explanations of the principal provisions of your benefits. If there is any conflict or ambiguity between the SPD and the official plan documents of the Plan (including insurance contracts and policies), the terms of the official plan documents will control.

This booklet includes descriptions of programs that are subject to ERISA and programs that are not subject to ERISA. Descriptions of the programs that are not subject to ERISA are included in this booklet for convenience, but their inclusion in the SPD is not intended to subject those programs to the requirements of ERISA.

SPD - Quick Reference Guide

The chart below shows what you'll find in each booklet.

SPD Booklet(s)	What You'll Find
Plan Overview and Administration Information	This booklet highlights the overall features (such as eligibility features) that pertain to the Health and Welfare Plan. If you want to know how the Health and Welfare Plan is administered, or you want to learn more about your legal rights under ERISA, be sure to read this booklet. This booklet also contains details about the Employee Assistance Program (EAP).
Medical/Prescription Drug Coverage – UMR Health Benefit Summary Plan Description: **Traditional PPO (Benefit Plan 001)** **High Deductible Health Plan (HDHP) with Copay (Benefit Plan 002)** **HDHP with HSA (Benefit Plan 003)**	These booklets provide details about the medical and prescription drug coverages available to you. The following associated benefits and services are included with the medical coverage: • Lantern • Vanderbilt MyHealth Bundles
Dental Coverage – Delta Dental of Tennessee Certificate of Coverage	Here is where you will find details about the dental coverage offered.
Vision Coverage –DeltaVision in partnership with VSP Certificate of Coverage	Here is where you will find details about the vision care benefits offered.
Life Insurance Coverage – Group Life Insurance Certificate	Here you'll learn about the: • Basic life insurance provided to you; • Supplemental life insurance available to you; and • Dependent life insurance available for your spouse or domestic partner and your children.
Accidental Death and Dismemberment (AD&D) Insurance Coverage – Group Accident Insurance Certificate	Here you'll learn about the: • Employee AD&D life insurance available to you; and • Dependent AD&D insurance available for your spouse or domestic partner and your children.
Short Term Disability (STD) Coverage – Group STD Insurance Certificate	This booklet explains the benefits available if you become injured or ill and cannot perform the duties of your occupation for a brief or extended period of time.
Long Term Disability (LTD) Coverage – Group LTD Insurance Certificate	This booklet describes the income protection available during periods of approved disability.
Flexible Spending Accounts (FSAs) (the Dependent Care FSA is not subject to ERISA)	This booklet explains how you can participate in the flexible spending accounts to help pay many of your health and/or dependent care expenses (depending on the FSA(s) you elect) with before tax dollars.
Employee Assistance Program (EAP) section of this booklet	The **"Employee Assistance Program (EAP)"** section of this booklet describes the program that helps you resolve personal problems through professional assistance.
Business Travel Accident	This policy booklet describes the accident protection available while you are traveling on a business trip for the Employer.
Identity, Financial and Privacy Protection (not subject to ERISA)	This summary describes the program that helps you with proactive monitoring for identity, credit and financial protection.

The Company has partnered with *Your Benefits Resources*™ (YBR) for the day-to-day administration of your health and welfare benefits. YBR is not the "plan administrator" as that term is defined under ERISA. The ERISA plan administrator's (Plan Administrator) contact information appears in the **"Plan Information"** section of this booklet.

If you have questions about the Health and Welfare Plan, please contact your Human Resources Representative at totalrewards@rymanhp.com. If you have questions about a particular coverage, you may contact the claims administrator (see the **"Carrier Directory"** section of this booklet for contact information).

Participation in the Plan

Who Is Benefits Eligible

You're eligible to participate in the Plan if you meet the general eligibility requirements of the Plan, which are described below. **To be eligible for a particular coverage option, you must also meet any eligibility requirements described in the coverage booklet for that option.**

- A regular, full-time employee of the Employer.* A full-time employee is a person, employed by the Employer, who is neither part-time, casual nor on-call, and who works for the Employer on a regular basis an average of 30 or more hours per week (this includes anyone whose eligibility is determined in accordance with the Company's Average Hours Audit Process).
- A regular, full-time employee of the Employer with a Visa that requires benefit coverage to be offered (example: H1B, H1B1, Trade NAFTA), or an employment authorization card such as a "green card."

*The Employee Assistance Plan (EAP) is available to all employees of the Employer who are classified as full-time, part-time, casual, or on-call.

Eligible Dependents

As an eligible employee, you may cover certain eligible dependents under the Plan. An eligible dependent under the Plan is one who meets the general eligibility requirements of the Plan, which are described below. **You will be required to provide a copy of documentation demonstrating eligibility of your dependents. To be eligible for a particular coverage option, your dependent must also meet any dependent eligibility requirements described in the coverage booklet for that option.**

- Legal spouse within the meaning of federal tax law (this includes a common law spouse if common law marriage is recognized under applicable state law).
- Certified domestic partners. You must certify the domestic partnership through *Your Benefits Resources*™ (YBR). (Refer to the Domestic Partner Policy, available on request from YBR or at https://workforcenow.adp.com for information.)
- Eligible children (defined below) up to age 26, regardless of their full-time student status, residency, financial support or marital status.
- Your certified domestic partner's children up to age 26.
- Certain coverages also may be available to your unmarried eligible child age 26 or older provided the child became mentally or physically disabled before age 19 (and remains disabled) and primarily depends on you for financial support (see important note immediately below under "Proof of Disability and Dependency Required" about the proof required to maintain coverage for the child after age 26).

An **eligible child** is a:

- Natural child;
- Legally adopted child, or child placed with you pending an adoption;
- Stepchild;
- Foster child;
- Child for whom coverage is required under a Qualified Medical Child Support Order (QMCSO); or
- Any other child for whom you have legal guardianship (temporary custody doesn't apply).

Generally, as long as you make a timely election, coverage for your eligible dependent takes effect on the later of the date you become eligible, or the date the individual becomes your dependent (for example, when you get married or have a child). **Once coverage for your eligible dependent(s) takes effect, dependents will remain covered though a 60-day verification period. If documents demonstrating eligibility of your dependent(s) are not submitted and approved during the verification period, coverage will be dropped retroactive to the original coverage effective date.**

Proof of Disability and Dependency Required

You are required to provide, within **31 days of the date coverage would otherwise end** (i.e., because the child reaches age 26, or upon recertification initiated by the Plan), satisfactory proof that your unmarried child is incapable of self-support, that the child depends mainly on you for support, and that the child's disability began before reaching

age 19 (and that your child remains disabled). **This process should begin approximately three months prior to the child turning age 26, and may be initiated by contacting Human Resources.**

You must complete and return the **Incapacitated Questionnaire** and provide any other documentation and/or information requested by the Plan. Proof may also include a medical examination (you will be notified if this applies). A Social Security Disability Award from the Social Security Administration may suffice as proof of disability, provided all other Plan eligibility requirements are met. Once approved, coverage under the Plan will be continued and/or reinstated.

The Plan Administrator and its delegate, including UMR, have the right to request, and may require, proof of continuing disability from time to time. Refer to the medical coverage booklet for more information.

Who Is Not Benefits Eligible

You're generally not eligible to participate in the Plan* if you're:

- A casual employee. A casual employee is a person, employed by the Employer, who is hired for a fixed term of one year or less with no reasonable expectation of being employed beyond that period. For purposes of the medical coverage under this Plan, however, a casual employee may be eligible to participate in the plan if the casual employee meets the requirements described in the **"Who is Benefits Eligible"** section of this booklet.
- A part-time employee. A part-time employee is a person, employed by the Employer, who is neither casual nor on-call, and who works on a regular basis less than an average of 30 hours per week.
- An on-call employee. An on-call employee is a person, employed by the Employer, who works only on an "as needed" basis. For purposes of the medical coverage under this Plan, however, an on-call employee may be eligible to participate in the Plan if the on-call employee meets the requirements described in the **"Who is Benefits Eligible"** section of this booklet.
- A nonresident alien, or on certain Visas and not eligible for coverage (for example: F1, J1, H2B).
- Classified in the records of the Employer as an independent contractor, regardless of whether you're later determined by the IRS or a federal or state court to be a common law employee of the Employer.
- A person who is in the military of any country (except as necessary to comply with USERRA), or who lives outside the United States or Canada.
- A person who is a member of a collective bargaining unit for which benefits under this Plan have not been provided pursuant to a collective bargaining agreement with an Employer.

*The Employee Assistance Plan (EAP) is available to all employees of the Employer who are classified as full-time, part-time, casual, or on-call.

Additional eligibility restrictions may apply to a particular coverage option. Refer to the eligibility requirements described in the coverage booklet for that option for more information.

No Dual Coverage under the Plan

If you and your spouse or domestic partner are both employed by an Employer, only one of you may cover children as dependents under any one coverage option. Also, if you have coverage as an employee, you may not have that same coverage as a dependent, even through your spouse or domestic partner.

How to Enroll

To enroll for coverage under the Plan, the following procedures apply (refer also to your enrollment materials for more information):

- **Making elections as a new hire**: Within 31 days of your eligibility date, you must enroll through *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 (1-888-438-9271) or www.ybr.com/ryman. If you miss the 31-day enrollment period, you will receive certain "default" coverages **for yourself only** and must wait until the next annual enrollment to make benefit elections for you or your dependents. (See the **"If You Don't Enroll"** section in this booklet).
- **Making elections during annual enrollment**: You must enroll through *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 (1-888-438-9271) or www.ybr.com/ryman. During annual enrollment you will have the opportunity to change your coverage options for the following year. Generally, there is no need to re-elect a medical (including prescription drug), dental, or vision option if you want to keep your current coverage—if you do not make an election, your prior year coverage will continue automatically (any exceptions will be

described in your annual enrollment materials). However, if the options you select under the Plan are no longer offered, you will be advised of your other options before the annual enrollment period begins. If you wish to continue your flexible spending account (FSA) elections, you will need to enroll each plan year. Elections made during annual enrollment are effective January 1.

- **Making new elections in line with a change in status**: You will have 31 days (60 days, in certain limited CHIP- and Medicaid-related circumstances) from the date of your change in status to elect new coverage. To process a change call *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 (1-888-438-9271) and speak with a Customer Care Representative or log on to www.ybr.com/ryman. (See the **"Changing Your Coverage"** section of this booklet).

Cost of Coverage Options

You and the Employer share in the cost of most coverages. Each coverage option has an assigned cost based on the level of benefit it provides. Your cost is then based on the coverage option you select and the number of family members you decide to cover.

Your coverage cost may change each plan year. Your cost for each coverage option and coverage category is listed in your enrollment materials. You can also find cost information online through YBR.

Pre-Tax Contributions

You pay your share for certain coverage options under the Plan with before tax contributions made through automatic payroll deductions taken in equal amounts throughout the year. This means that your contributions are deducted from your pay before taxes are calculated and withheld from your paycheck. This reduces your taxable income, and provides you with more take-home pay than if you paid these expenses on an after-tax basis. Refer to the **"Carrier Directory"** section or contact YBR for more information.

You are responsible for timely paying for your coverages under the Plan. If your paycheck doesn't have sufficient funds to pay for the full coverage amount a partial deduction will be taken. Any remaining deduction amount will be put in arrears and will be taken out of your next available paycheck. Tipped employees who make cash wages and may not have enough money in their paycheck to cover their benefit deductions will use the tipped arrearage process to pay their premiums. For questions about the deductions in arrears process, please contact totalrewards@rymanhp.com.

Because this Plan is governed by the Internal Revenue Code, you cannot change your elections during the year unless you have a **qualified change in status (see the "Changing Your Coverage" section of this booklet for more information)**. However, if you decline coverage for yourself or your eligible dependents (including your spouse) because of other health coverage, you may be able to enroll yourself or your eligible dependents in this Plan in the future, provided you enroll within 31 days after your other coverage ends.

Tax Consequence for Domestic Partner Coverage

Because domestic partners and their children generally do not satisfy the definition of "dependent" under the Internal Revenue Code, your Employer is legally required to report the entire value of health care coverage for a domestic partner and the domestic partner's children as taxable income to you. This includes the Employer's portion of the cost, plus the portion you pay on a before-tax basis.

No Guarantee of Tax Consequences

Neither the Company nor any Employer makes any commitment or guarantee that any amounts paid to or for the benefit of any person under the Plan will be excludable from that person's gross income for federal, state, and/or local income tax purposes, or that any other tax treatment will apply or be available to that person.

If You Don't Enroll

If you do not enroll when you're first eligible or during annual enrollment, here's what happens.

Initial Eligibility/Enrollment

Once you become eligible, you will receive the necessary enrollment information from YBR. If you do not enroll within 31 days of your eligibility date, you will receive default coverage **(for yourself only)**, as shown below.

Coverage	Default Coverage
Medical/Prescription Drug	No coverage
Dental	No coverage
Vision	No coverage

Basic Life and AD&D Insurance	One times salary
Supplemental Life and AD&D	No coverage
Dependent Life Insurance	No coverage
Flexible Spending Accounts (FSAs)	No participation

This means that you will have no medical, prescription drug, dental, vision, supplemental life and AD&D, dependent life or FSA coverage for yourself or your eligible dependents. To change default coverage, you must wait until the next annual enrollment period, unless you have a qualifying change in status (see the **"Changing Your Coverages"** section) and choose to change your coverage at that time. However, if you decline coverage for yourself or your eligible dependents (including your spouse) because of other health coverage, you may be able to enroll yourself or your eligible dependents in this Plan in the future, provided you enroll within 31 days after your other coverage ends (or within 60 days, if you or your dependents lose eligibility for Medicaid or CHIP coverage or become eligible for premium assistance under Medicaid or CHIP).

Annual Enrollment

If you don't enroll during annual enrollment but you enrolled in the past, most of your current coverages remain in effect for the following plan year (any exceptions will be described in your annual enrollment materials), except for the flexible spending accounts (FSAs). If you want to participate in the FSAs, federal regulations require you to reenroll during each annual enrollment and decide how much you want to contribute to each account for the upcoming plan year.

Additional Automatic Coverage

The Company provides Employee Assistance Program (EAP), Business Travel Accident Insurance, Short Term Disability, and Long Term Disability coverage at no cost to you. You do not need to enroll in these coverages.

Enrollment Pursuant to a Qualified Medical Child Support Order (QMCSO)

The Plan will provide group health plan coverage as required by any QMCSO, as required by ERISA. You, a custodial parent, a state agency, or an alternate recipient may enroll a child pursuant to the terms of a valid QMCSO.

Coverage under the Plan is subject to payment of the required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency. The Employer may withhold any required contributions for this coverage and remit payment to the appropriate party. Refer to the **"Qualified Medical Child Support Order"** notice later in this booklet for more information.

When Coverages Begin

The following chart shows when coverages under this Health and Welfare Plan begin provided you meet the eligibility requirements and you enroll within 31 days of your eligibility date (as applicable).

Coverage	Effective Date of Coverage
Medical/Prescription Drug	First day of the month following 30 days of employment
Dental	First day of the month following 30 days of employment
Vision	First day of the month following 30 days of employment
Life and AD&D Insurance	First day of the month following 30 days of employment
STD	After first 90 days of continuous full-time employment
LTD	Your date of hire
Flexible Spending Accounts	First day of the month following 30 days of employment
Employee Assistance Program	Your date of hire
Business Travel & Accident Insurance	First day of the month following 30 days of employment
Identity, Financial and Privacy Protection	First day of the month following 30 days of employment

Eligible Dependent(s)

If you enroll your eligible dependents for certain coverages when you first become eligible, such coverages begin at the time your coverages begin, subject to the dependent certification requirements. Upon enrollment of your dependent(s), you will receive a communication from Dependent Verification Services (DVS) and a message on the YBR website to verify dependents, which will require you to click on the DVS link. You must submit the required

documents to demonstrate eligibility of your dependent(s) within the 60-day verification period. Dependents are covered immediately and will remain covered through the verification period. If documents are not submitted and approved during the verification period, however, coverage will be dropped retroactive to the date coverage originally began for such dependent(s).

If you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided you enroll within 31 days of the marriage, birth, adoption, or placement for adoption. If you don't, you must wait until the next annual enrollment period. As with initial enrollment, dependent verification requirements apply with any newly added dependent.

Note: Please notify *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 (1-888-438-9271) or www.ybr.com/ryman as soon as possible if you wish to add or remove a dependent. If you have any questions about covering your dependents, please talk with a Customer Care Representative.

Changing Your Coverages

Your coverage choices are generally irrevocable during the plan year (i.e., they remain in effect from January 1 through December 31). You may only change your coverage during the annual enrollment period or when you have a qualifying change in status.

Qualifying changes in status include, but are not limited to:

- Your marriage, divorce, or legal separation;
- Birth or adoption of a child;
- Death of your covered child or spouse;
- Qualification of a medical child support order;
- Change in work site or residence for you, your spouse, and eligible dependent (resulting in a loss of plan eligibility);
- Your dependent either becomes eligible or no longer meets Plan eligibility requirements (see the **"Eligible Dependents"** section of this booklet);
- Loss or gain of coverage if your spouse's employment changes (resulting in a gain or loss of eligibility under your spouse's plan);
- Loss of eligibility for, or qualification for a subsidy with respect to the Plan, under Medicaid or CHIP;
- You, your spouse, or dependent changes from part-time employment to full-time, or vice versa (resulting in a gain or loss of eligibility under your, the spouse's or dependent's plan); and
- The employee of, or return from an unpaid leave of absence for you or your spouse.

The Plan may also allow for a coverage change at the time of establishment of a domestic partnership or termination of a domestic partnership.

Any change you make to your coverage must be consistent with and on account of the change in status you experience (and must be permitted under an applicable insurance policy). For example, if you have a baby, you may add coverage for that child only (not other children whom you did not cover previously). Whether a change is consistent with and on account of a change in status will be determined by the Plan Administrator. You will be required to provide a copy of documentation demonstrating eligibility of your dependents.

To request a change in benefits as a result of a change in status, contact *Your Benefits Resources*™ (YBR) within 31 days (60 days for a loss of eligibility for, or qualification for a subsidy with respect to the Plan, under Medicaid or CHIP) of the event at 1-888-GET-YBR1 (1-888-438-9271) or log on to www.ybr.com/ryman.

When Coverages Ends

When coverage ends depends on whether you're an employee, or covered as a dependent under the Plan. Special rules apply if you're an employee and on a leave of absence. Your Human Resources Representative can answer any questions you may have about these special rules.

Employees

Your coverage under the Plan will end on the earliest of the following:

- The last day of the month* in which you no longer meet the eligibility requirements of the Plan;
- The last day of the month* in which you end employment with the Employer; or
- The date the Plan is terminated, or amended to terminate coverage for a class of employees in which you are a member.

* For life insurance, Short Term Disability and Long Term Disability coverages, coverage ends on the date you no longer meet the eligibility requirements of the plan or you end employment with the Employer.

Dependents

Dependent coverage under the Plan will end on the earliest of the following:

- The date your coverage ends;
- The date you fail to make the required contribution for dependent coverage by the due date when in an arrearage situation;
- The last day of the month** in which a dependent is no longer an eligible dependent (for example, your child reaches the Plan's age limit); or
- The date the Plan is terminated, or amended to terminate dependent coverage.

** For life insurance coverage, coverage ends on the date the dependent is no longer an eligible dependent.

You may be eligible to continue your group health plan coverage through COBRA (the Consolidated Omnibus Budget Reconciliation Act). Your COBRA rights and obligations are described in **Appendix B** to this SPD. Also, domestic partners and their children who are covered as dependents may be eligible to continue coverage through COBRA-like coverage, as described in Appendix B to this SPD.

Coordination of Benefits

If You Have Coverage Under Another Plan

You may have applicable coverage under another plan in addition to coverage under this Plan. If this is the case, the intent of this Plan is not to duplicate benefits. For this reason, many plans, including this one, have a "coordination of benefits" (or COB) provision. *Refer to your coverage booklet for the COB terms specifically applicable to your coverage*. For example, refer to "Coordination of Benefits" in the medical coverage booklet for details about medical COB.

If You Qualify for Medicare

As an active employee, if you are entitled to Medicare, the Plan's group health plan (e.g., medical, prescription drug, dental, and vision) coverages are usually your primary coverage. The Plan provides you and your eligible dependents, who are Medicare entitled, primary coverage. Medicare provides secondary coverage for Medicare Part A (Hospitalization) benefits that may not be covered under the Plan. Medicare also provides secondary coverage for Medicare Part B (Doctors' Visits), provided you enroll in Medicare Part B and pay the applicable premiums.

Active employees age 65 and older (and their spouses age 65 and older) must be provided with the same group health plan coverage that's offered to younger workers under the Plan. For these Medicare-eligible individuals, the Plan is the primary payer, and Medicare is the secondary payer. This provision is referred to as "Medicare Secondary Payer Rule."

Situations Affecting Your Benefits

The benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual benefit maximums, pre-authorization requirements, or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for new or existing prescription drugs, medical tests, medical devices or medical procedures. Benefits under a coverage option may also be subject to coordination of benefits if you have coverage under another plan (see the **"Coordination of Benefits"** section above). These limitations are set forth and are explained in the particular coverage booklet(s).

If a Third Party Is Liable for Your Condition

The Plan doesn't pay benefits for any expenses:

- For which another party may be responsible as a result of liability for causing or contributing to your or your covered dependent(s) injury or illness; and
- For which you recover or become entitled recover from any source (including by way of a lawsuit, verdict, settlement, compromise, arbitration award, or otherwise, without regard to how any such recovery may be itemized, structured, or allocated, and without regard to whether responsibility is accepted or denied by the other party); or
- That are covered under the terms of any:
  - — Automobile medical;
  - — Automobile no fault;
  - — Uninsured or underinsured motorist, workers' compensation, or government insurance (other than Medicaid); or
  - — Similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your dependent(s).

If you or a dependent incur expenses as described above, the Plan automatically has a lien upon, and priority to, the proceeds of any recovery by you or your dependent(s) from such party to the extent of any benefits provided to you or your dependent(s) by the Plan. You or your dependent(s) or their representative shall execute such documents as may be required to secure the Plan's rights. The Plan shall be reimbursed the lesser of:

- The amount actually paid by the Plan under the policy; or
- The amount actually received from the third party.

The reimbursement will take place at the time the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration, or otherwise, and regardless of whether your recovery is full or partial (i.e., even if your recovery doesn't make you "whole").

The Plan and/or insurer may have additional rights—refer to the applicable coverage booklet for details.

Right of Recovery

Whenever the Plan makes payments for allowable expenses which in total exceed the maximum amount necessary to satisfy the amount the Plan should rightfully pay, the Plan has the right to recover this overpayment. The Plan may collect this amount from among one or more of the following, as the Plan Administrator shall determine:

- Any person to, for, or with respect to whom such payments were made.
- Any insurance companies.
- Any other organization.

The Plan may also offset any such amount against any benefit payment otherwise payable by the Plan.

The Plan and the insurer of a particular coverage may have additional rights—refer to the applicable coverage booklet for details.

Plan Amendment and Termination

Although the Company intends to continue this Plan, it has the right to terminate, suspend, withdraw, amend, or modify all or a part of this Plan at any time. The Company also has the right to amend any of the Plan's provisions to conform to legal requirements and other policies.

Claims for Benefits

To claim benefits under the Plan, you (or a beneficiary) must use the Plan's claims procedures, which are described generally in **Appendix A** to this SPD and specifically in the coverage booklets. Your claims for benefits will be decided in accordance with reasonable claims procedures, as required by ERISA (to the extent applicable). You must fully follow and exhaust the Plan's claims procedures before you can file a lawsuit in state or federal court.

Coverage While You're Disabled

If you become disabled, you may be eligible for up to 26 weeks of short term disability (STD) benefits (refer to the **Short Term Disability Coverage** booklet for details). While you're receiving STD benefits, your coverages under the Plan continue as long as you continue to make timely contributions toward the costs of these coverages.

If you remain disabled at the end of this 26-week period, you may be eligible to continue your group health plan (e.g., medical including, prescription drug), dental, and/or vision) coverages under COBRA, provided the coverages were in effect under the Plan on the date of termination. If you elect COBRA coverage, you'll be required to pay the appropriate COBRA premiums.

Events Permitting Continued Coverage

Under certain circumstances, you may be eligible for certain continued coverages under the Plan, under FMLA, USERRA, or COBRA.

Family and Medical Leave of Absence (FMLA)

If you take a leave of absence for certain reasons, such as to care for a sick family member or due to your own illness, or if you take a military family leave, you may be able to continue group health plan coverages under the Plan at the active employee rates.

To maintain coverages, you must continue contributions to the Plan for the duration of your approved leave of absence. If you drop coverages during the leave, the Plan won't pay benefits for any health-related expense incurred during the leave. At the end of the qualifying leave of absence, you can have your coverages reinstated on the date you return to work (assuming you are otherwise eligible and you pay any required contributions for the coverages). Refer to the FMLA Policy, or contact your Human Resources Representative for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA*)*

If you are absent from employment with the Employer because you are in "uniformed service," you may elect to continue group health plan coverage under the Plan as required by USERRA. The coverage period may continue for up to 24 months (and will run concurrently with any COBRA continuation coverage, to the extent allowed by law). Refer to the Military Leave Policy or contact your Human Resources Representative for more information.

Continuation of Coverage

When you lose group health plan coverage under the Plan, you may have the right to continue coverage under COBRA. Your COBRA rights and obligations are described in **Appendix B** to this SPD and in the YBR COBRA General Notice you receive when you enroll in the Health and Welfare Plan.

Termination of Coverage for False Representations or Fraud

If any individual makes a false representation to, or commits any fraud under or with respect to, the Plan, the Plan Administrator has the right to permanently terminate coverage for the individual and their dependents. A false representation may include, for example, submitting falsified claims or covering an individual who is not eligible to participate in the Plan (adding a spouse before the date of marriage or after a divorce, or adding a child who does not meet the Plan's definition of an eligible dependent, etc.). To the extent permitted by law, the Plan Administrator may also seek reimbursement for all claims or expenses paid by the Plan as a result of the false representations or fraud, and may reduce future benefits as an offset for amounts that should be reimbursed or pursue legal action against the individual.

Under the **medical coverage** portion of the Plan, any such termination of coverage will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation of material fact, the individual's coverage may be terminated on a retroactive basis (called a "rescission" of coverage), in which case notice of the rescission will be provided and the rescission decision will be subject to the review procedures discussed in **Appendix A** to this SPD.

Plan Information

Except as otherwise provided in the coverage booklets, the Health and Welfare Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974). This section provides important legal and administrative information you may need about the Plan.

Name of the Plan

OEG Employee Health and Welfare Plan (also referred to in this SPD as the Health and Welfare Plan or the Plan)

Plan Sponsor

RHP Corporate Properties, LLC
One Gaylord Drive
Nashville, TN 37214

In addition to the Company, other employers also may from time to time participate in the Plan (each, an Employer). Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer participates in the Plan.

Plan Administrator

Benefits Trust Committee
Ryman Hospitality Properties, Inc.
One Gaylord Drive
Nashville, TN 37214
615-316-6000

The Plan Administrator has the sole discretionary authority and responsibility to administer and control the Plan in accordance with its terms, and has, without limitation, the discretionary authority to interpret the Plan or its terms. The Plan Administrator's powers include making and enforcing rules it deems necessary or proper for the efficient administration of the Plan, allocating its responsibilities under the Plan to other persons, and deciding all questions concerning the Plan, including determining eligibility for benefits under the Plan.

The Plan Administrator keeps the records for the Plan, and will answer any questions you may have about the Plan.

If you have general questions about the Plan or your eligibility, you may contact **your Human Resources Representative at totalrewards@rymanhp.com.**

Agent for Service of Legal Process

Executive Vice President, General Counsel and Corporate Secretary
Ryman Hospitality Properties, Inc.
One Gaylord Drive
Nashville, TN 37214

Service may also be made on the Plan Administrator named above.

Plan Year

The plan year is January 1 through December 31.

Employer Identification Number

46-0975687

Plan Number

501

Funding Medium

Some of the coverage options under the Plan are self-funded and some are fully insured. Benefits under the self-funded coverage options are paid in part by employees' payroll deductions and in part by the Employer out of its general assets.

The fully insured coverage options are insured under group contracts or policies entered into between the Company and insurance companies. The insurance companies, not the Company or other Employers, are responsible for paying claims under these coverage options. Insurance premiums for the fully insured coverage options are paid in part by employees' payroll deductions and in part by the Employer out of its general assets.

The type of funding for each coverage under the Plan is described in the "Carrier Directory".

Carrier Directory

Benefit Type	Source of Contributions	Funding	Claims Administrator or Insurance Company
Medical Plans: **Traditional PPO Plan (Benefit Plan 001)** **HDHP with Copay (Benefit Plan 002)** **HDHP with HSA* (Benefit Plan 003)**	Employer and Employee Pre-tax Contributions	Self-funded; paid from the general assets of the Employer	**UMR** www.umr.com For **Lantern**: ryman.surgeryplus.com (registration is required) 1-855-200-2099 For **Vanderbilt MyHealth Bundles**: visit MyHealthBundles.org or: www.vanderbilthealth.com/service/myorthohealth www.vanderbilthealth.com/service/myhearinghealth www.vanderbilthealth.com/service/mymaternityhealth www.vanderbilthealth.com/service/myweightlosshealth www.vanderbilthealth.com/service/myspinehealth
Prescription Drug (for employees enrolled in medical coverage)	Employer and Employee Pre-tax Contributions	Self-funded; paid from the general assets of the Employer	**OptumRx** 1-800-334-8134 optumrx.com
Dental	Employer and Employee Pre-tax Contributions	Fully insured	**Delta Dental Plan of Tennessee** 240 Venture Circle Nashville, TN 37228 1-800-223-3104 www.deltadentaltn.com
Vision	Employer and Employee Pre-tax Contributions	Fully insured	**DeltaVision in partnership with VSP** 240 Venture Circle Nashville, TN 37228 1-800-877-7195 www.vsp.com
Flexible Spending Accounts (FSAs) (Dependent Care FSA not subject to ERISA)	Employee Pre-tax Contributions	Paid from the general assets of the Employer	**Smart-Choice Accounts™** 1-888-GET-YBR1 (1-888-438-9271) or www.ybr.com/ryman (click on the Smart-Choice Account link)
Life Insurance and Accidental Death & Dismemberment (AD&D)	Employer and Employee After-tax Contributions	Fully insured	**The Hartford** 1-800-563-1124
Short Term Disability	Employer Contributions	Fully insured	**The Hartford** 1-800-563-1124 Fax: 866-9542641 www.hartford.com
Long Term Disability	Employer Contributions	Fully insured	
Employee Assistance Program (EAP)	Employer	Prepaid	**Resources for Living** 1-800-272-7252 www.resourcesforliving.com (Login with Username: RHP; Password: RHP)
Business Travel Accident	Employer Contributions	Fully insured	**The Hartford** Refer to policy or contact Plan Administrator for contact information.
Identity, Financial & Privacy Protection (not subject to ERISA)	Employer and Employee After-tax Contributions	Prepaid	**Allstate Identity Protection Pro Plus by Allstate Identity Protection** www.myaip.com 1-800-789-2720

Employee Assistance Program (EAP)

Using the EAP

The Company has engaged Resources for Living (an Aetna company) to provide Employee Assistance Program (EAP) benefits to you and to any members of your household and your child(ren) to age 26, even if your child(ren) do not live at home.

* If you are enrolled in the HDHP with HSA medical option, your Health Savings Account (HSA) is not subject to ERISA and is not a part of the Plan.

There is no cost for enrollment in the EAP, and enrollment for you and your covered household member(s) and child(ren) is automatic.

EAP services are confidential* and are available 24 hours a day, 7 days a week. Information about accessing the services is provided below. When you call, an EAP specialist can help you identify the nature of your concerns and refer you to the right resources to address them.

The EAP is intended to provide short-term, professional counseling services that are designed to help address the personal concerns and life issues that you are facing. The EAP provides you, your household member(s) and your eligible child(ren) with access to various services, including the following:

Emotional Well-Being Support

You can call on the EAP any time for in-the-moment emotional well-being support from licensed clinicians. You can also access *up to six (6) counseling sessions*—face to face, telephone or online with televideo—*per problem per calendar year* with EAP network contracted providers. These services are available for a wide range of issues, including:

- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse
- Self-esteem and personal development

Daily Life Assistance

Call the EAP for personalized guidance and help finding resources for:

- Child care, parenting and adoption
- Summer programs for kids
- School and financial aid research
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Home repair and improvement
- Household services and more

Online Resources

The EAP member website is also available 24 hours a day, 7 days a week, and offers a range of tools and resources to help you with emotional well being, work/life balance, and more, including:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app
- myStrength tools to help you overcome depression, anxiety, stress, substance misuse and/or chronic pain

* All calls to the EAP are confidential, except as otherwise required by law.

There is also a Discount Center on the website, where you can find deals on brand-name products and services, including fitness and other program discounts.

Identity Theft Services

The EAP services include *one hour* of fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services also include a free emergency kit for victims of identity theft.

Legal Services

You can get a *free 30-minute consultation* with a participating attorney for each new legal topic related to:

- General issues
- Divorce
- Family issues
- Wills and other document preparation
- Criminal law issues
- Elder law and estate planning
- Real estate transactions
- Mediation services

If you choose services beyond the initial consultation provided by the EAP, those services are available from participating attorneys at a *25% discount* (this discount does not apply to flat legal fees, contingency fees, or plan mediator services).

Legal services (including discounts) are not available for any work-related issues. Also, the legal issue(s) must be related to you and/or your covered household member(s) or child(ren) to be covered by the EAP.

Financial Services

You can also get a *free 30-minute consultation* for each new financial topic related to:

- Budgeting
- Credit and debt issues
- Retirement or other financial planning
- College funding
- Tax and IRS questions and preparation
- Mortgages and refinancing

You can also get a *25% discount* on tax preparation services.

Services must be for financial matters related to you and/or your covered household member(s) or child(ren) to be covered by the EAP.

How to Access the EAP

To access EAP services, you can call the number listed below for assistance:

Telephone: **1-800-272-7252** (toll-free)

When short-term counseling is appropriate, you will receive a referral to an EAP counselor—you must use a network provider to receive counseling (and other) services.
Other resources and information are available on the EAP website. To access the EAP website:

Visit: www.resourcesforliving.com (Username: RHP; Password: RHP)

Other Important Information About the EAP

Use of EAP Providers

The counseling and other services described above are only available when a counselor or other service provider referred by/contracted with the EAP is used to obtain covered (or discounted) services. The availability (or continued availability) of any particular counselor or other service provider cannot be guaranteed and is subject to change.

Exclusions/Limitations on EAP Benefits

The counseling services available under the EAP are intended to be short-term in nature. You are responsible for services in excess of the limitations described above; for example, any counseling sessions received after the six (6) sessions available for one problem under the EAP are your responsibility (such sessions *may* be covered under your medical coverage, and your EAP counselor may be able to assist with the transition of your care). The EAP does not include coverage for any level of care other than short-term counseling. You are not required to use or exhaust these EAP counseling sessions before using any benefits under your medical coverage.

Services from/by providers who are not a part of the Resources for Living network are not covered under this EAP. Similarly, services must be accessed through the EAP to be covered.

Legal services (free 30-minute initial consultation or discounted services) are not available for any work-related issues.

Services (including legal and financial services) that relate to individuals other than you or your covered household member(s) or child(ren) are not covered by the EAP.

Also, the following are not covered by the EAP (this list is not exhaustive):

- Court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, or custody visitations
- Services covered by Workers' Compensation
- Diagnostic testing or treatment
- Formal psychological evaluations
- Psychiatrist visits, including medication management
- Prescription medications
- Inpatient, residential, partial residential, or intensive outpatient care or treatment
- Ongoing counseling for a chronic diagnosis that requires long-term care
- Biofeedback, hypnotherapy, and/or aversion therapy
- Legal representation in court
- Investment advice

Claims for EAP Benefits

When you receive counseling from a Resources for Living EAP provider, you will not have any claims to file—the network provider is responsible for filing claims with Resources for Living. If you receive a bill for authorized EAP services, contact Resources for Living immediately. Expenses received from non-EAP network providers are not covered.

If your claim for benefits involves group health coverage (this is generally limited to the counseling services available under the EAP), and your claim for benefits is denied, in whole or in part, the claim notification and review procedures will comply with the applicable requirements of ERISA. These claims procedures are described in **Appendix A** to this SPD.

Notices Applicable to Group Health Plans

Qualified Medical Child Support Order

The Plan also provides coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO) even if you do not have legal custody of the child; the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, the Employer may withhold any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the Employer to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If you have any questions or you would like to receive a copy of the Plan's written procedure for determining whether a QMCSO is valid, please contact the Plan Administrator.

Medical child support orders should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining whether the order is qualified. If the Plan Administrator determines that the order is qualified, you may be required to cover your non-custodial child(ren) under the Plan. As a beneficiary covered under the Plan, your child will be entitled to all information the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Your Right to Special Enrollment

Under HIPAA, a special enrollment period for group health plan coverage may be available if you lose coverage under certain conditions or when you acquire a new dependent by marriage, birth, adoption, or placement for adoption. A special enrollment period may also be available if you lose eligibility to participate in Medicaid or Children's Health Insurance Program (CHIP) or if you qualify for premium assistance under Medicaid or CHIP at the state level.

If you decline enrollment for yourself or your dependent child(ren) and/or your spouse because of other health insurance coverage 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 other dependents' other coverage). However, you must request enrollment within 31 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 31 days after the marriage, birth, adoption, or placement for adoption.

If your or your dependent's coverage under Medicaid or CHIP terminates as a result of a loss of eligibility or you or your dependent become eligible for a subsidy with respect to coverage under this Plan under Medicaid or CHIP, you will have 60 days to request enrollment (this 60-day time period for requesting enrollment only applies to these Medicaid- and CHIP related events; all other requests for enrollment must be made within 31 days).

To request special enrollment or obtain more information, contact *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 (1-888-438-9271) or www.ybr.com/ryman.

The Newborns' and Mothers' Health Protection Act of 1996

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 normal 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 as applicable). Refer to the medical coverage booklet for details. You may also contact the Plan Administrator for more information.

Women's Health and Cancer Rights Act of 1998

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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Your medical coverage booklet describes these deductibles and coinsurance.

If you would like more information on WHCRA benefits under your medical coverage, refer to the medical coverage booklet, or contact the Plan Administrator.

Your Rights Under ERISA

This statement of ERISA rights is required by federal law and regulation. (This statement does not apply to the Dependent Care Flexible Spending Account or any other coverages that are not subject to ERISA.)

As a Plan participant, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan 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, such as worksites and union halls, all documents governing the Plan, including coverage contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including coverage contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of 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, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you're 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're successful, the court may order the person you've sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds that your claim is frivolous.

Assistance with Your Questions

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

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A — Benefit Claim and Eligibility Determinations

Claims for Benefits Under the Plan

What is a Claim for Benefits?

A claim for benefits is a request for a Plan benefit or benefits you make in accordance with the Plan's reasonable procedures for filing benefit claims (as described in this Appendix). If you ask a question concerning eligibility for coverage under the Plan without making a claim for benefits, the eligibility determination is not a claim for benefits governed by the ERISA claims procedure rules (however, see the section entitled **"Eligibility Determinations Under the Plan"** at the end of this Appendix for information about eligibility determinations under the Plan).

This section generally describes how to file a claim for benefits and how appeals are processed under most types of coverage under the Plan (those to which ERISA applies), as required by ERISA. ***You will find more detailed information about claims and appeals under specific coverage options in the applicable coverage booklet(s); therefore, you should first review the applicable coverage booklet to address your specific claim situation.***

How to File a Claim for Benefits

Where you submit your claim for benefits and the deadline for filing your claim depend on which coverage option you are submitting your claim for benefits to. In some coverage options, if you go to a network or contracted provider, the provider will generally file a claim for you. Otherwise, you will need to file a claim yourself. Generally, you should file a claim as soon as possible (even if you have not met your deductible, if applicable under such coverage option). If you do not file a proper claim within the particular coverage option's claim filing deadline, your claim for benefits will generally be denied. *Specific claim filing deadlines are described in the applicable coverage booklets.*

The claims administrators and/or the Plan Administrator have the right to request repayment if they overpay a claim for any reason (or pay a claim in error).

Designating an Authorized Representative

You may provide the claims administrator and/or the Plan Administrator, as applicable, with a written designation and authorization (on a form prescribed or approved by the claims administrator or Plan Administrator) for an "authorized representative" to represent you and act on your behalf and consent to the release of information related to you to the authorized representative with respect to a claim for benefits or an appeal. Refer to the applicable coverage booklet or contact the applicable claims administrator to determine how to designate an authorized representative under that coverage option.

Benefit Claim Review Process and Applicable Time Periods

The coverage options of the Plan each have a claim review process that is followed whenever you submit a claim for benefits. When you file a claim for benefits, the claims administrator for the particular coverage option reviews your claim and makes a decision either to approve or deny the claim, in whole or in part.

If your claim is approved, benefits will be paid either to you or on your behalf. If your claim is denied, or if the claims administrator needs more information before it can approve your claim, you will be notified in writing within certain time periods. If your claim is denied, you can appeal. For more information, see the section below entitled **"If Your Claim for Benefits Is Denied."**

A participant or beneficiary must exhaust the Plan's reasonable claims procedures prior to bringing any court action to obtain Plan benefits.

The claims administrator processes payments for claims, answers questions, and reviews appeals according to the particular coverage option's provisions, except for issues related to eligibility determinations under certain coverage options (see the section entitled **"Eligibility Determinations Under the Plan"** at the end of this Appendix for information about eligibility determinations under the Plan). The claims fiduciary is the named fiduciary responsible for serving as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals. In many cases, the Plan Administrator is the claims fiduciary. However, in other cases, the claims administrator or insurance company is also the claims fiduciary and makes all final benefit claim determinations under the coverage option it administers or insures. Refer to the applicable coverage booklet or contact the Plan Administrator for more information.

The following chart will help you determine which time periods (outlined in the **Claims and Appeals Timelines**) apply under ERISA for claims administrators' decisions about your claims and appeals, depending on:

— The particular coverage option to which you are submitting the claim; and

— In the case of group health coverage options, the type of claim you are submitting:

If you submit a claim for benefits under the following coverage option(s) (these lists are not exhaustive):	And your claim is of the following type:	Then refer to this Claims and Appeals Timeline (below) for the applicable time periods for receiving claim and appeal decisions:
• Medical (including Prescription Drug), collectively called "**medical coverage**" in this Appendix • Dental • Vision • Employee Assistance Program (EAP) (counseling services under the EAP only) • Health Care Flexible Spending Account (Health Care FSA or Limited Use FSA) These are called "**group health coverage(s)**" in this Appendix.	**Urgent Care***	See the **Claims and Appeals Timeline** entitled **Group Health Coverage—Urgent Care Claims**.
	Pre-Service**	See the **Claims and Appeals Timeline** entitled **Group Health Coverage—Pre-Service Claims**.
	Post-Service***	See the **Claims and Appeals Timeline** entitled **Group Health Coverage—Post-Service Claims**.
	Concurrent Care****	See the **Claims and Appeals Timeline** entitled **Group Health Coverage—Concurrent Care Claims**.
• Short Term Disability • Long Term Disability These are called "**disability coverage(s)**" in this Appendix.	**Any claim for benefits under the disability coverage(s).**	See the **Claims and Appeals Timeline** entitled **Disability Coverage Claims**.
• Life Insurance • AD&D • Travel Accident These are called "**other coverage(s)**" in this Appendix.	**Any claim for benefits under the other coverage(s).**	See the **Claims and Appeals Timeline** entitled **Other Coverage Claims**.

* ***Urgent Care*** *means a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care decisions could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. (In the case of* ***medical coverage*** *to which the Affordable Care Act applies, the determination whether the claim is for urgent care is determined by the attending provider and the Plan shall defer to that determination.)*

** ***Pre-Service*** *means any claim for a benefit with respect to which the terms of the Plan condition the receipt of the benefit, in whole or in part, on the approval of the benefit in advance of obtaining medical care.*

*** ***Post-Service*** *means any claim for a benefit that is not a pre-service claim; that is, it does not require approval in advance of obtaining medical care, and a claim for such benefits is filed after the medical care has been received. All Health Care Flexible Spending Account claims are post-service claims.*

**** ***Concurrent Care*** *means that the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and there is a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments.*

If Your Claim for Benefits Is Denied or Your Coverage is Rescinded

If your claim for a benefit payment is denied, in whole or in part (or if your **medical coverage** or your **disability coverage** is rescinded, if required by law), you will receive a written notice of the adverse benefit determination (denial) from the claims administrator (or the Plan Administrator) within the applicable time period outlined in the applicable **Claims and Appeals Timeline** below. (Note, however, that if your claim is an **urgent care** claim, this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.)

The denial notice will include:

- The specific reason(s) for the adverse benefit determination (denial);
- References to specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why the material or information is necessary; and

- An explanation of the steps (and the time limits that apply to those steps) you must take if you disagree with the denial and wish to have your benefit claim reviewed, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Additional Information Provided for Group Health Coverage Claims

In addition to the information listed above, in the case of an adverse benefit determination under a **group health coverage**, your written notice will also include:

- A copy of any internal rule, guideline, protocol or other similar criterion relied upon to determine the claim, or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy of such rule, guideline, protocol, or other criterion free of charge.
- If the denial of your claim is based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination, applying the terms of the Plan to your medical circumstances, or a statement that you can request the explanation free of charge.

In the case of an adverse benefit determination under **medical coverage** to which the Affordable Care Act* applies, your written notice will also include the following:

- Sufficient information to identify your claim, including the date the service was rendered, the name of the professional who provided the service, the amount of the claim, etc., and a statement describing the availability, on request, of any diagnosis and treatment codes utilized by the Plan (along with a description of their corresponding meanings).
- The denial code and its corresponding meaning that corresponds to the specific reason(s) for the adverse benefit determination and a description of the Plan's standard, if any, that was used in denying the claim.
- A description of any available internal appeals and external review processes, including information describing how to initiate an appeal.
- A description of the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

**References to the "Affordable Care Act" mean the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as otherwise subsequently amended.*

Additional Information Provided for Disability Coverage Claims

In addition to the information applicable to all benefit claims and listed at the beginning of this section, above, in the case of an adverse benefit determination under **disability coverage**, your written notice will also include the following:

- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following, if applicable: (i) the views of health care professionals treating you and vocational professionals who evaluated you that you presented to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration about you that you presented to the Plan.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

How To Request Review of an Adverse Benefit Determination (a Denied Claim)

If you do not agree with the adverse benefit determination (including a rescission of your **medical coverage** or **disability coverage**), you (or your authorized representative) may request that determination be reviewed in accordance with the reasonable claims procedures described here and in the applicable coverage booklet.

Unless the applicable coverage booklet provides otherwise, you must file your written request for review of any **group health coverage** or **disability coverage** adverse benefit determination within **180 days** after you receive the written notification of benefit denial. All other coverages' written requests for review must be filed within **60 days** after you receive the written notification of benefit denial (unless the applicable coverage booklet provides otherwise). Your request for review must be in writing and must include the following:

- A description of your claim sufficient to identify the claim (for example, for a claim for benefits under a group health coverage, the patient's name and identification number from the ID card, the date(s) of medical service(s), and the provider's name);
- A summary of all the reasons why you believe the benefits should be paid (or coverage should not be rescinded), including any documents, records or other information relating to or that support your claim; and
- Any issues or comments that you think are pertinent to your claim.

However, if your claim involves **urgent care**, your request for review may be submitted orally or in writing, and all necessary information related to the review may be transmitted between you and the Plan by telephone, facsimile, or other available, similarly expeditious method.

You may include with your request for review written comment, documents, records, and/or other information relating to your claim. During the time limit for requesting an appeal, upon request and free of charge, you will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

Your claim for benefits will be reviewed fairly and fully, and a decision will be made on your claim within the time period outlined in the applicable **Claims and Appeals Timeline** (for the applicable coverage and claim type) following receipt of your review request. As described in the applicable **Claims and Appeals Timeline**, if additional time is needed to render a decision, you will be notified of the reasons why the extension is needed and the date by which you may expect a decision.

In the case of a claim for benefits under a **group health coverage** or **disability coverage**, the party considering the appeal will not give deference to the initial claim denial and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor that individual's subordinate. Additionally, if a **group health coverage** or **disability coverage** determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate), the claims fiduciary deciding the appeal will consult with an appropriate health care professional (who was not consulted during the initial adverse benefit determination and is not subordinate to a professional consulted during the initial adverse benefit determination). Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

In the case of a claim for benefits under a **medical coverage** that is subject to the requirements of the Affordable Care Act, as part of its full and fair review, you must be provided (free of charge) with the new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim as soon as possible and sufficiently in advance of the date on which the final adverse benefit determination is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. In addition, before the Plan can issue a final adverse benefit determination based on a new or additional rationale, you must be provided (free of charge) with the rationale as soon as possible and sufficiently in advance of the date on which the final adverse benefit determination is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time period will be tolled to give you a reasonable opportunity to respond.

In the case of a claim for benefits under a **disability coverage**, before the Plan can issue an adverse benefit determination on review, you shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. In addition, before the

Plan can issue an adverse benefit determination on review based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date.

Notice of Decision on Appeal

If the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are generally paid to you or your beneficiary unless, in the case of a **group health coverage**, the provider notifies the claims administrator that you have assigned benefits directly to that provider.

If the original adverse benefit determination is upheld in whole or in part, you will receive a written notice within the time period outlined in the applicable **Claims and Appeals Timeline** (for the applicable coverage and claim type) stating:

- The specific reason(s) for the adverse benefit determination;
- References to specific Plan provisions on which the denial is based;
- A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits; and
- A statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal required by the particular coverage option.

Additional Information Provided for Group Health Coverage Claims

In the case of and adverse benefit determination on review under a **group health coverage**, your written notice will also include:

- A copy of any internal rule, guideline, protocol or other similar criterion relied upon to determine the claim, or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy of it (the rule, guideline, protocol, or other criterion) free of charge.
- If the denial of your claim is based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination, or a statement that you can request the explanation free of charge.

In the case of an adverse benefit determination under **medical coverage** to which the Affordable Care Act applies, your written notice will also include:

- Sufficient information to identify your claim, including the date the service was rendered, the name of the professional who provided the service, the amount of the claim, etc.; and a statement describing the availability, on request, of the diagnosis codes and treatment codes utilized by the Plan (along with a description of their corresponding meanings).
- The denial code and its corresponding meaning that corresponds to the specific reason(s) for the adverse benefit determination and a description of the Plan's standard, if any, that was used in denying the claim, including a discussion of the decision.
- A description of any available internal appeals and external review processes.
- A description of the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

Additional Information Provided for Disability Coverage Claims

In addition to the information applicable to all benefit claims and listed at the beginning of this section, above, in the case of an adverse benefit determination on review under **disability coverage**, your written notice will also include the following:

- A description of any contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for your claim.

- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following, if applicable: (i) the views of health care professionals treating you and vocational professionals who evaluated you, and that you presented to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration about you that you presented to the Plan.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If, on the first appeal, the Plan upholds the denial of your claim for benefits, and the coverage option provides for two internal levels of appeal, you may file a second appeal within **60 days** after receiving the notice of denial of your first appeal (unless the applicable coverage booklet provides otherwise). The second appeal will follow the same procedures as outlined above for the initial appeal. Note that even if the claims administrator allows for two levels of appeal, *there is typically only one level of appeal for an **urgent care** claim*. Refer to the applicable coverage booklet, or contact the particular claims administrator or the Plan Administrator, to determine whether a particular coverage option provides for two levels of appeal.

In certain circumstances, for a claim for benefits of **medical coverage**, you may be entitled to an external appeal. See the section entitled "External Review Process Available Under Certain Circumstances," below, for more information.

Claims and Appeals Timelines

Group Health Coverage—Urgent Care Claims

Timing for Urgent Care Claim Decision	Timing and Notification of Urgent Care Appeal Decision(s)
As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the claims administrator. If you fail to provide sufficient information with your claim to determine whether, or to what extent, benefits are covered by or payable from the Plan, you will be notified no later than **24 hours** after the claims administrator receives your claim about the specific information you need to submit. You will have at least **48 hours** to provide this information. You will be notified of the claim decision as soon as possible, but not later than **48 hours** after the earlier of: (i) the claims administrator's receipt of the specific information or (ii) the deadline to provide this information passes. **If you fail to follow proper claim procedures,** you will be notified of the failure as soon as possible, but not later than **24 hours** after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 24-hour time period only applies if your claim is made to the proper person and names the specific claimant; the specific medical condition or symptom; and the specific treatment, service, or product for which approval is requested.	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the claims administrator.

Group Health Coverage—Pre-Service Claims

Timing for Pre-Service Claim Decision	Timing and Notification of Pre-Service Appeal Decision(s)
Within a reasonable period of time appropriate to the medical circumstances but not later than **15 days** after receipt of your claim by the claims administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the claims administrator. **Extension of time for processing claim—**If an extension is needed, you will be notified before the end of the first 15-day period why the extension is necessary and when the claims administrator expects to render a decision. If an extension is necessary because you failed to submit necessary information, the notice will specify what information is necessary, and you will have at least **45 days** to provide it. You will be notified of the claims administrator's decision within **15 days** after its receipt of the additional information or within **15 days** after the 45-day deadline to provide the additional information passes, whichever is sooner. **If you fail to follow proper claim procedures,** you will be notified of the failure to follow the proper claims procedures as soon as possible, but no later than **5 days** after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 5-day time period only applies if your claim is made to the proper person and names the specific claimant; the specific medical condition or symptom; and the specific treatment, service, or product for which approval is requested.	**If the coverage option provides for <u>one</u> internal level of appeal** A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for review by the claims administrator. **If the coverage option provides for <u>two</u> internal levels of appeal** A reasonable period of time appropriate to the medical circumstances, but not later than **15 days** after receipt of your request for first or second review by the claims administrator.

Group Health Coverage—Post-Service Claims

Timing for Post-Service Claim Decision	Timing and Notification of Post-Service Appeal Decision(s)
Within a reasonable period of time, but not later than **30 days** after receipt of your claim by the claims administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the claims administrator. **Extension of time for processing claim—**If an extension is needed, you will be notified before the end of the initial 30-day period why the extension is necessary and when the claims administrator expects to render a decision. If an extension is necessary because you failed to submit necessary information, the notice will specify what information is necessary, and you will have at least **45 days** to provide it. You will be notified of the claims administrator's decision within **15 days** after its receipt of the additional information or within **15 days** after the 45-day deadline to provide the additional information passes, whichever is sooner.	**If the coverage option provides for <u>one</u> internal level of appeal** A reasonable period of time, but not later than **60 days** after receipt of the request for review by the claims administrator. **If the coverage option provides for <u>two</u> internal levels of appeal** A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for first or second review by the claims administrator.

Group Health Coverage—Concurrent Care Claims

Timing for Concurrent Care Claim Decision	Timing and Notification of Concurrent Care Appeal Decision(s)
If the treatment involves **non-urgent care** and you request an extension of the course of treatment, the request will be considered a new claim for benefits and it will be decided according to the Pre-Service Claim or Post-Service Claim time periods described above, depending on the type of claim. If the treatment involves **urgent care** and you request an extension of the course of treatment, the claims administrator must notify you of its determination as soon as possible, taking into account the medical exigencies, but generally no later than **24 hours** after receipt of the claim. Your request must be made within **24 hours** prior to the expiration of the prescribed period of time or number of treatments. If your claim is not made to the Plan within **24 hours** before the expiration of the course of treatment or number of treatments, notice of the claim decision will be provided as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the claims administrator. If you fail to provide sufficient information with your claim to determine whether, or to what extent, benefits are payable from the Plan, you will be notified no later than **24 hours** after the claims administrator receives your claim about the specific information you need to submit. You will have at least **48 hours** to provide this information. You will be notified of the claim decision as soon as possible, but not later than **48 hours** after the claims administrator receives the specific information or within **48 hours** after the deadline to provide this information passes. The claims administrator may decide not to pay any longer for an ongoing course of treatment or to pay only for a reduced number of treatments. If there is a reduction or termination of treatment (other than by Plan amendment or termination), the claims administrator must notify you sufficiently in advance to allow you to appeal and obtain a determination on review before the treatment is reduced or terminated. **If you fail to follow proper claim procedures—**For claims involving a request for an extension of concurrent care that is **not urgent**, you will be notified of the failure to follow the proper claims procedures as soon as possible, but no later than **5 days** after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 5-day time period only applies if your request is made to the proper person and the request names the claimant; the specific medical condition or symptom; and the specific treatment, service, or product being requested. If your claim involves **urgent care** and you fail to follow the proper claims procedures, you will be notified of the failure as soon as possible, but no later than **24 hours** after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 24-hour time period only applies if your request is made to the proper person and the request names the claimant; the specific medical condition or symptom; and the specific treatment, service, or product being requested. *To the extent required by law, the Plan will provide continued medical coverage for an ongoing course of treatment pending the outcome of internal appeals*.	If it is a **non-urgent claim** for ongoing care, the timing of the notice of decision on review will be handled under either the **Pre-Service Claim** or **Post-Service Claim** time periods outlined above, depending on the type of claim. If it is an **urgent care claim** for ongoing care, as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the claims administrator.

Disability Coverage Claims

Timing for Disability Coverage Claim Decision	Timing and Notification of Disability Appeal Decision(s)
Within a reasonable period of time, but not later than **45 days** after receipt of your claim by the claims administrator, unless an extension of up to an additional **30 days** is necessary due to matters beyond the control of the claims administrator. **Extension of time for processing claim—**If an extension is needed, you will be notified before the end of the initial 45-day period why the extension is necessary and when the claims administrator expects to render a decision. If, due to matters beyond the claims administrator's control, a decision cannot be made within this 30-day extension period, the claims administrator may extend the determination period for an additional **30 days**, provided you are notified prior to the end of the initial 30-day extension. The notice will explain the circumstances requiring the extension and the date when the claims administrator expects to make a decision. If you file a disability claim that is not complete, the claims administrator will notify you within **45 days** after receiving your claim of the information that is necessary to complete the claim. You will have **45 days** to provide the additional information. The claims administrator will notify you of its decision within **30 days** after receiving the additional information or within **30 days** after the 45-day deadline to provide the additional information passes, whichever is sooner.	A reasonable period of time, but not later than **45 days** after receipt of your request for review by the claims administrator. If necessary due to special circumstances, the period may be extended for an additional **45 days**. In this case, you will be notified in writing prior to the extension of the special circumstances and the date a decision will be rendered. A decision shall be made as soon as possible, but no later than **90 days** after receipt of the request for review.

Other Coverage Claims

Timing for Other Coverage Claim Decision	Timing and Notification of Other Coverage Appeal Decision(s)
Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the claims administrator. **Extension of time for processing claim—**If special circumstances require an extension of time for processing the claim, you will receive a written notice before the end of the initial 90-day period, and this extension will not exceed an additional **90 days**. The notice will explain why an extension of time is necessary and when the claims administrator expects to render a decision.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the claims administrator. If necessary, the period may be extended for an additional **60 days**. In this case, you will be notified in writing prior to the extension of the special circumstances and the date a decision will be rendered. A decision shall be made as soon as possible, but no later than **120 days** after receipt of the request for review.

Deemed Exhaustion of Internal Claims and Appeals Procedures—*Medical and Disability Coverages*

In the case of a claim for benefits under **medical coverage** to which the Affordable Care Act applies, if the Plan fails to strictly adhere to the internal claims and appeals procedures described in this Appendix, you will be deemed to have exhausted the internal claims and appeals procedures. Accordingly, you may initiate an external review as described below, as applicable. You are also entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals procedure that would yield a decision on the merits of the claim. If you choose to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

In the case of a claim for benefits under **disability coverage**, if the Plan fails to strictly adhere to the claims and appeals procedures described in this Appendix, you will be deemed to have exhausted the claims and appeals procedures. Accordingly, you will be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims and appeals procedure that would yield a decision on the merits of the claim. If you choose to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Exceptions for *De Minimis* Violations

The paragraphs above will not apply to de minimis violations of these procedures that do not cause, and are not likely to cause, prejudice or harm to you, so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing, good faith exchange of information between you and the Plan. In addition, the violation must not be a part of a pattern or practice of violations by the Plan.

With respect to a claim for **medical coverage** benefits, you may request a written explanation of the violation from the Plan, and the Plan shall provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violations should not cause the internal claims and appeals procedures under the Plan to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review as described above on the basis that the Plan met the standards for this "*de minimis*" exception, you have the right to resubmit and pursue the internal appeal of the claim and the Plan will, within a reasonable period of time (not to exceed 10 days), provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. The time periods for re-filing the claim shall begin to run upon your receipt of this notice from the Plan.

With respect to a claim for **disability coverage** benefits, you may request a written explanation of the violation from the Plan, and the Plan shall provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violations should not cause the administrative remedies under the Plan to be deemed exhausted. If a court rejects your request for immediate review as described above on the basis that the Plan met the standards for this "*de minimis*" exception, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable period of time after the receipt of that decision, the Plan shall provide you with notice of the resubmission.

External Review Process Available Under Certain Circumstances

In the case of a final internal adverse benefit determination on your appeal (described above in the **Notice of Decision on Appeal** Section of this Appendix A) under a **medical coverage** that is subject to these requirements of the Affordable Care Act, only under certain circumstances as required by the Affordable Care Act (generally, these include decisions involving "medical judgment" or a rescission of coverage), you may be entitled to request an independent, external review of the determination.

Also, under a new law called the Consolidated Appropriations Act, 2021 (CAA), which includes the No Surprises Act (Title I of division BB of the CAA) and Transparency provisions (Title II of division BB of the CAA), you may have certain additional rights, including to external review of a final adverse benefit determination relating (as required by the CAA) to coverage of emergency services received from an out-of-network provider or facility or to certain services provided by an out-of-network provider while you are at an in-network hospital.

You will be provided with information about the external review process with the notice you receive of the Plan's final internal benefit determination on your claim.

For details, refer to the Explanation of Benefits (EOB) that you receive from the medical claims administrator and/or the coverage booklet for your **medical coverage**, or contact the Plan Administrator or the claims administrator. You may also contact the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA for information about your rights or for assistance.

Eligibility Determinations Under the Plan

Eligibility Review Process and Applicable Time Periods

The Plan has a review process that is followed whenever you submit a request to participate in a coverage option or to change an election to participate during the Plan year. For example, it may be a request to begin, add, or stop participation in the Plan. *Except where the Plan Administrator has delegated this to the claims administrator* (refer to the applicable coverage booklet or contact the Plan Administrator), the Plan Administrator makes all eligibility determinations under the Plan and is authorized to administer the Plan and has the discretionary authority to interpret the Plan and decide all eligibility questions. Any decision made by the Plan Administrator in connection with the Plan is conclusive and binding on all persons.

Timing for Eligibility Determinations

The Plan Administrator will make an eligibility determination within a reasonable period of time, but not later than **90 days** after receipt of your request to participate or change an election to participate in the Plan.

Extension of Time for Processing Eligibility Determinations

If special circumstances require an extension of time for processing the request, you will receive a written notice before the end of the initial 90-day period, and this extension will not exceed an additional **90 days**. The notice will explain why an extension of time is necessary and when the Plan Administrator expects to render a decision.

How to Request Review of a Denied Eligibility Request

If you do not agree with the eligibility determination, you (or your authorized representative) may request that the determination be reviewed by the Plan Administrator. Send your request to:

Attention: Benefits Trust Committee
Ryman Hospitality Properties, Inc.
One Gaylord Drive
Nashville, TN 37214

You must file your written request for review of any eligibility determination under the Plan within **60 days** after you receive the written notification of an adverse eligibility determination. Your request for review must be in writing and must include the following:

- A summary of all the reasons why you believe your eligibility request should be granted, including any documents, records or other information relating to or that support your position; and
- Any issues or comments that you think are pertinent to your position.

Timing and Notification of Appeal Decision

Your request will be reviewed and a decision will be made within a reasonable period of time, but not later than **60 days** after receipt of the request for review by the Plan Administrator. If necessary, the period may be extended for an additional **60 days**. In this case, you will be notified in writing prior to the extension, and a decision shall be made as soon as possible, but no later than **120 days** after receipt of the request for review.

Appendix B — COBRA Continuation Coverage

If your employment ends for reasons other than gross misconduct and in certain other circumstances (called "qualifying events"), COBRA allows you and/or your eligible dependents to continue group health (for example, medical (including prescription drug), dental, and vision) coverages for a specific period of time. You (or your covered spouse or dependent children) can elect to temporarily continue coverage under the Plan if you (or your covered spouse or dependent children) would otherwise lose coverage when a "qualifying event" occurs. This continuation coverage is commonly known as COBRA coverage. Your covered spouse and each of your dependent children have the right to elect COBRA coverage even if you don't elect it. Except as described in "Important Information Regarding coverage for Certified Domestic Partners" below, *nothing in this SPD is intended to expand your rights beyond COBRA's requirements.*

You must pay the required cost of coverage. This chart shows the coverage and cost provisions for various qualifying events.

Qualifying Event	Who May Continue Coverages	Duration Of Coverage	Cost
Your employment ends for any reason other than gross misconduct	You, Your Spouse, and/or Your Dependent Children	Up to 18 months	102%
You experience a reduction in work hours that results in a loss of coverage	You, Your Spouse, and/or Your Dependent Children	Up to 18 months	102%
Your employment ends or you experience a reduction in work hours and you or a dependent are disabled or become disabled within the first 60 days of COBRA coverage	You, Your Spouse, and/or Your Dependent Children	Up to 29 months in total: Months 1-18 Months 19-29	 102% 150% (if the disabled individual's coverage is continued; otherwise 102%)
You divorce or legally separate	Your Ex-Spouse, and/or Your Dependent Children	Up to 36 months	102%
Your dependent children lose eligibility under the generally applicable provisions of the Plan (e.g., upon reaching age 26)	Your Dependent Children	Up to 36 months	102%
You die	Your Spouse and/or Your Dependent Children	Up to 36 months	102%

Qualifying Events for COBRA

Covered Employee's Termination of Employment or Reduction in Hours: If your employment terminates (for reasons other than your gross misconduct) or if your hours are reduced to the point where you would ordinarily lose coverage under the Plan, you (or your covered spouse or dependent children) may elect COBRA coverage for up to 18 months from the date of the employment termination or reduction in hours. For these 18-month qualifying events, you (or your covered spouse or dependent children) must pay 102% of the full cost of the coverage.

Covered Employee's Death: If you die while you're employed and your dependents are covered by the plan, your spouse (and any covered dependent children) may elect COBRA coverage for up to 36 months from the date of your death. If you're not married, or your spouse isn't eligible for COBRA coverage, your dependent children may elect COBRA coverage for up to 36 months from the date of your death.

Divorce or Legal Separation: If your divorce or legal separation occurs prior to termination of employment, your spouse (and any dependent children) may elect COBRA coverage for up to 36 months from the date of the divorce or legal separation. If your spouse isn't eligible for COBRA coverage, your dependent children may elect COBRA coverage for up to 36 months.

If your divorce or legal separation occurs while COBRA coverage is in effect, your covered spouse and any dependent children (only) may be able to extend coverage from 18 to up to a total of 36 months (see **"Second Qualifying Events"** below).

Child No Longer a Dependent: If your dependent child is no longer eligible for coverages under the Plan because the child no longer meets the Plan's definition of an eligible dependent, your dependent child may elect COBRA coverage for up to 36 months.

Medicare Enrollment: If within 18 months prior to your COBRA coverage effective date, you enrolled in Medicare as your primary coverage, then your spouse (and any dependent children) may elect COBRA coverage for up to 36 months from your Medicare enrollment date. If your spouse isn't eligible for COBRA coverage, your children may continue COBRA coverage for up to 36 months from your Medicare enrollment date. For example, if you became entitled to Medicare 8 months before the date on which your employment terminates, COBRA coverage for your spouse and/or children who lost coverage as a result of your termination can last up to 36 months after the date of your Medicare enrollment (also called entitlement), which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Important Information Regarding Coverage of Certified Domestic Partners

A certified domestic partner and the child(ren) of the domestic partner (unless the child(ren) are the employee's dependent(s) for this purpose under federal law) are not qualified beneficiaries under COBRA, and therefore do not have federal rights or protections under COBRA. However, the Health and Welfare Plan extends (to the extent permitted under applicable insurance policies or contracts) to certified domestic partners the opportunity to elect COBRA-like continuation coverage upon the happening of certain events (if they cause a loss of group health plan coverage), similar to the qualifying events under COBRA: These COBRA-like rights are administered in a manner, and are subject to requirements, similar to those described in this appendix and in the current YBR COBRA notices.

Refer to the Company's Domestic Partner Policy and/or contact *Your Benefits Resources*™ (YBR) for more information.

Second Qualifying Events

If your spouse and/or dependent children (only) have another qualifying event while already on COBRA coverage due to your employment termination or reduction in hours, they may elect to extend the period of COBRA coverage for up to 36 months from the date of employment termination or reduction in hours. For example, assume that you (or your spouse or dependent children) elect COBRA coverage because of your employment termination. If you die during the first 18 months of COBRA coverage, your spouse and dependent children could continue COBRA coverage for up to 36 months from your date of employment termination.

For these 36-month qualifying events, you (or your spouse or dependent children) must provide timely notice of the second qualifying event and must pay 102% of the full cost of the coverage.

Notice Requirement for Employee

If your spouse or dependent child qualifies for COBRA coverage due to a qualifying event such as divorce, legal separation, or ceasing to meet the Plan's definition of a dependent, you (or your covered spouse or dependent child) must notify the Plan Administrator. You must give this written notice prior to the qualifying event, or as soon as possible thereafter (but not more than 60 days after the qualifying event). When the Plan Administrator receives your notice, it must in turn notify you, your spouse and dependent children (individually or jointly) of the right to elect COBRA coverage. If you (or your covered spouse or dependent child) fail to provide the Plan Administrator with timely notice when one of these qualifying events occur, the right to COBRA coverage will be lost.

Extension of Coverage Period If Disabled

If, at the time of your qualifying event or within the first 60 days of COBRA coverage due to employment termination or reduction in hours, you (or a covered family member) are or become totally and permanently disabled (as determined by the Social Security Administration, or SSA) and qualify for Social Security disability benefits, COBRA coverage may be extended an additional 11 months for a total of up to 29 months, as long as such individual remains disabled.

If the disabled qualified beneficiary's coverage continues during the 11-month disability extension period, you (or your covered spouse or dependent children) must pay 150% of the full cost of coverage. This 11-month extension is available to you and each family member who would otherwise lose coverage because of the employment termination or reduction in hours. To obtain the 11-month extension, you (or a covered family member) must notify the Plan Administrator within 60 days of Social Security's disability determination and within 18 months of the original qualifying event. In the event you (or a covered family member) no longer qualify for Social Security disability benefits, you must notify the Plan Administrator within 30 days. Your (and your covered family members') COBRA coverage will then terminate as of the later of the first day of the month after the Social Security's disability determination or the end of the COBRA coverage period that applied without the disability extension.

Adding New Dependents

While on COBRA coverage, you may enroll newly-acquired adopted or newborn dependent children for COBRA coverage if you notify the Plan Administrator within 31 days of the birth or placement for adoption.

For information on adding coverage for a newly-acquired spouse, refer to the section of the **Plan Overview and Administration** booklet on **"Your Right to Special Enrollment."**

Sixty-Day Deadline to Elect COBRA

To elect COBRA coverage, you (or your covered spouse or dependent children) must submit a completed COBRA election form to the Plan Administrator within 60 days after you (or your covered spouse or dependent children) receive the election form, or if later, 60 days after coverage under the Plan would otherwise end if COBRA coverage is not elected. You (or your spouse or dependent children) cannot elect COBRA coverage after the expiration of this 60-day deadline.

Cancellation of COBRA Coverage

COBRA coverage will be cancelled if before the end of the 18-month coverage period (or, if applicable, 29 or 36-month COBRA coverage period) one of the following situations occurs:

- Premiums for the COBRA coverage aren't paid on a timely basis by you, your spouse, or your dependent child, as the case may be. To be timely, a payment must be paid within 30 days of its due date (or 45 days of the due date for the initial payment).
- After you (or your spouse or dependent children) have elected COBRA coverage under this Plan, you (or they) become covered under another group health plan. However, you (or they) may continue COBRA coverage if the other group health plan limits coverage for pre-existing medical conditions that you (or they) may have.
- After you (or your spouse or dependent children) have elected COBRA coverage under this Plan, you (or your spouse or dependent children) become enrolled in Medicare.
- The Plan terminates for all Employer employees.

Once COBRA coverage is cancelled, it won't be reinstated.

Special Health Care Flexible Spending Account (Health Care FSA and Limited Use FSA) Rules

You may be able to elect COBRA coverage for your Health Care Flexible Spending Account (either the Health Care FSA or the Limited Use FSA), though special rules apply. COBRA coverage under the Health Care Flexible Spending Account will be offered to you only if you have an underspent Health Care Flexible Spending Account. You will have an underspent Health Care Flexible Spending Account if the annual limit you elected to contribute to the account, reduced by your reimbursable claims submitted up to the time of your qualifying event, is equal to or more than the amount of your premiums for the Health Care Flexible Spending Account coverage that will be charged for the remainder of the plan year. The 18, 29 and 36-month COBRA coverage periods and the extension described above do not apply to the Health Care Flexible Spending Account. If you are eligible for COBRA coverage under the Health Care Flexible Spending Account, that coverage will continue only for the remainder of the plan year in which your qualifying event occurs.

FMLA Leave

Under special rules that apply if you do not return to work at the end of an FMLA leave (if you are covered under the Plan immediately before taking the leave), you may be entitled to elect COBRA even if you were not covered under the Plan during the leave. Please contact the Plan Administrator for more information regarding these special rules.

You May Have Other Coverage Options Besides COBRA.

Note that, instead of COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov. You can also learn more about Medicare at https://www.medicare.gov/medicare-and-you.

Special Second Election Period for Certain Eligible Employees Who Did Not Elect COBRA

Certain employees and former employees who lose coverage because of a trade-related termination of employment or reduction of hours but do not elect COBRA coverage as described above, and who become eligible for trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA), may be entitled to a second opportunity to elect COBRA continuation coverage under the Plan. This special second election period lasts for 60 days or less—it begins on the first day of the month in which the employee is eligible to receive trade adjustment assistance and ends six months after the employee's coverage under the Plan ends due to the trade-related termination of reduction of hours. If you are an employee or former employee and you qualify for TAA or ATAA, contact the Plan Administrator promptly after qualifying for TAA or ATAA and within the election period described above (and be prepared to provide a copy of the certificate you received that shows you are eligible for assistance) or you will lose any right that you may have to elect COBRA during the special second election period. Please contact the Plan Administrator for more information about the special second election period.

Appendix C — HIPAA Notice of Privacy Practices

HIPAA Notice of Privacy Practices for Protected Health Information

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.

Effective Date of this Notice: January 2026

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") requires health plans to notify plan participants about their policies and practices to protect the confidentiality of participant health information. This document is intended to satisfy the HIPAA notice requirement for all individually identifiable health information created, received, or maintained by the Plan (as defined below) sponsored by RHP Corporate Properties, LLC (the "**Company**").

This HIPAA Notice of Privacy Practices for Protected Health Information ("**Notice**") describes how protected health information may be used or disclosed by OEG Employee Health and Welfare Plan* ("**Health and Welfare Plan**") to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law (the Health and Welfare Plan is also referred to in this Notice as the "**Plan**"). This Notice also sets out the Plan's legal obligation concerning your protected health information, and describes your rights to access and control your protected health information.

Protected health information ("**PHI**") is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition in the past, present or future.

The Plan is required by law to protect and maintain the privacy of your PHI as set forth in this Notice and to provide to you and other individuals this Notice of its legal duties and privacy practices regarding PHI. The Plan is required to abide by the terms of the Notice currently in effect. The Plan is also required to notify affected individuals in the event of a breach involving unsecured protected health information.

The Plan reserves the right to change the terms of this Notice at any time. The Plan reserves the right to make the revised or changed Notice effective for PHI that the Plan already has about you, as well as any information the Plan receives in the future. If the Plan makes a material change to the Notice, it will post the revised Notice on the website and will provide a copy to you. A copy of the current Notice is available on the ADP website at https://workforcenow.adp.com (Home tab) under **Benefits Information**.

**This Notice of Privacy Practices applies only to the health care components (e.g., the Health Care Flexible Spending Account Program, which includes the Health Care FSA and the Limited Use FSA) of the Health and Welfare Plan. Where a coverage is fully insured, the insurance carrier will provide its own HIPAA Notice of Privacy Practices (for example, Vision Service Plan (VSP) provides the notice with respect to the vision coverage it insures).*

HOW THE PLAN USES AND DISCLOSES YOUR PHI

The Plan may use and disclose your PHI as described below. The Plan is required to comply with any state laws that impose stricter standards than the uses and disclosures described in this Notice. Your PHI may be stored and disclosed electronically.

For Purposes of Treatment: The Plan may use or disclose your PHI for treatment purposes. "Treatment" is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose your PHI to a health care provider when needed by the provider to treat you.

To Make or Obtain Payment: The Plan may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits. Further, the Plan may disclose your PHI when a provider requests information regarding your eligibility for coverage, or the Plan may use your PHI to determine if a treatment that you received was medically necessary.

To Conduct Health Care Operations: The Plan may use or disclose PHI for their own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. "Health care operations" includes quality assessment and improvement activities, activities designed to improve health or reduce health care costs; case management and care coordination; contacting participants with information about treatment alternatives and other related functions, and business management and general administrative activities of the Plan, including customer service and resolution of internal grievances. For example, the Plan may use PHI to conduct case management, quality improvement and utilization review, or to engage in customer service and grievance resolution activities. *However, the Plan is prohibited from using or disclosing genetic information for underwriting purposes, such as determinations of eligibility or benefits, or for setting premium or contribution rates.*

For Disclosure to the Company: In accordance with HIPAA requirements, the Plan may disclose your PHI to the Company as the plan sponsor of the Plan ("**Plan Sponsor**") for plan administration functions performed by Plan Sponsor on behalf of the Plan. Unless authorized by you in writing, your PHI may not be used by the Company for any employment-related actions or decisions or in connection with any other employee benefit plan sponsored by the Company. In addition, the Plan may provide summary health information to the Plan Sponsor so that it may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan also may disclose to the Plan Sponsor information on whether you are participating in the Plan.

Business Associates: The Plan contracts with individuals and entities ("**Business Associates**") to perform various functions on the Plan's behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, transmit, use, and/or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard the information. The Plan's Business Associates include its third party administrator(s), which administer(s) many of the functions in connection with the operation of the Plan, and other companies which provide services or products which support the operation of the Plan.

When Legally Required: The Plan will use or disclose your PHI when it is required to do so by any federal, state or local law.

For Public Health Activities: The Plan may use and disclose your PHI for public health activities authorized by law, such as communicable disease reporting.

For Health Oversight Activities: The Plan may disclose your PHI to a government health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action, and similar activities.

To Report Abuse, Neglect, or Domestic Violence: As authorized by law, the Plan may disclose your PHI to a government authority if the Plan believes that you have been a victim of abuse, neglect, or domestic violence.

In Connection with Judicial and Administrative Proceedings: The Plan may disclose your PHI in response to an order of a court or administrative tribunal. The Plan also may disclose your PHI in response to a subpoena, discovery request, or other lawful process, but only when reasonable efforts have been made either to notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes: As authorized by law, the Plan may disclose your PHI to a law enforcement official for certain law enforcement purposes.

To Coroners, Medical Examiners, and Funeral Directors: The Plan may disclose your PHI to coroners, medical examiners, and funeral directors, as authorized by law, prior to and in reasonable anticipation of death.

For Organ, Eye, or Tissue Donation: The Plan may use or disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of facilitating the donation and transplantation.

For Research Purposes: The Plan may use or disclose your PHI for research if certain requirements are met, such as approval by an institutional review board.

In the Event of a Serious Threat to Health or Safety: The Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.

For Specified Government Functions: In certain circumstances, the Plan may use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

For Workers' Compensation: The Plan may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Communication with Family/Disaster Notification: Unless you object, the Plan may disclose to your family members or others involved in your care or payment for your care, information relevant to their involvement in your care or payment for your care, or information necessary to inform them of your location and condition. The Plan also may release information to disaster relief agencies so they may assist in notifying those involved in your care of your location and general condition.

AUTHORIZATION TO USE OR DISCLOSE PHI

Other than as stated above, the Plan will not use or disclose your PHI, other than with your written authorization. Subject to compliance with limited exceptions, the Plan will not use or disclose psychotherapy notes (when such notes are maintained by the Plan), use or disclose your PHI for marketing purposes, or sell your PHI unless you have signed an authorization.

If you (or your representative) provide a written authorization to the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time to stop future uses or disclosures. However, the revocation will not be effective for information that the Plan already has used or disclosed, relying on the authorization, before you notified the Plan of your decision to revoke the authorization.

IMPORTANT INFORMATION ABOUT YOUR GENETIC INFORMATION

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Plan requests that you not provide any genetic information when responding to a request for medical information.

"Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

You have the following rights regarding your PHI that the Plan maintains. *You can exercise any of these rights by sending your written request to the contact designated under "**Contact Person**" below.*

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your PHI. However, the Plan is not required to agree to your request, except for requests to restrict disclosures to the Plan when you or someone on your behalf has paid in full out-of-pocket for your care and when the disclosures are not required by law. If the Plan agrees to a restriction, the Plan will comply with your request unless the information is needed to provide you emergency treatment.

Right to Receive Confidential Communications: You have the right to request that the Plan communicate with you through alternative means or locations. The Plan will not request that you provide reasons for your request and will accommodate your reasonable requests. The Plan may require you to provide information on how payment will be handled and an address or other method to reach you. Requests must be made in writing.

Right to Inspect and Copy Your PHI: You have the right to inspect and copy your PHI that is used to make decisions about your Plan benefits, by making a request in writing. If you request a copy of your health information, the Plan may charge a reasonable fee for its labor and supply costs for creating the copy and postage, if applicable. If your information is stored electronically and you request an electronic copy, the Plan will provide it to you in a readable electronic form and format.

Right to Amend Your PHI: If you believe that your PHI records are inaccurate or incomplete, you may request that the Plan amend the records. A request for an amendment of records must be made in writing and must include a reason to support your request. The Plan may deny the request if it does not include a reason to support the amendment and for other certain reasons, including that the records are accurate and complete.

Right to an Accounting of Disclosures of PHI: You have the right to request a list of disclosures of your PHI made by the Plan for certain reasons. The list will not include disclosures we are not required to record, such as disclosures made pursuant to your authorization. The Plan will provide the first accounting you request during any 12-month

period without charge. Additional accounting requests made during the same 12-month period may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable. Requests must be made in writing.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have already received this Notice or previously agreed to receive the Notice electronically. A copy of the current Notice is available on the ADP website at https://workforcenow.adp.com (Home tab) under **Benefits Information**.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan. You may also file a complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services, generally within 180 days of the date the violation occurred.

Any complaints to the Plan must be made in writing to the contact designated under "**Contact Person**" below. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Plan has designated the Executive Vice President, General Counsel & Corporate Secretary of Ryman Hospitality Properties, Inc. as its Privacy Officer and contact person for all issues regarding privacy of the Plan and exercising your privacy rights. You may contact the Privacy Officer, in writing, at:

Ryman Hospitality Properties, Inc.
Attention: HIPAA Privacy Office
One Gaylord Drive
Nashville, TN 37214

If you have any questions regarding this notice or any privacy-related practices please contact the Privacy Office at the address above, by e-mail at HIPAA@RymanHP.com, or by phone at (615) 316-6000.

ADDITIONAL INFORMATION

This Notice does not create any right to employment for any individual, nor does it change the Company's rights to discipline or discharge any of its employees in accordance with its applicable policies and procedures or to amend or terminate the Plan at any time.

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