Ryman Hospitality Properties Employee Health and Welfare Plan

Flexible Spending Accounts (FSAs)

a part of the

Summary Plan Description (SPD)

(Updated effective as of January 1, 2024)

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Introduction

The Flexible Spending Accounts (FSAs) offer benefits-eligible employees the opportunity to pay certain health care and dependent care expenses with before-tax dollars. By paying for these expenses with before-tax dollars, you may be able to reduce your taxable income and pay fewer taxes. This may, in turn, provide you with more take-home pay. The Flexible Benefits Plan portion of the Ryman Hospitality Properties Employee Health and Welfare Plan (the Plan) has three types of FSAs—two kinds of Health Care Flexible Spending Accounts and a Dependent Care FSA:

Health Care Flexible Spending Accounts

- The ***Health Care Flexible Spending Account (Health Care FSA)***, *not available to an employee enrolled in the HDHP with HSA medical option under the Plan*, can be used to pay for most out-of-pocket medical, prescription, dental, vision or other health care expenses for yourself and your dependents as long as these expenses are not covered by the Plan (or another plan); and
- The ***Limited Use Flexible Spending Account (Limited Use FSA)***, *available to an employee enrolled in the HDHP with HSA medical option under the Plan*, can be used only to pay for out-of-pocket dental and vision expenses for yourself and your dependents as long as these expenses are not covered by the Plan (or another plan).

Dependent Care Flexible Spending Account

- The ***Dependent Care Flexible Spending Account (Dependent Care FSA)*** can be used to pay for eligible day care expenses for a dependent child or adult relative while you and/or your spouse (if you are married) work, or while your spouse is a full-time student or disabled.

These are separate accounts for separate purposes. The funds in one account cannot be used to satisfy expenses in the other account. You can participate in one of the Health Care Flexible Spending Accounts or the Dependent Care FSA or one of the Health Care Flexible Spending Accounts and the Dependent Care FSA—or none at all—depending on your needs.

Contributions to these accounts are made through payroll deductions on a before-tax basis. After you have incurred an eligible expense, you should submit a claim for reimbursement. The reimbursements you receive are tax-free.

Be sure you learn as much as possible about the FSAs before you enroll. This will help you properly estimate your contributions, which is important because the law requires you to forfeit your unused contributions to the Dependent Care FSA and any unused contributions in excess of the applicable carryover amount (this currently is $640) in the Health Care FSA or Limited Use FSA at the end of the plan year. The FSAs operate on a calendar plan year.

Notwithstanding anything in this booklet to the contrary, the Dependent Care FSA is not an employee welfare benefit plan and is not subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

About this Material

This booklet provides a summary of the coverage available through the FSAs—the Health Care Flexible Spending Account (Health Care FSA), the Limited Use Flexible Spending Account (Limited Use FSA), and the Dependent Care Flexible Spending Account (Dependent Care FSA). The Health Care FSA, Limited Use FSA, and Dependent Care FSA are each a part of the Plan. Important information about the Plan can be found in the **Plan Overview and Administration Information** booklet which, together with this booklet, forms the Summary Plan Description (SPD) for the FSAs. These booklets should be read together and kept together.

Not all Plan provisions, limitations, and exclusions are included in this booklet. Detailed provisions are described in the official Plan documents. Copies of these documents are available from Human Resources for your inspection during normal business hours. In the event of any conflict between the information in this booklet and the Plan documents, the Plan documents will govern.

If you have any questions about the program, you should direct these questions to the Human Resources Department.

Although Ryman Corporate Properties, LLC (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.

Si usted tiene preguntas acera del Plan, por favor llame *Your Benefits Resources*™ al 1-888-GET-YBR1. Interpretes en Español estan disponibles para asistir con su llamada.

FSA - Quick Reference Guide

The FSAs are administered by *Smart-Choice Accounts*™. *Smart-Choice Account*'s contact information is:

Smart-Choice Accounts™
P.O. Box 785040
Orlando, FL 32878-5040

Telephone: 1-888-GET-YBR1
Fax: 1-888-211-9900
Web site: log on to the YBR Web site at www.ybr.com/ryman and select the *Flexible Spending Account* link.

— Steps To Follow	— About the FSAs
— Before Enrollment (Decide in which FSA(s) to enroll)	**Health Care Flexible Spending Accounts** ■ Health Care FSA: minimum election of $50 per year; up to the Plan maximum for the plan year (currently $3,200); or or ■ Limited Use FSA: minimum election of $50 per year; up to the Plan maximum for the plan year (currently $3,200) **Dependent Care Flexible Spending Account** ■ Dependent Care FSA: minimum election $50 per year; maximum up to $5,000 per year (or $2,500 if married, filing separately)
— During Annual Enrollment (or when you first become eligible)	■ For the Health Care FSA, estimate your out-of-pocket expenses for all health care (medical, Rx, dental, vision, etc.) expenses not covered by a plan ■ For the Limited Use FSA, estimate your out-of-pocket dental and vision expenses not covered by a plan ■ For the Dependent Care FSA, calculate your estimated dependent day care expenses using the guidelines in this booklet
— During the Plan Year	■ Before-tax contributions from your pay go into your account(s) ■ You file a claim for tax-free reimbursements from your account(s) to pay for eligible expenses ■ Make changes in FSA contributions that are consistent with employment and other changes in status (subject to IRS guidelines).

— Steps To Follow	— About the FSAs
— At Plan Year-End	■ All claims for reimbursement of eligible expenses for a plan year—including all supporting documentation—must be received by the Plan no later than the March 31 following the end of the plan year ■ "Use it or lose it"—the IRS requires that any money left unclaimed in your Dependent Care FSA at the end of the year, and any unused funds in excess of the applicable carryover amount (this currently is $640) in your Health Care FSA or your Limited Use FSA (described immediately below) at the end of the year will be forfeited. For this reason, it is important to contribute only what you expect to pay for eligible expenses. ■ Any unused funds in your Health Care FSA or Limited Use FSA (up to a current maximum of $640), called the "carryover" amount, will be carried over into the following plan year, to be used to pay for eligible expenses incurred in that next plan year. The carryover amount will not count against the amount you may elect to contribute for that next plan year. For example, even if $640 is carried over from 2024 into the following plan year (2025), you could still elect to contribute the maximum annual contribution (currently, $3,200) to your Health Care FSA or Limited Use FSA for that next plan year. Note that if you have carryover funds remaining in your Health Care FSA at the end of the plan year, and you elect to participate in the HDHP with HSA medical option for the next plan year, your carryover funds will be converted to a Limited Use FSA so as not to disqualify you from contributing to your Health Savings Account (HSA) during that next plan year.

Participating in the FSAs

Eligibility

Participation is voluntary. You are eligible to contribute to the FSAs if you are a benefits-eligible employee as described in the **Plan Overview and Administration Information** booklet of the SPD.

How to Enroll

To enroll for coverage through the FSAs the following procedures apply:

- **Making contribution elections as a new hire**: Within 31 days of your eligibility date, you must enroll for benefits for the rest of the current plan year through *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 or www.ybr.com/ryman.
- **Making contribution elections during annual enrollment**: During the annual enrollment period, you choose your benefits for the following plan year. At that time, you may elect to enroll (or reenroll) in the applicable FSA(s). You will receive materials to help you make your benefit choices and complete the enrollment process. **You must make a new election every year.** You must enroll through *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 or www.ybr.com/ryman.
- **Making new contribution elections in line with a change in status**: You will have 31 days from the date of your qualifying change in status to elect new coverage consistent with your change in status. To process a change, call *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 and speak with a Customer Care Representative. (See the section "Changing Your Elections" for more information).

Cost

The Internal Revenue Service (IRS) and the Plan limit the amount you can contribute to an FSA as shown in the table below.

— Type of FSA	— Minimum Annual Contribution	— Maximum Annual Contribution
— **Health Care FSA**	— $50	— $3,200±
— **Limited Use FSA**	— $50	— $3,200±
— **Dependent Care FSA**	— $50	— $5,000*

±The maximum annual contribution election amount for the current (2024) plan year is $3,200, and is subject to change in future plan years (as determined by the Company and subject to the limit set by the IRS). The limit for the applicable plan year will be described in the enrollment materials for that year.

*If you are married, and filing separate income tax returns, the maximum you can contribute to the Dependent Care FSA is $2,500. In addition, if you are married, your contributions to this account cannot exceed the lesser of your or your spouse's annual income. If you are single, legally separated, divorced or in a domestic partner relationship, you may contribute the full $5,000 if you claim the child on your tax returns.

Under federal law, the pre-tax Dependent Care benefits received by non-highly compensated employees in a year must be at least 55% of the Dependent Care benefits received by highly compensated employees in the same year. If the Plan does not satisfy this 55% test, then federal law requires the Company to reduce the pre-tax Dependent Care benefits received by highly compensated employees to the extent necessary to pass the test. Other nondiscrimination requirements also apply to the FSAs and may impact your contributions. You will be notified during the year if you are affected.

When Participation Begins

Your participation begins on your eligibility date, provided you enroll within 31 days of your eligibility date. If you enroll during the annual enrollment, your coverage begins on the following January 1. Only eligible expenses incurred after your participation begins will be reimbursed from your FSA.

Changing Your Elections

Your FSA contributions generally remain in effect from January 1 through December 31. However, you may change your contribution elections during the plan year if you have a qualifying change in status, as permitted by IRS regulations (and other guidance) and as determined by the Plan Administrator. Any change you make to your FSAs must be consistent with and due to the change in status you experience.

A **qualifying change in status** generally includes:

- Your marriage, divorce, or legal separation;
- The birth or adoption of a child;
- A change in residence or worksite for you, your spouse, or dependent;
- Death of your covered child or spouse;
- Your dependent either becoming eligible or no longer meeting eligibility requirements;
- A loss or gain of coverage if your spouse's employment status changes;
- A change from part-time employment to full-time, or vice-versa, for you, your spouse, or dependent; and
- The start of an unpaid leave of absence for you or your spouse.

A qualifying change in status generally must result in either a gain or loss of eligibility for you or your spouse's or other dependent's plan. You can make coverage changes by calling *Your Benefits Resources*™ (YBR) at 1-888-GET-YBR1 and speaking with a Customer Care Representative or by visiting www.ybr.com/ryman. You may be required to submit timely documentation evidencing the change in status.

If you have a qualifying status change during the year and need to change your coverage outside of the annual enrollment period, you must do so within 31 days of the event that makes the change necessary. Otherwise, you cannot make a coverage change before the next annual enrollment period unless you or your eligible family member has another qualifying change in status.

In addition you may change your Dependent Care FSA election when there is a change in providers, a change in care costs, or such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with IRS regulations (and other guidance).

When Participation Ends

Your participation automatically ends on December 31 each year (unless you participated in one of the Health Care Flexible Spending Accounts and the carryover rule described in this booklet applies). Otherwise, you must re-enroll during annual enrollment to maintain an FSA for the following calendar year.

Your participation also ends:

- On the last day of the month in which you terminate;
- On the last day of the month in which you transfer to an ineligible status;
- If you fail to make any required contributions; and
- If the Company terminates the Plan.

When your participation ends, contributions to your FSA will stop as of the pay period in which your participation ended. You can file for any reimbursement of any available balances in your Health Care FSA or Limited Use FSA for any eligible expenses incurred on or before your participation ending date. You can file for any reimbursement of any contributions made to your Dependent Care FSA for any eligible expenses incurred through the end of the plan year.

Coverage During a Leave

There are four types of leaves of absence that you can take from the Company and still be treated as an employee of the Company while on that leave. The four types of leave are:

1. Short Term Disability (STD) Leave
2. Family and Medical Leave (FMLA)
3. Personal Leave of Absence (PLOA)
4. Military Leave of Absence

Participation in FSAs While on Unpaid Leave of Absence (including STD, FMLA, PLOA and Military Leave)

Due to IRS regulations, if you take an unpaid leave of absence (such as to care for a sick family member or due to your own illness), you will only be able to continue coverage under the Health Care FSA or Limited Use FSA by continuing to pay your contribution on an after-tax basis during your leave. You will be direct billed by YBR. Unless you continue your contributions during the leave, any health care expenses you incur while on leave cannot be reimbursed by the Health Care Flexible Spending Accounts. At the end of the qualifying leave of absence, you can also have your previous benefits reinstated, if you contact YBR within 31 days. Your contributions to the Dependent Care FSA will stop and any dependent care expenses you incur while on unpaid leave will not be eligible for reimbursement. You will need to re-enroll in the Dependent Care FSA upon return from your leave, by contacting YBR within 31 days.

Workers' Compensation and FSAs

If you are not actively at work while you are receiving workers' compensation benefits, but are still receiving a payroll check from the Company, your contributions to the Health Care FSA or Limited Use FSA and/or Dependent Care FSA will remain in effect at the same deduction amount as before you leave, provided the amount of the payroll check is sufficient to cover the full deduction.

Continuing Participation Under COBRA

If you or your dependents would otherwise lose your coverage under the Health Care FSA or Limited Use FSA because of a reduction in your working hours, termination of employment, death, legal separation, divorce or your dependent becoming ineligible, or reasons other than gross misconduct, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and/or your dependents to continue your participation in the Health Care FSA or Limited Use FSA coverage until the end of the current plan year under certain circumstances (if your FSA is not overspent). If you elect to make the required contributions and continue coverage under the terms of COBRA, you can continue to use your account for expenses incurred after you terminate employment, up to the end of the current plan year. If you do not wish to continue coverage under COBRA, you may continue to submit claims for expenses incurred before your qualifying event.

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. To continue participation, you must make a contribution of 102% of your regular contribution, with the additional 2% being an administrative fee.

COBRA coverage continues until the earliest of the following:

- You or a covered dependent no longer make contributions for coverage;
- You or a covered dependent become covered by other coverage, including Medicare, that does not restrict coverage for pre-existing conditions; or
- The plan year ends.

For more information on continuation of coverage under COBRA, including important notice requirements that apply, refer to **Appendix B** of the **Plan Overview and Administration Information** booklet of the SPD or contact the Human Resources Department.

How the FSAs Work

Your Options

The Company offers three types of FSAs—two Health Care Flexible Spending Accounts and a Dependent Care Flexible Spending Account:

- The ***Health Care Flexible Spending Account (Health Care FSA)***, *not available to an employee enrolled in the HDHP with HSA medical option under the Plan*, allows you to put aside money on a before-tax basis to pay for your medical, prescription, dental, vision or other health care expenses that are not covered by any plan; or

- The ***Limited Use Flexible Spending Account (Limited Use FSA)***, *available to an employee enrolled in the HDHP with HSA medical option under the Plan*, allows you to put aside money on a before-tax basis to pay for your dental and vision expenses that are not covered by any plan.

- The ***Dependent Care Flexible Spending Account (Dependent Care FSA)*** allows you to put aside money on a before-tax basis to pay for a child's day care or the day care of a dependent adult while you and/or your spouse (if you are married) work, or while your spouse is a full-time student or disabled.

Each year during annual enrollment, you indicate how much you want to contribute to each of the Health Care FSA or Limited Use FSA and the Dependent Care FSA. Any amounts carried over to your Health Care FSA or Limited Use FSA from a prior year will not affect the maximum amount you can contribute to your Health Care FSA or Limited Use FSA for the current year.

Starting January 1 (or the date you make your election if you are a new hire), a prorated portion of your pay is deducted each pay period before federal income and Social Security taxes (and, where applicable, state and local taxes) are withheld.

When you incur eligible expenses during the year, you pay for them out-of-pocket (unless you use the Smart-Choice debit card described in **"The Health Care Flexible Spending Accounts Debit Card Program"** section of this booklet).

You request reimbursement from the accounts for expenses incurred during the calendar year. Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

Eligible Expenses incurred between January 1 and December 31 of the calendar year will be reimbursed, as long as they are submitted to Smart-Choice Accounts by March 31 of the next calendar year.

Under your Health Care FSA or Limited Use FSA, the total amount of your reimbursement during any calendar year cannot exceed the total amount that you have elected to contribute for that year, plus any carryover amounts (currently up to $640 of unused funds) from the prior year. You may receive reimbursement from your Health Care FSA or Limited Use FSA up to the total amount that you have elected

to contribute for that year plus any carryover amounts (and less any reimbursements you have already received for that year), at any time during the year, even if you have not yet contributed the money to your Health Care FSA or Limited Use FSA.

Under the Dependent Care FSA, the total amount of your reimbursement during any calendar year cannot exceed the total amount that you have elected to contribute for that year; and the amount of any reimbursement under the Dependent Care FSA you can receive at any point during the year may not exceed that amount you have contributed to your Dependent Care FSA (less any reimbursements you have already received for that year) through the date of reimbursement.

You have until March 31 of the year following the plan year to submit claims incurred during that plan year.

Expenses that were incurred while you were not a participant in the Health Care FSA or Limited Use FSA are not eligible for reimbursement. For Dependent Care FSA participants whose period of coverage ends before the end of the plan year, you may submit a claim for eligible expenses (up to amount contributed) that are incurred during the period beginning on the first day of your participation through the last day of the plan year.

Account Restrictions

The IRS restricts FSAs in several ways:

- Money contributed to any one spending account cannot be used to pay expenses from the other.
- **If there is any money left in your Health Care FSA or Limited Use FSA after the deadline for filing reimbursement requests, up to the full carryover amount (currently $640) of those unused funds will be carried over into your Health Care FSA or Limited Use FSA (as applicable) for the following plan year, to be used for reimbursements in that year.** Any amounts in excess of the carryover amount cannot be returned to you, and any forfeited deposits will be used to pay the costs of administering the accounts. (This $640 carryover amount is subject to change in future years—refer to the enrollment materials for the carryover amount applicable for a future plan year.)
- Only eligible expenses incurred while you are covered by the Health Care FSA (any eligible health care expenses) or Limited Use FSA (eligible dental and vision expenses only) may be submitted for reimbursement.
- **If there is any money left in your Dependent Care FSA after the deadline for filing reimbursement requests, the excess contribution cannot be returned to you.** (This is called the “use it or lose it” rule.) Forfeited deposits will be used to pay the costs of administering the accounts.
- Only eligible dependent care expenses incurred in the plan year (beginning with your participation date) for which you’ve made contributions to the Dependent Care FSA may be submitted for reimbursement.
- All claims for eligible expenses for a plan year must be received for reimbursement no later than March 31 following the end of the Plan year.

Account Statements

Active participants with remaining FSA balances will receive a statement in the fourth quarter showing available FSA balances and amounts paid to date from their FSA(s).

The Tax Advantage

Making before-tax contributions through automatic payroll deduction lowers the amount of current income taxes and Social Security taxes that you would otherwise be required to pay. This is because the tax withheld from your pay will be based on your pay after your contributions to your FSAs rather than on your total pay. In effect, the government is giving you a discount on your eligible health care or dependent day care expenses, typically a discount equal to your total tax rate, which could be 20% - 40% or more.

You may want to check with your tax advisor before enrolling in any of these accounts to determine if they are the best alternatives for your needs.

Effect on Social Security Benefits

Because you do not pay Social Security taxes on your contributions, your FSA contributions may reduce your wages reported for Social Security purposes. The effect on your future Social Security benefit at disability or retirement is usually very small.

Health Care Flexible Spending Accounts

The Health Care Flexible Spending Account (Health Care FSA) reimburses you for your health-related expenses that are recognized by the IRS as deductible medical expenses, and are not paid by the Company health care plans, or by any other plan or insurance under which you may be covered. The Limited Use Flexible Spending Account (Limited Use FSA) only reimburses for eligible dental and vision expenses.

Eligible Dependents

You can use the Health Care FSA or Limited Use FSA for your qualifying (under tax law) dependents' health-related expenses, even if you do not cover those family members under the Company medical or dental plans. Your eligible dependents are generally your spouse and those whom you may claim as a dependent on your tax return.

Note: *Because domestic partners and their dependents are generally not considered qualifying dependents under the Internal Revenue Code, benefits cannot be provided to them on a before-tax basis. Since contributions to the Health Care FSA or Limited Use FSA are made on a before-tax basis, the law does not allow you to be reimbursed for expenses incurred by domestic partner or his or her children from this account, unless they are also your spouse and/or dependents for this purpose under the Internal Revenue Code.*

Eligible Health Care Expenses

Eligible expenses can be reimbursed from your Health Care FSA or Limited Use FSA if the expense is incurred during the time you participate in the account within the plan year. Expenses are eligible only to the extent that they are not paid by another benefit plan or insurance you may have. In most cases, expenses are considered eligible if the IRS considers them deductible for income tax purposes. To see a listing of eligible expenses please go to www.ybr.com/ryman and click on *Smart-Choice Accounts*. For the Limited Use FSA, only eligible dental and vision expenses are reimbursable.

Here is a partial list of eligible health care expenses that are reimbursable under the Health Care FSA:

- Medical insurance deductibles, copayments, and coinsurance;
- Prescription medication;
- Over-the-counter drugs and medicine;
- Insulin; and
- Menstrual care products.

For a complete list of expenses allowed by the IRS, contact your tax advisor or refer to the IRS Publication 502, available by calling 1-800-TAX-Form (829-3676) or by visiting the IRS web site at www.IRS.gov. Use IRS Publication 502 with caution however, because it is meant to help taxpayers determine what medical expenses can be deducted, not what is reimbursable under a health care flexible spending arrangement (like the Health Care FSA). There are some differences between the two categories.

Expenses Not Covered

The IRS has a list of health care expenses it does not consider reimbursable from a health care flexible spending account. To see a listing of expenses that are not eligible for reimbursement under the Health Care FSA please go to www.ybr.com/ryman and click on *Smart-Choice Accounts*.

Here is a partial list of ineligible health care expenses:

- Medical or dental or other insurance premiums;
- Vitamins, herbal and dietary supplements;

- Athletic club memberships, spas and non-prescribed weight loss plans;
- Marriage counseling fees
- Toothpaste, cosmetics, toiletries;
- Funeral and burial expenses;
- Nurse care for healthy child;
- Long-term care services or premiums; and
- Cosmetic surgery or similar procedures, unless necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from accident or trauma, or a disfiguring disease.

Health Care Flexible Spending Account or Income Tax Deduction

You can pay for health care expenses through your Health Care FSA or Limited Use FSA **or** claim the expense as a health care expense on your income tax return. **You cannot do both.**

To deduct health care expenses on your income tax return, your health care expenses for the year must exceed the current allowable deduction amount as determined by the IRS.

When you use your Health Care FSA or Limited Use FSA, all eligible health care expenses, up to the Plan's maximum (currently $3,200) per year, plus up to the full carryover amount (currently $640), are paid with tax-free dollars. **However, you cannot take a tax deduction for any expenses reimbursed through your Health Care FSA or Limited Use FSA. Please consult a tax advisor to determine whether you should participate in an FSA or use the income tax deduction.**

The Heath Care Flexible Spending Accounts Debit Card Program

The *Smart-Choice* debit card program, featuring the Smart-Choice MasterCard®, is a fast way for you to pay for eligible health care expenses that aren't covered by insurance, if you've chosen to contribute a minimum of $50 to your Health Care FSA. As you use your card, eligible health care expenses will be deducted automatically from your account.

Note: *Dependent care expenses are not eligible for reimbursement through the debit card program.*

How to Use Your Smart-Choice Debit Card

When you enroll in the Health Care FSA or Limited Use FSA and elect to contribute more than $50 for the plan year, you will receive a package containing one Smart-Choice debit card issued in your name, activation instructions, a Cardholder Agreement, and information explaining approved use of the card. You may request additional cards for your spouse and/or dependent through the *Smart-Choice Accounts* web site at no additional charge.

Your Smart-Choice debit card remains active as long as you have a positive account balance, continue to participate in a Health Care Flexible Spending Account, and remain actively employed. Your card will be cancelled upon termination of employment—inactive participants may not use the card. By signing and using your Smart-Choice debit card, you certify that:

- You will only use the card for your own eligible health care expenses and those of your eligible dependents.
- Any expense paid with the card has not been, or will not be, reimbursed by another source.

The Smart-Choice debit card has been designed for use at merchants and providers that primarily provide health services and prescriptions (for example, pharmacies, physician's offices, hospitals, and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to use it as either "credit" or as "debit." If you choose the credit option you must provide your signature. If you choose debit, you must use your personal four-digit Personal Identification Number (PIN) that you set up when your Smart-Choice debit card was issued.

To protect cardholders from unauthorized Smart-Choice debit card purchases, *Smart-Choice Accounts* has set transaction amount limits that can be charged for various service and provider categories. Only in rare

cases (involving unusually large expenses) should you experience a problem in using your card. A complete listing of service and provider limits is available on the *Smart-Choice Accounts* web site.

Important: Save your receipts.
Because the IRS requires that all debit card transactions be verified as eligible health care expenses, you will be required to provide *Smart-Choice Accounts* with supporting documentation to validate your expenses. Make sure that you save all of your itemized receipts (indicating the date of service, name of the service provider, name of the product or service, and any amount paid by other coverage). Refer to the Cardholder Agreement for more information.

The Smart-Choice debit card has a three-year expiration. However, the card can only be used in plan years during which you've made contributions to a Health Care Flexible Spending Account. Keep in mind that the contribution amount for one plan year cannot be accessed through the card after the end of that year, except for any carryover amount (currently, up to $640). If you reenroll in the Health Care Flexible Spending Account for the following year, the new contribution amount will be available through the card at the start of the second plan year.

Note: *After the end of any given plan year, expenses incurred in the prior plan year can only be submitted through the manual claim process.*

Lost or Stolen Cards

If your Smart-Choice debit card is lost or stolen—or you believe that there has been any unauthorized use of your card—you must contact Customer Service immediately at 1-888-GET-YBR1. Customer Service Representatives are available to assist you between 7:00 a.m. and 7:00 p.m. Central time, Monday through Friday (excluding applicable holidays). After normal business hours, you may call 1-866-438-5797 to report a lost or stolen debit card.

Validation of Smart-Choice Debit Card Transactions

As required by the IRS, all Smart-Choice debit card transactions must be validated as eligible health care expenses. This process involves requesting receipts or other supporting documentation from you to verify that the Smart-Choice debit card transaction has been approved as an eligible health care expense. All Smart-Choice debit card transactions will be validated electronically at the pharmacy or via paper documentation after purchase. You should retain your receipts for all transactions, as they will be required for validation purposes.

Automatic Validation with Approved Merchants

When you purchase eligible health care items by using your Smart-Choice debit card with approved merchants, your transaction can be validated automatically without having to provide an itemized receipt or supporting documentation. To be "approved," a merchant must have an inventory information approval system (IIAS) installed. These IIAS-certified merchants have the ability to identify eligible items at the point of sale, which eliminates the need for additional documentation. They have programmed their systems to only allow eligible items and services to be processed on the Smart-Choice debit card.

Any ineligible items must be paid for with another form of payment. For a complete listing of eligible expenses and approved merchants, visit the *Smart-Choice Accounts* web site. Please note that the listing is subject to change at any time.

Automatic Validation for Other Medical Providers

Your Smart-Choice debit card can also be used for other types of health care transactions without the need for submission of itemized receipts or further review. These transactions include recurring expenses, and copayments. Below is a brief explanation of each type of transaction.

Recurring Transactions

If you purchase an eligible health care item or service using your Smart-Choice debit card and provide the requested supporting documentation, that same item or service will be validated automatically the next time you purchase it with your Smart-Choice debit card (at the same provider and for the same dollar amount).

In addition, any recurring Smart-Choice debit card transactions will carry over to the new plan year for participants who reenroll in a flexible spending account—this means you'll be able to continue purchasing the same health care item or service (provided that the dollar amount does not change) without having to submit supporting documentation to *Smart-Choice Accounts* again the following plan year.

Copayments

Your Smart-Choice debit card will be programmed to recognize your plan's copayment amounts without any additional validation being required (for example, a $25 copayment at a physician's office).

Supporting Documentation

Manual claim submission and supporting documentation are sometimes required for the purchase of any health care service or item that isn't validated automatically. These types of purchases are conditionally reimbursed, pending validation of the expenses.

The process for supporting documentation is outlined below:

- The merchant is reimbursed for the amount of the charge, and your available Health Care Flexible Spending Account balance is reduced.
- You'll be sent a letter, text or e-mail informing you that itemized receipts or other documentation are required to validate the Smart-Choice debit card transaction.
- If the documentation you provide is insufficient, you'll be sent a letter, text or e-mail instructing you to provide more documentation.

Expenses for which you don't provide adequate documentation are considered ineligible and treated as overpayments. See the "**Overpayment Process**" section for more information.

Overpayment Process

If you purchase products or services with your Smart-Choice debit card that are not eligible for reimbursement through your Health Care Flexible Spending Account, you will receive notification from *Smart-Choice Accounts* that your transaction has been deemed an overpayment.

The primary situations that could result in an overpayment are:

- Your failure to respond to substantiation requests for Smart-Choice debit card transactions within 30 days after the initial request was sent by *Smart-Choice Accounts*.
- Your Smart-Choice debit card transactions were authorized at the point-of-sale, and then later deemed ineligible after the substantiation process was completed.
- Paper claim adjustments were made because of contribution amount changes, ineligible expenses, or improper processing of the claim.

Once an overpayment has been identified, the following actions will be taken immediately:

- Your Smart-Choice debit card will be suspended and will remain suspended until the overpayment is recovered.
- You'll be notified, via e-mail or by a mailed notification if no e-mail address is on file for you, that you must refund the overpayment by mailing a check to *Smart-Choice Accounts*.
- Future paper claims will be processed and eligible amounts will be applied to the outstanding overpayment. Payment will not be made on any claim until the overpayment has been fully recouped.
- If you provide the required substantiation documentation, recovery of overpayments that were caused by an unsubstantiated Smart-Choice debit card transaction will be cancelled.
- Smart-Choice Accounts will allow you to resolve an overpayment on your account in several ways. You'll be given the option to:
    - Resubmit your claim that resulted in an overpayment with additional receipts or other documentation. If the claim is approved, the overpayment will be satisfied.

- Submit new claims for eligible out-of-pocket expenses within the current plan year if you have a remaining balance. If these claims are approved, the overpayment will automatically be paid back until the entire overpayment is paid off.
- Repay your overpayment by check. You can pay online via electronic check or by mailing a check to Smart-Choice Accounts, P.O. Box 785040, Orlando, FL 32878-5040. The repayment will be reflected in your account two to three business days after it is received. You can enter an electronic check payment directly on the site. This functionality is only for online checks and cannot accept credit card numbers. When online, you can view your overpayment and immediately take action by providing the following information:
    - Payment Amount
    - Institution Name
    - Account Type
    - Routing Number
    - Account Number

The overpayment will remain active on the account until all amounts are recovered. *Smart-Choice Accounts* will provide the Company with a monthly report of outstanding overpayments.

Employer Options for Overpayment Recovery

If the overpayment amount is not recovered through the options above, the Company will determine if further action should be taken, which may include:

- The Company may choose to withhold the overpayment amount from your wages or other compensation, to the extent allowed by law.
- The Company may choose to report the overpayment as taxable income on your W-2 form only after all other options have been exhausted.
- If the Company is not able or does not choose to recover the overpayment through wage withholding, the Company may treat the overpayment as any other business indebtedness (for example, through formal collection activity, write-off, etc.).

Important Information Regarding Errors, Liability, and Related Disclosures

The following disclosures relate to issues concerning the Smart-Choice debit card and certain matters pertaining to it. Any other issues that relate to your Health Care Flexible Spending Account (such as benefit eligibility, participation, enrollment, claims, or substantiation) that are governed under the terms of the Plan and ERISA will be subject to the dispute procedures available under the Plan.

Consumer Liability

You must notify *Smart-Choice Accounts* immediately if you believe your card has been lost or stolen. Call Your Benefits Resources Customer Care Center at 1-888-GET-YBR1 to prevent the loss of all of the money you have accrued under the plan, although there's no guarantee that such a loss won't occur. If you believe your Smart-Choice debit card has been lost or stolen and you notify *Smart-Choice Accounts* within two business days after you learn of the loss or theft, you will not lose any money ($0) if someone used your card without your permission. After normal business hours, you may call 1-866-438-5797 to report a lost or stolen card.

Also, if the periodic statement you view or receive shows Smart-Choice debit card transactions that you did not make, you must notify *Smart-Choice Accounts* immediately. If you do not notify *Smart-Choice Accounts* within **60** days after the statement was mailed to you or made available electronically, you may not recover any money you lost after the **60** days if *Smart-Choice Accounts* can prove that it could have stopped someone from using your card. If a good reason (such as a long trip or a hospital stay) kept you from notifying *Smart-Choice Accounts* of unauthorized Smart-Choice debit card transactions, the time period for notification will be extended.

Documentation

Information regarding Smart-Choice debit card transactions under the Health Care Flexible Spending Accounts are made available on the *Smart-Choice Accounts* web site and will be mailed to you in a periodic statement.

Smart-Choice Accounts Liability

If *Smart-Choice Accounts* does not complete a transaction on time or in the correct amount, according to the Cardholder Agreement, it will be liable for your losses or damages. However, some exceptions apply. *Smart-Choice Accounts* will not be liable if, for example:

- You do not have enough available funds at your employer or under the Health Care Flexible Spending Account (through no fault of *Smart-Choice Accounts*) to make the transaction.
- *Smart-Choice Account*'s system was not working properly, and you knew about the breakdown before you started the transaction.
- Circumstances beyond *Smart-Choice Account*'s control (such as fire or flood) prevented the completion of the transaction, despite reasonable precautions that have been taken.
- Any other exceptions stated in the Cardholder Agreement apply.

Confidentiality

Smart-Choice Accounts may disclose information to third parties about your Smart-Choice debit card account or the transactions that you make using the Smart-Choice debit card under the following circumstances:

- Where it's necessary for completing transactions;
- To verify the existence and condition of your Smart-Choice debit card account for a third party, such as a merchant;
- To comply with a government agency or court order;
- As provided in the Cardholder Agreement or in the Plan; or
- If you give *Smart-Choice Accounts* your written permission.

In Case of Errors Relating to Your Smart-Choice Debit Card

Call *Smart-Choice Accounts* at the number provided on the back of your card as soon as possible if you think a Smart-Choice debit card transaction in the statement or receipt is wrong, or if you need more information about a transaction listed in the statement or receipt. *Smart-Choice Accounts* must receive notification of any errors no later than **60** days after you received the first statement (either via the *Smart-Choice Accounts* Web site or by mail) in which the problem or error appeared. When you contact *Smart-Choice Accounts*, be prepared to:

- Provide your name and Social Security Number,
- Describe the error or the Smart-Choice debit card transaction that you're unsure about, and explain the reason you believe there's an error or why you need more information, and
- Provide the dollar amount of the suspected error. If you call *Smart-Choice Accounts*, you may be required to send your complaint or question in writing within **10** business days.

Smart-Choice Accounts will determine whether an error occurred within **10** business days after it receives notification from you and will correct any error promptly. If more time is needed to correct the error, however, *Smart-Choice Accounts* may take up to **45** days to investigate your complaint or question. If this additional time is necessary, *Smart-Choice Accounts* will credit the monies held by your employer for the amount that you think is in error, so that you will have use of the total amount during the investigation. If *Smart-Choice Accounts* requests that you put your complaint or question in writing and it does not receive the information within **10** business days, *Smart-Choice Accounts* may not provide this credit. *Smart-Choice Accounts* will inform you of the results within three **(3)** business days after completing the investigation. If *Smart-Choice Accounts* decides that there was no error, a written explanation will be mailed to you. You may ask for copies of the documents that were used in the investigation.

Important Information Regarding Electronic Delivery of Statements and Notices

The following information applies to you only if you agreed to accept electronic delivery of statements and notices via the *Smart-Choice Accounts* web site. At your request*, Smart-Choice Accounts* agrees to provide you with a paper copy of any statement or notice at no additional charge.

You can make the request by calling Customer Service between 7:00 a.m. and 7:00 p.m. Central time, Monday through Friday (excluding applicable holidays), by phone at the telephone number listed on the back of your Smart-Choice debit card. You also have the right to withdraw your consent to the electronic delivery of statements and notices at any time by calling Customer Service.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Care Spending Account reimburses you for eligible dependent care expenses incurred while you are at work. If you are married, you can use the account for eligible Dependent Flexible Care expenses if you and your spouse are employed outside the home, or if your spouse is looking for work, disabled or a full-time student.

You should note that the Dependent Care FSA is not subject to ERISA. Dependent Care FSA participants are not entitled to the protections of ERISA, including ERISA claims procedures and the right to sue under ERISA.

Eligible Dependents

You can be reimbursed for day care expenses, if the expenses are necessary to allow you and your spouse—if you are married—to work or look for work (an exception applies if your spouse is not working or looking for work, but is either a full-time student or is physically or mentally incapable of self-care).

In general, your day care expenses must be for a:

- Person who is under age 13 and who is your "qualifying child" under the Internal Revenue Code.
- Dependent child, spouse or other adult who is physically or mentally incapable of self-care. If the dependent care services are provided outside your home, the spouse or dependent must live in your home at least eight hours each day in order to qualify.

These services may be provided inside or outside your home by a babysitter, companions, or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

Note: *Because domestic partners and their dependents are generally not considered qualifying dependents under the Internal Revenue Code, benefits cannot be provided to them on a before-tax basis. Since contributions to the Dependent Care FSA are made on a before-tax basis, the law does not allow you to be reimbursed for expenses incurred by you or your domestic partner for the care of his or her dependents from this account unless they are also your spouse and/or dependents for this purpose under the Internal Revenue Code.*

Eligible Dependent Care Expenses

Expenses eligible to be reimbursed through the Dependent Care FSA can include:

- Before and after-school care;
- Care provided in or outside your home by someone other than your dependent under age 19;
- Day care centers qualified under state or local law; and
- FICA and other taxes you may pay for eligible providers.

For a complete list of expenses allowed by the IRS, contact your tax advisor or refer to Internal Revenue Service (IRS) Publication 503, available by calling 1-800-TAX-Form (829-3676) or by visiting the IRS web site at www.IRS.gov.

You can claim expenses for services provided in your home, as long as these services are not provided by someone you claim as a dependent on your tax return or an immediate family member under age 19. In addition, the IRS requires you to report on your annual tax return the taxpayer identification number of each Dependent Care provider you use. In some cases, that number could be your Dependent Care provider's Social Security Number. So before you decide to contribute to the Dependent Care FSA, make sure you can provide your Dependent Care provider's taxpayer identification number with your claim(s).

Expenses Not Covered

Expenses that cannot be reimbursed through the Dependent Care FSA include costs for:

- Care or services provided by your spouse, children under age 19 or anyone you could claim as a dependent for federal income tax purposes;
- Child support payments;
- Expenses for overnight camps;
- Food, clothing or entertainment for a dependent;
- General babysitting other than during work hours;
- Nursing home expenses, unless the dependent spends at least eight hours a day in your household; and
- Private school tuition for kindergarten or above.

Dependent Care FSA or Federal Tax Credit

You may prefer to use your day care expenses to claim a child care credit when you file your federal tax return. The child care credit means that you use a special formula to determine the amount of any credit for which you qualify. The credit is then subtracted from any tax you owe.

The Dependent Care FSA is an alternative way to save taxes for those employees who may prefer not to file for the federal dependent care tax credit. Certain individuals may be better off using the federal dependent care tax credit instead of the Dependent Care FSA. In general, the Dependent Care FSA may be better for you if your taxable family income is above $24,000 per year, but you should confirm this with your tax advisor.

You cannot claim the same expenses for a dependent care tax credit and for reimbursement. But child care expenses that are not reimbursed may still be eligible for the dependent care tax credit on your income tax form. **However, any amount you receive through the spending account reduces on a dollar-for-dollar basis the expense amount that you can consider when calculating the dependent care tax credit. You may want to check with a tax advisor if you are unsure if your dependent care expenses qualify for a tax deduction.**

Claims Information

Deadline for Claims

During the plan year, as you incur eligible expenses, you can submit claims to *Smart-Choice Accounts* for reimbursement. To do this, you must complete a claim form and include acceptable documentation of your eligible expenses when it's required. All eligible expenses—including all supporting documentation—must be received no later than the March 31 following the end of the plan year. That means you have until March 31 to submit claims incurred during the previous plan year.

For the Health Care FSA or Limited Use FSA, claims for a particular plan year must be incurred January 1 (or when you begin participation, if later) and while you are participating. For the Dependent Care FSA, claims for a particular plan year must be incurred January 1 (or when you begin participation, if later) through December 31.

How to File a Claim

Online

Smart-Choice Accounts offers the convenience of creating your claim form online. To get started, log on to the YBR Web site at www.ybr.com/ryman and select the *Spending Account* link. You will then be asked to enter relevant claim information. Once you have entered the requested information, you will be able to review your claim before you submit it. The final steps to submitting your claim are to print a copy, sign it, and fax or mail it to *Smart-Choice Accounts* with the required documentation of your expenses (such as itemized receipts) for processing. You will also have the option of completing your claim form online and uploading your documentation and receipts directly to the Smart-Choice Accounts web site. Select the upload feature to take advantage of this paperless process.

Fax or Mail

If you do not have Internet access, you can obtain a paper claim form through the Human Resources Department or by calling *Smart-Choice Accounts*. Once you have completed and signed the claim form, you will need to include itemized receipts or other required documentation of your expenses with your form when you fax or mail it to *Smart-Choice Accounts* for processing.

Where do I send my claim form?

Fax your claim to: 1-855-673-6719

Mail your claim to: Smart-Choice Accounts
P.O. Box 660114
Dallas, TX 75266-0114

Important: Whether you initiate a claim through the Web site or by fax/mail, you must provide itemized receipts or other required documentation for products purchased or services rendered. In certain cases, you may have to provide this documentation for verification purposes when using your debit card. If you do not provide this supporting documentation, your claim will not be processed and you won't be reimbursed.

Keep in mind, *Smart-Choice Accounts* offers a debit MasterCard® that you can use to pay for eligible Health Care FSA or Limited Use FSA expenses. Dependent care expenses aren't eligible for reimbursement through the debit card program. For more information about the debit card payment option, see the **"Health Care Flexible Spending Accounts Debit Card Program**" section of this booklet.

The following are examples of documents you may provide for claim processing:

- EOB from your health plan(s) if the plan(s) partially reimbursed you for an eligible expense.
- Itemized bills or receipts for eligible expenses that are not covered by your health plan(s).
- Bills for eligible dependent care expenses or other proof of payment for services rendered.
- Proof of medical necessity for certain types of expenses.

Receiving Reimbursements

Once your claim and receipt have been received, a decision on your claim will be made generally within 10 days. If approved, a reimbursement from your account will then be made to you one of the following ways:

- **Direct Deposit—**Money will be deposited in your account in 2 to 3 business days. This is the fastest way to receive your money. If you have not enrolled in direct deposit, go to the Your Preferences tab on the *Smart-Choice Accounts* site to sign up.
- **Check Mailed to You—**A check will be mailed within 2 business days (allow for standard mailing time for postal delivery).

Health Care Flexible Spending Accounts

You can request and receive reimbursements for your eligible health care expenses up to your entire annual contribution amount at any point while you are a participant during the year, even if you have not yet contributed the entire amount. Health Care FSA and Limited Use FSA claims are processed daily. Claims must be filed by the deadline indicated under the "**Deadlines for Claims**" section, above.

Dependent Care Flexible Spending Account

When you request reimbursement for your eligible Dependent Care expenses, you will be reimbursed only up to your current account balance amount. The unpaid amounts will be paid as you contribute those amounts to the account. Dependent Care FSA claims are processed daily. Claims must be filed by the deadline indicated under the "**Deadlines for Claims**" section, above.

Additional Claims Procedures

Health Care Flexible Spending Accounts

The following additional procedures apply only to claims made under the Health Care Flexible Spending Accounts.

Response to Your Health Care FSA or Limited Use FSA Request for Reimbursement

Your request for reimbursement should be processed as soon as administratively possible, and no later than 30 days after *Smart-Choice Accounts* receives your paperwork. These periods may be extended an additional 15 days if:

- Special circumstances require the extension; and
- Proper notice of the extension is given to the participant.

If such extension is due to your failure to submit information sufficient to decide your Health Care FSA or Limited Use FSA claim, the extension notice must describe the required information and you will be given **45** days from the receipt of such notice to submit the specified information.

If Your Health Care FSA or Limited Use FSA Claim Is Denied

If your claim is denied (in whole or in part), you will receive a written explanation of the denial. This explanation:

- States the specific reasons for the denial;
- References the pertinent provisions of the Plan upon which the denial is based;
- Describes any additional information that is needed to perfect the claim and why;
- Outlines how you can request a review of your claim;
- References any internal rule, guideline or protocol that was relied on to make the denial, and provides that a copy of such information will be provided to you free of charge upon your request; and
- Provides that if the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial will be provided to you free of charge upon your request.

Appealing Your Health Care FSA or Limited Use FSA Claim

If all or a portion of or your Health Care FSA or Limited Use FSA claim is not eligible for reimbursement, you will receive notification of the denial from *Smart-Choice Accounts*. If you disagree with the reimbursement outcome please contact YBR. If after review with the Service Center Representative, it is determined that the claim (or a portion of it) was correctly denied, you may appeal the denial at no cost to you by completing and submitting an Appeal Form to the Benefits Trust Committee (the Committee) within **180** days from the date you received the denial notification. If you do not submit an Appeal Form to the Committee during this period, no further action will be taken and you will not be able to file an appeal for this claim at a later date. To request an Appeal Form to be mailed to you, call 1-888-GET-YBR1.

The Committee's mailing address is:

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

When completing the Appeal Form, please state the reason you believe the claim for benefits was improperly denied. The following procedures will apply in considering your appeal:

- You may submit any comments, questions, documents, or information that you deem appropriate.
- You will be provided, upon request and free of charge, reasonable access to and copies of information (other than legally or medically privileged information) relevant to your claim for benefits.
- On each level of appeal, the claims reviewer will review the relevant information that you submit even if it is new information.
- No deference will be given to the initial decision regarding your claim for benefits.
- Each level of review will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of review will not be involved in the appeal).
- In deciding an appeal of any unfavorable benefit determination that is based in whole or in part on a medical judgment, the Committee will consult with a health care professional who has appropriate training and experience. The health care professional cannot be the same health care professional consulted for the initial decision nor a subordinate of that individual.
- Each medical or vocational expert whose advice was obtained regarding your claim will be disclosed to you, regardless of whether their advice was relied on to deny your claim.
- The Committee will review your appeal within **60** days of receipt and provide you with an electronic or written explanation of the benefit determination.
- You cannot file suit until you have exhausted these appeals procedures.

If Your Appeal of a Health Care FSA or Limited Use FSA Claim is Denied

If your Health Care FSA or Limited Use FSA appeal is denied, you will receive written notice of the decision including the following information:

- The reason(s) for the denial and the provisions on which the denial is based;
- A reference to any internal rule, guideline or protocol that was relied upon to deny your claim, or a statement that such information will be provided to you free of charge upon your request; and
- If the unfavorable benefit determination was made based on a lack of medical necessity, an experimental treatment, or another similar exclusion or limit, upon request the Committee will provide an explanation of the scientific or clinical judgment for the unfavorable benefit determination free of charge.

You will also be provided (free of charge) copies of all of the documents, records and other information relevant to your claim. You will have the right to bring a civil action under Section 502(a) of ERISA. **You must exhaust these claims and appeals procedures before you may bring a civil action under ERISA.**

For additional information about the claim/appeals process, contact Smart-Choice Accounts or the Plan Administrator, or refer to the **"Claims for Benefits Under the Plan"** section of the **Plan Overview and Administration** booklet**.**

Dependent Care Flexible Spending Account

The following additional procedures apply only to claims made under the Dependent Care FSA.

Response to Your Dependent Care Flexible Spending Account Request for Reimbursement

Your request for reimbursement should be processed as soon as administratively possible, and no later than 90 days after *Smart-Choice Accounts* receives your paperwork. These periods may be extended an additional 90 days if:

- Special circumstances require the extension; and
- Proper notice of the extension is given to the participant.

If Your Dependent Care Flexible Spending Account Claim is Denied

If your claim is denied (in whole or in part), you receive a written explanation of the denial. This explanation:

- States the specific reasons for the denial;
- References the pertinent provisions of the program upon which the denial is based;
- Describes any additional information that's needed to perfect the claim and why;
- Outlines how you can request a review of your claim.

Appealing Your Dependent Care Flexible Spending Account Claim

If all or a portion of or your Dependent Care FSA claim is not eligible for reimbursement, you will receive notification of the denial from *Smart-Choice Accounts*. If you disagree with the reimbursement outcome please contact YBR. If after review with the Service Center Representative, it is determined that the claim (or a portion of it) was correctly denied, you may appeal the denial at no cost to you by completing and submitting an Appeal Form to the Committee within **180** days from the date you received the denial notification. If you do not submit an Appeal Form to the Committee during this period, no further action will be taken and you won't be able to file an appeal for this claim at a later date. To request an Appeal Form to be mailed to you, call 1-888-GET-YBR1.

The Committee's address is:

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

When completing the Appeal Form, please state the reason you believe the claim for benefits was improperly denied. You may submit any comments, questions, documents, or information that you deem appropriate. The Committee will review your appeal within **60** days of receipt and provide you with an electronic or written explanation of the benefit determination.

Other important information regarding your appeals:

- You will be provided, upon request and free of charge, reasonable access to and copies of information relevant to your claim for benefits.
- On each level of appeal, the claims reviewer will review the relevant information that you submit even if it is new information.

Once you have received your notice from the Committee, review it carefully. The notice will contain:

- The reason(s) for the denial and the provisions on which the denial is based; and
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.

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