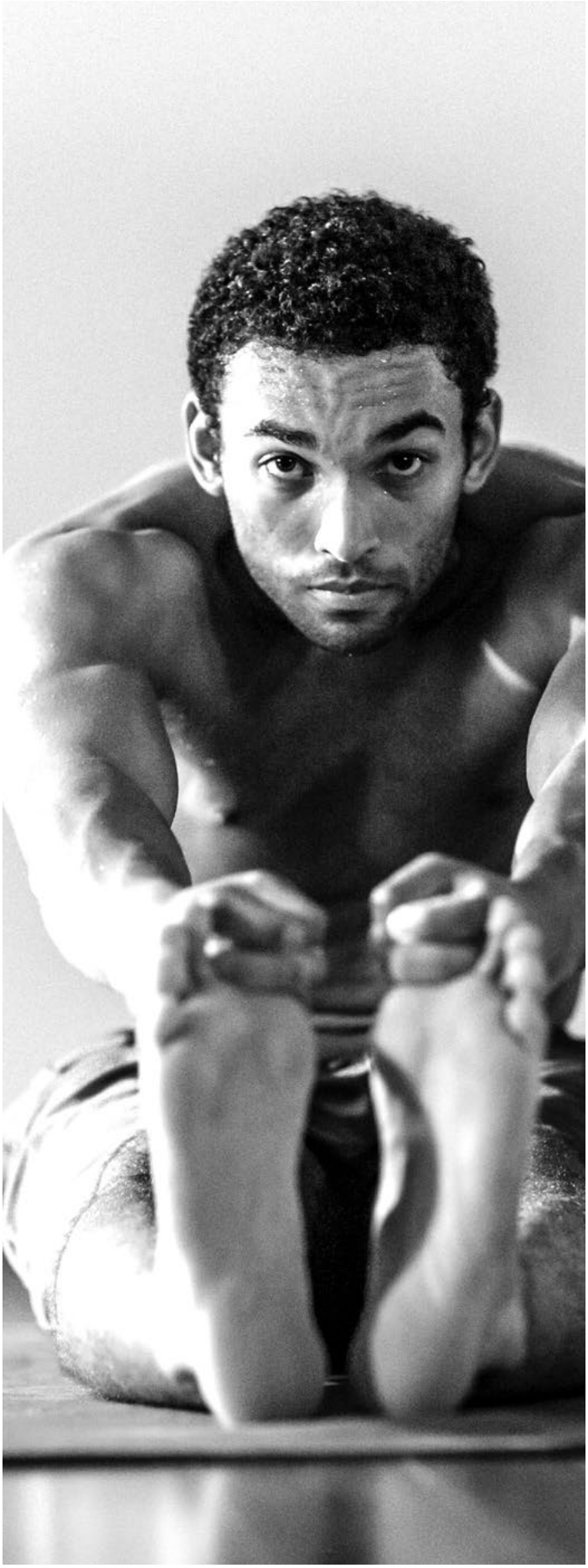

LIFE TIME℠
THE HEALTHY WAY OF LIFE COMPANY
2016–2017
Benefit Plan Information
Medical & Flex Benefits Administered by
HealthEZ.

This benefit guide describes most of the benefit plans available to you as a team member of Life Time. The details of these plans are contained in the official plan documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your summary plan description(s). If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the plan document(s), the plan document(s) will govern. Please note that the benefits described in this guide, including type and plan design, may be changed at any time at the discretion of Life Time.



IF YOU ARE A CURRENT LIFE TIME TEAM MEMBER:

The Life Time Open Enrollment period for the 2016–2017 plan year begins August 10, 2016, and must be completed by August 26, 2016. The effective date of coverage for the benefits you elect during this timeframe will be October 1, 2016. The elections you make during this Open Enrollment period will remain in place through September 30, 2017, unless you experience a Qualified Life Event (see page 5).

Each year during Open Enrollment, all eligible Life Time team members must complete online enrollment through Workday, even if you intend to waive enrollment or make no changes to your coverage. Life Time benefit plans require active enrollment from team members. This means you must re-enroll in your benefits in order to continue them in the next plan year. If you do not enroll during Open Enrollment, your medical, dental, vision and pretax accounts will terminate September 30, 2016.

Our medical plans for the 2016–2017 plan year have changed. The only medical plan that remained in place is the plan formerly known as Plan 3. This plan has been renamed HSA 5000. We have eliminated Plan 1 and Plan 2 and replaced them with Copay Plan and HSA 2000. These are new plans that have great benefits to our team members.

IF YOU ARE A NEW LIFE TIME TEAM MEMBER:

Welcome to Life Time. This booklet is a summary of our benefit offerings for full-time eligible team members. To view full-plan documents, please visit LT Pulse. New team members are eligible for benefits the first of the month following 60 consecutive days as an active, full-time team member. You must enroll before your benefit start date. All team members are required to complete an Open Enrollment task. Depending on your hire date, you may need to complete both your new hire task and an Open Enrollment task at the same time. If you have questions about the enrollment process or any of the benefits we offer, please refer to LT Pulse, ltfbenefits.com or contact HR at 888.848.7070.

IF YOU ARE AN ACA ELIGIBLE TEAM MEMBER:

As a part-time team member, you can earn medical plan eligibility based on your initial or standard 12-month measurement period, if during the measurement period you are consistently working 130 hours per month. You may enroll your eligible dependents in the same plan you choose for yourself.

BENEFIT PARTNER CONTACT INFORMATION

Company	Service	Phone Number	Website
LIFE TIME℠ THE HEALTHY WAY OF LIFE COMPANY	HR and Payroll	888.848.7070	See the Human Resources & Benefits site on LTPulse
HealthEZ®	Medical and Flexible Spending Account Administrator and Nurseline	800.948.3253	ltfbenefits.com
BYB Boost Your Baby Boost Your Baby	Maternity Case Management	800.808.4848	boostyourbaby.com
 EyeMed Vision Care	Vision Administrator	866.800.5457	eyemed.com
 Delta Dental	Dental Administrator	800.448.3815	deltadentalmn.org
HSA Optum	HSA Administrator	877.470.1772	mycdh.optum.com
 CVS | Caremark	Prescription Drug Administrator	800.552.8159	caremark.com
401k Fidelity Investments	401k	800.835.5095	401k.com
 CBIZ	401k Advisor	877.323.3867	cbiz.com
	COBRA Administrator	800.815.3023, opt.6	cbiz.com
 The Standard	Life and Disability Insurance Administrator	888.937.4783	standard.com
 LifeWorks	Employee Assistance Program	888.267.8126	lifeworks.com User ID: Lifetime Password: fitness

CONTENTS

YOUR BENEFIT PLAN

Life Time provides a wide variety of benefits and gives you the opportunity to customize a benefits package that meets your personal needs. HealthEZ is your benefits administrator. You can manage your account online at ltfbenefits.com or call HealthEZ customer service at 800.948.3253.

HOW YOUR BENEFITS WORK

Eligibility Requirements for Team Member Coverage.

A person is eligible for team member coverage from the first day that he or she:

1. is a full-time, active team member of the employer. A team member is considered to be full-time if he or she normally is scheduled at least 36 hours per week (32 hours per week for technical spa team members) and is on the regular payroll of the employer for that pay period. Medical eligibility can also be gained when a team member works 30 hours or more during the initial or standard measurement periods as defined by the Affordable Care Act (ACA).
2. is in a class eligible for coverage.
3. completes the employment waiting period of the **first of the month following 60 consecutive days** as an active full-time team member. A "waiting period" is the time between the date of hire and the first day of coverage under the plan.

Eligibility Requirements for Dependent Coverage.

A family member of a team member will become eligible for dependent coverage on the first day that the team member is eligible for team member coverage and when the family member satisfies the requirements for dependent coverage.

Life Time offers medical coverage to your lawful spouse or domestic partner who is NOT eligible for coverage elsewhere.

Your spouse or domestic partner can be covered on the Life Time plan if he/she:

- is also a team member of Life Time.
- is not employed.
- is employed but not eligible for benefits with his/her current employer.
- is eligible for Medicare or Medicaid.

Legal documentation will be required for enrollment and must be uploaded in Workday when enrolling. Foster children are eligible for dependent coverage. Children of domestic partners are not considered to be dependents unless the team member is a legal guardian.

At any time, the plan may require proof that a legal spouse, domestic partner or a child qualifies or continues to qualify as a dependent as defined by this plan.

WHEN BENEFITS START

Effective Date of Team Member Coverage.

A team member will be covered under this plan as of the first day of the calendar month following the date that the team member satisfies all of the following:

1. The eligibility requirement
2. The active full-time team member requirement
3. The enrollment requirements of the Plan
4. Employed for at least 60 days

CHOOSING YOUR BENEFITS

Some benefits are automatic. You don't have to choose them because Life Time pays the entire cost. But you must actively choose any benefit that you pay for. Disability and Life plans can be dropped at any time. There is open enrollment for employee Life insurance and Long-Term Disability every 3 years.

Your part of the cost is automatically taken out of your paychecks. There are two ways that the money is taken out:

After taxes

- After your taxes are calculated (Additional Life Insurance, Dependent Life Insurance and Short-Term and Long-Term Disability)
- Domestic partner coverage is paid after tax

Before taxes

- Before your taxes are calculated (Medical premiums, Dental premiums, Vision, 401k, HSA Contributions

(Optum only), Transit, Flexible Spending Account Contributions and Dependent Care Spending Account Contributions)

- There is a definite advantage to paying for some benefits with before-tax money. Taking money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less tax.

WHEN CAN YOU ENROLL?

You may enroll in Workday using the Benefit button in your In box from August 10 through August 25. If you need your username or password for Workday, please go to reset.lifetimefitness.com.

WHEN COVERAGE ENDS

All benefits end on the last day of the month in which your employment with Life Time ends or you are no longer eligible for benefits (excluding Flexible Spending Accounts and disability coverages, which end on termination date).

MEDICAL INSURANCE

For most people, medical insurance is no longer a "want" – it's a need. We've all seen the cost of medical care skyrocket over the years, so we need insurance to help protect not only our physical fitness, but our financial fitness as well.

By offering many combinations of deductibles, covered services and payment levels, there's sure to be a medical option that will help your family stay physically and financially fit.

QUALIFIED LIFE-CHANGING EVENTS

Generally, you can only change your benefit choices during the annual benefits enrollment period. However, you may be able to change certain benefit choices mid-year if you have a qualified change in status, including:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

You must notify the Life Time HR department via **Workday of any changes within 30 days of the change.**

Please refer to LTPulse for more information.

Please contact the Life Time Leave Administrator for all leaves of absence by calling HR at 888.848.7070.

ALL PLANS

HealthEZ: 800.948.3253

Certain features and benefits are consistent across the health plan options offered to team members:

- You can go to any healthcare provider you choose, but you will receive richer benefits if you go to an in-network provider. See the following Provider Networks chart to identify your network coverage.
- If you choose in-network as opposed to non-network providers, your out-of-pocket expenses will be minimized.
- All preventive visits are 100% covered for in-network providers.
- Female contraceptives are covered at 100% at your retail pharmacy, in-network providers, and through mail order.
- Non-covered services do not contribute to meeting deductibles or out-of-pocket maximums.
- Deductible amounts and copays count toward meeting the out-of-pocket maximum.

PREVENTIVE SERVICES

The following preventive services are covered 100% on all plans and available at no cost to to you or other individuals on your plan. **Please note that there is no coverage for preventive services when out of network.**

- Initial blood pressure, diabetes and cholesterol tests
- Cancer screenings (including mammograms and colonoscopies); see the Summary Plan Description for more information
- Regular well-baby and well-child visits from birth to age 18
- Routine vaccinations
- Flu and pneumonia shots

Provider Networks

The chart below shows provider networks by state.

State	Network	Website
MN, ND, IA, western WI	America's PPO	americasppo.com
AZ	Arizona Foundation for Medical Care	azfmc.com
IN	Sagamore	sagamorehn.com
FL	Evolutions Healthcare Systems	ehsppo.com
NV	Nevada Preferred Healthcare Providers	nvpp.com
CO, MI	Cofinity	cofinity.net
OH	Ohio Health Choice	ohiohealthchoice.com
Others and travel network	PHCS Network	multiplan.com

Please note: Deductible period is October 1, 2016, to September 30, 2017.

Medical Plan Options	Copay Plan	HSA $2,000*	HSA $5,000*
Plan Type	Physician/Hospital PPO	Physician/Hospital PPO	Physician/Hospital PPO
Individual/Family Deductible	In: $1,000 / $2,000 Out: $3,500 / $7,000	In: $2,000 / $4,000 Out: $6,000 / $10,000	In: $5,000 / $10,000 Out: $10,000 / $20,000
Individual/Family Coinsurance	In: 20% Out: 50%	In: 20% Out: 50%	In: 10% Out: 50%
Individual/Family Out of Pocket: (Including Deductible)	In: $3,000 / $6,000 Out: $7,000 / $13,000	In: $5,000 / $10,000 Out: $10,000 / $14,000	In: $6,450 / $12,900 Out: $12,900 / $25,800
Preventative Services	Covered in Full	Covered in Full	Covered in Full
Physician Office Services (Primary Care Physician)	$50 Copay, No Deductible	20% after Deductible	10% after Deductible
Physician Office Services (Specialty Care Physician)	$75 Copay, No Deductible	20% after Deductible	10% after Deductible
Emergency Room	$200 Copay, then Deductible, 20%	20% after Deductible	10% after Deductible
Outpatient Diagnostic, X-Ray, Lab	20% after Deductible	20% after Deductible	10% after Deductible
Outpatient Hospital Services	20% after Deductible	20% after Deductible	10% after Deductible
Inpatient Hospital Services	20% after Deductible	20% after Deductible	10% after Deductible
Pharmacy	Generic $15 Copay Preferred Brand $60 Copay Non-Preferred Brand Copay of $90 Specialty – 20% to Max Copay of $200 2x Mail	20% after Deductible	10% after Deductible
Premiums (Monthly)			
Employee	$126.16	$99.50	$77.65
Employee & Spouse	$251.75	$190.60	$166.49
Employee & Child(ren)	$194.97	$147.64	$129.02
Family	$360.93	$273.30	$238.81

*HSA plan options: Per IRS requirements, $2,600 individual deductible on family plan.

PHARMACY INFORMATION

Caremark: 800.552.8159

The pharmacy company for Life Time is Caremark. You can find Caremark online at caremark.com or call 800.552.8159.

- Register online at Caremark.com to receive round-the-clock access to your prescription history, coverage information, order status and online refills – securely, safely and confidentially. You will need your participant ID number located on your HealthEZ benefit ID card to register.
- Caremark.com can help you make informed decisions about your health. You can look up detailed health and drug information, and use interactive tools and cost calculators to review your prescription choices and healthcare options.
- When logged in to Caremark.com, you can print a mail service order form. Mail it to Caremark with your doctor's handwritten prescription for a 90-day supply and your first order will arrive at your doorstep. Once your prescription is on file, ordering refills online is convenient, fast and a great way to manage your long-term medications. Specialty medications must be purchased through mail order or retail.
- **Female oral contraceptives are covered 100%. Female non-oral contraceptives are covered at 100% in an in-network doctor's office.**

UNDERSTANDING AN HSA

Optum: 877.470.1772

A Health Savings Account (HSA), combined with a high-deductible health plan, offers you a number of unique features that put you in control of your healthcare choices and how you spend your healthcare dollars. **HSA accounts are owned by individual members and are not part of a group account. Optum is the custodian for Life Time's HSA accounts. You can reach Optum at 877.470.1772 or find them online at mycdh.optum.com.**

In Workday, this is called: Health Savings Account (HSA) Optum Health Savings Account. Optum charges a monthly maintenance fee which is deducted from your HSA account.

What is an HSA and how does it work?

An HSA is a tax-advantaged account established to pay for qualified medical expenses for those who are covered under a high-deductible health plan (HDHP). With money from this account, you pay for healthcare expenses until your deductible is met. Then, in accordance with the terms of your healthcare plan, your insurance company pays for covered expenses in excess of your deductible. Any unused funds are yours to retain in your HSA and accumulate toward your future healthcare expenses.

Who qualifies for an HSA?

An eligible individual is anyone who:

- is covered under a high-deductible health plan
- is not covered by any other plan that is not an HDHP
- is not currently enrolled in Medicare or TRICARE
- has not received medical benefits through the Department of Veterans Affair (VA) during the preceding three months
- may not be claimed as a dependent on another person's tax return

Who qualifies as a dependent?

A person generally qualifies as your dependent for HSA purposes if you claim them as an exemption on your federal tax return. Please see IRS publication 502 for exceptions, available at irs.gov/pub/irs-pdf/p502.pdf.

What is a "high-deductible health plan" (HDHP)?

A HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. Our HSA $3,000 plan and HSA $5,000 plan are qualified HDHP, as defined by IRS regulations. Visit treas.gov and search for "Health Savings Accounts" to find the most up-to-date information.

What other kind of health coverage makes an individual ineligible for an HSA?

Generally, an individual is ineligible for an HSA if the individual, while covered under an HDHP, is also covered under a health plan (whether as an individual, spouse or dependent) that is not an HDHP.

What other kinds of health coverage may an individual maintain without losing eligibility for an HSA?

An individual does not fail to be eligible for an HSA merely because, in addition to an HDHP, the individual has coverage for any benefit provided by "permitted insurance." Permitted insurance is insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, relating to ownership or use of property (e.g., automobile insurance), insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization.

What can I use the HSA for?

The HSA can be used:

- to pay for qualified medical, dental, vision and certain over-the-counter and prescription drug expenses as defined in IRS Publication 502
- as supplemental income, but money withdrawn is taxable and if you are under age 65, it will be subject to a 20% penalty

What if I use my HSA to pay for something other than a qualified medical expense?

If you are under age 65, it will be subject to applicable income taxes and a 20% penalty.

Are health insurance premiums qualified medical expenses?

Generally, health insurance premiums are not qualified medical expenses. Exceptions include qualified long-term care insurance, COBRA healthcare continuation coverage, any health plan maintained while receiving unemployment compensation under federal or state law, and for those age 65 or over (whether or not they are entitled to Medicare) any employer-sponsored retiree medical coverage premiums for Medicare Part A or B, or Medicare HMO. Conversely, premiums for Medigap policies are not qualified medical expenses.

CONTRIBUTIONS TO AN HSA

Who may contribute to an HSA?

Anyone may contribute to the HSA of an eligible individual. If a team member establishes an HSA, for example, the team member, their employer, or both may contribute to the team member's HSA in a given year. Family members may also make contributions to an HSA on behalf of another family member as long as that other member is an eligible individual. Contributions can be changed in Workday every pay period. You may contribute pre-tax up to age 65.

Can I enroll in both the HSA and a health Flexible Spending Account (FSA)?

If you enroll in both and HSA and an FSA or Health Reimbursement Arrangement (HRA), you cannot make deductible contributions to the HSA for that coverage period if the FSA or HRA are "general purpose" arrangements that pay or reimburse for qualified medical expenses. However, you still may be able to make deductible contributions to an HSA even if you are also covered under an FSA or HRA if those arrangements are "limited purpose" FSAs or HRAs that restrict reimbursements to certain "permitted benefits" such as vision, dental or preventive care benefits.
Other permissible combinations include "suspended HRAs" and "post-deductible" FSAs or HRAs. Contact your legal or tax advisor to review these situations.

How much can I contribute to my HSA?

In 2016, your annual HSA contribution may not exceed IRS limits of $3,350 for individual coverage or $6,650 for family coverage. In 2017, the limit for single coverage increases to $3,400. IRS limits are indexed for inflation on an annual basis. Visit treas.gov and click on "Health Savings Accounts" for updates.

If I open my HSA on June 1, what is my permitted contribution amount for that year?

Maximum annual HSA contributions can be made anytime during the year, regardless of when during that year the HSA was opened. For example, if an individual opens an HSA on June 1, the full contribution can be made for that year and then another full contribution can be made after January 1 of the following year. Penalties may apply if HDHP coverage does not continue for 12 months. Tax-deductible limits and HDHP qualifying deductible are indexed for inflation on an annual basis. Visit www.treas.gov and click on "Health Savings Accounts" for updates.

Can I change my contributions to my HSA during the year?

Generally, if you make contributions through an employer's cafeteria plan, you will not be subject to the "change in status" rules applicable to other qualified benefits. If this is the case, you will be able to make changes in your contributions providing the applicable notice of change provided by your employer. If you do not contribute to your HSA through a cafeteria plan, you are free to start, stop or modify your contributions at any time.

You can change your HSA contribution every pay period if you wish. To change your contribution, please create a Life Event in Workday and follow the appropriate steps. Further instruction can be found on LTPulse.

How do I make contributions?

Contributions can be made through payroll deduction with your employer, or you can contribute directly into your HSA yourself.

Will HSA contributions that I made via lockbox deposit or online via eContribute show up on my W-2?

No. Contributions made by either of these methods are

considered after-tax contributions for purposes of W-2 reporting. In order to receive the tax benefit of after-tax contributions, you must claim them on your tax return.

When can HSA contributions be made? Is there a deadline for contributions to an HSA for a taxable year?

For an established HSA, contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, this is April 15 of the year following the year for which contributions are made.

What happens when HSA contributions exceed the maximum amount that can be deducted or excluded from gross income in a taxable year?

Contributions by an individual to an HSA, or if made on behalf of an individual to an HSA, are not tax-deductible when they exceed the limits. Contributions by an employer to an HSA for a team member are included in the gross income of the team member if they exceed the limits or if they are made on behalf of a team member who is not an eligible individual. In addition, if not withdrawn in a timely manner, an annually assessed excise tax of 6% is imposed on the account holder for excess individual and employer contributions.

What are catch-up contributions for individuals age 55 or older?

For individuals between the ages of 55 and 65, the HSA contribution limit is $1,000 in calendar year 2010 and following years.

If my spouse is age 55 or older, am I eligible to make the catch-up contribution?

No. The primary account holder must be age 55 or older in order to make the catch-up contribution.

What happens to my remaining account balance at the end of the year?

Any remaining balance will carry over to the next year (no use-it-or-lose-it requirement).

Can I contribute funds from my Individual Retirement Arrangement (IRA) to my HSA?

During your lifetime, you are allowed a one-time contribution from one of your IRAs to one of your HSAs. The contributions must be made in a direct trustee-to-trustee transfer. The IRA transfer will not be included in income or subject to additional tax due to early withdrawal. The transfer limited to the maximum HSA contribution for the year and the amount contributed is not allowed as a deduction. Penalties may apply if HDHP coverage does not continue for 12 months.

Are rollover contributions from Archer MSAs and other HSAs permitted?

Yes. Rollover contributions from Archer MSAs and other HSAs are permitted. Qualifying rollover contributions must be made in cash and are not subject to annual contribution limits.

DISTRIBUTIONS

When can I initiate distributions from an HSA?

Once your account is funded and we have received your signed application, you can initiate distributions from the HSA at any time.

What are the qualified medical expenses that are eligible for tax-free distributions?

Qualified medical expenses are expenses paid by the account holder for diagnosis, cure, mitigation, treatment or prevention of disease. Examples of these expenses are certain over-the-counter and prescription drugs, transportation to care providers, qualified long-term care expenses and certain health insurance premiums. Such expenses are "qualified medical expenses" only if they are ineligible for insurance or any other type of coverage. For more information, visit irs.gov/pub/irs-pdf/p502.pdf.

How are distributions from an HSA taxed?

Distributions from an HSA used exclusively to pay for qualified medical expenses of the account holder, his or her spouse, or dependents are tax exempt and not included in gross income. In general, amounts retained in an HSA can be used for qualified medical expenses and will be excludable from gross income even if the

individual is not currently eligible to make contributions to the HSA.

However, any amount of the distribution not used exclusively to pay for qualified medical expenses of the account holder, spouse or dependents is includable in gross income of the account holder. Such distributions are subject to an additional 10% tax on the amount includable, except in the case of distributions made after the account holder's death, disability or attaining age 65.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

What are the tax rules of an HSA?

An HSA provides you triple tax savings by allowing:

- tax deductions from gross income when you contribute to your HSA
- tax-free earnings through interest and investments
- free withdrawals for qualified medical expenses

What happens to the HSA if I die?

Upon death, ownership of the HSA is transferred to your designated beneficiary.

What are the income tax consequences for the beneficiary after the HSA account holder's death?

Upon death, any balance remaining in the account holder's HSA becomes the property of the individual named in the HSA as the beneficiary of the account. If the account holder's surviving spouse is the named beneficiary of the HSA, the HSA is treated as though the surviving spouse were the account holder, and the distributions used for qualified medical expenses are not subject to income tax.

If, by reason of the death of the account holder, the HSA passes to a person other than the account holder's surviving spouse, the HSA ceases to be an HSA as of the date of the account holder's death, and the person is required to include in gross income the fair market value of the HSA assets as of the date of death.

Who is responsible for determining whether HSA distributions are used exclusively for qualified medical expenses?

As the HSA account holder, you must ensure that distributions are used for qualified medical expenses and receipts should be maintained as evidence that distributions have been made for these purposes. You are responsible for ensuring contributions to the HSA do not exceed IRS limits.

If I change employers, what happens to my HSA?

Since you are the owner of the HSA, you may continue to maintain the account if you change employers.

How will HSA statements be delivered and how frequently?

Monthly HSA statements itemizing deposits and withdrawals will be available online or you may opt to receive paper statements at an additional fee.

Can I reimburse myself with HSA funds for qualified medical expenses incurred prior to my enrollment in an HSA?

No. Qualified medical expenses may only be reimbursed, tax-free, if the expenses are incurred after the date your HSA was established.

UNDERSTANDING AN FSA

HealthEZ: 800.948.3253

Save tax dollars every year you enroll!

When you enroll in a Flexible Spending Account, you can pay for your transit, medical, dental and/or dependent (day care) expenses with money withheld from your paycheck. You can contribute up to $2,550 into your medical flexible spending account. Money withheld is not subject to Social Security (FICA) and federal or state income taxes.

Medical and dependent (day care) expenses that you are currently paying are only partially tax deductible, if at all. The money you set aside in your FSA is excluded from your taxable income.

A few simple steps

Estimate your annual medical and/or day care expenses, and monthly transit.

- Elect the amounts in Workday you want withheld from your check. In Workday, this is called: Medical Care Reimbursement Account – HealthEZ Full Medical Care Reimbursement Account. In Workday, the dependent care FSA is called: Dependent Care Reimbursement Account – HealthEZ Dependent Care Reimbursement Account.
- When you want to make a qualified purchase from your FSA, use your Benny debit card at a participating merchant, and you won't have to submit a receipt for reimbursement. Visit myBenny.com for more information.
- After you have incurred a medical or dependent care expense, fill out the claim for reimbursement form available online at ltfbenefits.com.
- Mail the claim to HealthEZ (7201 W. 78th St, Bloomington, MN 55439) or fax to 952.896.0372.
- Your claim will be processed, and if the expenses qualify, a reimbursement check will be provided to you according to the payment schedule. Direct Deposit is available.

How does this work?

Every time you get paid, the money you elected to have withheld from your check is placed in a reimbursement account. During the year, as you incur medical and/or day care expenses, you submit claims to HealthEZ. You are reimbursed for those expenses from your reimbursement account. Remember, that money is tax-free.

Important Facts

- You must submit receipts or an Explanation of Benefits demonstrating the date of service and the payment amount that you are responsible for. Or have your day care provider sign the reimbursement form.
- All expenses must be incurred within the current benefit plan year.
- You may elect to participate only at the time of hire, qualified life event or Open Enrollment.
- Any money not used by the end of the year is forfeited.
- If you are highly compensated, your flexible spending/day care spending account may be reduced due to federal testing requirements.

I'm enrolled/enrolling in the HSA. Can I still use an FSA?

Those who have elected to participate in the HSA benefit can have certain expenses submitted under a Limited FSA. The expenses eligible for the Limited FSA are dental, vision and preventive care expenses only. Make sure that you select the correct option on the Enrollment form. The rest of your medical expenses are then reimbursed through your HSA account. In Workday, this is called: Medical Care Reimbursement – HealthEZ Limited Medical Reimbursement Account.

WHAT EXPENSES QUALIFY?

Qualified Expenses – Medical

- Most medical or dental expenses not covered by your insurance, including hospital costs, deductibles, nursing care and nursing expenses
- Eye care (exams, glasses and contacts)
- Dental care (exams, x-rays, fillings and crowns)
- Chiropractor visits
- Prosthetics
- Prescription drugs and supplies
- Psychiatric treatment and/or therapy
- Transportation expenses relative to illness
- Hearing care including exams and hearing aids

Qualifications – Dependent Care

- If you are married, both you and your spouse must work or be a full-time student.
- Your child generally must be under 13 years of age. If the dependent is not a child, he/she must be physically or mentally incapable of taking care of himself/herself.
- You must incur this day care expense because you have to work.
- You must provide ID numbers from your day care center or private provider for tax purposes.
- Your provider cannot be one of your own children unless they are 19 years of age or older.

How much can you save?

This chart shows the savings you can realize by enrolling in a Flexible Spending Account. Assume you have estimated your medical and dental expenses at $1,500.

Without a Flex Plan		With a Flex Plan
$24,000	Annual salary	$24,000
$0	Before-tax expense	$1,500
$24,000	Taxable income	$22,500
	Less	
$3,600	Federal tax @ 15%	$3,375
$1,836	FICA tax @ 7.65%	$1,721
$504	State tax @ 2.1%	$473
$5,940	Total taxes	$5,569
$1,500	After-tax expense	$0
$16,560	Net take-home pay	$16,931
	Annual savings to you!	$371

Note: Federal and State tax rates vary according to income levels and state residency. The example assumes the minimum federal tax rate and a 2.1% state tax rate. Consult with your flexible benefit plan consultant or your accountant for calculating the actual amount.

FSA QUESTIONS

Is there an annual limit for Dependent Care?

Yes, the maximum you can elect is $5,000. If you enroll in a dependent (day care) account, you cannot claim the child care credit on your tax return for those expenses reimbursed from your FSA. Check with your tax advisor to see which would be better for you.

Can I change my election during the year?

Generally, no. There are a few exceptions, such as the birth of a child or your spouse loses his/her job. If this "major life change" does occur, you must notify your Human Resources Department within 30 days.

Are over-the-counter drugs reimbursable?

You can pay for certain over-the-counter and prescription drug expenses as defined in IRS Publication 502. A complete list of allowable drugs is available online at ltfbenefits.com.

TRANSPORTATION BENEFITS

HealthEZ: 800.948.3253

Life Time Contribution

Life Time will match contributions up to $20 per month. For instance, if you need $100 per month to buy a bus pass, you should elect $80, and Life Time will contribute up to $20. In Workday, this is called: Transportation Spending Account – HealthEZ Bus/Van Pool Spending Account or Transportation Spending Account – HealthEZ Parking Spending Account Plan.

What specific Transportation Benefits are provided by the Plan?

- Transit Pass Benefits permit a team member to pay, with pretax dollars, for his or her share of the cost of coverage of qualifying Transit Pass Expenses for mass transit passes, vouchers, etc. for commuting to work;
- Commuter Highway Vehicle (Van Pool) Benefits permit a team member to pay, with pretax dollars, for his or her qualifying Commuter Highway Vehicle Expenses for commuting to work; and
- Qualified Parking Expenses permit a team member to pay, with pretax dollars, for his or her share of the Cost of Qualified Parking Expenses. Life Time reimburses for transportation expenses that cover a period of one month or more. Consequently, the Plan does not reimburse for daily or metered parking.

What are Transportation Expenses?

Transportation Expenses means your expenses incurred or paid during the month for which an election is in force, provided that you are currently a team member at the time the Transportation Benefit is provided to you. (Transportation Benefits are provided on the date you receive a Transit Pass [as defined below] or similar item, or in any other case, the date you use the Transportation Benefit.) Transportation Expenses include Transit Pass Expenses, Commuter Highway Vehicle Expenses and Qualified Parking Expenses, which are defined as follows:

- Transit Pass Expenses are expenses incurred or paid for a pass, token, fare card, voucher or similar item (Transit Pass) for transportation (a) on mass transit facilities (such as train, bus, subway or ferry), whether or not publicly owned; or (b) provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).
- Commuter Highway Vehicle (Van Pool) Expenses are expenses incurred or paid for transportation in a Commuter Highway Vehicle if such transportation is in connection with travel between your residence and place of employment. A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver), and for which at least 80% of the mileage for a year is for purposes of transporting team members in connection with travel between their residences and their places of employment, and on trips during which the number of team members transported for such purposes is at least half of the adult seating capacity of the vehicle (not including the driver).
- Qualified Parking Expenses are expenses incurred or paid for parking at or near your regular place of employment with the Employer, or expenses incurred to park your car at a location from which you commute to your regular place of employment by (a) carpool; (b) a Commuter Highway Vehicle; (c) mass transit facilities; or (d) transportation provided by any person in the business of transporting persons for compensation or hire, if such transportation is in a Commuter Highway Vehicle. You may not submit expenses incurred by anyone other than you. The Plan does not reimburse for daily or metered parking.

What must I do to be reimbursed for my Transportation Expenses?

A Transportation Expense is paid when the service has been provided and you formally pay for the service; it is not paid when you are formally billed for or charged for the service. Submit a claim to the Administrator on a Reimbursement Form that will be supplied to you. You must also include bills, invoices, statements from an independent third party, parking receipts, used transit passes or other evidence of payment showing the amounts of such payments, together with any additional documentation that the Administrator may request, showing that the Transportation Expenses have been incurred or paid, and the amount of such Transportation

Expenses. Please note that, by law, the administrator may not be able to reimburse you for the expense of a Transit Pass if a "voucher" (or something similar) is readily available.

What if I overestimate my Transportation Expenses?

If your reimbursement request was for less than your current Transportation Account balance, the unused amounts in your Transportation Account will roll over and be available for future reimbursements, so long as you continue to participate in the Plan. You may need to adjust the election for the next monthly Period of Coverage in order to use up your surplus Transportation Account balance. For example, if your monthly parking election (and anticipated monthly expense) is $100, but you only incur $75 worth of Transportation Expenses in January, you might want to change your election for February to $75 in order to use up the $25 surplus from January. Then you can increase your election back to $100 for March prior to March 1.

What if I underestimate my Transportation Expenses?

If your reimbursement request was for an amount that was less than the monthly maximum amount (described above), but more than your current Transportation Account balance, the excess part of the reimbursement will be carried over into following months to be paid out as your balance becomes adequate (subject to the monthly maximum described above). Remember, though, that you can't be reimbursed for any total expenses above your available credits to your Transportation Account.

Limits

Transit/Van Pool: up to $130/month, and may be increased or decreased each month of the plan year.

Parking: up to $220/month, and may be increased or decreased each month of the plan year.

New York City Transit/Van Pool: Up to $255/month and may be increased or decreased each month of the plan year.

CARE MANAGEMENT PROGRAMS

Life Time offers you access to trained nursing staff to help you navigate the maze of chronic or complex medical conditions. Active Care Management will be required for pregnancies as well as other diseases such as diabetes, cancer and heart disease, to name a few. For those who fall into these categories, there will be a penalty for failure to participate in a care management program. If you're diagnosed with a complex condition, please feel free to call the HealthEZ nurseline.

Some of the offerings through care management include:

Boost Your Baby

Boost Your Baby (boostyourbaby.com) connects moms and dads with extensive child and parent resources. In addition to helpful information like proper nutrition and pregnancy-friendly workouts, you'll have access to Mommy Mentors, nurse specialists and doctors who can provide special support and information.

When you're pregnant, please reach out to HealthEZ by calling 800.808.4848. A high-risk assessment is completed with each woman who enters the maternity program. The goal of this program is to encourage healthy, full-term babies and happy, informed parents. **Failure to participate in Boost Your Baby will result in a $350 penalty applied at the time of the baby's delivery.**

Case Management

Nurse case managers assist and educate members with complex medical and behavioral problems such as transplants, cancers and substance abuse. **Failure to participate in case management when asked will result in a penalty of 50% of the normal plan payment.**

Disease Management

Nurses provide literature and education to those with diseases such as diabetes, heart disease, low-back pain and asthma. Our goal is to keep these diseases from progressing further. **Failure to participate in disease management when asked will result in a penalty of 50% of the normal plan payment.**

Utilization Review

This service provides monitoring of inpatient hospital admissions and certain outpatient procedures.

For more information about the kinds of programs available, please call the Life Time Benefits hot line at 800.948.3253 and ask for the care management department.

NURSELINE

If you need help deciding what level of medical care you need for yourself or your family, you can call our 24-hour nurseline. A registered nurse will answer your questions and can help direct you to a doctor or other healthcare provider in the provider network you use.

If you require immediate medical attention to treat a life-threatening condition or prevent permanent impairment, dial 911.

To reach a nurse, call 800.948.3253.

During normal business hours, tell a customer service representative you'd like to speak to a nurse. If you call after business hours and reach a recording, press 3 and you'll be connected to a nurse.

DENTAL COVERAGE

Delta Dental: 800.448.3815

There are three dental plans for you to choose from.

FREQUENTLY ASKED QUESTIONS

May I go to any dentist?

You have the freedom to see any dentist. However, **dentists who participate in Delta Dental PPO and Delta Dental Premier have agreed not to charge more than our maximum allowable amount.** This can result in lower out-of-pocket costs. Choosing a dentist in the Delta Dental PPO network may save you even more money. As an added convenience, you never have to file a claim when you use a participating dentist – the dentist files the claim for you.

How do I find a participating dentist?

Finding a participating dentist is easy. Simply visit deltadentalmn.org and use our interactive Dentist Search tool or call Customer Service locally at 651.406.5901 or toll free at 800.448.3815.

What happens if I visit a non-participating dentist?

If dental services are provided by a non-participating dentist, you will be responsible for paying the difference between our maximum allowable amount and what the dentist charges. You may be responsible for submitting your own claim. The address to submit claims in on the back of your Delta Dental ID card. In addition, reimbursement for covered services will be paid directly to you.

What if I have an emergency outside the United States?

Delta Dental automatically includes international emergency coverage in 137 countries. English-speaking customer service representatives are available 24 hours a day, seven days a week to help members arrange emergency care. For more information, visit deltadentalmn.org.

How do I find out if my claim was paid?

The Delta Dental site offers fast and easy dental benefit tools and information. In addition to claims inquiry, other interactive features include eligibility and benefits inquiry, oral health resources and much more. You may also call Customer Service to get claims status and payment information.

How is work in progress handled?

For services started prior to your effective date under the Delta Dental plan, payment of the claim is based on the service completion date.

How do I know how much I'll be responsible for?

For major dental procedures, the dentist can submit a pre-treatment estimate to Delta Dental of Minnesota for determination of benefits and financial responsibility prior to the service.

Delta Dental of Minnesota			
In-Network PPO Summary	Delta 80	Delta 100	Delta Platinum
Diagnostic & Preventive Services Exams & cleanings, x-rays, fluoride treatments, space maintainers, sealants	80%	100%	100%
Basic Services	80%	80%	90%
Endodontics	80%	80%	90%
Periodontics	80%	80%	90%
Oral Surgery	80%	80%	90%
Major Restorative	40%	50%	75%
Prosthetics/Implants Repairs & Adjustments	40%	50%	75%
Prosthetics/Implants	40%	50%	75%
Orthodontics Treatment for the prevention/correction of malocclusion, available for adults and children	none	100% to $2,000 Child only	100% to $5,000 Adult and Child
Deductible (Oct 1-Sept 30) Per person/per family per coverage year No deductible for diagnostic and preventive services or orthodontics	$50 / $150	$50 / $150	$25 / $50
Annual Plan Maximum (Oct 1-Sept 30) Per covered person	$1,000	$1,500	$5,000
Lifetime Ortho Maximum Per covered person	N/A	$2,000 Child Only	$5,000
Premiums (Monthly)			
Employee	$13.34	$29.23	$36.00
Employee & Spouse	$21.74	$56.57	$69.87
Employee & Child(ren)	$29.08	$86.18	$106.17
Family	$57.35	$113.53	$139.69

*This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitation/exclusions, please refer to the Dental Benefit Plan Summary.

**Out-of-pocket expenses may increase if member utilizes a non-participating provider. For the greatest level of benefits and the least amount of out-of-pocket expenses, visit a Delta Dental PPO Provider. ^ of maximum allowable fee

EYEMED VISION CARE

EyeMed Vision Care: 866.800.5457

Your Vision Administrator is EyeMed Vision Care. You can find them online at eyemed.com or call 866.800.5457.

Comprehensive Vision Exam

Receive a comprehensive eye examination from a state-licensed optometrist or ophthalmologist when you visit a participating in-network provider.

Materials

Pair of Lenses for Eyeglasses

- One pair of standard single-vision, lined bifocal, lined trifocal or standard lenticular lenses is covered in full for the Enhanced Plan. The Basic Plan is subject to a $25 copay for single vision, bifocal, trifocal and lenticular. Standard Progressive is $90 copay for Basic, $65 for the Enhanced Plan.
- Standard scratch-resistant coating is covered in full.
- Lens Options – Options such as progressive lenses, polycarbonate lenses, tints, UV and anti-reflective coating are subject to additional copayments.

Frames

Receive a $130 retail frame allowance at both private practice providers and retail chain providers, with a 20% discount over the balance of the allowance.

Contact Lenses in Lieu of Lenses

Elective contact lenses

The fitting/evaluation fees are subject to a $55 copayment for a standard fit and follow-up; premium fit and follow-up has a 10% discount. Members receive an allowance of $105, with a discount of 15% off balance over $105 for conventional contact lenses. Disposable contact lenses have a $105 allowance also, but members pay 100% on any amount over $105.

Medically necessary contact lenses

Covered in full. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: To correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers

your contacts necessary, you should ask your provider to contact EyeMed concerning the reimbursement that EyeMed will make before you purchase such contacts.

Refractive Eye Surgery

EyeMed members receive 15% discount off retail, or 5% off the promotional price for refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit eyemedlasik.com or call 877.5LASER6.

Hearing Care

EyeMed members now have access to affordable hearing care discounts through Amplifon, the world's largest distributor of hearing aids and services. The EyeMed hearing discount through Amplifon includes:

- 40% off hearing exams at thousands of convenient locations nationwide
- Discounted, set pricing on thousands of hearing aids, including those with the newest, most advanced technology
- Low-price guarantee — if you find the same product at a lower price elsewhere, Amplifon will beat it by 5%
- 60-day hearing aid trial period with no restocking fee
- Free batteries for 2 years with initial purchase
- 3-year warranty plus loss and damage coverage

Call 844.526.5432 to find a hearing care provider near you to schedule a hearing exam.

Important to Remember

- Benefits available every 12 or 24 months are based on last date of service.
- While a card isn't required for services, all team members will receive two personalized ID cards or you may print a card by visiting eyemed.com.
- You can maximize your benefits and lower your out-of-pocket expenses when you visit an in-network provider (compared to the same product purchased at an out-of-network provider). You are able to choose from both independent providers and retail chain providers. It's up to you.
- You can find the best provider for you at eyemed.com. EyeMed's "Smart Locator" makes it easy for you to find an in-network provider. And you can search based on hours, services offered, and specific products and brands. You can even schedule an appointment online.
- EyeMed offers a member app for the iPhone and Android users that allows you to find a provider, check your benefits or share a mobile ID card.
- While a card isn't required for services, members have the ability to print a personalized ID card at eyemed.com. With EyeMed Vision Care, you are able to choose from network private practice providers and retail chain providers. Prior to using the EyeMed vision care program, if you would like to identify a network provider, visit EyeMed's website — eyemed.com — and choose provider locator or call EyeMed's Provider Locator Service at 866.800.5457 and follow the voice prompts.
- In-network benefits are now available online by utilizing glasses.com and contactsdirect.com.

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a EyeMed Vision Care participant.

Vision — EyeMed VIS				
	Basic		Enhanced	
	Frequency	Copay	Frequency	Copay
Comprehensive Vision Exam	1 every 12 months	$10 Copay	1 every 12 months	$0 Copay
Materials				
Pair of Lenses for Frames	1 every 12 months	$25	1 every 12 months	$0 Copay
Frames	1 every 24 months	Allowance	1 every 24 months	Allowance
Contact Lenses (in lieu of glasses)	1 every 12 months	Allowance	1 every 12 months	Allowance
Out-of-Network Provider				
Exam	1 every 12 months	up to $40	1 every 12 months	up to $40
Lenses				
Single	1 every 12 months	up to $40	1 every 12 months	up to $40
Bifocal	1 every 12 months	up to $60	1 every 12 months	up to $60
Trifocal	1 every 12 months	up to $80	1 every 12 months	up to $80
Lenticular	1 every 12 months	up to $80	1 every 12 months	up to $80
Frames	1 every 24 months	up to $45	1 every 24 months	up to $45
Contact Lenses (in lieu of glasses) have a separate allowance, not a copay.				
Medically Necessary		up to $105 up to $210	1 every 12 months 1 every 12 months	up to $105 up to $210

Premiums (Monthly)		
Employee	$5.04	$7.52
Employee & Spouse	$8.32	$12.32
Employee & Child(ren)	$10.08	$13.52
Family	$15.60	$20.96

VOLUNTARY SHORT-TERM DISABILITY

The Standard: 888.937.4783

Employee Benefit Amount

If you are disabled due to a covered injury or sickness, you will be eligible to receive a weekly benefit as stated in your certificate. This coverage is optional, but is an excellent opportunity to purchase group short-term disability insurance on a payroll deduction basis.

- 60.0% of your salary; the maximum weekly benefit is $1,250/week
- In Workday, this is called: Short-Term Disability (STD) - Standard Insurance Company Short-Term Disability (Employee)

Disability Definition

You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation; and you suffer a loss of at least 20% in your pre-disability earnings when working in your own occupation.

Benefit Waiting Period

You must be disabled for 14 continuous days before benefit payments start. Benefits will begin on the 15th day for Accidents or Illnesses. **Please note: If you do not enroll for STD when you are first eligible and later elect to enroll, you will be subject to a Late Entrant Penalty.** This means that for the first 12 months of coverage, disability benefits will begin on the 61st day for Illnesses and on the 15th day for Accidents. After being insured for 12 months, the benefit waiting period will revert back to benefits being payable on the 15th day for disabilities caused by physical disease, pregnancy or mental disorder.

STD benefits cover only non-occupational injury or sickness. Workers' Compensation normally covers an employee's work-related accident, injury or sickness.

Please note, your recovery period and time period for benefits for maternity claims is based on your delivery type and the level of your occupation. For example, standard recovery for sedentary occupations is 6 weeks for the vaginal delivery and 8 weeks for Cesarean delivery. If there are complications, the duration of benefits could be extended beyond the 6 or 8 weeks. This will vary from claim to claim.

Maximum Benefit Duration

The longest period for which STD benefits are payable for any one period of continuous disability, whether from one or more causes, is 76 days. It begins at the end of the Benefit Waiting Period. No STD benefits are payable after the end of the Maximum Benefit Period, even if you are still disabled.

Other Benefits Included

Pregnancy, alcoholism, drug addiction, and mental and nervous conditions are treated the same as any other illness. The definition of disability must be satisfied and the benefit waiting period completed before benefits would begin.

Partial disability benefits are also included. You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation; and you suffer a loss of at least 20% in your pre-disability earnings when working in your own occupation.

To qualify for the benefit, you must satisfy the benefit waiting period and be earning less than 80% of your pre-disability earnings. Partial disability benefits are reduced if your work earnings plus STD benefits exceed 100% of your pre-disability earnings. Benefits end the date your earnings exceed 80% of your pre-disability income, the date the maximum benefit duration ends, or the date you are no longer disabled.

Program Eligibility

All full-time team members regularly scheduled to work at least 36 hours each week (32 hours per week for technical spa team members). Team members must be capable of being actively at work on the day before coverage takes effect. A delayed effective date will apply if the team member is not actively at work on the date that the insurance would otherwise take effect.

This coverage is extended to you without requiring evidence of insurability as long as you meet eligibility requirements and enroll during your eligibility period. If you do not enroll in this coverage when you are initially

eligible and you choose to enroll at a later date, you will be subject to the late entrant penalty as outlined in the STD Benefit Waiting Period section on the previous page. 20% of your eligible team members must participate for this program to be effective.

Monthly Premium Calculation

John Doe is 33 and earns $500 per week. His cost per month is $10.50. 500 x 60%=300 x .0350 = $10.50 monthly deduction.

Age	Monthly Benefit Rate
< 30	0.0371
30–34	0.0350
35–39	0.0330
40–44	0.0309
45–49	0.0433
50–54	0.0495
55–59	0.0618
60–64	0.0742
65–69	0.0845
70–74	0.0927
75 +	0.0989

$_____ x 60% = $_____ x _____ = $_____

Weekly salary x 60% = weekly benefit x rate from table = monthly premium. The maximum covered weekly salary is $2,083. The maximum weekly benefit is $1,250.

Exclusions

Benefits are not payable: while you are not under the regular care of a physician; if disability is due to intentional, self-inflicted injury; if disability is due to an injury or sickness covered by Workers' Compensation or resulting from employment for wage and profit; if disability is due to war or involvement in a felony or riot; or while you receive payment under a salary continuance or retirement plan sponsored by your employer.

VOLUNTARY LONG-TERM DISABILITY

The Standard: 888.937.4783

Your Disability Administrator is The Standard. You can find The Standard online at standard.com or call 888.937.4783.

Employee Benefit Amount

This is an excellent opportunity to purchase group Long-Term Disability (LTD) insurance on a payroll deduction basis (this is not an annual open-enrollment benefit).

- 60.0% of your salary; the maximum benefit amount is $8,000/month
- In Workday, this is called: Long-Term Disability — LTD – Standard Insurance Company Long-Term Disability (Employee)

The LTD benefits are reduced by any other income you are eligible for under

- Primary & Family Social Security Disability or Retirement or any similar plan or act.
- Workers' Compensation Law, occupational disease law or any similar law.
- State Disability Plans or any compulsory benefit act or law.
- Other group disability plans or retirement benefits through your employer — and sometimes, any form of employment (full- or part-time).

Benefit Waiting Period

You must be continuously disabled for 90 days before LTD benefits become payable. No LTD benefits are payable for the Benefit Waiting Period.

You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental sisorder, you are unable to perform with reasonable continuity the material duties of your own occupation; and you suffer a loss of at least 20% in your pre-disability earnings when working in your own occupation. Your own occupation period is 24 months.

Following this, you are disabled from all occupations if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Any occupation means any occupation or employment which you are able to perform, whether due to education, training or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your indexed pre-disability earnings within 12 months following your return to work, regardless of whether you are working in that or any other occupation.

Temporary Recovery

You may temporarily recover from your disability and then become disabled again from the same cause or causes without having to serve a new benefit waiting period. Temporary Recovery means you cease to be disabled for no longer than the applicable allowable period. The allowable periods are a total of 90 days of recovery during the benefit waiting period and a total of 180 days during the maximum benefit period.

Maximum Benefit Duration

This is the maximum period of time that benefits will continue to be paid to you during a period of disability: to age 65 or Social Security normal retirement age. This is determined by your age at the time of your disability.

Preexisting Condition Exclusion

For newly eligible team members:
Preexisting Condition means a mental or physical condition whether or not diagnosed or misdiagnosed:

- For which you have done or for which a reasonably prudent person would have done any of the following:
  - Consulted a physician or other licensed medical professional;
  - Received medical treatment, services or advice;
  - Undergone diagnostic procedures, including self-administered procedures;
  - Taken prescribed drugs or medications
- Which, as a result of any medical examination, including routine examination, was discovered or suspected at any time during the 90-day period just before your insurance becomes effective.

Exclusion

You are not covered for a disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become disabled, you:

- Have been continuously insured under the Group Policy for 12 months; and
- Have been actively at work for at least one full day after the end of that 12 months.

For Late Enrollees

Preexisting Condition means a mental or physical condition whether or not diagnosed or misdiagnosed:

- For which you have done or for which a reasonably prudent person would have done any of the following:
  - Consulted a physician or other licensed medical professional;
  - Received medical treatment, services or advice;
  - Undergone diagnostic procedures, including self-administered procedures;
  - Taken prescribed drugs or medications;
- Which, as a result of any medical examination, including routine examination, was discovered or suspected at any time during the 12-month period just before your insurance becomes effective.

Exclusion

You are not covered for a disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become disabled, you:

- Have been continuously insured under the Group Policy for 12 months; and
- Have been actively at work for at least one full day after the end of that 12 months.

Other Benefits Included

Other features include coverage for pregnancy, alcoholism, drug addiction, and mental and nervous conditions. Additional benefits include partial disability benefits, survivor income benefit, assisted living benefit and conversion.

- You may work and still be eligible for LTD benefits. This is sometimes referred to as partial disability. You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation; and you suffer a loss of at least 20% in your pre-disability earnings when working in your own occupation. To qualify for the benefit, you must satisfy the benefit waiting period and be earning less than 80% of your pre-disability earnings. Partial disability benefits are reduced if your work earnings plus LTD benefits exceed 100% of your pre-disability

earnings. Benefits end the date your earnings exceed 80% of your pre-disability income, the date the maximum benefit duration ends, or the date you are no longer disabled. Premiums due during a total or partial disability period are waived after benefits become payable and for as long as they continue.

- A survivor income benefit is paid in the event of your untimely death. A lump sum benefit equal to 3 times your last monthly LTD benefit is paid to your surviving spouse or children if you should die. To qualify, you must have been disabled for 180 days and have been receiving LTD benefits under terms of the policy.
- An Assisted Living Benefit applies if you are severely disabled. Your LTD benefit is increased to 80% of pre-disability earnings if your disability causes you to be unable to perform two or more activities of daily living or if you are suffering severe cognitive impairment.
- Converting your LTD plan to an individual policy is an option if you lose your coverage through Life Time.

Program Eligibility

All full-time team members regularly scheduled to work at least 36 hours each week (32 hours for technical spa team members). Team members must be capable of being actively at work on the day before coverage takes effect. A delayed effective date will apply if the team member is not actively at work on the date that the insurance would otherwise take effect.

This coverage is extended to you without requiring evidence of insurability as long as you meet eligibility requirements and enroll during your eligibility period. If you do not apply for this coverage when you are initially eligible and you choose to apply at a later date, you will be subject to proof of insurability, and you may be responsible for any expenses associated with obtaining further medical information.

Monthly Premium Calculation

John Doe is 33 and earns $2,500 per month. His cost per month is $ 5.60. $2,500 x .00224 = $5.60 monthly deduction.

Age	Monthly Covered Payroll Rate
< 25	0.00126
25–29	0.00168
30–34	0.00224
35–39	0.00364
40–44	0.00546
45–49	0.00798
50–54	0.01078
55–59	0.01470
60–64	0.01316
65–69	0.00798
70–99	0.00658

$_____ x _____ = $_____

Monthly salary x rate from table = monthly cost. If your monthly salary exceeds $13,333, enter $13,333.

Standard Insurance Company does not pay LTD benefits for any period of disability:

- Caused or contributed to by the loss of your professional license, occupational license or certification;
- Which is the result of self-inflicted injury or attempted suicide;
- During which you are not under the regular care of a doctor;
- Due to active participation in a riot or in the commission of a felony;
- Due to war, declared or undeclared, or any act of armed aggression.

Disabilities Subject to Limited Pay Periods

Payment of LTD benefits is limited to 24 months during your entire lifetime for a disability caused by or attributed to mental disorders. However, if you are confined in a Hospital solely because of a mental disorder at the end of the 24 months, this limitation will not apply while you are continuously confined.

BASIC TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The Standard: 888.937.4783

As an eligible employee, you are automatically enrolled for Basic Term Life and AD&D Insurance equal to $50,000. The Basic Life and AD&D Insurance is provided at **NO COST** to you. Please make sure you add at least one beneficiary in Workday when you enroll. You can change your beneficiaries in Workday at any time.

ADDITIONAL TERM LIFE INSURANCE

The Standard: 888.937.4783

Employee Benefit Amount

This coverage is Group Term Life Insurance. The Life Insurance benefit is payable to the designated beneficiary upon your death. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product. This insurance is optional and can be purchased by you and your spouse. In Workday, this is called: Voluntary Life – Standard Insurance Company Employee Voluntary Life (Employee) or Voluntary Accidental Death and Dismemberment – Standard Insurance Company Voluntary Accidental Death and Dismemberment (Employee).

- Benefit options that are available are $40,000, $60,000, $80,000, $100,000, $150,000 or $200,000.
- Accidental Death & Dismemberment insurance is available in the same amounts, and must be elected in an amount equal to or less than the Life Insurance benefit amount.
- All Guarantee Issue at initial eligibility.

Evidence of insurability is required if you enroll or increase coverage more than 31 days after you become eligible. If you do not apply for coverage when you are initially eligible and you choose to apply at a later date, you may be responsible for any expenses associated with obtaining further medical information (Life Insurance is not an annual open-enrollment benefit).

Please note: Life Time team members who are married to each other and both are eligible for benefits, may only be insured for Life Insurance as a team member. You may not elect Spouse Life Insurance unless your spouse loses eligibility. If you have children, only one of you may elect coverage on the child(ren).

Reduction in Benefits

Your benefits will be reduced by 35% upon attainment of age 65, an additional 15% of the original amount at age 70, and an additional 15% of the original amount at age 75. Coverage will terminate upon retirement.

Monthly Premium Calculation

John Doe is 33 and elected $60,000 of Additional Life Insurance and $40,000 of AD&D Insurance. His cost per month for additional life insurance is $60,000 x .000088 = $5.28. His cost for Additional AD&D insurance is $40,000 x .00002 = $0.80 per month.

Employee Age	Per $1000 of Coverage
< 30	0.066
30–34	0.088
35–39	0.099
40–44	0.143
45–49	0.242
50–54	0.385
55–59	0.594
60–64	0.935
65–69	1.76
70–74	3.080
75 +	6.677
AD&D Rate	$0.02

$_____ x _____ = $_____

Additional Life Insurance amount x rate from table = monthly cost.

Spouse Benefit Amount

Benefit options available are $20,000, $30,000 or $50,000. Accidental Death & Dismemberment Insurance is available in the same amounts, and must be elected in an amount equal to or less than the Life Insurance benefit amount. The elected amount is guarantee issue if you are a timely enrollee. Your spouse's benefit will reduce by 35% upon the attainment of age 65, an additional 15% of the original amount at age 70, and an additional 15% at age 75.

In Workday, these are called: Spouse Life – Standard

Insurance Company Spouse Voluntary Life (Spouse) and Spouse Accidental Death and Dismemberment – Standard Insurance Company Spouse Accidental Death and Dismemberment (Spouse). (This is not an annual open enrollment benefit.)

Please note: Life Time team members who are married to each other and both are eligible for benefits, may only be insured for Life Insurance as a team member. You may not elect Spouse life unless your spouse loses eligibility. If you have children, only one of you may elect coverage on the child(ren).

Monthly Premium Calculation
John Doe's wife is 35 and elected $30,000 of Additional Life Insurance and $30,000 of AD&D Insurance. His cost per pay period for his wife's Additional Life Insurance coverage is $30,000 x .000099 = $2.97 per month. His cost for his wife's AD&D coverage is $30,000 x .00002 = $0.60 per month.

Spouse Age	Per $1000 of Coverage
< 30	0.066
30–34	0.088
35–39	0.099
40–44	0.143
45–49	0.242
50–54	0.385
55–59	0.594
60–64	0.935
65–69	1.76
70–74	3.080
75 +	6.677
AD&D Rate	$0.02

$_____ x _____ = $_____

Additional Life Insurance amount x rate from table = monthly cost. Additional AD&D amount x rate from table = monthly cost.

Dependent Children Benefit Amount

- $10,000 for children from live birth up to 26 years if unmarried.
- In Workday, this is called: Child Life – Standard Insurance Company Dependent Child Voluntary Life (Child).

Please note: For Life Time team members who are married to each other and both are eligible for benefits, only one of you may elect coverage on the child(ren).

Monthly Premium Calculation
John Doe elected Child Life Insurance for his three kids. His cost per month for his Child Life Insurance coverage is $1.00. The Child Life Insurance rate is $1.00 for $10,000 of coverage regardless of the number of eligible children you have.

Other Benefits Included

Waiver of Premium
Life Insurance coverage continues without premium payment up to Social Security Normal Retirement Age (SSNRA) if you become permanently and totally disabled from all occupations for which you are reasonably qualified. Total disability must begin before age 60 and must continue for 6 months before the benefit becomes effective.

Accelerated Death Benefit
An accelerated death benefit is available when a team member has qualified for Waiver of Premium. When a team member is diagnosed as terminally ill (having 12 months or less to live), the team member may withdraw up to 75% of the life insurance coverage up to a maximum of $500,000. NOTE: Receipt of an accelerated death benefit will reduce the amount payable at death and may result in taxable income or affect eligibility for certain government benefits. Check with your tax advisor or attorney before exercising this option.

Program Eligibility

All full-time team members regularly scheduled to work at least 36 hours each week (32 hours for technical spa team members). Team members must be capable of being actively at work on the day before coverage takes effect. A delayed effective date will apply if the team member is not actively at work on the date that insurance would otherwise take effect.

Portability

If your employment at Life Time ends, you may be eligible to buy portable group insurance coverage. You must apply within 31 days of losing coverage. See your Certificate of Coverage for further details.

Conversion

If your or your dependents' coverage ends or reduces for reasons other than failure to pay premium or payment of accelerated death benefit, you may buy an individual policy of Life Insurance without Evidence Of Insurability. Conversion election must be made within 31 days of your loss in coverage. See your Certificate of Coverage for further details.

401k

Fidelity: 800.835.5095

Your 401k Administrator is Fidelity Investments. You can find Fidelity Investments online at 401k.com or call 800.835.5095. Your 401k Advisor is CBIZ. You can find CBIZ online at cbiz.com or call 877.323.3867.

Life Time has a 401k plan that may match amounts team members contribute to the plan. Life Time's plan allows you to save for your retirement on a tax-deferred basis. All contributions and earnings within the Life Time 401k are not taxed at the time of deduction, providing tax savings now. You may enroll if you are at least 21 years of age. Enrollment is done at the Fidelity website 401k.com. Further enrollment instructions can be found on LTPulse.

You can receive FREE, unbiased, professional financial advice from CBIZ. You may call them at 877.323.3867 to answer questions regarding the 401k plan such as: How much of my paycheck should I put aside to help me retire?, and/or Which investments in the 401k plan are right for me?

ADOPTION BENEFIT

Life Time believes that team members who are building a family, whether through birth or adoption, should have benefits. The costs of adopting, as well as the need for bonding and adjustment with a new child, parallel the experience of those who give birth. For more information in regard to this benefit, please refer to the information listed on LTPulse.

LEAVE OF ABSENCE

Please contact the Life Time Leave Administrator at 888.430.5433 or email leaveofabsence@lifetimefitness.com for all Leave of Absence (FMLA, Military, ADA/Medical, etc.) inquiries. If you are on leave and the number of your dependents changes (ex: birth of a child), please refer to the "Qualified Life-Changing Event" section at the beginning of this booklet. You will be responsible for paying for your benefit premiums while out on leave.

EMPLOYEE ASSISTANCE PROGRAM

LifeWorks offers confidential assistance with personal, legal, work, financial and other life issues on a 24-hours-a-day, 7-days-a-week basis. Call 888.267.8126 or go to lifeworks.com to get assistance any time.

FrontierMEDEX

Travel Assistance through Life Time Group Life Insurance

This is a benefit brought onto Life Time's Life Insurance plan through *The Standard*.

Travel Assistance helps you cope with emergencies when you travel more than 100 miles from home or internationally for trips of up to 180 days. It can also help you with non-emergencies, such as planning your personal trip.

You do not have to enroll. As a participant in our company's Group Life Insurance coverage from Standard Insurance Company, you and your family members are automatically covered. All services are available 24 hours a day, every day.

For more information in regards to this benefit, please refer to the information listed on LTPulse.

KEY BENEFIT TERMS

- **COBRA** – A Federal law that allows workers and dependents (not including domestic partners) who lose their medical, vision, dental or medical flexible-spending account coverage to continue any of these coverages for a specified length of time by electing and paying for continuation benefits.
- **Co-insurance** – The percentage of the medical or dental charge that you pay after you pay the deductible.
- **Copayment** – A flat fee that you pay for medical services, regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.
- **Deductible** – The amount you pay toward medical and dental expenses each plan year before the plan begins paying benefits.
- **Domestic partner** – A team member's domestic partner who has the same principal place of abode for more than two years, and who relies on the team member for more than one half of his or her support for the calendar year in which the domestic partner is enrolled for coverage under the Plan.
- **Out-of-pocket** – The total amount a team member or dependent pays out-of-pocket in a given benefit period (typically a year), including any deductibles or co-insurance (copayments will apply to out-of-pocket). Once this maximum has been reached, the plan pays 100% of eligible expenses, up to the annual maximum.
- **Premium** – The amount paid or to be paid by the team member for benefit coverage.
- **Network** – Doctors, hospitals, chiropractors and other medical professionals who have agreed to provide team members with better prices for services. You will be placed in a network based on your address in Workday. Please be sure to keep your address current.

HEALTHEZPAY MEDICAL PAYMENT SERVICE

HealthEZ offers a medical payment service called HealthEZpay, which will automatically pay your medical bills on your behalf from an FSA or HSA account, or with a credit card or bank debit card.

With the Electronic Notification feature, you'll receive an email message when a medical bill is ready to be paid. You can then click through to a secure website to review and authorize payment. If you're a HealthEZpay member, you can pay using an account you currently have on file with HealthEZ. If you're not a HealthEZpay member, you can pay using the credit or bank debit card of your choice.

Sign up for HealthEZpay using the application form on the next page or by calling 888.409.2273.

HEALTH*ezpay*

LIFE TIME™
THE HEALTHY WAY OF LIFE COMPANY

Questions? Please call 1.888.409.2273, or email us at paymentservices@healthez.com

1. BASIC PERSONAL INFORMATION - REQUIRED

TITLE (MR., MRS., MS., DR., ETC.)

FIRST NAME

LAST NAME

Mail this form to:
HealthEZ Inc.
7201 West 78th Street
Suite 100
Bloomington, MN 55439
or fax it: 952.896.0372

2. PAYMENT OPTIONS AND ACCOUNT INFORMATION

HealthEZ can use a variety of account types to automatically fund your healthcare expenses. Please check the type of account you wish to use and fill in the appropriate account information.
If you choose HSA or Flex, use the debit card information for that account.

Primary Account (The first source to use for payment)

☐HSA ☐Flex ☐Visa ☐MasterCard ☐American Express ☐Discover

CREDIT or DEBIT CARD NUMBER

M M Y Y
EXPIRATION DATE

BILLING ADDRESS (If different from your home address)

CITY

STATE ZIP CODE -

Secondary Account (Used as backup for primary account)

☐HSA ☐Flex ☐Visa ☐MasterCard ☐American Express ☐Discover

CREDIT or DEBIT CARD NUMBER

M M Y Y
EXPIRATION DATE

BILLING ADDRESS (If different from your home address)

CITY

STATE ZIP CODE -

3. EMAIL NOTIFICATIONS - REQUIRED

Take Full Advantage of our Online Services:
By subscribing with your email you can receive notifications when your statements are available online and when a medical bill (over a specified amount) is ready to be paid by your credit card.

PREFERRED E-MAIL ADDRESS

4. AUTHORIZATION

I authorize HealthEZ, Inc. to use the information provided on this application to pay my healthcare providers directly. HealthEZ may not use any such information for any other purposes (such as payment of any fees to HealthEZ or for any marketing purposes) and may not disclose such information to any third party. I understand that I am liable for any charges under the terms and conditions with my credit card/debit card company. I also understand that I am entitled to fraud protection under the same terms and conditions.

SIGNATURE

M M - D D - 2 0 Y Y
DATE

IMPORTANT NOTE: The HealthEZ Medical Payment Service cannot be utilized with coordination of benefits.

Privacy and Security Policy

HealthEZ works diligently to protect the privacy and security of your sensitive financial and healthcare information. HealthEZ is committed to using every physical and technological method available to ensure the information you record on this application is used only for HealthEZ Medical Payment Service. If you do not wish to write your card number on this form, we will be happy to accept this information over the phone.

HEALTHEZ®

ENROLLMENT WORKSHEET

For Reference Only – All costs shown are employee monthly costs.
This worksheet is NOT an enrollment. All team members must log in to Workday to enroll.

Medical: *(circle election)*	Copay Plan	HSA $2,000	HSA $5,000	waive coverage
Employee	$126.16	$99.50	$77.65	
Employee & Spouse	$251.75	$190.60	$166.49	
Employee & Child(ren)	$194.97	$147.64	$129.02	
Family	$360.93	$273.30	$238.81	

Dental: *(circle election)*	Delta 80	Delta 100	Delta Platinum	waive coverage
Employee	$13.34	$29.23	$36.00	
Employee & Spouse	$21.74	$56.57	$69.87	
Employee & Child(ren)	$29.08	$86.18	$106.17	
Family	$57.35	$113.53	$139.69	

Voluntary Vision: *(circle election)*	Basic	Enhanced	waive coverage
Employee	$5.04	$7.52	
Employee & Spouse	$8.32	$12.32	
Employee & Child(ren)	$10.08	$13.52	
Family	$15.60	$20.96	

*Note: Your medical, dental & vision elections can all be different levels of coverage

Health Savings Account:

Participating *(circle one)* Yes No
If participating: Pay period contribution amount $_____

Medical Care Reimbursement Account:

Participating *(circle one)* Yes No
If participating: Annual contribution amount through September 30, 2017 $_____

Limited Flexible Spending Account *(with an HSA)*:

Participating *(circle one)* Yes No
If participating: Annual contribution amount through September 30, 2017 $_____

Transportation Spending Account:

Participating *(circle one)* Yes No
If participating: Annual contribution amount through September 30, 2017 $_____

Dependent Care Flexible Spending Account:

Participating *(circle one)* Yes No
If participating: Annual contribution amount through September 30, 2017 $_____

ENROLLMENT WORKSHEET

Voluntary Short-Term Disability

Participating *(circle one)* Yes or No

Age	Monthly Benefit Rate
< 30	0.0371
30–34	0.0350
35–39	0.0330
40–44	0.0309
45–49	0.0433
50–54	0.0495
55–59	0.0618
60–64	0.0742
65–69	0.0845
70–74	0.0927
75 +	0.0989

$_____ x 60% = $_____ * _____ = $_____

Weekly salary x 60% = weekly benefit x rate from table = monthly premium. The maximum covered weekly salary is $2,083. The maximum weekly benefit is $1,250.

Voluntary Long-Term Disability

Participating *(circle one)* Yes or No

Age	Monthly Covered Payroll Rate
< 25	0.00126
25-29	0.00168
30–34	0.00224
35–39	0.00364
40–44	0.00546
45–49	0.00798
50–54	0.01078
55–59	0.01470
60–64	0.01316
65–69	0.00798
70–99	0.00658

$_____ x _____ = $_____

Monthly salary x rate from table = monthly cost. If your monthly salary exceeds $13,333, enter $13,333.

Standard Insurance Company does not pay Long-Term.

ENROLLMENT WORKSHEET

Dependent Participation Detail

Legal Name	SS#	Relationship	Gender	DOB	Medical *Yes or No*	Dental *Yes or No*	Vision *Yes or No*

Beneficiary Information for Basic Life and Optional Life Insurance

Basic Life Primary Beneficiary

Name SS# Relationship %

Name SS# Relationship %

Basic Life Contingent Beneficiary

Name SS# Relationship %

Name SS# Relationship %

Optional Life Primary Beneficiary

Name SS# Relationship %

Name SS# Relationship %

Optional Life Contingent Beneficiary

Name SS# Relationship %

Name SS# Relationship %

ENROLLMENT WORKSHEET

Optional Life Insurance and Accidental Death and Dismemberment Insurance

Employee: Participating *(circle one)* Yes or No Amount of Coverage: $ _____

Employee Cost	
< 30	0.066
30–34	0.088
35–39	0.099
40–44	0.143
45–49	0.242
50–54	0.385
55–59	0.594
60–64	0.935
65–69	1.76
70–74	3.080
75 +	6.677
AD&D Rate	$0.02

$ _____ ÷ 1,000 X $ _____ = $ _____
Amount of Coverage Unit Cost from Above Employee Monthly Cost

Spouse: Participating *(circle one)* Yes or No Amount of Coverage: $ _____

Spouse Cost	
< 30	0.066
30–34	0.088
35–39	0.099
40–44	0.143
45–49	0.242
50–54	0.385
55–59	0.594
60–64	0.935
65–69	1.76
70–74	3.080
75 +	6.677
AD&D Rate	$0.02

$ _____ ÷ 1,000 X $ _____ = $ _____
Amount of Coverage Unit Cost from Above Employee Monthly Cost

Children: Participating *(circle one)* Yes or No Amount of Coverage: $10,000
Cost: $1.00

BE A SCHOOL LUNCH HERO

Support the School Lunch Hero Program in your 2016 benefits elections.

Join the movement as we help schools eliminate seven harmful ingredients from the food they serve, so every child receives the healthy food they deserve.

This is achieved by removing Trans Fats and Hydrogenated Oils, High-Fructose Corn Syrup, Hormones and Antibiotics in animal production, Added and Artificial Sweeteners, Artificial Colors and Flavors, Artificial Preservatives and Bleached Flour.

With over 30 million kids eating school lunch every day, let's make sure they get healthy, nutritious, real food. 100% of your contribution to the Life Time Foundation supports our school grant and education programs.

Be a School Lunch Hero!

Log in to WorkDay and make your contribution.

It's easy to donate.

1. Log in to **Workday**
2. Select **Benefits** on the home page
3. Under the **Change** section, select **Benefits**
4. From the **Benefits Event Type** drop-down menu, select **Life Time Foundation**
5. Choose **Effective Date** you want to start your election, click **Submit**, then click **Done**
6. You will immediately receive **Message** in your Workday inbox
7. Within that message, click **Elect**, then enter in the amount by year or by paycheck
8. Click **Continue**
9. Review your election and hit **Submit**

LIFE TIME℠ FOUNDATION | 100% OF YOUR DONATION SUPPORTS OUR MISSION

Our mission

is to provide an
Entertaining,
Educational,
Friendly & Inviting,
Functional & Innovative
experience of
uncompromising quality
that meets the health and fitness
needs of the entire family.

LIFE TIME℠

THE HEALTHY WAY OF LIFE COMPANY