SUMMARY PLAN DESCRIPTION & PLAN DOCUMENT
FOR

LIFE TIME®

HEALTHY WAY OF LIFE

FLEXIBLE SPENDING ACCOUNT PLAN

AMENDED & RESTATED JANUARY 1, 2020

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Introduction

This document is a Summary Plan Description and Plan Document for the Life Time, Inc. Flexible Spending Account Plan. Please read this document carefully so you will understand the benefits of your Flexible Spending Account Plan.

The benefits included the Life Time, Inc. Flexible Spending Account Plan are as follows:

1. Health Care Flexible Spending Account Plan (Health Care FSA)
2. Dependent Care Flexible Spending Account Plan (Dependent Care FSA).

Throughout this document, these plans will be referred to the Flexible Spending Account (FSA) or the Plan. The Plan allows covered employees to set money aside to pay for eligible medical expenses and/or dependent care expenses on a pre-tax basis. Each covered person's rights under the Plan are legally enforceable. You may not assign, or in any way transfer, your rights under the plan.

General Plan Information

Name of Plan:	**Life Time, Inc.** **Flexible Spending Account Plan**
Employer/Plan Sponsor:	**Life Time, Inc.** **2902 Corporate Place** **Chanhassen, Minnesota 55317**
Plan Administrator:	**America's TPA dba HealthEZ** **PO Box 211186** **Eagan, Minnesota 55121**
Named Fiduciary:	Life Time, Inc. Has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Same address and phone number as Plan Administrator.
Plan Sponsor ID No. (EIN):	41-1689746
Source of Funding:	The Plan is funded by the general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees.
Plan Year:	**October 1st to September 30th**
Plan Number:	**501**
Plan Type:	Health Care Flexible Spending Account Dependent Care Flexible Spending Account
Claims Administrator:	America's TPA dba HealthEZ PO Box 211186 Eagan, Minnesota 55121
Agent for Service of Process:	Life Time, Inc.

Termination or Amendment

The Employer has the right to amend or terminate the Plan, in whole or in part, at any time for any reason. If a change is made, you will be notified.

No Contract of Employment
The Plan does not constitute a contract of employment between you and the Employer, nor does your participation in the Plan give you any rights to continue as an employee of the Employer. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

Claims Administrator Is Not a Fiduciary
A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Type of Administration
The Health Care FSA component is a group health plan. The Health Care FSA and Dependent Care FSA components are self-funded by the Employer and are contract administration plans. A third-party administrator pays the claims out of the Employer's general assets.

Qualified Medical Child Support Order
The Health Care FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a).

About Your Flexible Spending Accounts

The Health Care Flexible Spending Account Plan (Health Care FSA) allows you to set aside part of your salary on a pre-tax basis to help pay for eligible health care expenses each year. Examples of eligible expenses include medical and dental care, as well as vision expenses for you, your spouse and your dependents. As you pay for these expenses, your Health Care FSA will pay you back.

Each year during open enrollment, **you can elect to set aside pre-tax dollars up to $2,750* (2020).** This money will be dipositive to into your Health Care Spending Account for the year. The total amount you decide to set aside is taken out of your paycheck in equal amounts throughout the year.

***The maximum contribution to this Health Care FSA Plan for each plan year shall mirror the FSA limit Internal Revenue Service ("IRS") announces for that taxable year. If IRS increases the FSA limit, this Plan's maximum contribution increases automatically to match IRS's announcement.**

The Dependent Care Flexible Spending Account Plan (Dependent Care FSA) allows you to set aside part of your salary on a pre-tax basis to help pay for eligible dependent care services each year. It covers eligible day care expenses for your dependent children under age 13. It may also be used for the care of other dependents, if they are considered your dependent for income tax purposes, if such individual is mentally or physically handicapped and incapable of self-care.

Each year during open enrollment, you can elect to set aside pre-tax dollars between $0 to $5,000 (or less, if subject to additional limitations). This money will be deposited into your dependent care spending account. **If your spouse also participates in a dependent care spending account, the tax-free benefit is limited to $5,000 for both of you. If you are married but filing taxes separately, the tax-free benefit is limited to $2,500.** The total amount you decide to set aside is taken out of your paycheck in equal amounts throughout the year.

Your contributions to the Health Care FSA and/or Dependent Care FSA are made through pre-tax payroll deductions. You cannot deposit cash directly into these accounts. During the Annual Open Enrollment Period, you can choose the amount of your deposits for the next year. Once you choose the amount of your contribution for a particular Plan Year, you cannot change your election unless you have a Change in Status.

Eligibility

New Employees

New employees will be eligible for both the Health Care FSA and Dependent Care FSA on the date the New Employee becomes eligible under the Life Time, Inc. Medical Plan.

However, an Employee is not eligible for the Dependent Care FSA if he or she is married and the spouse does not earn any income, unless the spouse is a full-time student, is actively looking for a job, or is disabled and unable to provide his or her own care. Your spouse is considered to be a full-time student if he or she goes to school for at least five months a year.
New employees must enroll within 31 days of becoming eligible to participate in the Plan.

Annual Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. The elections you make will be in effect for the following year, which begins on October 1st.

If you are already enrolled in the Plan and you wish to continue participating, you must re-enroll each year to continue your participation.

Making Changes to your FSA Election(s)

The IRS requires that your FSA elections remain in effect throughout the entire Plan Year. Once made, you cannot change your election during the year unless you experience a Change in Status. This applies to:

1. The account(s) you've elected to participate in; and
2. The amount of your pre-tax payroll deduction deposits into your account(s).

Change in Status

The following are examples of a qualifying Change in Status:

1. Gaining or losing a spouse (through marriage, divorce, or death);
2. Gaining or losing a dependent (through birth, adoption, placement for adoption, death, or loss of eligibility as a dependent);
3. Change in the employment status of you, your spouse, or your dependent that causes a change in eligibility (e.g., changing from part-time to full-time, or changing from hourly to salaried); and
4. Change in cost or coverage of dependent care (e.g., change from one child care provider to another that charges different rates).

The Employer may require documentation as proof of any claimed Change in Status.

You have 31 days from the date the change in status becomes effective to change your FSA account election(s). **The change in your election must be consistent with the Change in Status.** For example, if you change child care providers, you may change your Dependent Care FSA election, but your Health Care FSA election must remain the same.

If you do not report the Change in Status within the 31-day period, you will not be allowed to make the change until the next annual open enrollment period.

Effective Date for Change in Status. If you have a Change in Status, the change to your election(s) will be effective as of the date you request the change.

Leave of Absence

Paid Leave of Absence. Your participation in the Plan will not be affected if you are granted a paid leave of absence. Payroll deductions will continue, and you can still use your FSA to reimburse yourself for eligible expenses. You may report a Change in Status to change your elections if the circumstances of your leave also create a qualifying Change in Status.

Unpaid Leave of Absence – Health Care FSA. While on an unpaid leave of absence, you may continue participating in your Health Care FSA by making payments on an *after-tax basis* (contact your Human Resources Department for details). If you do not make your payments by the deadline or do not elect to continue your Health Care FSA, you may be offered COBRA coverage. If COBRA coverage is not elected, you will only be eligible for reimbursements for claims incurred before the effective date of your unpaid leave or the date you stopped making contributions, whichever is later.

If you did not elect to continue participating in the Health Care FSA while you were on unpaid leave of absence, you may elect to participate when you return to active status. The election must be made within 31 days of your return to active status.

Unpaid Leave of Absence – Dependent Care FSA. While on an unpaid leave of absence, your contributions and participation in the Dependent Care FSA will end. You can continue to be reimbursed from your Dependent Care FSA for Eligible Expenses you incurred while you were actively at work. However, you will not be reimbursed for expense incurred while on unpaid leave. Any balance in your account from contributions made before your leave can be used for claims incurred upon your return to work.

When you return from unpaid leave, you may elect to participate in the Dependent Care FSA. The election must be made within 31 days of your return to active status.

Termination of Employment

Health Care FSA. If your employment is terminated during the Plan Year, you can:

1. You can close your account. If you do so, **you will have until December 31st of the next plan year to submit claims** for Eligible Expenses *incurred before your termination* of employment date; or

2. You can continue your contributions on an after-tax basis by electing COBRA coverage. In this case, you can still claim reimbursements from your account for expenses incurred after you terminate through the end of the Plan Year, provided you continue your FSA participation by making after-tax contributions.

Dependent Care FSA. If your employment is terminated during the Plan Year, your contributions to your Dependent Care FSA will end. However, you can be reimbursed for Eligible Expenses *incurred before your termination* of employment date. **You have until December 31st of the next plan year to submit claims.**

Rehired. If your employment is terminated and you are subsequently rehired within the same Plan Year, you may re-enroll in the Plan at the same time that you are eligible to re-enroll in the Medical Plan. This will be considered a Change in Status, and you will have the opportunity to uses your prior elections or change your elections.

Continuation of Coverage – Health Care FSA Only

This optional continuation coverage only applies if it has been made available by Life Time, Inc. Life Time, Inc. may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Please contact the Human Resources Department at Life Time, Inc. to find out if and how this continuation of coverage applies.

Please note that the Dependent Care FSA is not eligible for continuation of coverage.

Healthcare Flexible Spending Account

Contributions

Maximum Contribution: $2,750 per year for 2020*****

***The maximum contribution to this Health Care FSA Plan for each plan year shall mirror the FSA limit Internal Revenue Service ("IRS") announces for that taxable year. If IRS increases the FSA limit, this Plan's maximum contribution increases automatically to match IRS's announcement.**

Eligible Expenses

You can be reimbursed by your Health Care FSA for expenses that are considered "medical care" under Section 213(d) of the Internal Revenue Code, so long as those expenses are not reimbursed by any other healthcare plan. IRS rules may change, so you are encouraged to check with a tax advisor regarding the eligibility of specific expenses. You can get additional information about eligible healthcare expenses from IRS Publication 502, "Medical and Dental Expenses," which is available from your local IRS office and the IRS website at www.irs.gov.

Eligible Healthcare Expenses include medical, vision, hearing, and dental expenses, as well as prescription drugs, over the counter drugs, medical supplies and menstrual products. However, please refer to IRS rules for coverage of specific expenses.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements and toiletries such as toothpaste, etc.)

In addition, as with any other expense reimbursed under any Other Plan covering health benefits, including a spouse's or dependent's plan, health expenses reimbursed through your Health Care FSA cannot be claimed as deductions on your income tax return.

Limited Healthcare FSA (Health Savings Account Participants Only)

If you are participating in another type of employer-sponsored benefit called a Health Savings Account (HSA), then you **may only claim reimbursements for dental and vision expenses**. This is called a Limited Healthcare FSA.

Filing Your Claim

You may submit claims for reimbursement to your Health Care FSA in the following ways:

EZpay. If you sign up for EZpay your FSA funds will automatically be used to pay your Eligible Expenses. Please call 1-800-948-3253 to learn how to set up EZpay.

Wex Debit Card. Your Employer has made available a debit card for your use. You can use this card at point-of-purchase for any eligible medical expenses.

Manual Submissions. Employees who pay for eligible medical expenses out-of-pocket can send a completed reimbursement form and the receipt to the Claims Administrator at HealthEZ, using one of the following options:

Mail: HealthEZ
7201 West 78th St. STE 100
Bloomington, MN 55439

Fax: 952-896-0372

Email: service@HealthEZ.com

Web Account: www.ltfbenefits.com

Reimbursements will then be processed within thirty (30) days of receipt.

Dependent Care Flexible Spending Account

Contributions

Maximum Contribution: $5,000 per year

If your spouse also participates in a dependent care spending account, the tax-free benefit is limited to $5,000 for both of you. If you are married but filing taxes separately, the tax-free benefit is limited to $2,500.

Eligible Expenses

You can only use your Dependent Care FSA to pay for eligible dependent care expenses. Eligible dependent care expenses are those that are necessary for you (or you and your spouse) to work outside the home.

NOTE: If you are married and your spouse does not earn any income, then you are not eligible for dependent care benefits unless your spouse is a full-time student, is actively looking for a job, or is disabled and unable to provide his or her own care. Your spouse is considered to be a full-time student if he or she goes to school for at least five months a year.

Your dependent care claims must meet four requirements before they can be approved:

1. You claim must be for the care of an "Eligible Dependent" (see below);
2. The care provided must be for an Eligible Dependent care expense (see below);
3. You cannot be reimbursed more than the amount in your Dependent Care FSA at any given time;
4. Your claim must be support by appropriate documentation. This includes the name, address, and social security number (or taxpayer identification number) of the dependent care provider.

Eligible Dependents. Each dependent that you claim dependent care expenses for must be:

1. A person under age 13 that you claim as a dependent on your federal tax return; or
2. A spouse or a person (other than a child under age 13) who is your dependent under federal tax law, but only if he or she is physically or mentally incapable of self-care.

Eligible Dependent Care Providers. If you want to be reimbursed from your Dependent Care FSA, services must be provided by:

1. A dependent care center (defined as a facility that provides care for more than six individuals that do not live at the facility). The care center must comply with all state and local laws and regulations. In most cases, this means that the facility is licensed; or
2. A person who is not your spouse or a dependent under IRC section 150(b). If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses take place

The care may be provided in your home or at an outside care center. You can choose care outside your home for a dependent other than your children only if the dependent usually spends at least eight hours each day in your home.

Services Eligible for Reimbursement. Generally, eligible dependent care services are services that provide for the dependent's well-being and protection. In most cases it does not include food, clothing or education. It does not include expenses for education of a dependent in kindergarten or any higher grade. It does not include expenses for overnight camp.

The following are examples of services eligible for reimbursement:

1. Expenses for care at a day care center that complies with all applicable state and local regulations.

2. Expenses for care provided by a housekeeper, babysitter or other person in your home relating to caring for a eligible dependent.

3. Expenses for care provided by a relative who cares for your eligible dependents, so long as that relative is over the age of 19 and are not your dependent under federal tax law.

4. Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit. Under current law, you can take a federal dependent care tax credit for part of your dependent care expenses if dependent care is needed so that you and your spouse can work outside the home. If you use your Dependent Care FSA to pay for a dependent care expense, you cannot claim the federal dependent care tax credit for the same expense. Remember that the maximum amount of the federal dependent care tax credit available to you each year will be reduced by the amount you chose to deposit in your Dependent Care FSA for that year. You are encouraged to speak with a tax advisor regarding this issue.

Filing Your Claim

You may submit claims for reimbursement for your Dependent Care FSA by sending a completed reimbursement form and the receipt to the Claims Administrator, HealthEZ, using one of the following options:

Mail: HealthEZ
7201 West 78th St. STE 100
Bloomington, MN 55439

Fax: 952-896-0372

Email: service@HealthEZ.com

Web Account: www.ltfbenefits.com

Reimbursements will then be processed within thirty (30) days of receipt.

Claim Denial & Appeal Process

Claim Denial

If your claim is denied for reimbursement, you will receive a written notice from the Claims Administrator, HealthEZ, within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

HealthEZ will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, HealthEZ will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Claim Appeal Process

If you have a question or concern about a claim reimbursement determination, you may informally contact a HealthEZ Customer Service representative before requesting a formal appeal. You may contact Customer Service at 1-800-948-3253. If the Customer Service representative cannot resolve the issue to your satisfaction, you may request a formal appeal as described below.

First Level of Appeal. If you wish to request a formal appeal of a denied claim for reimbursement, you should submit your request in writing to the following address:

HealthEZ
7201 West 78th Street, Suite 100
Bloomington, MN 55439
800-948-5888

You should include your name and a description of the claim determination that you are appealing, the reason you believe your claim should be reimbursed, and any written information to support your appeal.

Your first appeal request must be submitted in writing to HealthEZ within 180 days after you receive the denial.

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to decide the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

The first level appeal will be conducted, and you will be notified by HealthEZ of the decision in writing within 30 days from receipt of a request for appeal of a denied claim.

Final Level of Appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan Sponsor at the following address:

Attn: Human Resources
Life Time Fitness
2902 Corporate Place
Chanhassen, MN 55317

Your second level appeal request must be submitted in writing to the Plan Sponsor within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by the Plan Sponsor of the decision in writing within 30 days from receipt of a request for a second level appeal. The Plan Sponsor has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Defined Terms

The following terms have special meanings and when used in this Plan Document will be capitalized.

Change in Status means a qualifying event that allows you to change (1) your election amount in an FSA account in which you are already participating and (2) enroll or disenroll from an FSA account.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Dependent Care Flexible Spending Account Plan (Dependent Care FSA) is an account that uses pre-tax dollars to pay for eligible expenses related to care for your qualified dependent such care is necessary for you to work or if the dependent is disabled and unable to care for himself or herself.

Eligible Dependent means a dependent whose care costs may be reimbursed out of your Dependent Care FSA.

Eligible Expenses means expenses that may be reimbursed by either the Health Care FSA or Dependent Care FSA. The eligibility of any particular expense is subject to IRS rules.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

New Employee shall mean an Employee who was recently hired by the Employee and is subject to any eligibility requirements prior to becoming eligible for the Plan.

Employer is Life Time, Inc., and its Affiliates.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Health Care Flexible Spending Account Plan (Health Care FSA) is an account that uses pre-tax dollar to pay for eligible medical expenses, as defined by the IRS.

Health Savings Account (HSA) means an IRS-regulated, pre-tax account that may be established and controlled by the employee. Both the employee and employer can contribute to the Health Savings Account (HSA) up to the annual IRS maximums. The Health Savings Account (HSA), when combined with an HSA-eligible health plan, can be used to fund the deductible as well as pay other IRS-qualified medical, dental, or vision expenses.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Incur or Incurred – An Eligible Expense is “Incurred” on the date the service is rendered or the supply is obtained.

Other Plan shall include, but is not limited to:

(1) Any primary payer besides the Plan;

(2) Any other group health plan;

(3) Any other coverage or policy covering the Plan Participant;

(4) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(5) Any policy of insurance from any insurance company or guarantor of a responsible party;

(6) Any policy of insurance from any insurance company or guarantor of a third party;

(7) Worker's compensation or other liability insurance company; or

(8) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Medical Plan means the plan offered by the Employer which covers the medical services specified therein.

Plan means Life Time, Inc. Flexible Spending Account Plan, which is a benefits plan for certain Employees of Life Time, Inc. and is described in this document.

Plan Participant (Member) means any Employee or Dependent who is covered under this Plan.

Plan Year means the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Prior Plan means the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the effective date of this Plan and replaced by this Plan.

Run-Out Period means the period of time each Employee who is participating in an FSA account has after the end of the Plan Year to submit claims incurred during the Plan Year.

Plan Participants Rights Under ERISA

As a participant in Life Time, Inc. Flexible Spending Account Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public
Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age * * *) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up

to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Responsibilities for Plan Administration

PLAN ADMINISTRATOR. Life Time, Inc. Medical Plan is the benefit plan of Life Time, Inc., and its Affiliates, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Life Time, Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Life Time, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

SUMMARY OF MATERIAL REDUCTION (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Plan Participant. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATION (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.

Compliance with HIPAA Privacy Standards (Health Care FSA Only)

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Life Time, Inc.'s workforce are designated as authorized to receive Protected Health Information from Life Time, Inc. Flexible Saving Account Plan ("the Plan") in order to perform their duties with respect to the Plan: **Benefits Manager and appointed staff**.

SECTION 125 PLAN DOCUMENT

LIFE TIME, INC.

PREMIUM ONLY PLAN

PURPOSE

Life Time, Inc. Premium Only Plan (the "Plan") is adopted by Life Time, Inc. effective January 1, 2020. The purpose of the Plan is to allow Employees of Life Time, Inc. and other Participating Employers, to choose between at least one permitted taxable benefit, such as cash compensation from existing income and at least one qualified benefit such as health care coverage under medical plan(s) sponsored by the Company.

Life Time, Inc. intends that the Plan qualify as a "cafeteria plan" under section 125 of the Internal Revenue Code of 1986 ("Code") as amended, and that the Medical Insurance Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for federal income tax purposes.

Although this Plan has been reduced to writing in order to comply with section 125 of the Code, the Plan shall also serve as an amendment to each of the health plans described in Schedule A affected by its provisions in order to permit the benefits of this Plan to be fully implemented.

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Section 1

DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Adoption Agreement" means the written agreement by which an Affiliated Company adopts this Plan.

"Affiliated Company" means:

A. any company which a member of a controlled group of corporations with the Employer within the meaning of section 1563(a) of the Code, determined without regard to sections 1563(a) (4) and (e) (3) (C);

B. all organizations under common control with the Employer within the meaning of section 414 (c) of the Code:

C. all organizations which are included with the Employer in an affiliated service group within the meaning of section 414 (m) of the Code; or

D. any other entity required to be aggregated with the Employer pursuant to regulations under section 414 (o) of the Code.

"Beneficiary" means the person, persons or trust designated by written revocable designation filed with the Plan Administrator by the Participant to receive payments under this Plan, including the Participant and any dependents of a Participant.

"Cash" for purposes of section 125, cash means cash from current compensation (including salary reduction), payment for annual leave, sick leave, or other paid time off, severance pay, property, and certain after-tax employee contributions.

"Change in Status" has the meaning described in Section 4.3.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986 as amended, and the same as may be amended from time to time.

"Dependent" has the meaning described in Section 2.8.

"Effective Date" means January 1, 2020.

"Eligible Employee" means any non-union Employee regularly scheduled to work 30 or more hours per week for a Participating Employer.

"Employee" means an individual that the Employer classifies as a common-law employee, leased employee, or full time life insurance salesmen, and who is on the Employer's W-2 payroll, but does not include the following: (a) individuals classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency;
(c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; (f) any more-than-2% shareholder in a Subchapter S corporation; and (g) any employee who has been furloughed. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Life Time, Inc. and any other business organization which succeeds to its business and elects to continue this Plan.

"Enrollment Period" means the calendar month preceding the beginning of any Plan Year.

"Entry Date" means the first day of active employment as an Eligible Employee.

"ERISA" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Furloughed Employee" means All furloughed employees (and their dependents) who have been laid off due to the COVID-19 pandemic will retain their health benefit coverage until Life Time is able to reopen their locations and the furloughed employees return to work or until the end of the Plan Year on September 30th, 2020 (whichever comes first).

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Key Employee" means any Employee defined as such in section 416(1) (1) of the Code.

"Medical Insurance Benefits" means a health care coverage option, available from time to time under the Plan, as set forth in Schedule A hereto.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2.

"Participating Employer" means Life Time, Inc. and any Affiliated Company that adopts this Plan with the consent of the Employer. As of the Effective Date, the Employer is the only Participating Employer.

"Plan" means Life Time, Inc. Premium Only Plan which is described herein and as amended from time to time, and which is intended to constitute a separate, written Plan for the exclusive benefit of Eligible Employees.

"Plan Number" or "PN" assigned by Life Time, Inc. is 501.

"Plan Sponsor" means Life Time, Inc. ("Employer").

"Plan Year" means the twelve-month period commencing each October 1 and ending on the subsequent September 31.

"Premium Payment Benefits" means the amount set aside for Medical Insurance Benefits under Section 3.2 and credited to the Participant's Premium Only Account.

"Premium Only Account" means the account established in each Participant's name as provided under Section 3.2 and which is used to record the allocation of Premium Payment Benefits for the expenditure of the Medical Insurance Benefits elected by a Participant.

"Premium Expense" means the expense identified with the Medical Insurance Benefits elected by a Participant in accordance with Section 3.2.

"Qualified Benefits" For purposes of section 125, Qualified Benefit means benefits excludible from an employee's gross income under a specific provision of the Code and must not defer compensation, except as specifically allowed in section 125(d)(2)(B), (C) or (D). Examples of qualified benefits include the following: group-term life insurance on the life of an employee (section 79); or employer-provided accident and health plans. A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). See paragraph (q) in Sec. 1.125-1 for nonqualified benefits.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Salary Reduction Agreement" means a voluntary agreement whereby an Employee agrees to reduce his compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year) for purposes of obtaining the Medical Insurance Benefits offered by the Plan.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

Section 2

PARTICIPATION IN THE PLAN

2.1 Eligibility to Participate. Each Eligible Employee may elect to participate in the Plan if the Individual satisfies all of the following: (a) is an Employee of a Participating Employer; (b) is working 30 or more hours per week; and (c) has been employed by the Employer for one day or (d) the Employer has furloughed the Employee. Eligibility shall also be subject to the additional requirements, if any, specified in the Medical Insurance Plan.

Self-employed individuals are not eligible to participate in the Plan. New proposed regulations make clear that:

- sole proprietors,
- partners,
- directors of corporations, and
- 2-percent shareholders of an S corporation

are not employees for purposes of this Plan. (C Corporation owners who are employees and a director of the Corporation are eligible to participate in the Plan in their capacity as an Employee).

2.2 Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Salary Reduction Agreement under which the Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if such Salary Reduction Agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year). The Salary Reduction Agreement shall be governed by Section 3 hereof. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

An Eligible Employee's spouse or dependents can only receive benefits through the Plan if they are named on an Eligible Employee's qualifying policy. Eligible Employee's spouse or dependents cannot participate in the Plan independently.

2.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

A. the date on which the Plan terminates;

B. the date on which he ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage, certain Employees may continue eligibility for periods on the terms and subject to the restrictions described in Section 6.4;he first day of any Plan Year for which he has elected not to participate in the Plan;

C. the date on which he revokes his election and elects not to participate in Medical Insurance Benefits, on account of and consistent with a change in family status in

accordance with Section 4.3; or

D. the date on which he fails to make a contribution in accordance with Section 3.5.

Termination of participation in this Plan will automatically revoke the Participant's elections.

The Medical Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.4 Recommencement of Participation. If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.2. Notwithstanding the above, an election to participate in the Premium Payment Module will be reinstated only to the extent that coverage under the Medical Insurance Plan (here, major medical insurance) is reinstated. If an Employee becomes ineligible for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 before again becoming eligible to participate in the Plan.

2.5 FMLA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Medical Insurance Benefit coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical Insurance Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Medical Insurance Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Medical Insurance Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical Insurance Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

2.6 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.4(d) will apply.

2.7 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to Section 2.5 (regarding the payment of contributions with respect to FMLA Leave). A Participant whose coverage under the group health insurance plan is terminated on account of his or her being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service."

2.8 Definition of Dependent. Any individual who is a tax dependent of the Participant as defined in Code§ 152, with the following exceptions: (1) a dependent is defined as in Code§ 152, determined without regard to subsections (b)(l), (b)(2), and (d)(l)(B) thereof; and (2) a dependent means any child (as defined in Code§ 152(f)(l)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) a dependent means any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year), is treated as a dependent of both parents.

The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA). An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) The individual does not turn age 19 (24 if a full-time student*) by the end of the Plan Year

In addition, the following qualifying criteria apply to be a "dependent relative":

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does not apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer dependent children may be covered by either spouse, but not by both.

*NOTE: The Internal Revenue Service (the "IRS") Notice 2010-38 (the "Notice") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid by (or reimbursed to) the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. This coverage is provided to such adult child (as defined in Code§ 152(f){l)) regardless of whether the child satisfies the other requirements listed above. The Notice provides important guidance and further clarifications regarding these issues.

Section 3

BENEFITS AND METHODS OF FUNDING

3.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Section 2.2, Participants will be given the opportunity to elect Premium Payment Benefits, as described in Section 6. See Schedule A for a complete description of available benefits and refer to specific insurance premium rate sheets for individual maximum elective contribution.

3.2 Premium Payment Benefits. Upon proper election by a Participant in accordance with Section 3.3 herein, there shall be credited to each Participant's Premium Only Account any Premium Payment Benefits that correspond to the Participant's Salary Reduction Agreement determined in accordance with Section 3.3 hereof. Such Premium Payment Benefits shall not exceed the Premium Expense of the Medical Insurance Benefits elected, set forth in Schedule A attached hereto, as it may be revised by the Employer from time to time. The Participant's Premium Payment Benefits shall be credited as and when such sum is redirected from the Participant's compensation pursuant to the Salary Reduction Agreement then in effect. The Premium Payment Benefits shall be used to pay all or part of the Premium Expense of the Medical Insurance Benefits that the Participant has designated pursuant to Section 3.3. The Premium Expense paid on behalf of any Participant shall be a charge to the balance of his Premium Only Account. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. The Employer reserves the right to adjust Employee premium contributions at any time. Any increase in Employee contributions will require a 60 day notice.

3.3 Election of Benefits. An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the date in which participation will commence.

Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or when Employee first becomes eligible, a Salary Reduction Form identifying the Medical Insurance Benefits to be provided by the Employer to or on behalf of the Eligible Employee. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 4.4.

Each election under this Section 3.3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If an Eligible Employee separates from service with a Participating Employer during a period in which he is covered under Medical Insurance Benefits, the Employer may terminate the remaining portion of Medical Insurance Benefits coverage provided by the Plan. Any Participant or newly Eligible Employee who fails to execute an appropriate Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected cash compensation (regular income) to the

extent permissible.

3.4 Provision of Benefits. The Participating Employer shall provide the Medical Insurance Benefits the Participant has elected under the Plan. Eligibility for Premium Payment Benefits shall be subject to the additional requirements specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

***3.5** Employer and Employee Contributions.*

Employer Contributions. For Employees who elect Premium Payment Benefits, the Employer will contribute a portion of the Contributions (if applicable) as provided in the open enrollment materials furnished to Employees and/or on Election Form/Salary Reduction Agreement.

Employee Contributions. Employees who elect any of the Premium Payment Benefits, may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement, or may pay with after-tax deductions.

If a Participant does not have enough Premium Payment Benefits to pay for the Medical Insurance Benefits elected, the Participating Employer is authorized to withhold the additional amounts from a Participant's pay on an after-tax basis to the extent required for said Medical Insurance Benefits.

Participants are required to increase or decrease their payments under the terms of the Plan and as required by the Plan Administrator, if there is an increase or decrease in the premium payments required by an independent, third party provider in order to maintain any Medical Insurance Benefits.

Notwithstanding the foregoing, Medical Insurance Benefits shall cease to be provided to a Participant if said Participant fails to make a contribution required under the terms of the Plan.

3.6 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Medical Insurance Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Medical Insurance Benefits provided to all Employees under the Plan. The Employer may limit or deny any Employee's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.7 Insurance Contracts. Any dividends or retroactive rates or other refunds which may become payable under any Medical Insurance Benefits due to actuarial error in rate calculation shall be the exclusive property of and shall be retained by a Participating Employer.

3.8 Using Salary Reductions to Make Contributions. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits and for the purposes of this Plan and the Code, are considered to be Employer contributions. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

3.9 Funding the Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Section 4

IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

4.1 Irrevocability of Elections. Except as described in this Article 4, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

4.2 Procedure for Making New Elections if Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 2.1 or during the Open Enrollment Period under Section 2.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.4(d) through 4.4(i), within 30 days after the events described in such Sections, or within 60 days for loss of Medicaid or CHIP coverage or notice of eligibility for a Premium Assistance Subsidy). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

4.3 Change in Status Defined. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable Module. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code§ 125 or regulations issued there under, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) furloughed employees; (4) a commencement of or return from an unpaid leave of absence; (5) a change in worksite; and (6) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.4 Events Permitting Exceptions to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable Module of this Plan:

(a) *Open Enrollment Period* -A Participant may change an election during the Open Enrollment Period in accordance with Section 2.2.

(b) *Termination of Employment* - A Participant's election will terminate under the Plan upon

termination of employment in accordance with Sections 2.3 and 2.4, as applicable.

(c) *Leaves of Absence* - A Participant may change an election under the Plan upon FMLA leave in accordance with Section 2.5 and upon non-FMLA leave in accordance with Section 2.6.

(d) *Change in Status* - A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 2.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

IRS Notice 2010-38 states that the applicable Treasury Regulations have been amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, to include becoming newly eligible for

coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights* - If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code§ 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or
- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).
- a Participant or their Dependent becomes eligible for a Premium Assistance Subsidy (60-day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).
- a Participant or their Dependent loses Medicaid or CHIP coverage (60-day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).

(t) *Certain Judgments, Decrees and Orders* - If a judgment, decree, or order (collectively, an

"Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid* - If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid, but coverage for the unaffected Participants may not be canceled or reduced. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) *Change in Cost*- For purposes of this Section 4.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an

Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 2.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(i) *Change in Coverage* - The definition of "similar coverage" under Section 4.4(h) applies also to this Section 4.4(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the

affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment with a Loss of Coverage.* If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes *of* this Section 4.4(i)(l), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 2.1 may elect the

newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCRIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code§ 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s). Beginning April 1, 2009, employees and dependents are permitted to enroll in the Employer's group health insurance plan within 60 days of the loss of Medicaid or CHIP coverage.

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

A Participant entitled to change an election as described in this Section 4.4 must do so in accordance with the procedures described in Section 4.2.

4.5 Election Modifications For HSA Benefits May Be Changed Prospectively at Any Time

As set forth in Section 7.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election

except as otherwise described in this Section 4. A Participant entitled to change an election as described in this Section 4.5 must do so in accordance with the procedures described in Section 4.2.

4.6 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 5

PLAN ADMINISTRATOR

5.1 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination.

5.2 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(t) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit

consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

0) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

5.3 Reliance on Participant, Tables, etc. The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

5.4 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

5.5 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

5.6 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

5.7 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

5.8 Insurance Contracts. The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such

amounts are less than aggregate Employer contributions toward such insurance.

5.9 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

5.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code§ 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

Section 6

PREMIUM ONLY PLAN MODULE

6.1 Benefits. The only Medical Insurance Benefits that are offered under the Premium Payment Module are benefits under the Medical Insurance Plan providing major medical benefits and other ancillary benefits outlined in Schedule A. Notwithstanding any other provision in this Plan, the Medical Insurance Benefits outlined in Schedule A are subject to the terms and conditions of the Medical Insurance Plans, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Module by electing to pay for his or her share of the Contributions for Medical Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Module and to pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Section 4), such election is irrevocable for the duration of the Period of Coverage to which it relates. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

6.2 Contributions for Cost of Coverage. The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan. Medical Insurance Benefits will be provided by the Medical Insurance Plan(s), not this Plan. The types and amounts of Medical Insurance Benefits, the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plans are set forth in the Medical Insurance Plans. All claims to receive benefits under the Medical Insurance Plans shall be subject to and governed by the terms and conditions of the Medical Insurance Plan(s) and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits and COBRA. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the

opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Section 7

MISCELLANEOUS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under section 125 of the Code. No amendment shall deprive any Participant or Beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their Beneficiaries, except as may be specifically authorized by statute or regulation.

7.2 Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA and Section 7.4 hereof.

7.4 Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by a Participating Employer to disburse it, whose receipt shall be a complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Participating Employer.

7.5 Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Plan Administrator may require either directly to the Plan Administrator or to any person delegated by him/her.

7.6 Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting benefits under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

7.7 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Minnesota to the extent not preempted by any federal law.

7.8 Source of Benefits. The Participating Employer and any insurance company contracts purchased or held by a Participating Employer shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Participating Employer

upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.

7.9 No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to, purposes other than the exclusive benefit of Participants or their Beneficiaries, or for defraying reasonable expenses of administering the Plan.

7.10 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

7.11 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and Beneficiary.

7.12 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

7.13 Information to be Furnished. Participants shall provide the Employer and/or Participating Employer with such information and shall complete and sign such forms and documents, as may reasonably be requested from time to time for the Purpose of administration of the Plan.

Establishment of the Plan: Adoption of the Plan Document and Summary Plan Description

THIS SUMMARY PLAN DESCRIPTION, made by Life Time, Inc. (the "Company" or the "Plan Sponsor") as of January 1st, hereby sets forth the provisions of the Life Time, Inc. Flexible Spending Account Plan (the "Plan").

Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the benefits contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

LIFE TIME, INC.

By: _____

Name: Lisa Pollow

Title: SVP, HR

Date: 3/27/20