SUMMARY PLAN DESCRIPTION & PLAN DOCUMENT
FOR
LIFE TIME, INC.

LIFE TIME®

HEALTHY WAY OF LIFE

FLEXIBLE SPENDING ACCOUNT PLAN
AMENDED & RESTATED OCTOBER 1, 2023

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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, MN 55317
Plan Administrator:	Life Time, Inc. 2902 Corporate Place Chanhassen, MN 55317
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 1 to September 30
Plan Number:	501
Plan Type:	Health Care Flexible Spending Account Dependent Care Flexible Spending Account
Third Part Administrator/Claims Administrator:	America's TPA, LLC d/b/a 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 Flexible Spending Account (FSA) 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 between $0 to $3,050 (as adjusted for any IRS cost-of-living adjustments).** 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 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. You may not transfer money from one FSA to another.

At the end of each Plan Year, you will have a Run-Out Period to submit any claims for any Eligible Expenses incurred during the Prior Plan Year. **The Run-Out Period expires on December 31st. Funds are forfeited if not requested before the end of the Run-Out Period.**

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 30 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 30 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 30-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 30 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 30 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. 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. 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

Minimum Contribution: $0 per year

Maximum Contribution: $3,050 per year

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. However, please refer to IRS rules for coverage of specific expenses. Effective January 1, 2020, "Medical and Dental Expenses" will also include telehealth (as defined in the Coronavirus Aid, Relief, and Economic Security Act ("CARES" Act) to the extent not otherwise provided for coverage in your group health coverage), menstrual care products (as defined in Section 223(d)(2)(D) of the Internal Revenue Code), and over-the-counter drugs without prescriptions.

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 use the following instructions to set up your EZpay account:

1. Go to www.LTFBenefits.com and click the green Log In button.
2. Click the "Activate Account" link on the login page.
3. Click on EZpay Accounts" located on the left sidebar.

4. Enter your Card Information then select "Keep on File"
5. Fill in your information and click "Submit" to start enjoying the benefits of Auto-Pay with HealthEZ.

If you would rather have someone walk you through this process, please call 800-948-3253.

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, 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 and mailed to Employees within thirty (30) days of receipt.

Run-out Period

At the end of each Plan Year, you will have a Run-Out Period to submit any claims for any Eligible Expenses incurred during the Prior Plan Year. **The Run-Out Period expires on December 31st. Funds are forfeited if not requested before the end of the Run-Out Period.**

Dependent Care Flexible Spending Account

Contributions

Minimum Contribution: $0 per year

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 and mailed to Employees within thirty (30) days of receipt.

Run-Out Period

At the end of each Plan Year, you will have a Run-Out Period to submit any claims for any Eligible Expenses incurred during the Prior Plan Year. **The Run-Out Period expires on December 31st. Funds are forfeited if not requested before the end of the Run-Out Period.**

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.

If your claim for benefits is wholly or partially denied, the Plan Administrator shall provide you with a written notice of the denial. For the Health Flexible Spending Account, notice shall include:

- the reasons why the claim was denied;
- references to the Plan provisions on which the denial is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary;
- a description of the Plan's review procedures and the applicable time limits for requesting a review;
- a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review;
- an identification of any internal rule, guideline, protocol, or similar criterion that was relied upon in denying the claim, and a statement that a copy of the relevant rule, guideline, protocol, or criterion will be provided free of charge on request; and
- if the denial is based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial that applies the terms of the Plan to the Participant's medical circumstances or a statement that such an explanation shall be provided free of charge upon request.

Claim Appeal Process

If you have a question or concern about a claim reimbursement determination, you may informally contact a HealthEZ Member Experience representative before requesting a formal appeal. You may contact Member Experience at 800-948-3253. If the Member Experience 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. The Plan Administrator will provide you, upon written request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. The Plan Administrator shall also advise you of the identity of any medical or vocational experts whose advice was obtained by the Plan Administrator in connection with the denial of your claim, whether or not the advice was relied on by the Plan Administrator. If the Plan Administrator's denial of a claim was based on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be someone other than an individual with whom the Plan Administrator consulted in connection with the denial of the claim or a subordinate of such individual.

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, Inc.
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.

The Plan Administrator shall provide you with a written or electronic notice of the Plan's decision on review within 60 days after the Plan receives the request for review. For the Health Flexible Spending Account, if the decision is adverse, this notice shall include:

- the specific reasons for the decision;
- references to the Plan provisions on which the decision is based;
- a statement that you are entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- an identification of any internal rule, guideline, protocol or similar criterion that was relied upon, and a statement that a copy of the relevant rule, guideline, protocol or criterion will be provided free of charge on request; and
- if the decision is based on a medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision that applies the terms of the Plan to the your medical circumstances or a statement that such an explanation will be provided free of charge upon request.

The final decision of the Plan Administrator shall be conclusive and binding, unless it is found by a court of competent jurisdiction to have been arbitrary and capricious. Claims for benefits shall be subject to the limitations set forth in the Plan and the Plan Sponsor's cafeteria plan.

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.

Grace Period means the period of time an Employer who is participating in an FSA has after the end of the plan year to Incur and submit claims.

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 or Grace Period, if any.

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 coverage in the Health Care FSA 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**.

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 October 1, 2023, 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: Lisa Pollock

Name: Lisa Pollock

Title: SVP, HR

Date: 10/16/23