BENEFIT PLAN INFORMATION

2025/2026

MEDICAL ADMINISTERED BY HEALTHEZ.

This benefit guide describes most of the benefit plans available to you as a team member of Life Time. The details of these plans are contained in the official plan documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your summary plan description(s).

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the plan document(s), the plan document(s) will govern. Please note that the benefits described in this guide, including type and plan design, may be changed at any time at the discretion of Life Time.

2025/2026

LIFE TIME SPOUSAL/DOMESTIC PARTNER ELIGIBILITY VERIFICATION FORM

Spouse/Domestic Partner Medical Insurance Coverage

If a Life Time team member's spouse/domestic partner has employer-sponsored group medical insurance coverage available to him/her/them through their employer, the spouse/domestic partner will not qualify for Life Time medical coverage.

If your spouse/domestic partner is not offered employer-sponsored group medical insurance coverage, you must update this form **annually** before he/she/they can continue to be covered under the Life Time medical insurance plan. If your spouse/domestic partner has medical insurance available through their employer and does not elect to enroll, your spouse/domestic partner will not be allowed to enroll under the Life Time Fitness plan. If you have questions regarding this Eligibility Verification Form, contact the Life Time Benefits Team at 952.401.2316.

You must complete both part A and B (if applicable) of this form and attach this to your benefit enrollment in Workday. If you do not attach this form, your enrollment will not be approved and Life Time will automatically remove medical coverage for your spouse/domestic partner.

If your spouse/domestic partner becomes eligible for employer coverage at a later date or loses his/her/their coverage, you are required to complete a new Eligibility Verification Form and file it with a life event in Workday within 30 days of the event date.

PART A – Team Member Completes This Side First

Team Member Name:_____

Spouse/Domestic Partner Name: _____

Please check only ONE of the following that applies to you:

My spouse/domestic partner is: (Check One)

_____ Not employed

_____ Retired and does not have medical insurance through his/her/their former employer or retirement system

_____ Self-employed and does not have medical insurance

_____ Employed ***only*** by Life Time

If this section applies, check here and sign bottom of Part A. You do not need to complete Part B

My spouse/domestic partner is employed at_____and: (Check One)

_____ Does not have group medical insurance offered to him/her/them

_____ Is part-time and not eligible for him/her/their employer's medical insurance

Sign bottom of form and have spouse/domestic partner's employer complete Part B

READ BELOW AND SIGN:

Team Member Acknowledgment of Responsibility: I have read the above information regarding the spouse/domestic partner requirement for medical insurance coverage. I acknowledge that the information on this form is accurate to the best of my knowledge. I understand that if any false statement is made or information withheld, Life Time will have the right to recover any overpayment and recoup any legal fees incurred, and that medical insurance coverage and my employment may be immediately terminated.

Team Member Signature:_____

Team Member Number:_____ Date:_____

LIFE TIME

2025/2026

LIFE TIME SPOUSAL/DOMESTIC PARTNER ELIGIBILITY VERIFICATION FORM

Spouse/Domestic Partner Medical Insurance Coverage

PART B – To Be Completed by Spouse/Domestic Partner's Employer

Spouse/Domestic Partner Name:_____

Employer Name:_____

Employer Address:_____

To Whom It May Concern:

If a Life Time employee's spouse/domestic partner has employer-sponsored group medical insurance coverage available to him/her/them through their employer, the spouse/domestic partner will not qualify for Life Time medical coverage.

It has been indicated by our employee that you are the employer of their spouse/domestic partner. Due to our spouse/domestic partner provision indicated above, additional information is required to make a proper evaluation of the spouse/domestic partner eligibility.

1. Do you provide group medical insurance coverage for your employees?

   Yes_____ No_____

   a. If Yes, answer question 2.
   b. If you answered No, please sign, date and return.

2. Is the above-named employee eligible to enroll in your medical insurance program?

   Yes_____ No_____

   a. If Yes, answer Question 3.
   b. If No, please indicate why:_____
   Please sign, date and return.

3. Is the above-named employee covered under your medical insurance program?

   Yes_____ No_____

   a. If Yes, please provide the following information:

   Carrier:_____

   Group No:_____

_____ _____
Employer Representative Signature Date

_____ _____
Printed Name and Title Phone Number

LIFE TIME

IF YOU ARE A CURRENT LIFE TIME TEAM MEMBER:

The Life Time Open Enrollment period for the 2025/2026 plan year begins August 5, 2025, and must be completed by August 21, 2025. The effective date of coverage for the benefits you elect during this time frame will be October 1, 2025. The elections you make during this Open Enrollment period will remain in place through September 30, 2026, unless you experience a Qualified Life Event (see page 8).

Please review the benefits booklet carefully since it contains general coverage information, monthly coverage costs as well as directions on how to enroll. Each of our benefits will require an active enrollment, which means you must log in to Workday to review and elect benefits for the 2025/2026 plan year. **You must enroll by the deadline of August 21 for these changes to be effective with the new plan year on October 1.**

HIGHLIGHTS

- Life Time will continue to offer three (3) comprehensive medical plan options. Please review closely to determine which plan is best for you and your family.
- For team members enrolled in the HDHP plans, Life Time covers the cost of the accident benefit program.
- When you are evaluating your options, please remember the High Deductible Health Plans (HDHP 2300 and HDHP 5500) feature a preventive drug list (generic) that offers you 100% coverage. This offers you savings on prescriptions that you take regularly to help manage certain health conditions such as high cholesterol, high blood pressure, diabetes and others. Applicable generic drugs will be available to you at no cost before your deductible is met, in accordance with IRS guidance.
- Doctor On Demand is part of our medical plans.

IF YOU ARE A NEW LIFE TIME TEAM MEMBER:

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

IF YOU ARE AN ACA-ELIGIBLE TEAM MEMBER:

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

ALL TEAM MEMBER NOTICE:

If you are adding a spouse, domestic partner, or dependent children to any plans in your enrollment you will need to provide documentation showing they are eligible dependents. A list of acceptable documents can be found on LT Central. If you do not provide the required documents, coverage will be removed and COBRA does not apply.

BENEFIT PARTNER CONTACT INFORMATION

COMPANY	WEBSITE	SERVICE	PHONE NUMBER	WEBSITE
LIFE TIME		HR and Payroll	888.848.7070	See the Human Resources & Benefits site on LT Central
healthEZ		Medical and helpline	800.948.3253	ltfbenefits.com
dr. on demand by Included Health **Doctor On Demand**		Telehealth Services	800.997.6196	doctorondemand.com
BYB Boost Your Baby **Boost Your Baby**		Maternity Case Management	800.808.4848	byb@healthez.com
EyeMed Vision Care		Vision Administrator	866.800.5457	eyemed.com
Delta Dental of Minnesota		Dental Administrator	800.448.3815	deltadentalmn.org
HSA **Fidelity**		HSA Administrator	800.544.3716	netbenefits.com
401k **Fidelity Investments**		401(k)	800.835.5095	401k.com
$ **CBIZ**		Flexible Employee Benefits	855-410-2249	myplans.cbiz.com
		401(k) Advisor	877.323.3867	cbiz.com
		COBRA Administrator	800.815.3023, opt. 6	cbiz.com
The Standard		Life, Disability and Accident Insurance Administrator	Short- & Long-Term Disability Claims, Absence Management 800.831.7618	standard.com
			Life Insurance Claims 800.628.8600	
			Accident Insurance, Critical Illness, Hospital Indemnity 866.851.5505	
TELUS Health		Employee Assistance Program	888.267.8126	one.telushealth.com User ID: Lifetime Password: fitness
LegalShield and IDShield		Legal / Identity Services	Legal Shield: 763.856.9583 ID Shield Emergency Customer Service: 866-696-0927	admin@itcprotects.com

CONTENTS

LIFE TIME MEMBERSHIP

At Life Time, we champion healthy, happy lives for our members, including, of course, our Team Members. We support you and your Healthy Way of Life goals and want to do so no matter where you live, work or play. This means, regardless of the club level where you work, you will receive a Diamond-level membership.

Membership Add-Ons. Team Members receive either a Single or Family membership depending upon role. Spouses, domestic partners and dependent children (age 25 and under) may be added to Single memberships (dependent children are required to have their own membership at age 26).

IMPORTANT REMINDERS

Membership Add-Ons are allowed for spouses, domestic partners and dependent children (age 25 and under) only. Extended family members, roommates, friends and/or others may not be added on to a membership.

Dependent children are required to have their own membership at 26. Therefore, if a dependent child wishes to continue their Life Time membership, they must establish a new, separate membership upon reaching age 26.

Questions. If you have any questions, please speak with your manager or feel free to contact **HRSupport@lt.life**.

Thank you, as always, for the passion you exude to positively change lives and for choosing to be a valued Team Member.

YOUR BENEFIT PLAN

Life Time provides a wide variety of benefits and gives you the opportunity to customize a benefits package that meets your personal needs.

HOW YOUR BENEFITS WORK

ELIGIBILITY REQUIREMENTS FOR TEAM MEMBER COVERAGE.

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

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

ELIGIBILITY REQUIREMENTS FOR DEPENDENT COVERAGE.

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

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

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

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

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

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

A complete list of acceptable documentation can be found on Workday and LT Central.

WHEN BENEFITS START

EFFECTIVE DATE OF TEAM MEMBER COVERAGE.

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

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

CHOOSING YOUR BENEFITS

You will see an enrollment in your Workday inbox from August 6 to August 22 for open enrollment, or one will be issued to you 10 days after your full-time hire date for newly eligible team members. For all employer-paid coverage, enrollment in Workday is preselected as enrolled. You can waive disability and additional life insurance at any time. Disability and additional Life plans can be dropped at any time. There is open enrollment for employee Life insurance and Long-Term Disability every 3 years if you waive coverage during your initial eligibility.

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

AFTER TAXES

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

BEFORE TAXES

- Before your taxes are calculated (Medical premiums, Dental premiums, Vision, 401(k), HSA Contributions, Transit, Flexible Spending Account Contributions and Dependent Care Spending Account Contributions)
- There is a definite advantage to paying for some benefits with before-tax money. Taking money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less tax.

WHEN COVERAGE ENDS

All benefits end on the last day of the month in which your employment with Life Time ends or you are no longer eligible for benefits.

COBRA allows workers and dependents (not including domestic partners) who lose their medical, dental, vision or medical flexible spending account coverage to continue any of these coverages for a specific length of time by electing and paying for continuation of benefits.

QUALIFIED LIFE-CHANGING EVENTS

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

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

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

Please refer to LT Central for more information on how to update your benefits.

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

MEDICAL COVERAGE

HEALTHEZ: 800.948.3253

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

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

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

- For coverage, you must see an in-network provider.
- If you choose non-network providers, you will not have any coverage, with the exception of a life-threatening emergency.
- All preventive visits are 100% covered for in-network providers.
- Female contraceptives are covered at 100% at your retail pharmacy, in-network providers and through mail order.
- Non-covered services do not contribute to meeting deductibles or out-of-pocket maximums.
- Deductible amounts and copays count toward meeting the out-of-pocket maximum.

PREVENTIVE SERVICES

The following preventive services are covered 100% on all plans and available at no cost to you or other individuals on your plan.

- Initial blood pressure, diabetes and cholesterol tests
- Cancer screenings (including age-appropriate mammograms and colonoscopies); see the Summary Plan Description for more information
- Regular well-baby and well-child visits from birth to age 18
- Routine vaccinations
- Flu, pneumonia and COVID-19 shots
- Preventive dermatology visit

PROVIDER NETWORKS

We have partnered with Aetna, one of the largest national networks available for team members living outside of Minnesota and Wisconsin. Aetna will be your primary medical network.

If you have specific questions on your care or your network, please call HealthEZ at the dedicated number for Life Time, which is listed on the back of your card, 800.948.3253.

When contacting a provider, please give your network information.

STATE	NETWORK	WEBSITE
Minnesota	America's PPO	americasppo.com
Wisconsin	Health EOS	multiplan.com
All others*	Aetna	aetna.com/asa

* The providers below are excluded from your network:
California: Sutter Health

HELPLINE

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

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

TO REACH A NURSE, CALL 800.948.3253.

During normal business hours, tell a customer service representative you'd like to speak to a nurse. If you call after business hours and reach a recording, press 1 and you'll be connected to a nurse.

CARE MANAGEMENT PROGRAMS

Life Time offers you access to trained nursing staff to help you navigate the maze of chronic or complex medical conditions. Active Care Management will be required for pregnancies as well as diseases such as diabetes, cancer and heart disease, to name a few. If you're diagnosed with a complex condition, please feel free to call the HealthEZ helpline.

SOME OF THE OFFERINGS THROUGH CARE MANAGEMENT INCLUDE:

Boost Your Baby

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

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

Case Management

Nurse case managers and registered dietitians assist and educate members with complex medical and behavioral problems such as transplants, cancers and substance abuse.

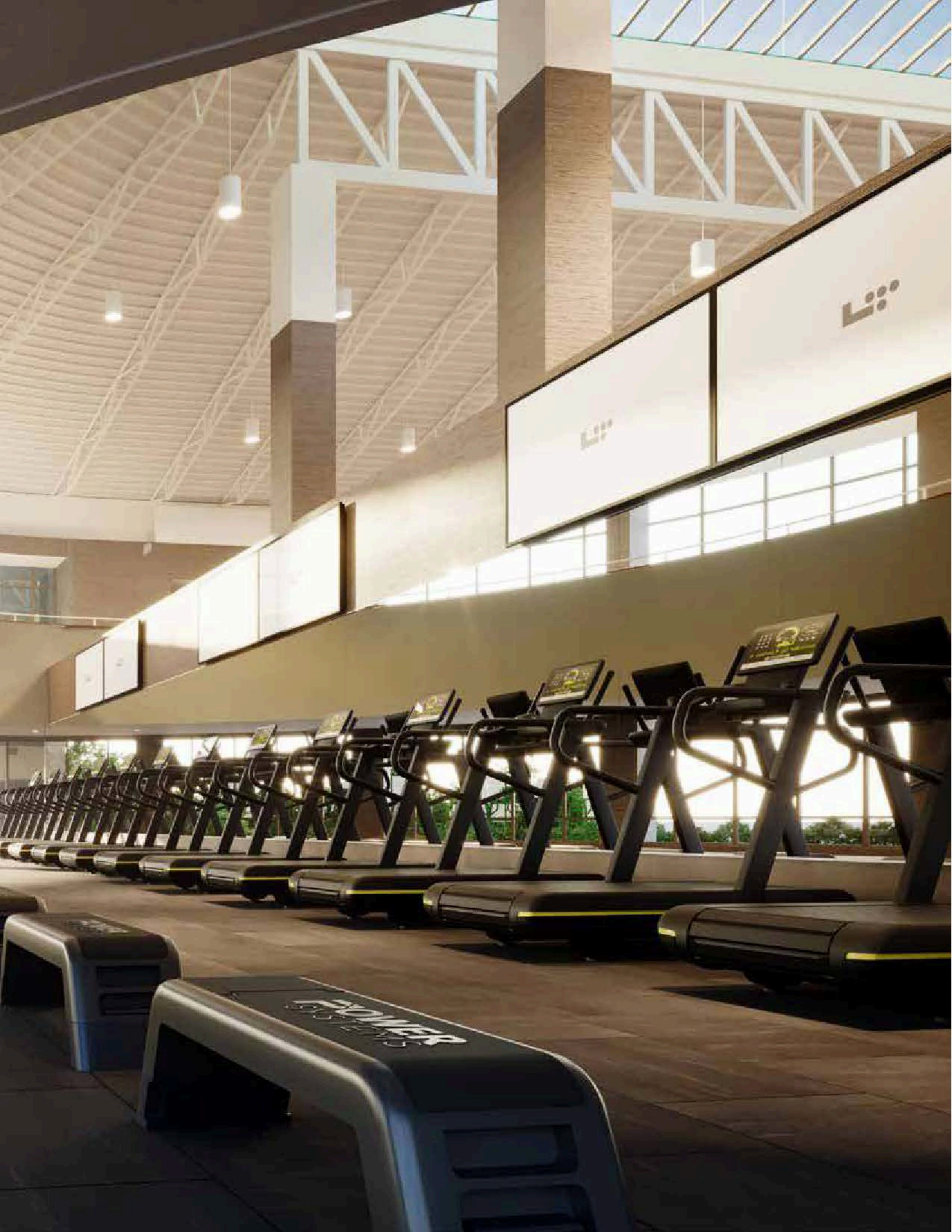
Disease Management

Nurses provide literature and education to those with diseases such as diabetes, heart disease, low back pain and asthma. Our goal is to keep these diseases from progressing further.

Utilization Review

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

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



MEDICAL COVERAGE – IN NETWORK

PLEASE NOTE: DEDUCTIBLE PERIOD IS OCTOBER 1, 2025 TO SEPTEMBER 30, 2026.

MEDICAL PLAN OPTIONS	**Copay Plan $1,500**		**HDHP $2,300**	**HDHP $5,500**
Plan Type	Physician/Hospital PPO		Physician/Hospital PPO	Physician/Hospital PPO
Individual/Family Deductible	$1,500 / $3,000		$2,300 / $3,700	$5,500 / $11,000
Individual/Family Coinsurance	20%		0%	10%
Individual/Family Out of Pocket: (Including Deductible)	$2,800 / $5,600		$2,300 / $3,700	$6,900 / $13,800
Embedded Deductible	Yes		No	Yes
Preventive Services	Covered in Full		Covered in Full	Covered in Full
Physician Office Services (Primary Care Physician)	$25 Copay, No Deductible		0% after Deductible	10% after Deductible
Physician Office Services (Specialty Care Physician)	$50 Copay, No Deductible		0% after Deductible	10% after Deductible
Physical Therapy at LifeClinics	$15 Copay, No Deductible		0% after Deductible	10% after Deductible
Physical Therapy at other in-network providers	$25 Copay, No Deductible		0% after Deductible	10% after Deductible
Chiropractic Care at LifeClinics	$15 Copay, No Deductible		0% after Deductible	10% after Deductible
Chiropractic Care at other in-network providers	$50 Copay, No Deductible		0% after Deductible	10% after Deductible
Emergency Room	$300 Copay, then 20% after Deductible		0% after Deductible	10% after Deductible
Outpatient Diagnostic, X-Ray, Lab	20% after Deductible		0% after Deductible	10% after Deductible
Outpatient Hospital Services	20% after Deductible		0% after Deductible	10% after Deductible
Inpatient Hospital Services	20% after Deductible		0% after Deductible	10% after Deductible
Doctor On Demand				
General Consult	$0		$0	$0
Dermatology	$0		$0	$0
Psychiatrist	$0		$0	$0
Therapist 1st visit	$0		$0	$0
Therapist ongoing	$0		$0	$0
Pharmacy	Retail	Mail Order (per 90-day supply)		
Generic	$15 copay	$45 copay	0% after deductible	10% after deductible
Brand Formulary	$60 copay	$180 copay	0% after deductible	10% after deductible
Brand Non-Formulary	$90 copay	$270 copay	0% after deductible	10% after deductible
Specialty	30% coinsurance	(only available up to a 30-day supply)	0% after deductible	30% after deductible
Generic Preventive	applicable copay above	applicable copay above	covered 100%	covered 100%
PREMIUMS (MONTHLY)				
Employee	$244.65		$148.99	$111.24
Employee & Spouse	$492.33		$301.90	$255.73
Employee & Child(ren)	$405.06		$233.43	$198.07
Family	$683.35		$442.84	$338.53

There is no out-of-network coverage.

PHARMACY INFORMATION

Caremark: 833.894.0681

The High Deductible Health Plans (HDHP 2300 and HDHP 5500) feature a generic-only preventive drug list. This offers you savings on prescriptions that you take regularly to prevent certain health conditions such as high cholesterol, high blood pressure, as well as others. Applicable generic drugs will be available to you at no cost before your deductible is met in accordance with IRS guidance. To view a list of these generic drugs, please visit LT Central.

The pharmacy company for Life Time is Caremark. You can find Caremark online at caremark.com or call 833.894.0681.

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

dr. on demand
by Included Health

PROVIDED TO THOSE ENROLLED ON MEDICAL PLAN.

Members can use the service to connect with a medical doctor 24 hours a day, 365 days a year.

Doctor On Demand by Included Health "virtual visit" lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! We partner with Doctor On Demand to bring you care from the comfort and convenience of your home or wherever you are.

HOW TO USE THIS SERVICE

1. Simply download and launch the FREE app.
2. Follow the steps to register. You will need your HealthEZ subscriber and group number from your medical ID card.
3. Explain the reason for your call. You will be asked some medical history questions along with any questions that pertain to the current symptoms.
4. Most urgent and acute care visits are handled within minutes. Most therapy and psychiatry visits can be scheduled within days.

GENERAL CONSULTATIONS

- Doctor On Demand service is available 24 hours a day, 7 days a week, 365 days a year for you to speak with a doctor. Physicians are available for general consults and are licensed to prescribe when appropriate.
- There are no limits to the number of calls you can make and no cost per call when enrolled in the Life Time medical plan and registered with your subscriber and group number.
- Use the service whenever you have a health question or an acute need that requires the attention of a physician.

SOME COMMON CONDITIONS THAT ARE FREQUENTLY TREATED USING DOCTOR ON DEMAND:

- Bronchitis
- Earache
- Sore Throat
- Pink Eye
- Strep
- Depression
- Respiratory Infections
- Urinary Tract Infections
- Allergies
- Sinusitis
- Anxiety
- So much more ...

DOCTOR ON DEMAND IS AVAILABLE FOR MENTAL HEALTH AND DERMATOLOGY

You can now schedule and connect with a Dermatologist or schedule and connect with a Psychiatrist or Psychologist for your mental health needs. There is no cost to you for these services.

GETTING THE MOST FROM THIS BENEFIT

Download the Doctor On Demand app prior to needing the coverage. Then later, when you are in pain or need attention immediately, you have quick access to the care you need. Save money by reducing your use of higher-cost alternatives like urgent care facilities and emergency departments for non-emergency care. Minimize travel time and expenses while waiting in the comfort of your own home or office. Get the peace of mind that comes from confirming health choices with a medical doctor.

MENTAL HEALTH RESOURCES

Just as learning about physical health or financial health has helped us create stronger families and a more caring environment, we believe that combating stigma will help us make Life Time – The Healthy Way of Life Company a more supportive and accepting organization — and might even have a positive impact on our community at large. Mental illnesses are surprisingly common. One in five Americans, from all walks of life, experiences a mental illness each year. But because of the stigma, most people live with their symptoms for 10 years before seeking treatment. This affects not only those with mental illnesses, but their friends and loved ones, too. Life Time has a suite of benefits for you to help navigate life's challenges.

RESOURCES FOR ALL TEAM MEMBERS:

TELUS Health – 888.267.8126

Life Time partners with TELUS Health to provide you and anyone in your household free, confidential support. If you are experiencing stress, having financial difficulties, struggling at work or home, please call TELUS Health 888.267.8126 to speak with someone 24/7.

Available online too at one.telushealth.com
user ID: Lifetime password: fitness

National Alliance on Mental Illness
800.950.NAMI (6264) www.nami.org/Home

One in five adults experiences mental illness each year. Find unlimited support and education here, both nationally and locally, including crisis line, online discussion groups, video resources and more.

Make It OK – makeitok.org

Make It OK helps to foster conversations regarding mental well-being and most importantly about removing the stigma of mental illness. The site provides education in a multimedia format, from videos to stories and guides and checklists on how to avoid hurtful language surrounding mental illness. Makeitok.org in partnership with NAMI and HealthPartners, Inc.

RESOURCES FOR TEAM MEMBERS ON THE MEDICAL PLAN:

Doctor On Demand – 800.997.6196

Now is the time to make mental healthcare a priority. Feel like yourself again with therapy by phone or video. Choose a licensed therapist or psychiatrist that best fits your needs. Visits are affordable, flexible and convenient. See page 13 of the benefit guide for detail. Download the app for a confidential visit. doctorondemand.com

HealthEZ – ltfbenefits.com 800.948.3253

HealthEZ is here to support your needs and help you find the right care. Your medical plan offers a range of coverage for anyone experiencing mental health distress or emotional and substance abuse issues, including psychiatry, individual therapy, psychology testing and more. The HealthEZ Care Management Team and 24/7 helpline is standing by to help.

Life Time Mind – mind.lifetime.life

LT Mind is a holistic performance coaching program proprietary to Life Time aimed at helping you optimize your performance, achieve your goals and enhance your well-being. Offerings for all team members include online training and virtual mental resiliency coaching. ltmind@lt.life or call 952.229.7857

ACCIDENT INSURANCE

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room — and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in. In the event of a covered accident, the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills — expenses major medical may not take care of.

If you enroll in one of our HDHP medical plans, Life Time will pay 100% of the cost of this coverage as long as you remain covered by this plan. You will need to ELECT THIS in Workday.

ACCIDENT INSURANCE WILL PAY YOU TO HELP OFFSET COSTS FOR THINGS LIKE:

- Ambulance rides
- Wheelchairs, crutches and other medical appliances
- Emergency room visits
- Torn cartilage and ligaments
- Bandages, stitches and casts

Benefits include:

- Transportation and lodging benefits
- An Emergency Room treatment benefit
- Rehabilitation for an injury
- Fractures and dislocations
- An accidental-death benefit
- A dismemberment benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is available for you, your spouse and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire (no COBRA)
- Fast claims payment

HERE'S HOW IT WORKS:

In the event of a covered accident, your Acciden insurance will pay a benefit directly to you. You can use this money where you need it most — whether that's to help with your deductible, copays and other medical bills, or your daily expenses while you recover.

Let's say your teenage daughter gets injured during tryouts for her school basketball team and goest to urgent care for treatment. Diagnosis: dislocated elbow and fracture of the forearm and wrist. Although surgery isn't necessary, she will need follow-up appointments and physical therapy.

You'd get an additional 25% if your child is injured while participating in an organized athletic activity — whether it's football practice, a soccer game or dance class. See example below.

BENEFITS PAID TO YOU

Urgent Care Visit	$50
X-ray	$50
Dislocated Elbow	$800
Arm Fracture	$550
Wrist Fracture	$550
Physician Follow-up Appointment	$50
Physical Therapy Appointment (2 visits)	$100
SUBTOTAL	**$2,150**
Youth Organized Sports Benefit (25% of subtotal)	**$538**
Total paid directly to you	**$2,688**

PREMIUMS (MONTHLY)

	Copay Plan or No Medical Election	HDHP 2300 & HDHP 5500
Employee	$7.55	$0
Employee & Spouse	$11.74	$0
Employee & Child(ren)	$14.46	$0
Family	$22.56	$0

HOSPITAL INDEMNITY INSURANCE

Group hospital indemnity insurance empowers you to plan ahead financially with flexible, affordable options for offsetting your out-of-pocket expenses resulting from an unexpected hospital inpatient admission.

This hospital indemnity plan from The Standard can help with the treatment costs and inpatient hospital stay. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With this plan, you receive cash benefits paid to you directly, free from taxes — giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Hospital Confinement Benefit	$250 per day to a maximum of 15 days per confinement
Hospital Admission Benefit	$1,500 maximum per calendar year
Critical Care Unit Confinement Benefit	$250 per day to a maximum of 15 days per confinement

FEATURES:

- Benefits are paid directly to you. FAST claims payment process.
- Coverage is available for you, your spouse or domestic partner, and children.
- This plan provides coverage without answering any medical questions and no preexisting limitation.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire (no COBRA).

EXAMPLE #1 OF HOW IT WORKS:

Ruptured Ulcer: Kim is out of town on vacation and experiences abdominal pain and a racing heartbeat. She is rushed to the hospital, admitted and diagnosed with a ruptured ulcer and has to be taken in for surgery. She ends up hospitalized for 10 days, three of which are in a critical care unit.

Here is what your plan would cover for this example:

Benefits Paid to YOU	Benefit Amount
Hospital Admission	$1,500
Hospital Confinement (10 days)	$2,500
Critical Care Unit Confinement (3 days)	$750
Total Paid to YOU	$4,750

EXAMPLE #2 OF HOW IT WORKS:

Pregnancy: Brooke's pregnancy took an unexpected turn when the baby had to be delivered via C-section. Both Brooke and her baby were in good health but needed to stay in the hospital for three days as required by her doctor so she could recover from the surgery.

Here is what your plan would cover for this example:

Benefits Paid to YOU	Benefit Amount
Hospital Admission	$1,500
Critical Care Unit Confinement (3 days)	$750
Total Paid to YOU	$2,250

Employee	$13.05
Employee & Spouse	$22.05
Employee & Child(ren)	$18.47
Family	$32.90

CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances. While major medical insurance may pay for a good portion of the costs associated with the illness, there are a lot of expenses that are just not covered — from deductibles and copays to living expenses.

This Critical Illness insurance policy from The Standard can help with the treatment costs of a covered critical illnesses — such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) — giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

GROUP CRITICAL ILLNESS COVERAGE INCLUDES:

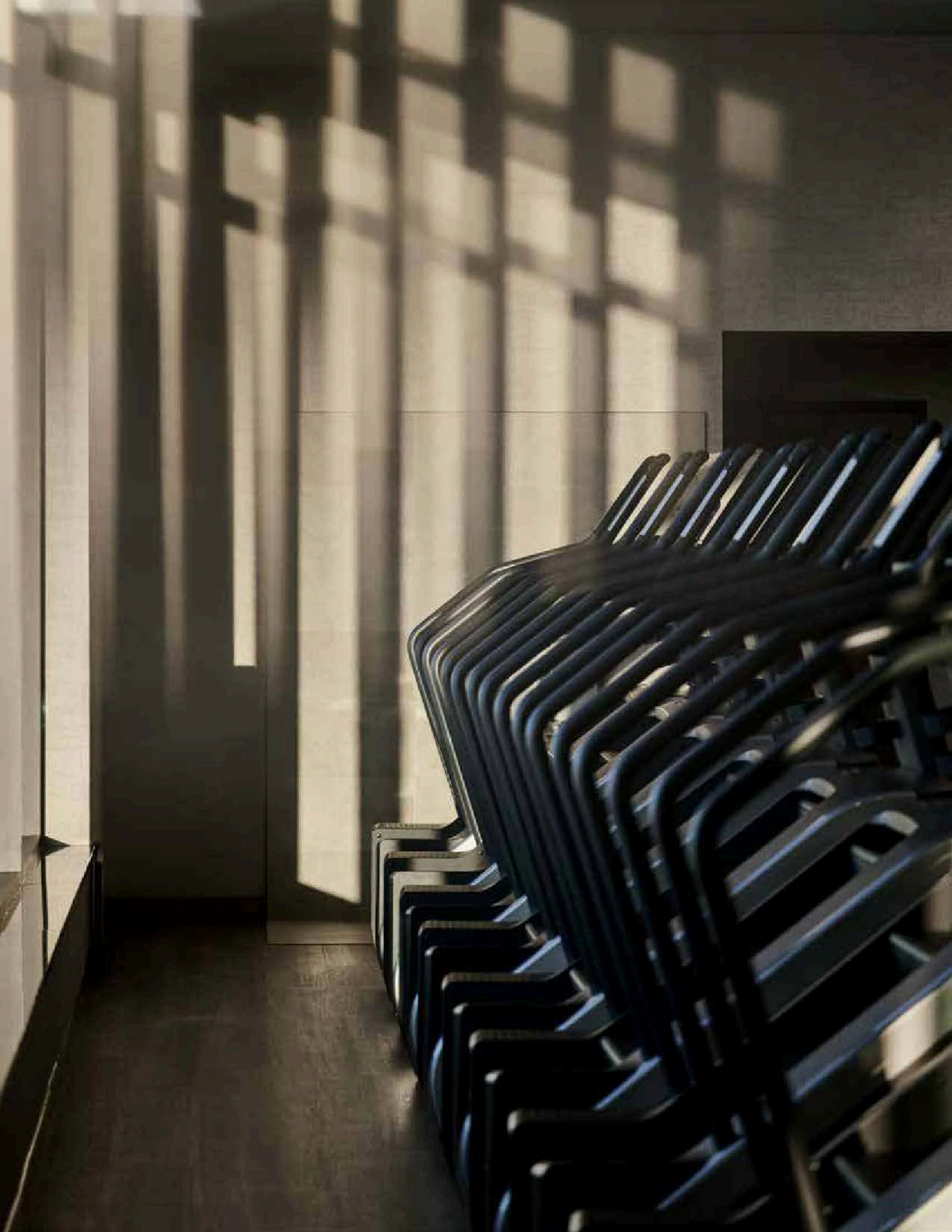
- Health Screening Benefit — The Standard pays YOU a $50 benefit just for getting a cancer screening or physical.
- Critical illness benefit payable for:
  - cancer
  - heart attack (myocardial infarction)
  - stroke
  - kidney failure (end-stage renal failure)
  - major organ transplant
  - bone marrow transplant (stem cell transplant)
  - advanced multiple sclerosis
  - coronary artery bypass surgery
  - coma
  - skin cancer (25% of benefit)
  - advanced Parkinson's disease
  - advanced Alzheimer's disease

FEATURES:

- Benefits are paid directly to you, unless you choose otherwise. FAST claims payment process.
- Coverage is available for you, your spouse if you take coverage, and if you select coverage your policy automatically covers your children to age 26.
- Upon initial eligibility, Guarantee Issue is $50,000 for team members and $30,000 for spouses. Spouses coverage cannot exceed team members coverage. Benefits will not be paid for a diagnosis that occurs prior to the effective date of coverage.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire (no COBRA).

EXAMPLE OF HOW CRITICAL ILLNESS COVERAGE WORKS

1. Critical Illness coverage is selected in Workday. You choose to buy $20,000 of coverage.
2. You experience chest pains and numbness in your left arm.
3. You visit the emergency room.
4. A physician determines that you have suffered a heart attack.
5. You submit a claim form. The Critical Illness policy coverage pays you $20,000.



CRITICAL ILLNESS PREMIUMS (MONTHLY)

EMPLOYEE						
NON-TOBACCO						
	18–29	**30–39**	**40–49**	**50–59**	**60–69**	**70+**
$5,000	$1.15	$1.70	$3.35	$6.55	$11.60	$20.40
$10,000	$2.30	$3.40	$6.70	$13.10	$23.20	$40.80
$15,000	$3.45	$5.10	$10.05	$19.65	$34.80	$61.20
$20,000	$4.60	$6.80	$13.40	$26.20	$46.40	$81.60
$25,000	$5.75	$8.50	$16.75	$32.75	$58.00	$102.00
$30,000	$6.90	$10.20	$20.10	$39.30	$69.60	$122.40
$35,000	$8.05	$11.90	$23.45	$45.85	$81.20	$142.80
$40,000	$9.20	$13.60	$26.80	$52.40	$92.80	$163.20
$45,000	$10.35	$15.30	$30.15	$58.95	$104.40	$183.60
$50,000	$11.50	$17.00	$33.50	$65.50	$116.00	$204.00
TOBACCO						
$5,000	$1.25	$2.05	$5.00	$12.00	$24.45	$43.20
$10,000	$2.50	$4.10	$10.00	$24.00	$48.90	$86.40
$15,000	$3.75	$6.15	$15.00	$36.00	$73.35	$129.60
$20,000	$5.00	$8.20	$20.00	$48.00	$97.80	$172.80
$25,000	$6.25	$10.25	$25.00	$60.00	$122.25	$216.00
$30,000	$7.50	$12.30	$30.00	$72.00	$146.70	$259.20
$35,000	$8.75	$14.35	$35.00	$84.00	$171.15	$302.40
$40,000	$10.00	$16.40	$40.00	$96.00	$195.60	$345.60
$45,000	$11.25	$18.45	$45.00	$108.00	$220.05	$388.80
$50,000	$12.50	$20.50	$50.00	$120.00	$244.50	$432.00

SPOUSE						
NON-TOBACCO						
	18–29	**30–39**	**40–49**	**50–59**	**60–69**	**70+**
$5,000	$1.15	$1.70	$3.35	$6.55	$11.60	$20.40
$10,000	$2.30	$3.40	$6.70	$13.10	$23.20	$40.80
$15,000	$3.45	$5.10	$10.05	$19.65	$34.80	$61.20
$20,000	$4.60	$6.80	$13.40	$26.20	$46.40	$81.60
$25,000	$5.75	$8.50	$16.75	$32.75	$58.00	$102.00
$30,000	$6.90	$10.20	$20.10	$39.30	$69.60	$122.40
TOBACCO						
$5,000	$1.25	$2.05	$5.00	$12.00	$24.45	$43.20
$10,000	$2.50	$4.10	$10.00	$24.00	$48.90	$86.40
$15,000	$3.75	$6.15	$15.00	$36.00	$73.35	$129.60
$20,000	$5.00	$8.20	$20.00	$48.00	$97.80	$172.80
$25,000	$6.25	$10.25	$25.00	$60.00	$122.25	$216.00
$30,000	$7.50	$12.30	$30.00	$72.00	$146.70	$259.20

DENTAL COVERAGE

DELTA DENTAL: 800.448.3815

Life Time plans provide you with three choices when it comes to dental coverage. Delta 80, Delta 100 and Delta Platinum. Delta Dental of Minnesota administers the plans. There are two networks of dentists available through Delta Dental of Minnesota: Delta Dental Premier and Delta Dental PPO.

FREQUENTLY ASKED QUESTIONS

MAY I GO TO ANY DENTIST?

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

If you select Delta Platinum, you and any dependents you cover must remain enrolled in that plan for a minimum of two plan years.

HOW DO I FIND A PARTICIPATING DENTIST?

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

WHAT HAPPENS IF I VISIT A NON-PARTICIPATING DENTIST?

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

WHAT IF I HAVE AN EMERGENCY OUTSIDE THE UNITED STATES?

Claims incurred for dental treatment performed outside of the United States should obtain a detailed bill from the treating dentist. The member should complete the Claim Form available on our website to file the claim with Delta Dental of Minnesota. Eligible services will be covered at the Out-of-Network benefit level and the rate of exchange on the date the service was performed. Please feel free to contact Customer Service at 800.448.3815, if you have any questions about this process.

HOW DO I FIND OUT IF MY CLAIM WAS PAID?

Visit DeltaDentalMN.org for fast and easy dental benefit tools and information. In addition to claims inquiry, other interactive features include eligibility and benefits inquiry, oral health resources and much more. You may also call Customer Service to get claims status and payment information.

HOW IS WORK IN PROGRESS HANDLED?

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

HOW DO I KNOW HOW MUCH I'LL BE RESPONSIBLE FOR?

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

DELTA DENTAL OF MINNESOTA			
IN-NETWORK DELTA PPO SUMMARY	**Delta Platinum**	**Delta 100**	**Delta 80**
Diagnostic and Preventive Services Exams and cleanings, x-rays, fluoride treatments, space maintainers, sealants	100%	100%	80%
Basic Services	90%	80%	80%
Endodontics	90%	80%	80%
Periodontics	90%	80%	80%
Oral Surgery	90%	80%	80%
Major Restorative	90%	50%	40%
Prosthetics/Implants Repairs and Adjustments	90%	50%	40%
Prosthetics/Implants	90%	50%	40%
Orthodontia Maximums Adult Child(ren)	 $5,000 lifetime max $5,000 lifetime max	 $0 $2,000 lifetime max	 $0 $0
Deductible (Oct 1–Sept 30) Per person/per family per coverage year No deductible for diagnostic and preventive services or orthodontics	$25 / $50	$50 / $150	$50 / $150
Annual Plan Maximum (Oct 1–Sept 30) per covered person	$5,000	$1,500	$1,000
Lifetime Ortho Maximum per covered person	$5,000 Adult $5,000 Child	$2,000 Child Only through age 18	N/A
PREMIUMS (MONTHLY)			
Employee	$67.89	$55.11	$25.15
Employee & Spouse	$131.70	$106.63	$40.98
Employee & Child(ren)	$200.13	$162.48	$54.83
Family	$263.36	$214.03	$108.11

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

Delta 100 and Delta 80 Plans – Posterior Composites are covered under Major Restorative, subject to the deductible, then covered at 80%. All other services under Major Restorative are covered at the percentage indicated in the summary above.

Save Money, Go In Network – By seeking care from a Delta Dental PPO or Delta Dental Premier network dentist, you will realize the greatest savings as a result of our negotiated discounts. Providers participating in our Delta Dental PPO network typically deliver the greatest discount, resulting in the lowest out-of-pocket expenses. Your out-of-pocket expenses may increase if you utilize a non-participating provider because we have no contract with these dentists. You are responsible for the full-billed amount when you receive care from an out-of-network provider.

If you select Delta Platinum, you and any dependents you cover must remain enrolled in that plan for a minimum of two plan years.

EYEMED VISION CARE

EyeMed Vision Care: 866.800.5457

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

COMPREHENSIVE VISION EXAM

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

MATERIALS

Pair of Lenses for Eyeglasses

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

Frames

Receive a $140 retail frame allowance at both private practice providers and retail chain providers, with a 20% discount over the balance of the allowance.

CONTACT LENSES IN LIEU OF LENSES

Elective contact lenses

The fitting/evaluation fees are subject to a $40 copayment for a standard fit and follow-up; premium fit and follow-up has a 10% discount. Members receive an allowance of $130, with a discount of 15% off balance over $130 for conventional contact lenses. Disposable contact lenses have a $130 allowance also, but members pay 100% on any amount over $130.

Medically necessary contact lenses

Covered in full. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: To correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact EyeMed concerning the reimbursement that EyeMed will make before you purchase such contacts.

REFRACTIVE EYE SURGERY

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

HEARING CARE

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

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

Call 877.203.0675 to find a hearing care provider near you to schedule a hearing exam.

IMPORTANT TO REMEMBER

- Benefits available every 12 or 24 months are based on last date of service.
- While a card isn't required for services, all team members will receive two personalized ID cards or you may print a card by visiting eyemed.com.
- You can maximize your benefits and lower your out-of-pocket expenses when you visit an in-network provider (compared to the same product purchased at an out-of-network provider). You are able to choose

from both independent providers and retail chain providers. It's up to you.

- You can find the best provider for you at eyemed.com. EyeMed's "Smart Locator" makes it easy for you to find an in-network provider. And you can search based on hours, services offered, and specific products and brands. You can even schedule an appointment online.
- EyeMed offers a member app for the iPhone and Android users that allows you to find a provider, check your benefits or share a mobile ID card.
- While a card isn't required for services, members have the ability to print a personalized ID card at eyemed.com. With EyeMed Vision Care, you are able to choose from network private practice providers and retail chain providers. Prior to using the EyeMed vision care program, if you would like to identify a network provider, visit EyeMed's website — eyemed.com — and choose provider locator or call EyeMed's Provider Locator Service at 866.800.5457 and follow the voice prompts.

- In-network benefits are now available online by utilizing:
  - Glasses.com
  - Contacts Direct: contactsdirect.com
  - LensCrafters: lenscrafters.com
  - Oakley.com
  - Target Optical: targetoptical.com
  - Ray-Ban: ray-ban.com
- Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are an EyeMed Vision Care participant.

VISION — EYEMED VISION				
	BASIC		ENHANCED	
	FREQUENCY	COPAY	FREQUENCY	COPAY
Comprehensive Vision Exam	1 every 12 months	$10 Copay	1 every 12 months	$0 Copay
Materials				
Pair of Lenses for Frames	1 every 12 months	$25	1 every 12 months	$0 Copay
Frames	1 every 24 months	Up to $140	1 every 24 months	Up to $140
Contact Lenses (in lieu of glasses)	1 every 12 months	Up to $130	1 every 12 months	Up to $130
OUT-OF-NETWORK PROVIDER				
	FREQUENCY	REIMBURSEMENT	FREQUENCY	REIMBURSEMENT
Exam	1 every 12 months	up to $40	1 every 12 months	up to $40
Lenses				
Single	1 every 12 months	up to $40	1 every 12 months	up to $40
Bifocal	1 every 12 months	up to $60	1 every 12 months	up to $60
Trifocal	1 every 12 months	up to $80	1 every 12 months	up to $80
Lenticular	1 every 12 months	up to $80	1 every 12 months	up to $80
Frames	1 every 24 months	up to $45	1 every 24 months	up to $45
Contact Lenses (in lieu of glasses) have a separate allowance, not a copay.				
Medically Necessary		up to $130	1 every 12 months	up to $130
		up to $210	1 every 12 months	up to $210

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

INCOME REPLACEMENT: EMPLOYER-PAID SHORT-TERM DISABILITY

The Standard: 800.831.7618

As a full-time benefit-eligible team member, you will be automatically enrolled in this benefit. Life Time will be paying for the cost of short-term disability for all full-time benefit-eligible team members.

EMPLOYEE BENEFIT AMOUNT

If you are disabled due to a covered injury or sickness, you will be eligible to receive a weekly benefit as stated in your certificate.

- 75% of your salary; the maximum weekly benefit is $1,250/week
- This benefit is considered taxable income
- In Workday, this is called: Short-Term Disability (STD) — Standard Insurance Company Short-Term Disability (Employee)

DISABILITY DEFINITION

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

BENEFIT WAITING PERIOD

Your type of disability will determine the benefit waiting period. Benefits will begin on day 1 of a disability caused by an accident/injury and day 8 for a disability caused by illness/pregnancy.

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

Please note, your date of disability, your recovery period, and the time period for benefits for maternity claims are based on your delivery type and the level of your occupation. This will vary from claim to claim.

MAXIMUM BENEFIT DURATION

The longest period for which STD benefits are payable for any one period of continuous disability, whether from one or more causes, is 83 or 90 days. It begins at the end of the Benefit Waiting Period. No STD benefits are payable after the end of the Maximum Benefit Period, even if you are still disabled.

OTHER BENEFITS INCLUDED

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

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

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

PROGRAM ELIGIBILITY

All full-time team members regularly scheduled to work at least 36 hours each week (30 hours per week for LifeSpa, personal training and racquet sports team members). Team members must be capable of being actively at work on the day before coverage takes effect. A delayed effective date will apply if the team member is not actively at work on the date that the insurance would otherwise take effect.

EXCLUSIONS

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

INCOME REPLACEMENT: VOLUNTARY LONG-TERM DISABILITY

The Standard: 800.831.7618

EMPLOYEE BENEFIT AMOUNT

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

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

THE LTD BENEFITS ARE REDUCED BY ANY OTHER INCOME YOU ARE ELIGIBLE FOR UNDER

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

BENEFIT WAITING PERIOD

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

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

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

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

TEMPORARY RECOVERY

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

MAXIMUM BENEFIT DURATION

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

PREEXISTING CONDITION EXCLUSION

For newly eligible team members:

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

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

EXCLUSION

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

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

FOR LATE ENROLLEES

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

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

EXCLUSION

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

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

OTHER BENEFITS INCLUDED

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

- You may work and still be eligible for LTD benefits. This is sometimes referred to as partial disability. You are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation; and you suffer a loss of at least 20% in your pre-disability earnings when working in your own occupation. To qualify for the benefit, you must satisfy the benefit waiting period and be earning less than 80% of your pre-disability earnings. Partial disability benefits are reduced if your work earnings plus LTD benefits exceed 100% of your pre-disability earnings. Benefits end the date your earnings exceed 80% of your pre-disability income, the date the maximum benefit duration ends, or the date you are no longer disabled. Premiums due during a total or partial disability period are waived after benefits become payable and for as long as they continue.
- A survivor income benefit is paid in the event of your untimely death. A lump sum benefit equal to 3 times your last monthly LTD benefit is paid to your surviving spouse or children if you should die. To qualify, you must have been disabled for 180 days and have been receiving LTD benefits under terms of the policy.
- An Assisted Living Benefit applies if you are severely disabled. Your LTD benefit is increased to 80% of pre-disability earnings if your disability causes you to be unable to perform two or more activities of daily living or if you are suffering severe cognitive impairment.
- Converting your LTD plan to an individual policy is an option if you lose your coverage through Life Time.

PROGRAM ELIGIBILITY

All full-time team members regularly scheduled to work at least 36 hours each week 30 hours per week for LifeSpa, personal training and racquet sports team members). Team members must be capable of being actively at work on the day before coverage takes effect.

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

MONTHLY PREMIUM CALCULATION

John Doe is 33 and earns $2,500 per month. His cost per month is $6.10. $2,500 x .00244 = $6.10 monthly deduction.

AGE	MONTHLY COVERED PAYROLL RATE
< 25	0.00137
25–29	0.00183
30–34	0.00244
35–39	0.00397
40–44	0.00595
45–49	0.00870
50–54	0.01175
55–59	0.01602
60–64	0.01434
65–69	0.00870
70–99	0.00717

$_____ x _____ = $_____

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

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

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

DISABILITIES SUBJECT TO LIMITED PAY PERIODS

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

BASIC TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The Standard: 800-628-8600

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

ADDITIONAL TERM LIFE INSURANCE

The Standard: 800-628-8600

EMPLOYEE BENEFIT AMOUNT

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

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

Evidence of insurability is required if you enroll or increase coverage more than 31 days after you become eligible. If you do not apply for coverage when you are initially

eligible and you choose to apply at a later date, you may be responsible for any expenses associated with obtaining further medical information (Life Insurance is not an annual open enrollment benefit).

REDUCTION IN BENEFITS

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

Monthly Premium Calculation

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

Employee Age	Per $1,000 of Coverage
< 30	0.066
30–34	0.088
35–39	0.099
40–44	0.143
45–49	0.242
50–54	0.385
55–59	0.594
60–64	0.935
65–69	1.760
70–74	3.080
75 +	6.677
AD&D Rate	$0.02

$_____ x _____ = $_____

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

SPOUSE BENEFIT AMOUNT

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

In Workday, these are called: Spouse Life – Standard Insurance Company Spouse Voluntary Life (Spouse) and Spouse Accidental Death and Dismemberment – Standard Insurance Company Spouse Accidental Death and Dismemberment (Spouse). (This is not an annual open enrollment benefit.)

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

Monthly Premium Calculation

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

Spouse Age	Per $1,000 of Coverage
< 30	0.066
30–34	0.088
35–39	0.099
40–44	0.143
45–49	0.242
50–54	0.385
55–59	0.594
60–64	0.935
65–69	1.760
70–74	3.080
75 +	6.677
AD&D Rate	$0.02

$_____ x _____ = $_____

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

DEPENDENT CHILDREN BENEFIT AMOUNT

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

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

Monthly Premium Calculation

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

OTHER BENEFITS INCLUDED

Waiver of Premium

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

Accelerated Death Benefit

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

PROGRAM ELIGIBILITY

All full-time team members regularly scheduled to work at least 36 hours each week (30 hours per week for LifeSpa, personal training and racquet sports team members). Team members must be capable of being actively at work on the day before coverage takes effect. A delayed effective date will apply if the team member is not actively at work on the date that insurance would otherwise take effect.

PORTABILITY

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

CONVERSION

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

PRETAX SPENDING ACCOUNTS

UNDERSTANDING AN HSA

Fidelity 800.544.3716

A Health Savings Account (HSA), combined with a high-deductible health plan, offers you a number of unique features that put you in control of your healthcare choices and how you spend your healthcare dollars. **HSA accounts are owned by individual members and are not part of a group account. Fidelity is the custodian for Life Time's HSA accounts. You can reach Fidelity at 844.973.3925 or find them online at netbenefits.com.**

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

WHAT IS AN HSA AND HOW DOES IT WORK?

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

pays for covered expenses in excess of your deductible. Any unused funds are yours to retain in your HSA and accumulate toward your future healthcare expenses.

WHO QUALIFIES FOR AN HSA?

An eligible individual is anyone who:

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

WHO QUALIFIES AS A DEPENDENT?

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

WHAT IS A "HIGH-DEDUCTIBLE HEALTH PLAN" (HDHP)?

A HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. Our HDHP $2,300 plan and HDHP $5,500 plan are qualified HDHP, as defined by IRS regulations. Visit treasury.gov and search for "Health Savings Accounts" to find the most up-to-date information.

WHAT OTHER KIND OF HEALTH COVERAGE MAKES AN INDIVIDUAL INELIGIBLE FOR AN HSA?

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

WHAT OTHER KINDS OF HEALTH COVERAGE MAY AN INDIVIDUAL MAINTAIN WITHOUT LOSING ELIGIBILITY FOR AN HSA?

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

WHAT CAN I USE THE HSA FOR?

The HSA can be used:

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

WHAT IF I USE MY HSA TO PAY FOR SOMETHING OTHER THAN A QUALIFIED MEDICAL EXPENSE?

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

ARE HEALTH INSURANCE PREMIUMS QUALIFIED MEDICAL EXPENSES?

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

CONTRIBUTIONS TO AN HSA

WHO MAY CONTRIBUTE TO AN HSA?

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

CAN I ENROLL IN BOTH THE HSA AND A HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)?

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

HOW MUCH CAN I CONTRIBUTE TO MY HSA?

In 2025, your annual HSA contribution may not exceed IRS limits of $4,300 for individual coverage or $8,550 for family coverage. in 2026, the limit for single coverage increases to $4,400 and $5,750 for family coverage. IRS limits are indexed for inflation on an annual basis. Visit treasury.gov and click on "Health."

IF I OPEN MY HSA ON JUNE 1, WHAT IS MY PERMITTED CONTRIBUTION AMOUNT FOR THAT YEAR?

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

CAN I CHANGE MY CONTRIBUTIONS TO MY HSA DURING THE YEAR?

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

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

HOW DO I MAKE CONTRIBUTIONS?

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

WILL HSA CONTRIBUTIONS THAT I MADE VIA LOCKBOX DEPOSIT OR ONLINE VIA ECONTRIBUTE SHOW UP ON MY W-2?

No. Contributions made by either of these methods are considered after-tax contributions for purposes of W-2 reporting. In order to receive the tax benefit of after-tax contributions, you must claim them on your tax return.

WHEN CAN HSA CONTRIBUTIONS BE MADE? IS THERE A DEADLINE FOR CONTRIBUTIONS TO AN HSA FOR A TAXABLE YEAR?

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

WHAT HAPPENS WHEN HSA CONTRIBUTIONS EXCEED THE MAXIMUM AMOUNT THAT CAN BE DEDUCTED OR EXCLUDED FROM GROSS INCOME IN A TAXABLE YEAR?

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

WHAT ARE CATCH-UP CONTRIBUTIONS FOR INDIVIDUALS AGE 55 OR OLDER?

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

IF MY SPOUSE IS AGE 55 OR OLDER, AM I ELIGIBLE TO MAKE THE CATCH-UP CONTRIBUTION?

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

WHAT HAPPENS TO MY REMAINING ACCOUNT BALANCE AT THE END OF THE YEAR?

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

CAN I CONTRIBUTE FUNDS FROM MY INDIVIDUAL RETIREMENT ARRANGEMENT (IRA) TO MY HSA?

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

ARE ROLLOVER CONTRIBUTIONS FROM ARCHER MSAS AND OTHER HSAS PERMITTED?

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

DISTRIBUTIONS

WHEN CAN I INITIATE DISTRIBUTIONS FROM AN HSA?

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

WHAT ARE THE QUALIFIED MEDICAL EXPENSES THAT ARE ELIGIBLE FOR TAX-FREE DISTRIBUTIONS?

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

HOW ARE DISTRIBUTIONS FROM AN HSA TAXED?

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

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

IS TAX REPORTING REQUIRED FOR AN HSA?

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

WHAT ARE THE TAX RULES OF AN HSA?

An HSA provides you triple tax savings by allowing:

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

WHAT HAPPENS TO THE HSA IF I DIE?

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

WHAT ARE THE INCOME TAX CONSEQUENCES FOR THE BENEFICIARY AFTER THE HSA ACCOUNT HOLDER'S DEATH?

Upon death, any balance remaining in the account holder's HSA becomes the property of the individual named in the HSA as the beneficiary of the account. If the account holder's surviving spouse is the named beneficiary of the

HSA, the HSA is treated as though the surviving spouse were the account holder, and the distributions used for qualified medical expenses are not subject to income tax.

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

WHO IS RESPONSIBLE FOR DETERMINING WHETHER HSA DISTRIBUTIONS ARE USED EXCLUSIVELY FOR QUALIFIED MEDICAL EXPENSES?

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

IF I CHANGE EMPLOYERS, WHAT HAPPENS TO MY HSA?

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

HOW WILL HSA STATEMENTS BE DELIVERED AND HOW FREQUENTLY?

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

CAN I REIMBURSE MYSELF WITH HSA FUNDS FOR QUALIFIED MEDICAL EXPENSES INCURRED PRIOR TO MY ENROLLMENT IN AN HSA?

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

UNDERSTANDING AN FSA

CBIZ Flex: 855-410-2249
myplans.cbiz.com or the My Plans by CBIZ mobile app.

SAVE TAX DOLLARS EVERY YEAR YOU ENROLL!

When you enroll in a Flexible Spending Account, you can pay for your transit, medical, dental and/or dependent (day care) expenses with money withheld from your paycheck. You can contribute up to $3,300, the IRS calendar year maximum, into your medical flexible spending account. Money withheld is not subject to Social Security (FICA) and federal or state income taxes.

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

A FEW SIMPLE STEPS

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

- Elect the amounts in Workday you want withheld from your check. In Workday, this is called: Medical Care Reimbursement Account – Full Medical Care Reimbursement Account. In Workday, the dependent care FSA is called: Dependent Care Reimbursement Account – Dependent Care Reimbursement Account.
- When you want to make a qualified purchase from your FSA, use your pretax CBIZ debit card at a participating merchant, and you won't have to submit a receipt for reimbursement. Visit client.joinforma.com/login for more information.
- After you have incurred a medical or dependent care expense, fill out the claim for reimbursement form available online at myplans.cbiz.com.
- Your claim will be processed, and if the expenses qualify, a reimbursement check will be provided to you according to the payment schedule. Direct Deposit setup within the member portal is a preferred method for reimbursement.

HOW DOES THIS WORK?

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

IMPORTANT FACTS

- You must submit receipts or an Explanation of Benefits demonstrating the date of service and the payment amount that you are responsible for. If you do not have an itemized receipt or any of the required information while filing a claim online, you can include a completed Dependent Care Flexible Spending Account (DCFSA) form when you file a claim from your CBIZ account. To access the DCFSA form log in to the CBIZ My Plan member portal.
- All expenses must be incurred within the current benefit plan year.
- You may elect to participate only at the time of hire, qualified life event or Open Enrollment.
- Any money not used by the end of the year is forfeited.
- If you become ineligible for an FSA benefit, all funds must be used by the end of the month or any unused funds will be forfeited.
- You have 90 days from the date your benefit ends to submit expense for reimbursement.
- If you are highly compensated, your flexible spending/day care spending account may be reduced due to federal testing requirements.

I'M ENROLLED/ENROLLING IN THE HSA. CAN I STILL USE AN FSA?

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

WHAT EXPENSES QUALIFY?

QUALIFIED EXPENSES – MEDICAL

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

QUALIFICATIONS – DEPENDENT CARE

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

HOW MUCH CAN YOU SAVE?

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

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

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

FSA QUESTIONS

IS THERE AN ANNUAL LIMIT FOR DEPENDENT CARE?

Yes, the maximum you can elect is $5,000 for the tax year prior to December 31, 2025. If you enroll in a dependent (day care) account, you cannot claim the child care credit on your tax return for those expenses reimbursed from your FSA. Check with your tax advisor to see which would be better for you.

CAN I CHANGE MY ELECTION DURING THE YEAR?

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

ARE OVER-THE-COUNTER DRUGS REIMBURSABLE?

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

TRANSPORTATION BENEFITS

CBIZ Flex 855-410-2249
myplans.cbiz.com or the My Plans by CBIZ mobile app.

LIFE TIME CONTRIBUTION

Life Time will match contributions up to $50 per month. For instance, if you need $100 per month to buy a bus pass, you should elect $50, and Life Time will contribute up to $50. In Workday, this is called: Transportation Spending Account – Bus/Van Pool Spending Account or Transportation Spending Account – Parking Spending Account Plan.

WHAT SPECIFIC TRANSPORTATION BENEFITS ARE PROVIDED BY THE PLAN?

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

WHAT ARE TRANSPORTATION EXPENSES?

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

- Transit Pass Expenses are expenses incurred or paid for a pass, token, fare card, voucher or similar item (Transit Pass) for transportation (a) on mass transit facilities (such as train, bus, subway or ferry), whether

or not publicly owned; or (b) provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).

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

WHAT MUST I DO TO BE REIMBURSED FOR MY TRANSPORTATION EXPENSES?

A Transportation Expense is paid when the service has been provided and you formally pay for the service; it is not paid when you are formally billed for or charged for the service. Submit a claim by logging in to your member portal at myplans.cbiz.com. You must also include bills, invoices, statements from an independent third party, parking receipts, used transit passes or other evidence of payment showing the amounts of such payments, together with any additional documentation that the Administrator may request, showing that the Transportation Expenses have been incurred or paid, and the amount of such Transportation Expenses. Please note that, by law, the administrator may not be able to reimburse you for the expense of a Transit Pass if a "voucher" (or something similar) is readily available.

WHAT IF I OVERESTIMATE MY TRANSPORTATION EXPENSES?

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

WHAT IF I UNDERESTIMATE MY TRANSPORTATION EXPENSES?

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

LIMITS 2025

Transit/Van Pool: up to $325/month and may be increased or decreased each month of the plan year.

Parking: up to $325/month and may be increased or decreased each month of the plan year.

New York City Transit/Van Pool: Up to $325/month and may be increased or decreased each month of the plan year.

401(k)

Fidelity: 800.835.5095

Your 401(k) Administrator is Fidelity Investments. You can find Fidelity Investments online at 401k.com or call 800.835.5095. Your 401(k) Advisor is CBIZ. You can find CBIZ online at fitconnect.cbiz.com or by calling 866-224-9348.

Life Time has a 401(k) plan that may match amounts team members contribute to the plan. Life Time's plan allows you to save for your retirement on a pretax basis, an after-tax Roth basis or a combination of pretax and after-tax Roth basis. You pay no federal or state income taxes on pretax contributions, company contributions or investment earnings until you receive them. Roth contributions are made after taxes have been withheld. You may enroll if you are at least 21 years of age. Enrollment is done at the Fidelity website 401(k).com. Further enrollment instructions can be found on Workday and LT Central.

At no additional charge you can receive unbiased, professional financial advice from CBIZ. You can schedule a virtual consultation via the online scheduler at fitconnect.cbiz.com , by calling them at 866-224-9348 or emailing them at fit@cbiz.com. Your CBIZ Team can help you answer questions regarding the 401(k) plan such as: How much of my paycheck should I put aside to help me retire? and/or Which investments in the 401(k) plan are right for me?

ADOPTION BENEFIT

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

LEAVE OF ABSENCE

Please contact The Standard at 800.831.7618 for all Leave of Absence (FMLA, Military, Medical, etc.) inquiries. Please contact Life Time via email leaveofabsence@lt.life for all ADA inquiries. If you are on leave and the number of your dependents changes (e.g., birth of a child), please refer to the "Qualified Life-Changing Event" section at the beginning of this booklet. You will be responsible for paying for your benefit premiums while out on leave.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is a confidential service provided by your employer that offers help with personal and work-related issues.

Professionally trained advisors are available to help with family problems, marital concerns, financial and legal matters, stress, depression and other issues affecting your personal or work life. The EAP is free and confidential. Advisors are available to help 24 hours a day, 7 days a week, 365 days a year.

From time to time, we all need support to deal with an issue or challenge. If you could benefit from professional help to proactively address a personal or work-related concern, you can turn to TELUS Health. The Employee Assistance Program (EAP) is available to you and your dependents at no additional cost (as defined in your benefits plan) and includes access to confidential counseling. Here are just some of the ways that EAP counseling can help:

- You're dealing with conflict or changes at work and it's affecting your productivity.
- You'd like to learn to better control anger or manage stress.
- You recently learned you have a chronic illness or disability.
- You're going through a separation or divorce.
- You're concerned about an addicted spouse or family member.
- You're struggling with self-esteem or communication issues; parenting challenges; midlife concerns; sexual orientation or gender identity, or other personal issues.

To get started, call TELUS Health toll-free, anytime, to speak with a caring Advisor for guidance, resources, and referrals to counseling support -provided face to face, telephonically or via video sessions for short-term, solution focused counseling. Counselors are experienced therapists with a minimum of a master's degree in psychology, social work, educational counseling or another social services field.

The EAP is a service provided by Life Time at no cost to you. That means that you pay nothing to use it. However, if you accept a referral to services outside the EAP, you will be responsible for costs that may be associated with resources external to the EAP.

If you are or a family member is going through a difficult time, remember the EAP is only a phone call away. Contact TELUS Health today.

TELUS Health offers confidential assistance with personal, legal, work, financial and other life issues 24 x 7 x 365. Call 888.267.8126 or go online to one.telushealth.com to get assistance any time.

Username: Lifetime
Password: Fitness

ASSIST AMERICA

TRAVEL ASSISTANCE THROUGH LIFE TIME GROUP LIFE INSURANCE

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

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

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

For more information in regard to this benefit, please refer to the information listed on Workday and LT Central.

VOLUNTARY INDIVIDUAL BENEFITS

Life Time is committed to providing you with progressive benefit solutions designed to add real value and enhance the quality of your life and the lives of your family members. We are excited to let you know of two unique benefit options in our comprehensive benefits package: **LegalShield and IDShield.**

LEGALSHIELD

For more than 44 years, LegalShield has been offering legal plans to its members, creating a world where everyone can access legal protection — and everyone can afford it. Unexpected legal questions arise every day and with LegalShield on your side, you will have access to a quality law firm 24/7 for covered personal situations. A LegalShield plan includes: will preparation for you and your spouse, toll-free telephone consultation on an unlimited number of personal matters (preexisting included), letters and phone calls on your behalf, contract and document review, 24/7 emergency access, 25% preferred member discount, access to the Member Perks discount program and much, much more.

For a full plan description, email:
admin@itcprotects.com

Individual and family enrollment options available via payroll deduction at group discounted pricing:

Individual Coverage is $14.95 per month / Family Coverage is $15.95 per month

Individual coverage for team members in MA, NY, NC and NV is $15.95 per month

IDSHIELD

Identity theft continues to be the top consumer complaint reported by the Federal Trade Commission. Every two seconds, someone becomes a victim of identity theft. Because of this, LegalShield created IDShield — the most comprehensive identity theft protection plan available on the market today. IDShield includes: EXTENSIVE and CUSTOMIZED privacy, security and credit monitoring, Credit Score Tracker, email alerts, $3 million protection policy with unlimited service guarantee, **and full and complete restoration — covering all types of identity theft**, the Member Perks program and much more.

For a full plan description, email:
admin@itcprotects.com

Individual and family enrollment options available via payroll deduction at group discounted pricing:

Individual Coverage is $8.45 per month / Family Coverage is $15.95 per month

Rates for Enrolling in Both Plans:

- LegalShield & IDShield – Individual Coverage – $23.40 per month
- LegalShield & IDShield – Family Coverage – $28.90 per month (additional discount applies)

KEY BENEFIT TERMS

- **COBRA** – A federal law that allows workers and dependents (not including domestic partners) who lose their medical, vision, dental or medical flexible-spending account coverage to continue any of these coverages for a specified length of time by electing and paying for continuation benefits.
- **Coinsurance** – The percentage of the medical or dental charge that you pay after you pay the deductible.
- **Copayment** – A flat fee that you pay for medical services, regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.
- **Deductible** – The amount you pay toward medical and dental expenses each plan year before the plan begins paying benefits.
- **Domestic partner** – A team member's domestic partner who has the same principal place of abode for more than two years, and who relies on the team member for more than one half of his or her or their support for the calendar year in which the domestic partner is enrolled for coverage under the Plan.
- **Out-of-pocket** – The total amount a team member or dependent pays out-of-pocket in a given benefit period (typically a year), including any deductibles or coinsurance (copayments will apply to out-of-pocket). Once this maximum has been reached, the plan pays 100% of eligible expenses, up to the annual maximum.
- **Premium** – The amount paid or to be paid by the team member for benefit coverage.
- **Network** – Doctors, hospitals, chiropractors and other medical professionals who have agreed to provide team members with better prices for services. You will be placed in a network based on your address in Workday. Please be sure to keep your address current.
- **Embedded Deductible** – Each family member has an individual deductible in addition to the overall family deductible. Meaning if an individual in the family reaches his or her or their deductible before the family deductible is reached, his or her services will be paid by the insurance company.
- **Non-Embedded Deductible** – There is no individual deductible. So the overall family deductible must be reached either by an individual or by the family, in order for the insurance company to pay for services.

EZPAY

EZpay is a free medical payment service that allows you to pay your medical bills from your own credit card, debit card, FSA or HSA card — simply, easily and safely.

Sign up from your custom benefits site!

1. Log in or create an account by clicking "Activate your account" on the login page.
2. Click on "EZpay Accounts" located in the menu.
3. Add your card of choice by filling in the information, then click "Submit" to start enjoying the benefits of Auto-Pay with HealthEZ.

You will receive an email once a bill is processed, and will be asked to approve payment if you owe money.

EZpay will pay by default if you do not respond in:

- 2 business days for claims under $250
- 5 business days for claims over $250

EZpay will combine your payment with any medical plan payments so your provider is paid in full.

BE THE SPARK.
BE A CHANGEMAKER.

At Life Time, we believe that a healthy way of life doesn't stop at our doors—it extends to the communities we serve and the future we're shaping. Through the Life Time Foundation, we're reimagining school meals, expanding access to movement for all kids, and restoring natural spaces so future generations can thrive. But real change takes all of us.

That's where you come in.

By contributing just $1 per paycheck, you become a Changemaker—part of a growing movement of Life Time team members who believe in building a better tomorrow. Your support fuels our mission to nourish kids with real food, help them move more and stress less, and protect the planet they'll inherit.

How to Become a Changemaker

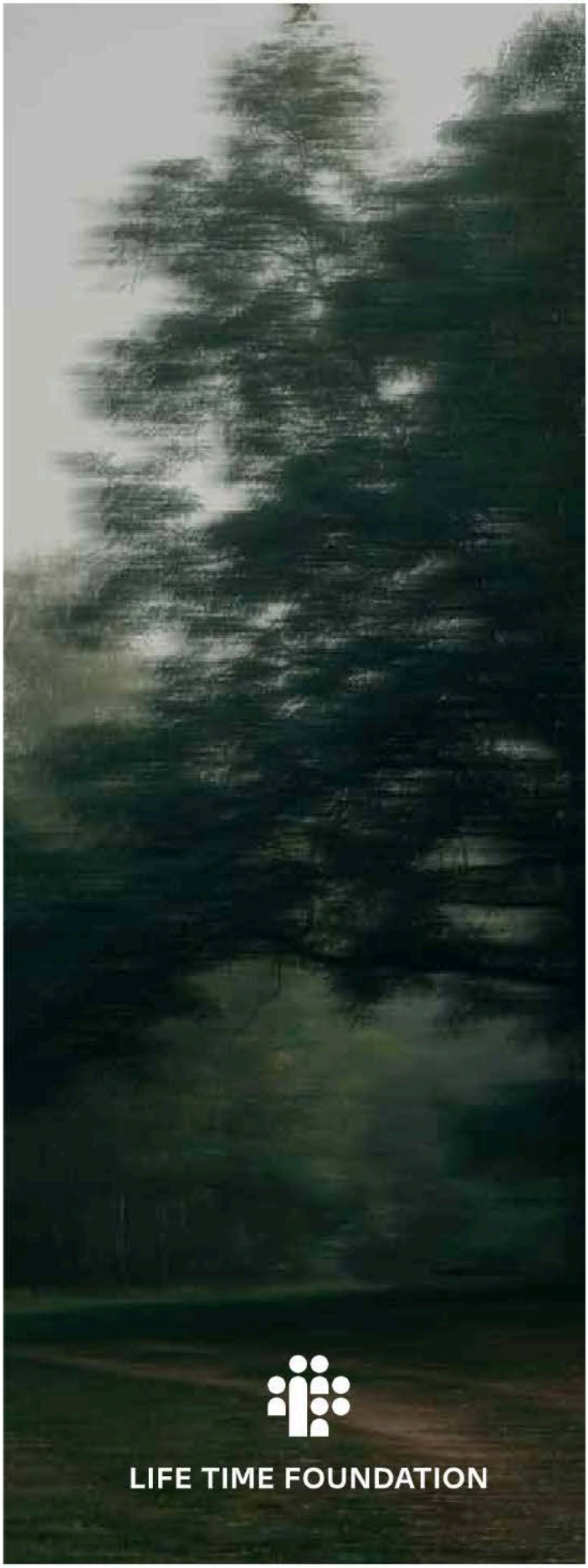
1. Login to Workday, click **MENU**.
2. Select **BENEFITS** and **PAY**.
3. Select **CHANGE BENEFITS**.
4. From the **CHANGE REASON** drop-down, select **LIFE TIME FOUNDATION**.
5. Choose the **BENEFIT EVENT DATE** (when you want to start your election), then click **SUBMIT**, then **DONE**.
6. You will immediately receive a **MESSAGE** in your Workday inbox.
7. Within that message, click **ENROL**L, then enter the amount you'd like to contribute by year or by paycheck.
8. Click **SELECT** to opt-in.
9. Choose the **AMOUNT** you want to contribute. This can be **PER PAYCHECK** or **ANNUAL**.
10. Make sure to **REVIEW AND SIGN** your contribution.
11. After you review your selection, click **SUBMIT**.

*all donations are tax deductible

Every Changemaker receives an exclusive sticker, merch, and gets first access to Foundation news, events, and

impact. Thank you for being the heart of our mission!

—The Life Time Foundation Team



OUR MISSION

To provide
Entertaining,
Educational,
Friendly and Inviting Experiences
of uncompromising quality
that empower everyone to live a healthy and happy life.

LIFE TIME®