TW Ventures Inc. Flexible Spending Account Plan

SUMMARY PLAN DESCRIPTION

For Tier 1 and Tier 2 Employees

Effective January 1, 2021

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Introduction

This is the Summary Plan Description of the TW Ventures Inc. Flexible Spending Account Plan (the "Plan") currently available to eligible Tier 1 and Tier 2 employees of Participating Employers. It describes the major provisions of the Plan as in effect on January 1, 2021 and provides information participants are legally entitled to know. The terms "you" and "your" as used in this Summary Plan Description refer to an employee who otherwise meets all the eligibility and participation requirements under the Plan. Receipt of this Summary Plan Description does not guarantee that the recipient is a participant under the Plan and/or otherwise eligible for benefits under the Plan. You may participate in this Plan even if you waive coverage under the TW Ventures Inc. Group Benefits Plan. The Plan Year begins each January 1st and ends the following December 31st.

TW Ventures Inc., or any successor, reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time and for any reason, by action of TW Ventures Inc. Please note that the Plan does not create an employment contract between you and your Participating Employer, and the Plan does not give you any right, expressed or implied, of continued employment with your Participating Employer.

About This Summary Plan Description

The information in this Summary Plan Description applies to eligible employees of Participating Employers. This summary tries to explain Plan provisions in everyday language, but you will come across linked words and phrases that have specific meanings within the context of the Plan. Click the links for the definitions of these terms, which are also available in "Key Terms and Definitions." Also, be sure to read "Other Information You Should Know", and "Your Rights Under ERISA" for important administrative guidelines and facts about your rights under applicable law, the Plan and the Program. If there's any discrepancy between this Summary Plan Description and the official Plan document, the Plan document takes precedence. You can get a copy of the Plan document by writing to the Plan Administrator.

Overview

The Plan offers three types of coverage – Health Care FSAs, Dependent Day Care FSAs and a Group Health Care Contribution "Pass Through" Account. Your coverage options depend on your eligibility tier – either Tier 1 or Tier 2.

Which tier applies to me? To determine which eligibility tier applies to you, here are the basic questions you'll need to answer:

- ***Do you work for a Participating Employer?*** You must be a non-union, active full-time employee, you must work for a Participating Employer and you must be paid through Cast & Crew. If you work for a Participating Employer that is affiliated with Telepictures, you are a Tier 1 eligible employee. If you work for a Participating Employer that is affiliated with Warner Horizon, WAG Pictures, Inc. or TV Affiliates, you are a Tier 2 eligible employee. For a list of the Participating Employers, go to tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com or www.benefitsfortvhires.com or contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information.
- ***Do you work the required number of hours?*** You must be regularly scheduled to work at least 30 hours per week.

You can find a more detailed discussion of the Plan's eligibility rules in the section called "Who's Eligible."

What coverage options are available for each tier? The table below summarizes the coverages offered by the Plan to employees in each eligibility tier.

If your eligibility tier is…	Then these are the coverage options available to you…
Tier 1	Health Care Flexible Spending Account (FSA) Dependent Day Care FSA Group Health Care Contribution "Pass Through" Account
Tier 2	Group Health Care Contribution "Pass Through" Account

What are the coverage options offered by the Plan and how do they work? The table below summarizes the coverage options offered by the Plan.

Coverage option	How it works
Health Care FSA	**Note - Only Tier 1 employees are eligible to participate in the Health Care FSA.** If you are a Tier 1 employee, you can contribute up to the limit announced during open enrollment on a pre-tax basis to reimburse expenses you or your eligible dependents incur for health expenses not covered under any other health program (e.g., deductibles, coinsurance, copayments, amounts over reasonable & customary, eye glasses, hearing aids, non-cosmetic orthodontia). Your coverage under the Health Care FSA extends only to your dependents who are eligible for pre-tax health care under current federal income tax law (see below). The limit may increase annually if the IRS approves a cost-of-living adjustment.
Dependent Day Care FSA	**Note – Only Tier 1 employees are eligible to participate in the Dependent Day Care FSA.** If you are a Tier 1 employee, you can contribute up to $5,000 per year ($2,500 if married and filing a separate return) on a pre-tax basis to reimburse qualified day care expenses for eligible children under age 13 and other qualified dependents, generally if both you and your spouse work. Under current federal income tax law, only certain dependent care expenses are eligible for reimbursement. More detailed information is included in this Summary Plan Description and in IRS Publication 503, "Child and Dependent Care Expenses," available from your local IRS office or on the IRS website.
Group Health Care Contribution "Pass Through" Account	For both Tier 1 and Tier 2 employees, your contributions for medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan are deducted from your pay, generally on a pre-tax basis. These contributions "pass through" the Plan and are not reimbursable. Your coverage under the Group Health Care Contribution "Pass Through" Account extends only to your dependents who are eligible for pre-tax health care under current federal income tax law (see below).

Which dependents are eligible for pre-tax health care? Generally, your dependents eligible for pre-tax health care under current federal income tax law include your spouse, individuals who may be claimed as your dependents for federal income tax filing purposes or could be claimed as a dependent if he or she had earned income less than the IRS limit for dependents, and your biological and adopted children, stepchildren, and foster children through the end of the year in which they reach age 26. However, health care expenses for domestic partners, children of domestic partners and parents residing in your home who cannot be claimed as dependents on your income tax return may not be eligible for pre-tax health care or Health Care FSA reimbursement under the Plan. You may refer to the IRS Publication 502 "Medical and Dental Expenses" for more information on eligible dependents.

Are there any Internal Revenue Service (IRS) requirements? In order to be eligible for the tax benefits of the Plan, there are several requirements imposed by the IRS. For example, if you are Tier 1 employee you should be aware that the IRS "use it or lose it" rule requires you to forfeit unused amounts in your Health Care FSA or Dependent Day Care FSA at the end of the Plan Year. **Also, please note the Dependent Day Care FSA is subject to specific non-discrimination restrictions, which can limit the elections made by** highly compensated employees**.**

When can I enroll? The Plan Administrator will notify you when you are eligible to enroll. Note that you must be in current employment status to enroll in the Plan. For Tier 1 and Tier 2 employees, you are in current employment status if you are an active employee on the date your enrollment would be effective. You can find a more detailed discussion of the Plan's enrollment rules in the section called "Enrollment."

Who's Eligible

Your eligibility tier is determined based on the requirements described below. Keep in mind that the eligibility tiers are mutually exclusive - for example, you can't be a Tier 1 employee and a Tier 2 employee at the same time. Here's how your eligibility tier is determined:

Tier 1 Employees. You are eligible to participate in the Plan as a Tier 1 employee if you are employed by a Participating Employer affiliated with Telepictures, you are a non-union, active full-time employee, you are paid through Cast & Crew and you are regularly scheduled to work 30 or more hours per week. You are also eligible to participate in the Plan as a Tier 1 employee if you are a grandfathered employee. You are a "grandfathered" employee if you are employed by a Participating Employer affiliated with Warner Horizon, you are a non-union, active full-time employee, you are paid through Cast & Crew, you are regularly scheduled to work 30 or more hours per week and you were offered a 3-year written employment agreement between November 1, 2008 and September 1, 2010.

Tier 2 Employees. You are eligible to participate in the Plan as a Tier 2 employee if you are employed by a Participating Employer that is affiliated with Warner Horizon, WAG Pictures Inc. or TV Affiliates, you are a non-union, active full-time employee, you are paid through Cast & Crew and you are regularly scheduled to work 30 or more hours per week.

Enrollment

Health Care FSA and Dependent Day Care FSA. If you are a Tier 1 employee, you should be aware that participation in the Health Care FSA and Dependent Day Care FSA is not automatic. You must affirmatively enroll for the Health Care FSA and/or the Dependent Day Care FSA when you first become eligible to participate and again each calendar year. You have several enrollment opportunities, as explained below.

- ***Initial enrollment.*** When you become eligible to participate in the Plan, you will be directed to the benefits website at tpbenefits.com for information regarding Plan coverage and enrollment instructions. You must affirmatively enroll in the Health Care FSA and/or the Dependent Day Care FSA within 30 days of your "eligibility date." Your eligibility date is the first day of the month following 30 continuous days of employment. If you enroll within 30 days of your eligibility date, your participation begins on your eligibility date. If you do not enroll within 30 days of your eligibility date, you must wait until the next open enrollment period unless you have a qualified change in status.
- ***Annual enrollment.*** You may enroll or re-enroll during the annual open enrollment period, which is held in the Fall. If you enroll or re-enroll during the annual open enrollment period, your participation begins on the next January 1 and stays in effect throughout the next calendar year.
- ***Qualified change in status***. You may enroll or change your enrollment within 30 days of a qualified change in status. See the "Qualified Change in Status" discussion below to understand when these changes become effective.

Group Health Care Contribution "Pass Through" Account. If you are a Tier 1 or a Tier 2 employee, you are automatically enrolled in the Group Health Care Contribution "Pass Through" Account if you enroll in medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan. If you experience a qualified change in status and you change your enrollment under the TW Ventures Inc. Group Benefits Plan, then a corresponding change will be made automatically to your pre-tax contributions under the Group Health Care Contribution "Pass Through" Account.

Annual enrollment. TW Ventures Inc. holds an annual open enrollment each Fall, during which Tier 1 employees can enroll for the following year in the Health Care FSA and/or the Dependent Day Care FSA. Enrollment elections under the Health Care FSA or Dependent Day Care FSA do not carry over from one year to the next. Participation in the Group Health Care Contribution "Pass Through" Account is automatic for those enrolled in medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan. Whatever election you make during open enrollment takes effect on the next January 1 and stays in effect for the full calendar year unless you experience a qualified change in status and file an amended election within 30 days.

Qualified change in status. Your elections generally must stay in effect until the end of the current calendar year. Once made, you can't change your elections during the calendar year unless you have a qualified change in status. A qualified change in status includes the following:

- Your legal marital status changes (e.g., through marriage, divorce, legal separation or annulment) or you enter into or dissolve a domestic partnership.
- The number of your eligible dependents changes (such as when a child becomes your dependent through birth or adoption; a person's status as an eligible dependent changes; or a dependent dies).
- Your covered dependent no longer satisfies the requirements for coverage under the Plan because he or she reaches the limiting age or any similar circumstance.
- Eligibility for employer-sponsored health coverage is affected because you become or your eligible dependent becomes employed or unemployed (and is not rehired within 30 days).
- Eligibility for employer-sponsored health coverage is affected because you take or return or your eligible dependent takes or returns from an unpaid work-related leave of absence.
- Eligibility for employer-sponsored health coverage is affected because your or your eligible dependent's employment status changes from full-time to part-time (or vice versa).
- Eligibility for employer-sponsored health coverage is affected because you go or your eligible dependent goes on strike, or you are or your eligible dependent is locked out, or you return or your eligible dependent return from a strike or lockout.
- The coverage options available to you change because you change or your eligible dependent changes residences, worksites or Participating Employers.
- You previously waived participation in group health coverage under the TW Ventures Inc. Group Benefits Plan for yourself and/or your eligible dependent because you and/or your dependent, as applicable, were covered under another group health plan and subsequently lost that coverage due to loss of eligibility (including for reasons of attainment of the maximum age for dependent coverage or because an HMO or other similar arrangement ceases to provide coverage to individuals who no longer reside, live or work in a service area and no other coverage option is available under the other group health plan) or because employer contributions for the other group health coverage were terminated.
- You or your eligible dependent is affected by a change made by another employer-sponsored cafeteria plan or another employer-sponsored qualified benefits plan (such as a medical, dental or vision plan). If you are a Tier 1 employee, this includes the ability to make an election, or change an election, under the Dependent Day Care FSA if your spouse

participates in another employer-sponsored dependent day care account and your spouse's contributions to that account are stopped by the spouse's employer to avoid a nondiscrimination failure.

- You either become eligible for or lose eligibility for, or your eligible dependent either becomes eligible for or loses eligibility for, Medicare or Medicaid coverage (to the extent permitted by law).
- You lose or an eligible dependent loses coverage under Medicaid or a state children's health insurance program (CHIP) because you are no longer eligible for coverage (you must make this change within 60 days of the loss of coverage).
- You are or an eligible dependent is determined to be eligible for assistance with the cost of Company-sponsored group health plan coverage under Medicaid or a state children's health insurance program (CHIP) (you must make this change within 60 days of the determination).
- Your or your dependent's COBRA coverage under another plan is exhausted.
- For the Group Health Care Contribution "Pass Through" Account only, the Plan Administrator in accordance with IRS guidelines, determines that there's a significant change in the employer-sponsored health coverage you have or your eligible dependent has.
- For the Group Health Care Contribution "Pass Through" Account only, your eligible dependent's employer-sponsored group health plan has a different open enrollment period (and a different plan year), and you would like to make a change in your coverage under the TW Ventures Inc. Group Benefits Plan to correspond with an election change under your eligible dependent's plan.
- For the Dependent Day Care Account only, there is a change in the cost of your dependent day care. Your election may be changed only if the cost change is imposed by a dependent care provider who is not your relative. However, if your dependent care provider is a relative, you cannot increase or decrease your contribution even if the cost to you increases or decreases.
- A judgment, decree or other order resulting from a divorce, legal separation, annulment or change in legal custody, such as a Qualified Medical Child Support Order, requiring health coverage for your child or dependent foster child.

If you have a qualified change in status, you have 30 days to change your coverage elections (as noted above, two of the qualified change in status events give you 60 days to change your coverage election). The change in your elections must be due to and consistent with the qualified change in status and is subject to Internal Revenue Code requirements. Once a coverage change has been approved, it generally becomes effective on the first day of the month following the date you submit your status change, as long as you submit the status change within 30 days (or within 60 days if applicable) of the qualified change in status event. However, if your qualified change in status involves a newborn or newly-adopted child, coverage begins on the date of birth or adoption as long as you submit your status change within 30 days of the date of birth or adoption. Documentation verifying a qualified change in status must be provided to the TW Ventures Inc. Benefits Department upon request. Please note that if you are a Tier 1 employee you won't be allowed to reduce or cancel your Health Care FSA or Dependent Day Care FSA election to less than the amount you contributed or the amount you have been reimbursed as of the qualified change in status date. Also, reimbursement of claims for expenses incurred before your qualified change in status may be limited to the amount of your prior election. Documentation verifying a qualified change in status must be provided to the Plan Administrator upon request. Failure to comply will result in the amended election request being denied.

Your ability to change coverage during a calendar year is restricted under federal income tax rules because contributions for coverage (other than coverage for domestic partners and their children who are not eligible for non-taxable health benefits as your dependent(s) under federal tax law) are made on a pre-tax basis. Federal income tax rules require you to make pre-tax contribution elections that remain in effect for the entire Plan Year. Therefore, you may not be able to make changes to your coverage under the TW Ventures Inc. Group Benefits Plan during a Plan Year unless you experience a qualified change in status.

If you experience or your eligible dependent experiences a qualified change in status because (i) you gain a new dependent by marriage, birth, adoption or placement for adoption, (ii) you previously waived participation in group health coverage under the TW Ventures Inc. Group Benefits Plan for yourself and/or your eligible dependent due to coverage under another group health plan and subsequently lose coverage under that plan, (iii) you lose or your eligible dependent loses coverage under Medicaid or a state children's health insurance program (CHIP) because you are no longer eligible for coverage, or (iv) you are or your eligible dependent is determined to be eligible for assistance with the cost of employer-sponsored group health plan coverage under Medicaid or a state children's health insurance program (CHIP), you may enroll in any of the medical coverage options under the TW Ventures Inc. Group Benefits Plan that are available to similarly situated new employees, and you may pay for your share of the coverage pre-tax (subject to Internal Revenue

Code rules) through the Group Health Care Contribution "Pass Through" Account.

Transfers. If you transfer from a nonparticipating employer to a Participating Employer, you may enroll within 30 days after your eligibility date (the first day of the month following 30 continuous days of employment). If you transfer from one Participating Employer to another and already have a Flexible Spending Account (FSA) in the Plan, the FSA will carry over to your new Participating Employer. A transfer between Participating Employers does not by itself constitute a qualified change in status.

How to enroll. Go to tpbenefits.com or contact the TW Ventures Inc. Benefits Department at (818) 640-9437 if you do not have access to the internet.

What Happens During a Leave of Absence

Military leave. Your coverage under the Plan continues while you are on National Guard or Reserve Corps duty, fulfilling routine, periodic service obligations. If you are called into active military service and you are a Tier 1 employee, you may continue your participation in the Health Care FSA (but not your Dependent Day Care FSA) for the duration of a qualified military leave, as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA). If you decide to continue your participation in the Health Care FSA during your leave, you must pay your Health FSA contributions (see "Paying for your Health FSA coverage during leave" below). Refer to your Participating Employer's intranet site or contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information about your options during a qualified military leave. **Eligibility for the Dependent Day Care FSA ends if you are on military leave.**

Family and medical leave. Your Participating Employer complies with, and in some cases exceeds the obligations of, the Family and Medical Leave Act (FMLA) and similar state and local laws. If you are a Tier 1 employee and have been employed by your Participating Employer for at least 12 months and have worked 1,250 hours or more within a 12-month period, you may elect to continue your participation in the Health Care FSA (but not your Dependent Day Care FSA) if you go on leave which is designated as FMLA leave during any 12-month period as a result of your own serious medical condition; to care for a new child (including a newly-adopted or newly-placed foster care child); to care for an immediate family member who has a serious health condition; for certain covered activities if your spouse, domestic partner, son, daughter or parent is on active duty (or has been notified of a call or order to active duty) in the U.S. Armed Forces and is deployed to a foreign country; or for other reasons designated by the FMLA. In addition, if you are a Tier 1 employee you may elect to continue your participation in the Health Care FSA (but not your Dependent Day Care FSA) if you go on an unpaid leave for up to 26 weeks during a 12-month period in order to care for your spouse, domestic partner, son, daughter, parent or next of kin who is a covered service member of the U.S. Armed Forces who is injured in the line of active duty (or a veteran who was a member of the U.S. Armed Forces at any time during the five-year period preceding the date on which the veteran undergoes medical treatment, recuperation or therapy for an injury incurred in the line of active duty). If you decide to continue your participation in the Health Care FSA during your leave, you must pay your Health FSA contributions (see "Paying for your Health FSA coverage during leave" below). **Eligibility for the Dependent Day Care FSA ends if you are on an unpaid FMLA leave.**

All other unpaid leaves of absence. If you are a Tier 1 employee and go on unpaid leave other than military leave or FMLA leave, you may decide to continue your participation in the Health Care FSA during your leave. If you decide to continue your participation in the Health Care FSA during your leave, you must pay your Health FSA contributions (see "Paying for your Health FSA coverage during leave" below). **Eligibility for the Dependent Day Care FSA ends if you are on an unpaid leave of absence.**

Paying for your Health FSA coverage during leave. If you are a Tier 1 employee and wish to continue your Health Care FSA participation during an FMLA leave or other approved unpaid leave, you must either pay your contributions on an after-tax basis during your leave or pre-pay your contributions by increasing your payroll deductions prior to your leave. If you do not wish to make your contributions on an after-tax basis during the leave or pre-pay before your leave begins, your participation in the Health Care FSA will terminate and you will have two options to choose from if you return to work in the same Plan Year:

- You can resume your contributions to the Health Care FSA at the same level in effect before your leave. In this case, the amount available for reimbursement for the Plan Year will be reduced by the amount of the missed contributions; or
- You can "make up" for the missed contributions by increasing your weekly contributions when you return to work.

In this case, the amount available for reimbursement for the Plan Year will not be reduced by the amount of the missed contributions.

Regardless whether you choose to resume your former contribution level or make up for missed contributions, expenses incurred during your leave will not be eligible for reimbursement from your Health Care FSA. **In other words, expenses incurred during your leave will be eligible for reimbursement from your Health Care FSA only if you pay your contributions on an after-tax basis during your leave or pre-pay your contributions prior to your leave.**

If you return to work in the following Plan Year, you will participate in the Health Care FSA based on whatever election you made during the annual open enrollment period for that Plan Year.

When Participation Ends

If you are a Tier 1 employee, your participation in the Health Care FSA and the Dependent Day Care FSA ends as of December 31 each year. You must actively enroll for the following calendar year.

For both Tier 1 and Tier 2 employees, your participation also ends when any of the following happens:

- Your employment terminates.
- You elect to discontinue coverage (subject to qualified change in status rules).
- You are no longer an eligible employee of a Participating Employer.
- You retire.
- You die.
- You stop making required contributions.
- Your Participating Employer stops offering the Plan.

If your participation terminates during the year, you will have until March 31st of the next year to submit claims for expenses incurred through your last day of Plan participation.

What Happens When You Return to Work

If you return to work for a Participating Employer within 60 calendar days of the last day of the month in which your employment terminated with another Participating Employer, then you must re-satisfy the Plan's eligibility requirements except for the 30-day waiting period. In most cases, this means that you will be eligible for benefits under the Plan on the first day of the month following your rehire date (or date of transfer). If you return to work for a Participating Employer 60 or more days after the last day of the month in which your employment terminated with another Participating Employer, then you must re-satisfy the Plan's eligibility requirements including the 30-day waiting period. For more information, refer to the section called "Who's Eligible."

Continuing Your Health Care FSA Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you generally can extend participation in the Health Care FSA until the end of the calendar year if your contributions to the Health Care FSA have exceeded your reimbursements from that account. Under this provision, you may elect to continue participation on an after-tax basis under the Health Care FSA if you lose coverage because your employment terminates for reasons other than gross misconduct or if you are no longer an eligible employee because your hours are reduced. The following is a brief summary of COBRA coverage available for the Health Care FSA. For more information, see "Your COBRA Continuation Rights". Information on continuing group health plan coverage under the TW Ventures Inc. Group Benefits Plan is available in the Summary Plan Description for that plan.

A COBRA election form will be provided to you. If you then wish to continue participation on an after-tax basis, the election form must be completed and returned to the COBRA Administrator within 60 days after the later of the date you were provided the election form, or the date your eligibility stops. If you choose to continue participation, you must pay

102 percent of the amount you elected to contribute on an after-tax basis.

You may continue your COBRA participation in the Health Care FSA only until the end of the calendar year. COBRA participation will stop before the end of the year under any of the following circumstances:

- Failure to make the required contributions on a timely basis
- Termination of the Plan and all other group health plans provided by TW Ventures Inc.

COBRA may also be available for eligible dependents who lose coverage. For more information, see "Your COBRA Continuation Rights".

PLEASE NOTE THAT THE COBRA ELECTION AND PAYMENT DEADLINES ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. HOWEVER, THE EXTENSIONS DO NOT MAKE COBRA COVERAGE AUTOMATIC – YOUR COBRA CONTINUATION COVERAGE DOES NOT BEGIN UNTIL YOU MAKE YOUR COBRA ELECTION. SEE APPENDIX A FOR DETAILS.

Funding Your Flexible Spending Accounts

By enrolling in the Health Care FSA, the Dependent Day Care FSA and/or the Group Health Care Contribution "Pass Through" Account, you are authorizing your Participating Employer to withhold your contributions from each of your paychecks. Your Health Care FSA and/or your Dependent Day Care FSA contributions will be deducted in equal installments from your pay. The amount of each deduction is based on the number of your anticipated pay periods during the Plan Year, as determined by the TW Ventures Inc. Benefits Department. Each Plan account is a separate election, with separate deductions. You cannot deposit cash directly into your account(s), use money from one account to pay expenses for another account or transfer money from one account to another.

Health Care FSA Annual Contributions

You can contribute $100 up to the annual limit announced during open enrollment on a pre-tax basis to your Health Care FSA (the annual limit may increase in future years if the IRS approves a cost-of-living adjustment). The annual limit does not include pre-tax contributions deducted from your pay and applied toward the cost of your health coverage under the TW Ventures Inc. Group Benefits Plan. You may not change your contribution amount during the Plan Year unless you have a qualified change in status. Claims incurred during the Plan Year must be submitted no later than March 31st of the following year. After that date, you lose the unspent or unclaimed balance.

Dependent Day Care FSA Annual Contributions

You can contribute $100 to $5,000 a year on a pre-tax basis to your Dependent Day Care FSA if you and your spouse file a joint tax return, or $5,000 if you, as a single parent, file as head of household. If you are married and file a separate tax return, the limit is $2,500 a year. (If you file a joint return, you can't contribute more than what you earn or your spouse separately earns if it is less than $5,000. If your spouse doesn't work and is either disabled or a full-time student, the IRS considers your spouse's earnings to be $250 a month if you have one eligible dependent and $500 if you have more than one eligible dependent.) You may not change your contribution amount during the Plan Year unless you have a qualified change in status. Claims incurred during the Plan Year must be submitted no later than March 31st of the following year. After that date, you lose the unspent or unclaimed balance.

"Highly compensated" employees. In addition to the annual Plan limits on how much you can contribute to your accounts, federal income tax law imposes an annual test that may limit the amount that highly compensated employees may contribute to the Dependent Day Care FSA. If this test is not passed, TW Ventures Inc. will be required to either reduce the contribution during the year and request a refund of reimbursements made above the revised limit, or adjust your W-2 statements, or both. You will be notified if you are affected.

Group Health Care Contribution "Pass Through" Account

Your share of the cost of coverage under the TW Ventures Inc. Group Benefits Plan will automatically be deducted from your paycheck. By making these payroll deduction contributions, you automatically establish a Group Health Care Contribution "Pass Through" Account under the Plan. The amount of your contributions for medical and/or dental and coverage is determined by TW Ventures Inc. each year. Generally, your contributions toward the cost of medical and/or dental coverage are withheld on a pre-tax basis for federal tax purposes. However, as required under federal tax law, your contributions toward the cost of coverage for a domestic partner (and his or her dependents) who do not qualify for non-taxable health benefits under federal tax law is withheld from your pay on an after-tax basis.

The amount you contribute to the Group Health Care Contribution "Pass Through" Account is separate from any Health Care FSA contribution election you may make. You may not change your contribution amount during the Plan Year unless you have a qualified change in status.

The Tax Advantages

For federal income and Social Security taxes, your taxable income is reduced by the amount you contribute to your Health Care FSA , Dependent Day Care FSA and/or Group Health Care Contribution "Pass Through" Account on a pre-tax basis. (Depending on your income level, you may be paying less into Social Security; your Social Security retirement benefits may be slightly reduced, too.) These pre-tax contributions are also excluded from most state and local taxes.

Although your pre-tax contributions reduce your taxable income by the amount you contribute, your income used in calculating other benefits offered by TW Ventures Inc. (such as life insurance and 401(k) plan contributions) is not affected at all. You should also know that any eligible reimbursements you receive from your account(s) are free from federal income tax as long as you have not taken (nor intend to take) a tax deduction for the same expenses when you file your federal tax return.

Issues to Consider

Here's an overview of how your accounts(s) can affect your cash flow, your annual income tax return and your other benefits.

Annual election only. Under IRS rules, you must decide how much to contribute to the Health Care FSA or Dependent Day Care FSA for the Plan Year before each year begins, during open enrollment, or for new hires and employees who transfer from a non-participating employer to a Participating Employer, before your participation begins. You should be careful in projecting your expenses.

"Use it or lose it." Plan your contributions carefully. If you do not spend (i.e., incur eligible expenses equal to) all of the money in your Health Care FSA or Dependent Day Care FSA by December 31 of the year for which you make your contribution, you lose the unspent or unclaimed balance.

You have until March 31st of the year following the year in which you make your Health Care FSA and Dependent Day Care FSA contributions to file claims. (For example, if you elect to contribute $1,000 to your Health Care FSA for 2021, you have until December 31, 2021 to incur claims for $1,000 of expenses and you must submit all claims for expenses by March 31, 2022.) You may not carry over any unspent or unclaimed account balances from one year to the next, nor can you transfer money from one account to another.

PLEASE NOTE THAT THE DEADLINES FOR FILING HEALTH CARE FSA CLAIMS AND APPEALING DENIED HEALTH CARE FSA CLAIMS ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. SEE APPENDIX A FOR DETAILS.

Tax filing. Setting up a Health Care FSA could limit the amount of unreimbursed health care expenses you can deduct on your federal income tax return. Keep in mind that your health care expenses must exceed the annual threshold established under the Internal Revenue Code to make that deduction viable.

You can use both your Dependent Day Care FSA and the allowable federal income tax Dependent Day Care credit, **but you can't claim the same expenses for both**. Whatever you apply to your federal income tax credit is reduced dollar for

dollar by what you contribute to your Dependent Day Care FSA. Married couples can claim the tax credit only if they file a joint federal income tax return. Ask your tax advisor to help you choose the right alternative for your tax bracket.

Keeping Track of Your Accounts

In addition to seeing your deductions recorded on your paychecks, you can keep track of your Health Care FSA and Dependent Day Care FSA balances by logging on to www.payflex.com. You can review all claims submitted, contributions, payouts and the current balance.

You can also keep track of your Health Care FSA and Dependent Care FSA balances by using the PayFlex Mobile® app. The app is free and you can download it from your mobile device's app store. To access the app, you'll use the same username and password you use to access www.payflex.com. With the PayFlex Mobile® app, you can:

- View your account balance, deposits and payments
- Submit claims for reimbursement
- View your PayFlex Card purchases and submit documentation (if applicable) and
- View account alerts and PayFlex contact information

The Health Care FSA

If you are a Tier 1 employee and you are enrolled in medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan, you can use the Health Care FSA to pay for eligible health care expenses that are not covered by any health care coverage you may have, as long as the services associated with these expenses were incurred during a period of active Plan participation. You can participate in the Health Care FSA even if you do not enroll for coverage under the TW Ventures Inc. Group Benefits Plan. You can also claim health care expenses for any qualified dependent(s) who is (are) eligible for pre-tax health care benefits under federal tax law. See the definition of dependent in "Key Terms and Definitions" for more information.

Eligible Expenses

You can be reimbursed from your Health Care FSA for medical, dental, vision and other health care expenses incurred while you are a participant that qualify for a federal income tax deduction, except for premiums paid for health coverage. In addition, you can be reimbursed, with or without a prescription from your doctor, for certain over-the-counter or nonprescription drugs that treat an illness or medical condition (note that insulin is eligible for reimbursement even without a prescription). You can obtain additional information on eligible expenses, including eligible over-the-counter expenses, by visiting:

- https://www.payflex.com/individuals/common-eligible-expenses/health-care
- IRS Publication 502, "Medical and Dental Expenses," which is available on the IRS website or by calling their toll-free number (1-800-829-1040), lists the expenses that qualify for federal income tax deduction and therefore, also qualify for reimbursement from the Health Care FSA.

Also important, the IRS Publication provides a list of ineligible expenses that cannot be reimbursed through your FSA. Keep in mind that Plan expenses qualify for reimbursement based on the date the expense is incurred (i.e., the date the service is obtained), not when you are billed or pay the expense. Expenses for which you can claim a federal income tax deduction are based on when the bill is paid. This difference is significant and should be considered when making an election.

Health Care FSA Worksheet

The worksheet is designed to help you estimate which of your expenses can be reimbursed from the Health Care FSA and how much of your salary you may wish to contribute to your account. To complete this worksheet, you may want to refer to the following:

- Your tax return, checkbook and receipts for health care paid by you and your family last year (use these items to help you determine what you typically spend on health care)

- Any Explanation of Benefit (EOB) forms you received from your health care claims administrator(s) last year, to check your actual out-of-pocket expenses
- Your Summary Plan Description for the TW Ventures Inc. Group Benefits Plan and your applicable Certificates of Coverage (to check the coinsurance, deductible and other out-of-pocket expenses for which you are responsible)
- If applicable, your spouse's/domestic partner's benefit booklets on medical, dental, vision and other health care coverage
- https://www.payflex.com/individuals/common-eligible-expenses/health-care
- IRS Publication

Remember: Plan carefully when you estimate your eligible expenses because any money you contribute to your Health Care FSA and do not use to pay for services received January 1 through December 31 will be forfeited.

	Unreimbursed Health Care Expenses	
	This Year's Unreimbursed Service Expenses (Use this column to get an idea of your spending habits)	**Next Year's Projected Unreimbursed Service Expenses** (Use this column to determine your contribution)
Total Deductibles (e.g., Medical, Dental, Mental Health)*		
Medical and Mental Health Coinsurance and Copayments*		
Dental Coinsurance and Copayments*		
Glasses/Contact Lenses/Eye Examination Costs Not Covered by a Vision Plan or Medical Plan		
Medical Equipment		
Prescription Drug Coinsurance/Eligible Over-the-Counter Medications (including menstrual products)		
Other		
TOTAL		

* If possible, you may want to anticipate design changes that may be made to your coverage under the TW Ventures Inc. Group Benefits Plan and any coverage you have through your spouse or domestic partner in estimating your future expenses based on prior years' expenses, such as changes in annual deductible, copayment or coinsurance amounts or changes in covered services.

*

The Dependent Day Care FSA

If you are a Tier 1 employee, you can generally use the Dependent Day Care FSA to reimburse yourself pre-tax for certain dependent day care expenses incurred because you and your spouse, if applicable, work. If your spouse has no earned income for the calendar year, you can only use the Dependent Day Care FSA on a pre-tax basis if your spouse is a full-time student for at least five months during the year or is incapable of self-care. (If you file a joint return, you can't contribute

more than what you or your spouse earn if it is less than $5,000.)

Who Qualifies as a Dependent

You can use your Dependent Day Care FSA to cover the expenses of dependents, who are defined as any of the following (subject to federal tax law requirements):

- Your biological and adopted children (or descendants of your children, such as your grandchildren), and siblings under age 13 (or older if disabled) whom you can claim as dependents on your federal income tax return and who live with you for more than half the calendar year and have not provided more than half of their own support for the year. "Children" includes descendants of your children, such as your grandchildren, and descendants of your siblings, such as your nephews and nieces.
- Your spouse who is physically or mentally incapable of self-care and who lives with you for more than half the year.
- Anyone living with you (such as a domestic partner or elderly parent) for more than half the year who is mentally or physically incapable of self-care, as long as you claim that person as a dependent on your federal income tax return or could claim that person as a dependent if he or she had earned income less than the IRS limit for dependents.

If you are separated or divorced, your child's day care expenses may be reimbursed from your Dependent Day Care FSA only if you are the custodial parent, which means your child lives with you for the greater portion of the calendar year. The parent who claims the child as a dependent on his or her federal tax return is not necessarily the custodial parent for this purpose. In the case of joint custody (where a child spends equal time with each parent), the parent with the highest adjusted gross income can be reimbursed for expenses under the Dependent Day Care FSA.

Eligible Dependent Day Care Expenses

The Dependent Day Care FSA allows you to set aside money on a pre-tax basis to pay for certain eligible child and/or elder day care services so that you (and your spouse, if you are married) are able to work or attend school. The Dependent Day Care FSA is subject to IRS regulations, and only those expenses that comply with the Internal Revenue Code can be reimbursed. Eligible expenses that can be reimbursed from your Dependent Day Care FSA include day care, after-school care, summer day camp (but not overnight camp) and nursery school/pre-school (but not kindergarten). In all cases, the care must be provided while you are a participant and are working – the Dependent Day Care FSA may only reimburse expenses that you incur to enable you (and your spouse, if you are married) to work or attend school. Fees paid to child and adult day care centers are reimbursable only if the center meets applicable state and local regulations and provides care for more than six non-resident people. You can find more detailed information about eligible day care expenses from the following sources:

- https://www.payflex.com/individuals/common-eligible-expenses/dependent-care
- IRS Publication 503, "Child and Dependent Care Expenses," which is available from your local IRS office or on the IRS website.

Expenses are paid based on service dates, not when you are billed or pay the expenses.

Note: The IRS will allow you to receive pre-tax reimbursement of dependent day care expenses only if the caregiver (babysitter, dependent care center, housekeeper, etc.) declares your payment as taxable income. Make sure that your provider is aware of this rule and intends to comply with it; otherwise, the IRS may disqualify your reimbursement from special tax treatment and require you to pay taxes on it. When you make a claim for payment from your Dependent Day Care FSA, you will be required to give the name, address and Social Security or tax identification number of the individual or organization that is providing the services. Dependent Day Care FSA Worksheet

Complete this worksheet to determine which of your expenses can be paid from the Dependent Day Care FSA and how much of your salary you may wish to contribute into your account. You may want to refer to your tax return and receipts from dependent day care paid by you and your spouse last year.

Remember: Plan carefully when you estimate your eligible expenses because any money you contribute to your Dependent Day Care FSA and do not use to pay for eligible services received in the Plan Year will be forfeited. Refer to IRS Publication 503 to be sure expenses are eligible.

	This Year's Service Costs (Use this column to get an idea of your spending habits)	Next Year's Projected Service Costs (Use this column to determine your contribution)
Home Day Care		
Day Care Center		
Pre-School Programs		
After-School Care		
Home Health Care for a Disabled Adult		
Other		
TOTAL		

Group Health Care Contribution "Pass Through" Account

If you are a Tier 1 or a Tier 2 employee, you can use the Group Health Care Contribution "Pass Through" Account to pay your contributions for medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan.

Your contributions for medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan will be deducted from your pay. By electing medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan, you automatically establish a Group Health Care Contribution "Pass Through" Account under the Plan. The amount of your contributions for medical and/or dental coverage each year is determined by TW Ventures Inc. Payroll deductions will be adjusted automatically when there are changes in the amount of your contributions toward your coverage, to the extent permitted under federal tax rules. Your election is made when you complete the enrollment process used to choose medical and/or dental coverage for yourself and your dependents.

Group Health Care Contribution "Pass Through" Account contributions for yourself and your eligible dependents who are permitted to receive non-taxable health benefits as dependents under federal tax law will generally be withheld on a pre-tax basis. However, under current federal income tax law, the cost of medical and/or dental coverage under the TW Ventures Inc. Group Benefits Plan for domestic partners (and their dependents) who do not qualify for non-taxable health benefits under federal tax law cannot be contributed on a pre-tax basis. Therefore, if you elect to cover any eligible dependent who does not qualify for non-taxable health benefits as a dependent under federal tax rules (as described in this SPD), your contributions toward the cost of their coverage are withheld from your pay on an after-tax basis. In addition, the amount of your Participating Employer's contribution toward this coverage generally is treated as "imputed income" to you. You may also refer to IRS Publication 502 for more information on eligible dependents.

Note that different tax treatment may apply under state tax law. Please contact your tax or financial advisor for more information on state income tax rules.

Reimbursement from Your Health Care and Dependent Day Care FSAs

If you are a Tier 1 employee, this section explains how Health Care FSA and Dependent Day Care FSA reimbursement claims are processed and paid. The Claims Administrator for the Plan is PayFlex.

All claims should be directed to the applicable administrator (either the Claims Administrator or the Plan Administrator) and the entire claim procedure and appeals process will be handled through that administrator. If you have any questions as to which administrator you should direct your claim, please contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Claims filed with the Claims Administrator. Claims directly relating to reimbursement of covered expenses should be filed with the Claims Administrator. The Claims Administrator determines whether you have incurred a covered expense eligible for reimbursement under the Plan and is responsible for determining the amount of, and administering the payment of, any such reimbursement based on the information contained in the written claim. All claims that must be directed to the Claims Administrator must be filed no later than March 31st of the year following the year in which you make your Health Care FSA and/or Dependent Day Care FSA contributions.

Claims filed with the Plan Administrator. The Plan Administrator evaluates claims based on your eligibility to participate in the Plan. All claims that must be directed to the Plan Administrator must be filed no later than March 31st of the year following the year in which you make your Health Care FSA and/or Dependent Day Care FSA contributions, or within one year from the date of service, if earlier.

PLEASE NOTE THAT THE DEADLINES FOR FILING HEALTH CARE FSA CLAIMS AND APPEALING DENIED HEALTH CARE FSA CLAIMS ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. SEE APPENDIX A FOR DETAILS.

Instant Access to your Money

- **PayFlex Debit Card.** When you enroll in the Health Care FSA, you will be issued a debit card that can be used to pay for eligible products and services. When you receive the PayFlex card in the mail, call the number on the card to activate it and get your personal identification number (PIN). To use your card, simply swipe and select either "debit" or "credit". You can use your card at qualified merchants where MasterCard® is accepted, and where merchants can process health care cards. This includes doctor and dental offices, hospitals, pharmacies, hearing and vision care centers. You can also use your card at some discount and grocery stores. You can use the card to pay for eligible expenses including deductibles, copays and coinsurance, prescriptions and certain over-the-counter items and dental and vision costs. Visit https://www.payflex.com/individuals/common-eligible-expenses/health-care for a list of eligible expenses.

  If you don't use your card to pay for an expense, you can submit a claim to PayFlex either online, through PayFlex Mobile® app or by fax or mail.

Save your receipts! Remember to include supporting documentation when you submit your claim. Keep in mind that the IRS requires you to retain receipts for all expenses that are paid by your Health Care FSA.

Please note: Debit cards are not issued for the Dependent Day Care FSA.

How to File Claims for Reimbursement

Claim forms are available online by visiting tpbenefits.com or you may contact the TW Ventures Inc. Benefits Department at (818) 640-9437. The forms have instructions for submitting claims. To file a claim, you will need to:

- Complete and submit the claim form by the March 31st deadline
- Attach receipts that include expense amounts and dates of service. For eligible over-the-counter drugs, the receipt must also contain the **name of the drug**. If your pharmacy's receipt does not include the name of the over-the-counter drug or its price, request a handwritten receipt from the pharmacist or retailer.
- Send the form, the receipts and other supporting documents to the Claims Administrator (the address and fax number are on the form).
- Keep a copy for your records.

When filing Health Care FSA expenses, also attach a copy of the Explanation of Benefits (EOB) supplied by your health plan's claims administrator. Receipts should include a copy of a bill reflecting dates of service or your health plan's EOB form showing health expenses for which you have had to pay all or part of the cost. For HMOs, a provider's receipt showing the amount you had to pay, the person for whom the expense was incurred, a description of the service provided and date of service may be submitted. If you are requesting reimbursement for expenses not covered by a health care plan, attach a paid copy of the invoice reflecting the date the expense was incurred, the person for whom the expense was incurred and the amount and details of the expenses. Receipts for eligible over-the-counter drugs must also include the

specific name of the drug.

For Dependent Day Care FSA expenses, attach a copy of a receipt from the person who provided the care or have the person who provided the care sign the claim form (there is a space for signature on the form). Remember, you **must** include the care provider's name and address, the care provider's Social Security number or tax identification number, the date the care was provided, for whom and their age(s). The Claims Administrator will determine the qualification of the expense.

You can also use the PayFlex Mobile® app to submit a claim. After you log in, select **Manage** to get started. To send documents with your claim, simply take a picture and upload it through the app.

Routine requests for information regarding your benefits under the Plan will not be considered benefit "claims" subject to the Plan's claims and appeals procedures.

When to File Claims

You can submit a claim at any time on or before the March 31st deadline. Only the expenses incurred during the Plan Year (January 1 through December 31) are reimbursable through your account.

A claim is incurred on the date the service is obtained, not when you are billed or pay the expenses. Claims (including receipts) must be received by the Claims Administrator by March 31st of the year following the year in which you make your Health Care FSA and Dependent Day Care FSA contributions to be eligible for reimbursement.

PLEASE NOTE THAT THE DEADLINES FOR FILING HEALTH CARE FSA CLAIMS AND APPEALING DENIED HEALTH CARE FSA CLAIMS ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. SEE APPENDIX A FOR DETAILS.

Claims Procedure and Appeals Process

Within 30 days (90 days for Dependent Day Care FSA claims) after you have filed a written claim with the applicable administrator, the administrator will notify you of its decision. If the Claims Administrator (or the Plan Administrator, as the case may be, depending on the nature of the claim) needs more time to examine your request because of special circumstances, you will be informed within these 30 days (90 days for Dependent Day Care FSA claims) that additional time is needed, why it is needed and the date by which you can expect to receive a final decision. However, consideration of your request may be extended for only 15 more days (90 days for Dependent Day Care FSA claims). If your claim is denied, the Claims Administrator or Plan Administrator (as applicable) will notify you in writing and explain why it was denied.

If a claim is denied. If you receive notice that your claim has been denied, either in full or in part, the notice will explain the reasons for the denial including references to pertinent Plan provisions on which the denial was based. If your claim was denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim. The notice will also tell you how to request a review of the denied claim, based on the established rules for the Plan, as well as your right to sue in federal court once the administrative appeal process is complete.

As part of the review procedure, you or someone on your behalf may ask the Claims Administrator or Plan Administrator, (as applicable) for pertinent documents that affect your claim, at no charge. You may appeal the denial within 180 days (60 days for Dependent Day Care claims) after the claim is denied. Both the request and the appeal must be in writing.

In most cases, the Claims Administrator or the Plan Administrator (as applicable) will review and decide on the appeal within 60 days after you file your request. For Dependent Day Care FSA claims only, if the Claims Administrator or the Plan Administrator (as applicable) notifies you that special circumstances require a delay and explains the reasons for needing more time, there may be a limited extension (not to exceed 60 days) of the review and decision-making process.

Once a decision is reached, the Claims Administrator or the Plan Administrator (as applicable) will notify you in writing of the outcome. The notice will give the reasons for the decision and include references to pertinent Plan provisions. However, if you receive no response within the applicable period, you may consider your claim denied.

If your claim is denied on final appeal. You must use and exhaust the Plan's administrative claims and appeals procedure before bringing action at law or in equity to recover under the Plan. If the Claims Administrator or Plan Administrator denies your appeal, you may bring a suit for benefits. If any judicial or administrative proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the Claims Administrator or Plan Administrator in connection with the Plan's claims and appeal procedures, as described above. No legal actions may be brought on a claim more than 90 days after the Claims Administrator or Plan Administrator issues its final decision on the claim.

PLEASE NOTE THAT THE DEADLINES FOR FILING HEALTH CARE FSA CLAIMS AND APPEALING DENIED HEALTH CARE FSA CLAIMS ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. SEE APPENDIX A FOR DETAILS.

When Your Claims Are Reimbursed

Claims submitted using claim forms are processed no less frequently than weekly. Your eligible Health Care FSA claims will be reimbursed up to the maximum contribution elected for the year — even if all of it hasn't been deducted from your paychecks. As for the Dependent Day Care FSA, you will be reimbursed only up to the unused amount in your account when you file a claim. Any unpaid amounts still due to you will be processed in the next claim cycle when (and if) you have enough money in your account to cover them. If you have any questions about the Plan's reimbursement procedures, contact the Claims Administrator.

Direct Deposit. You can opt to have your reimbursement deposited directly into your personal bank account (as long as your financial institution is an Automated Clearing House member) rather than receiving the payment by check. In order to do so, you'll need to complete a Direct Deposit Authorization by accessing the FSA Direct Deposit Authorization Form at tpbenefits.com . It may take up to ten business days to complete the administrative steps, during which time you'll continue to receive checks for any reimbursement claims. You will receive an Explanation of Payment each time an electronic transfer is made to your account. You can cancel direct deposit at any time by submitting another FSA Direct Deposit Authorization Form indicating that you are canceling direct deposit.

Forfeitures. If any balance is left in either account after all claims timely filed with the Claims Administrator (by March 31st of the following year) are processed, the remaining balance will be lost, as required by the IRS. TW Ventures Inc. will use any forfeitures only to help pay the costs of administering the Plan.

Uncashed Checks. Unless you have elected direct deposit, any Health Care FSA claims not processed with your debit card and Dependent Day Care FSA reimbursements will be made by check sent to the address on file with the Plan. Any reimbursement payment made by check must be cashed within one year after it is issued. If any reimbursement check is not presented for payment within one year of the date of issue, the Plan will have no liability for the benefit payment, the amount of the check will be deemed a forfeiture and no funds will escheat to any state. Therefore, it is important to keep the Plan Administrator informed of your current address and to timely deposit your reimbursement checks. If you misplace a benefit payment or reimbursement check, you may contact the Claims Administrator within one year of the original date of issue to request that the check be re-issued.

Other Information You Should Know

How Benefits May Be Forfeited or Delayed

There are certain situations under which reimbursements may be forfeited or delayed. Most of these circumstances are spelled out in the previous sections, but payments also may be forfeited or delayed if you:

- Do not file a claim for reimbursement properly or on time (see "Your Rights Under ERISA")
- Do not furnish information required to complete or verify a claim
- Do not have a current address on file with your Participating Employer or the Claims Administrator
- Do not cash your reimbursement check within one year of the date of issue

If the Plan mistakenly pays a greater benefit than you're eligible for or pays benefits that were not authorized by the Plan, the Claims Administrator or Plan Administrator may seek any permissible remedy allowed by law to recover benefits paid in error.

Qualified Reservist Distribution

You may request a distribution from your Health Care FSA if you are ordered or called to active military duty for at least 180 days and do not elect to continue coverage under the Health Care FSA as described in the "Your COBRA Continuation Rights" and "Continuing Your Health Care FSA Coverage Under COBRA" sections of this Summary Plan Description. The amount of the distribution will equal your contributions to your Health Care FSA , less all reimbursements made from your account. Contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information.

Qualified Medical Child Support Orders

The Plan provides benefits in accordance with the requirements of any Qualified Medical Child Support Order ("QMCSO"). A QMCSO includes a judgment, decree or order (including a settlement agreement or administrative notice) issued either by a domestic relation or other court of competent jurisdiction, or through an administrative process established under state law and that has the force and effect of law under state law. This means that when a state agency issues a medical child support order — otherwise satisfying the QMCSO requirements in section 609(a) of ERISA — it must be honored by a group health plan.

This provision permits state courts (or state agencies) to require an employer that provides dependent health coverage to make that coverage available to a participant's child even though the child is not a legal dependent because of a separation or divorce.

To get a free copy of the procedures the Plan follows in the event a QMCSO is issued, contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Claim Fraud

The Claims Administrator regularly evaluates claims to detect fraud or false statements and will notify the Company regarding these matters. If a claim has been submitted for payment or paid by the Plan as a result of fraudulent representations, the Claims Administrator may seek reimbursement and may elect to pursue the matter by pressing criminal charges.

Compliance with Federal Law

The Plan is governed by regulations and rulings of the IRS, the Department of Labor and current federal income tax law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law "pre-empts" (that is, takes precedence over) state law.

Collective Bargaining Agreements

The Plan may also be referred to in collective bargaining agreements entered into by, or applicable to, your Participating Employer. You can ask your Participating Employer whether a collective bargaining agreement applies to you.

Ownership of Benefits

The benefits described in this Summary Plan Description are exclusively for Plan participants. Plan benefits cannot be sold, transferred or assigned for any reason except as provided by law.

Plan Administration

Your benefits as a participant in the Plan are provided under the terms of Plan, as described in this Summary Plan Description. The Plan is maintained for the exclusive benefit of Plan participants. The Plan Administrator has exclusive

authority and sole and absolute discretion to interpret the Plan, to make any factual determination to resolve factual disputes and to decide all matters in connection with the interpretation, administration and operation of the Plan in order to determine eligibility for benefits.

The Claims Administrator has complete authority and sole and absolute discretion to determine whether you have incurred a covered expense for which reimbursement may be payable under the Plan and to determine the amount of, and administer the payment of, any such reimbursements under the Plan.

Benefits will be paid under the Plan only if the Plan Administrator or Claims Administrator, as appropriate, determines in its discretion that the claimant is entitled to them. Decisions of the Plan Administrator and the Claims Administrator will be conclusive and binding upon all similarly situated individuals having an interest in the Plan. Please note that no other person or group has any authority to interpret the terms of the Plan (including this Summary Plan Description and any other documents, listed in this Summary Plan Description, governing the Plan) or to make any promises to you about them.

Amendment or Termination of the Plan. TW Ventures Inc., or any successor, reserves the right to amend, modify, suspend or terminate the Plan or any benefit offered under the Plan, in whole or in part, at any time and for any reason, by action of TW Ventures Inc.

Health Information Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its applicable regulations is a federal law that, in part, requires health plans like the Health Care FSA portion of the Plan to protect the privacy and security of your confidential health information. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the notice of privacy practices, which has been furnished to you. You can receive another copy of the Plan's notice of privacy practices by contacting the Plan Administrator.

Nondiscrimination

In addition to the limits described above in Dependent Day Care FSA Annual Contributions, the Plan is subject to various nondiscrimination requirements under the Internal Revenue Code. These nondiscrimination rules prevent the design or operation of the Plan in a way that disproportionately favors highly compensated employees. The Plan Administrator will notify you if you are affected by any of these nondiscrimination limitations.

Plan Facts

Plan Name:	TW Ventures Inc. Flexible Spending Account Plan
Type of Plan:	Welfare and cafeteria plan
Plan Sponsor:	TW Ventures Inc. 3500 West Olive Avenue, Suite 1000 Burbank, CA 91505 (818) 640-9437
Employer Identification Number:	13-3719008
Plan Number:	502

Plan Administrator and Named Fiduciary:	TW Ventures Inc. 3500 West Olive Avenue, Suite 1000 Burbank, CA 91505 (818) 640-9437
Claims Administrator:	PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000 (888) 678-8242 www.payflex.com
Agent for Service of Legal Process:	General Counsel TW Ventures Inc. 3500 West Olive Avenue, Suite 1000 Burbank, CA 91505 Legal process may also be served on the Plan Administrator.
Plan Year:	January 1–December 31
Plan Funding:	Employee payroll deductions
Financial Records:	TW Ventures Inc. maintains financial records of the Plan based on a Plan Year that ends on the date shown above. All financial records are maintained by the Company at the following address: TW Ventures Inc. 3500 West Olive Avenue, Suite 1000 Burbank, CA 91505 (818) 640-9437

Your Rights Under ERISA

The Health Care FSA benefits provided by the TW Ventures Inc. Flexible Spending Account Plan are covered by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The law does not require the Company to provide these benefits, but it does set certain standards for any that are offered.

Receive Information About Your Plan and Benefits. Specifically, ERISA entitles you, as a Health Care FSA participant, to:

- Examine without charge all Plan documents (including collective bargaining agreements and contracts, if any, where applicable) and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. The TW Ventures Inc. Benefits Department has these documents available, and you may make an appointment to examine them at any time during business hours.
- Obtain copies of all Plan documents and other pertinent Plan information, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description, by requesting these materials in writing. You may obtain copies by writing to the Plan Administrator. (The Company reserves the right to make a reasonable charge for copying any documents you request.)

Annual financial summary. ERISA entitles Plan participants to receive a summary of the annual financial report of the Plan. You do not need to request the summary annual report; the Company provides this information to all Plan participants once a year.

Continuation of coverage. You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the "Your COBRA Continuation Rights" and "Continuing Your Health FSA Coverage Under COBRA" sections of this Summary Plan Description on the rules governing your COBRA continuation coverage rights.

Claims for benefits. In order to receive the benefits for which you may be eligible under the Plan described here, you or your beneficiary may first be required to file a claim, as described in "Reimbursement from Your Health Care and Dependent Day Care FSAs". The law allows a reasonable amount of time for:

- The Claims Administrator to evaluate a claim directly related to determining whether you have incurred a covered expense for which reimbursements are payable under the Plan and determining the amount of, and administering the payment of, any such reimbursements based on the information contained in the written claim, or
- The Plan Administrator to evaluate a claim related to your eligibility to participate in the Plan and to evaluate a claim, other than directly related to determining whether you have incurred a covered expense for which reimbursements are payable under the Plan, based on the information contained in the written claim.

Routine requests for information regarding your benefits under the Plan will not be considered benefit "claims" subject to the Plan's claims and appeals procedures.

All claims should be directed to the applicable administrator (either the Claims Administrator or the Plan Administrator) and the entire claim procedure and appeals process will be handled through that administrator. If you have any questions as to which administrator you should direct your claim, please contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Claims filed with the Plan Administrator. All claims that must be directed to the Plan Administrator must be filed no later than March 31st of the year following the year in which you make your Health Care FSA and/or Dependent Day Care FSA contributions, or within one year from the date of service, if earlier.

Claims filed with the Claims Administrator. All claims that must be directed to the Claims Administrator must be filed no later than March 31st of the year following the year in which you make your Health Care FSA and/or Dependent Day Care FSA contributions.

PLEASE NOTE THAT THE DEADLINES FOR FILING HEALTH CARE FSA CLAIMS AND APPEALING DENIED HEALTH CARE FSA CLAIMS ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. SEE APPENDIX A FOR DETAILS.

Obligation of fiduciaries. In addition to creating rights for Plan participants, ERISA imposes obligations on the persons responsible for the operation of an employee benefit plan. These people, referred to as fiduciaries under the law, have an obligation to administer the Plan prudently and to act in the interest of the Plan participants and their beneficiaries. The law provides that fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

Obligations of employers. Many of the specific obligations ERISA imposes on employers are intended to make certain that all Plan participants are fully informed of their rights to benefits and the nature and extent of those benefits. No one may terminate your employment or discriminate against you to prevent you from receiving benefits or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that Plan

fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you believe that the Plan Administrator or Claims Administrator (as applicable) has improperly denied you benefits under this Plan, please remember that you must complete each step of the claims procedure described above, within the deadlines, before you can take any legal action. After exhaustion of the Plan's claims and appeals procedures described above, any further legal action taken against the Plan or its fiduciaries must be filed in a court of law no later than 90 days after the Claims Administrator's or Plan Administrator's final decision is rendered on the claim.

If it should ever become necessary for you or your beneficiary to take legal action to enforce your rights under ERISA or the terms of the Plan, legal process may be served on the Plan Administrator or on the General Counsel TW Ventures Inc.

A final word about your rights. Your rights can be determined only by referring to the full text of the Plan documents, which are available for your inspection from the Plan Administrator. The Company encourages you to contact TW Ventures Inc. at (818) 640-9437 if you have any questions about the foregoing statements or about your rights under ERISA. You may also contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210, to discuss questions about this statement of rights or about any rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your COBRA Continuation Rights

The below notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Health Care FSA. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. For additional information about your rights and obligations under the Health Care FSA under federal law, you should review this Summary Plan Description (including the Extended Participation section above) or contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

PLEASE NOTE THAT THE COBRA ELECTION AND PAYMENT DEADLINES DESCRIBED BELOW ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. HOWEVER, THE EXTENSIONS DO NOT MAKE COBRA COVERAGE AUTOMATIC – YOUR COBRA CONTINUATION COVERAGE DOES NOT BEGIN UNTIL YOU MAKE YOUR COBRA ELECTION. SEE APPENDIX A FOR DETAILS.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health Care FSA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. Under the Plan, if you elect COBRA continuation coverage, you must pay for COBRA continuation coverage.

You will become a qualified beneficiary if you lose your coverage under the Health Care FSA because either one of the following qualifying events happens:

- Your hours of employment are reduced (if applicable).
- Your employment ends for any reason other than gross misconduct.

When and How Is COBRA Coverage Provided?

COBRA continuation coverage will be offered to you only after the COBRA Administrator has been notified that a qualifying event has occurred. Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries until the end of the calendar year on an after-tax basis. If you have a balance in your Health Care FSA and wish to receive reimbursement for new health care expenses incurred after your coverage would otherwise end (see "When Participation Ends"), you must elect and pay for COBRA continuation coverage. You elect COBRA by completing the COBRA election form and returning it to the COBRA Administrator within 60 days after the later of the date you were provided the election form, or the date your eligibility stops. If you choose to continue participation through COBRA, you must pay 102 percent of the amount you elected to contribute on an after-tax basis. Your initial payment must be made within 45 days of the date of your COBRA election.

COBRA participation will stop before the end of the year under any of the following circumstances:

- Failure to make the required contributions on a timely basis
- Termination of the Plan and all other group health plans provided by TW Ventures Inc.

If You Have Questions

Questions concerning your Health Care FSA or your COBRA continuation coverage rights should be addressed to the TW Ventures Inc. Benefits Department at (818) 640-9437. You may also contact the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights, you should keep the Plan Administrator informed of any changes in your address. You should also keep a copy of any notices you send to the Plan Administrator or COBRA Administrator for your records.

COBRA Administrator

The COBRA Administrator is:

TW Ventures Inc.
3500 West Olive Avenue, Suite 1000
Burbank, CA 91505

Key Terms and Definitions

Claims Administrator is the company that reviews claims directly and is responsible for determining whether you have incurred an eligible expense for which reimbursement may be payable under the Plan. The Claims Administrator determines the amount of, and administers the payment of, any such reimbursements under the Plan. See Plan Facts for how to contact the Claims Administrator.

Company means TW Ventures Inc. or any successor.

Dependent with respect to the Health Care FSA and Group Health Care Contribution "Pass Through" Account means, subject to federal tax code requirements, your spouse; your natural and adopted child, stepchild, or foster child through the end of the month in which he or she reaches age 26; your unmarried grandchild (or other descendent of your child) or sibling (or descendent of your sibling) under age 19 (age 24 if a student) who lives with you for more than half the year and who has not provided more than half of his or her own support for the year; and any of the following individuals for whom you provide over one half of support for the calendar year: 1) your son or daughter or their descendants, 2) your stepson or stepdaughter, 3) your brother, sister, stepbrother or stepsister, 4) your mother or father (or an ancestor of either), 5) your stepmother or stepfather, 6) the son or daughter of your brother or sister, 7) the brother or sister of your mother or father, 8) your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law, or 9) your domestic partner spouse who lives with you. Note that dependent group health plan coverage under the TW Ventures

Inc. Group Benefits Plan is subject to the requirements of that plan. For the Dependent Day Care FSA, see "Who Qualifies as a Dependent" for the definition of a "dependent."

Domestic partner means:

- your same-sex or opposite-sex partner with whom you have entered into a legal civil union under applicable state law, or
- an adult of the same or opposite sex with whom you have been in an exclusive and committed relationship that is intended to be permanent. You and your partner must be responsible for each other's welfare on a continuing basis. You and your partner must both be at least 18 years old and may not be related by blood to a degree of closeness that would prohibit marriage under applicable state law as an opposite sex couple. Neither of you may be legally married to or in a legal civil union with another person. You may have to have an Affidavit of Domestic Partnership on file with your Participating Employer for a domestic partner who is not your legal civil union partner to be eligible for coverage.

Employee, for purposes of the TW Ventures Inc. Flexible Spending Account Plan, means an individual who is regularly employed full-time by a Participating Employer. Temporary employees, or anyone so classified by the Participating Employer, are generally not eligible to participate in any component of the Plan, nor are employees covered by a collective bargaining agreement, unless the agreement and the Plan, as amended, provides for Plan participation and eligibility. An individual classified as an independent contractor or a leased employee by a Participating Employer, or any individual otherwise not in a covered class who provides services to a Participating Employer while being paid by a business other than an Participating Employer, will not be considered an employee for purposes of the Plan even if this individual is considered a common-law employee of the Participating Employer by any entity for any other purpose. For purposes of the preceding sentence, a "leased employee" does not include an individual paid through Cast & Crew for services rendered to a Participating Employer. For the avoidance of any doubt, any employee who meets the Participation/Eligibility Requirements but is paid through a collective bargaining agreement for union services rendered during the majority of each annual term of his or her employment agreement, will not be eligible for this Plan.

Highly compensated employee is any employee or former employee who during the year was at least a five percent owner (under Code Section 414(q)) or during the preceding year received compensation above the threshold established under federal income tax law.

Participating Employer means affiliated Warner Media, LLC companies participating in the Plan. For a current list of Participating Employers, contact the Plan Sponsor. Any company that adopts the Plan and that later ceases to be an affiliate of Warner Media, LLC will cease to be a Participating Employer.

Plan means the TW Ventures Inc. Flexible Spending Account Plan, as described in this Summary Plan Description.

Plan Administrator for the Plan is TW Ventures Inc.

Qualified change in status means any of the qualified change in status events described in the Enrollment section.

Spouse means the person to whom you are legally married under the laws of the state in which the marriage was performed (including your common-law spouse in states that recognize common-law marriage).

APPENDIX A
PLAN CHANGES RELATED TO THE COVID-19 PANDEMIC

Certain Plan deadlines extended during Outbreak Period

Recent government guidance issued in response to the COVID-19 National Emergency requires the Plan to disregard the Outbreak Period when determining certain Plan deadlines. This means that deadlines related to COBRA notifications, elections and payments, and ERISA benefit claim and appeal rules for Health Care FSA claims will be tolled (meaning paused) until the end of the Outbreak Period. This guidance impacts applicable deadlines and timeframes that begin during the Outbreak Period as well as those that began prior to the Outbreak Period but that had not yet lapsed. The Outbreak Period is defined as the period from March 1, 2020, through 60 days after the announced end of the COVID-19 "National Emergency" (or such other time as the government agencies may announce in the future). While we don't know when the Outbreak Period will end, this relief from Plan deadlines is temporary.

COBRA continuation coverage. Your right to continue Health Care FSA coverage under COBRA is described in your COBRA general notice and in this SPD. The Plan will disregard the Outbreak Period for determining the following COBRA deadlines for qualified beneficiaries:

- The deadline to elect COBRA continuation coverage (normally 60 days starting on the date the election notice is sent)
- The deadline for the payment of COBRA initial premiums (normally 45 days after the COBRA election) or subsequent COBRA premiums

Contact TW Ventures, Inc. Benefits Department at (818) 972-8914 if you have any questions about COBRA for you and/or your dependents.

Benefit Claims and Appeals Deadlines. This SPD describes the benefit claim and appeal deadlines that apply to Plan benefits. The following deadlines are impacted:

- The Plan will disregard the Outbreak Period for determining the March 31 deadlines following the end of the 2019 and 2020 Plan Years for submitting Health Care FSA claims (**Note:** This extension relief does NOT apply to Dependent Care FSA claims). The deadline for submitting Health Care FSA claims is extended to 30 days after the Outbreak Period ends.
- The Plan will disregard the Outbreak Period for determining the deadline by which Health Care FSA claims have to be appealed.