TW Ventures Inc. Group Benefits Plan

SUMMARY PLAN DESCRIPTION

For Tier 1 and Tier 2 Employees

Effective January 1, 2021

Contents

Introduction

This is the Summary Plan Description of the TW Ventures Inc. Group Benefits 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. The Plan Year begins each August 1st and ends the following July 31st.

TW Ventures Inc., or any successor, reserves the right to amend, modify, suspend, or terminate the Plan, any insurance coverage offered under the Plan, and any underlying contract or policy with respect to 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. We've tried 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 for important administrative guidelines and facts about your rights under applicable law and the Plan.

This SPD is comprised of multiple documents – this document and one or more Insurance Documents issued by the Insurance Carriers that provide insurance coverage for medical, dental, vision, life insurance and accidental death and dismemberment ("AD&D") benefits. You will need to refer to both this document and the applicable Insurance Documents to understand your benefits under the Plan.

This document describes the Plan rules relating to eligibility, enrollment, when coverage begins, when coverage ends, plan information and your rights under ERISA. The Insurance Documents describe the Plan benefits, specifically:

- For medical, dental and vision insurance coverage, the Insurance Documents describe covered benefits, cost-sharing, exclusions, limitations on covered benefits, coordination of benefits, claim and appeal procedures and the Insurance Carrier's rights of recovery, reimbursement and subrogation; and

- For basic life and AD&D insurance coverage, the Insurance Documents describe the amount of benefits, the circumstances under which benefits are paid, the conditions that apply to receipt of benefits, age reductions, benefit features, the process for designating a beneficiary and claim and appeal procedures.

If there's any discrepancy between this document and the Insurance Documents on the Plan rules relating to eligibility, enrollment, when coverage begins and when coverage ends, this document will control. If there's any discrepancy between this document and the Insurance Documents on the Plan benefits, the Insurance Company Documents will control. To obtain copies of the Insurance Documents, visit the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com, www.benefitsfortvhires.com or contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Who's Eligible

Employees. The Plan offers fully-insured medical, dental and vision benefits to eligible employees and their dependents, plus basic life and AD&D insurance. To determine whether you are an eligible employee, here are the basic questions you'll need to answer:

- **Do you work for a Participating Employer?** You must be a non-union, active fulltime 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 considered 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 deemed to be a Tier 2 eligible employee. For a list of the Participating Employers, visit the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com, 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.

- **Are you working in Hawaii?** If you are working in Hawaii for a Participating Employer (regardless whether you reside in Hawaii permanently or temporarily), you are eligible for dental, vision, life insurance and AD&D benefits under this Plan. However, you are not eligible for medical benefits under this Plan. To obtain Hawaii medical insurance, please contact your Production Supervisor for assistance.

- **Are you a resident of a U.S. territory?** If you are a resident of a U.S. territory, for example, the Commonwealth of Puerto Rico, you are not eligible for any benefits under this Plan.

What coverage options are available for each tier? The table below summarizes the coverage options 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 or Tier 2	Medical – Choice of HMO (CA only), POS or Basic PPO (all medical coverage includes prescription drug coverage) Dental – Choice of HMO or PPO Vision Basic Life and AD&D (effective August 1, 2021, eligible employees are automatically enrolled in $50,000 of basic life and AD&D insurance coverage and you should complete the beneficiary form)

When can I enroll? Upon receipt of your non-union, full-time start paperwork from production, TW Ventures Inc. will notify you when you are eligible to enroll. Note that you must be in current employment status to enroll in the Plan. You can find a more detailed discussion of the Plan's enrollment rules in the section called "Enrollment."

Dependents. As an eligible employee, you may extend coverage to your eligible dependents including your spouse, domestic partner and children as long as you enroll yourself. When you enroll your eligible dependents for coverage, you will be required to provide documentation that each person meets the definition of an eligible dependent – a spouse, domestic partner or child as described below. Below is a list of the required documentation you must provide for each covered dependent.

Covered Dependent(s)	Required Documentation
Spouse	Marriage Certificate
Domestic Partner	Affidavit

Child(ren)	Birth Certificate or Proof of Birth

Enrolling individuals who do not qualify for dependent coverage under the Plan is considered fraudulent and may result in retroactive cancellation of coverage and disciplinary actions up to and including termination of employment. If you are unsure about whether a family member meets the definition of an eligible dependent under the Plan, contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Spouse. Your spouse is 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).

Domestic partner. Your domestic partner is:

- 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.

Dependent children. Your dependent children are eligible for coverage until the end of the month in which they turn age 26, regardless of student status and whether or not they can be claimed as dependents on your federal income tax return. This means that even if your child is married, financially independent, or no longer in school, he or she will be eligible for coverage under the Plan through the end of the month in which he or she reaches age 26. "Dependent children" includes your or your spouse's biological children, stepchildren, foster children, legally adopted children, children for whom adoption procedures have been started, children whom you have been ordered to cover through a Qualified Medical Child Support Order and other children who live with you and for whom you are the appointed legal guardian. Your domestic partner's children are also eligible for coverage as long as they meet all other criteria for coverage of dependent children described above. Your dependent child's spouse or domestic partner and your child's dependent children are not eligible for coverage under the Plan.

Disabled children. An unmarried disabled adult child who is primarily dependent on you for support and who would otherwise not be eligible due to age limitations under the Plan can be enrolled within 60 days of your initial eligibility, subject to verification by the Claims Administrator that the disability occurred before age 26. If you do not enroll this disabled adult child when you first become eligible, you may do so during any subsequent open enrollment period, subject to the same verification. If your unmarried child becomes disabled while covered under the terms of the Plan, coverage can continue without regard to age for as long as the child remains disabled and is primarily dependent on you for support. Extended coverage for disabled children is subject to periodic verification by the Claims Administrator.

Imputed income for domestic partners and other non-tax dependents. If you elect to cover a domestic partner and/or child who does not qualify for non-taxable medical benefits as a dependent under federal tax rules, the full amount of the Participating Employer's contribution toward this coverage generally is treated as "imputed income" to you (the employee). This means that the amount that the Participating Employer pays for coverage for your non-tax-dependent domestic partner or child will be shown on your IRS Form W-2 and will be taxable income for federal and, in most cases, state tax purposes.

Former spouses or domestic partners. An ex-spouse or former domestic partner is not considered an eligible dependent, even if you are legally required to provide his or her health insurance. However, if you divorce while your spouse is covered by the Plan, or if you end your domestic partnership while your domestic partner is covered by the Plan, he or she may be able to continue individual coverage for a limited period at his or her own expense (see "Continuing Your Coverage Under COBRA").

Survivors. Surviving spouses or domestic partners and/or dependent children of deceased employees are generally eligible to continue Plan participation for a limited period following the employee's death (see "Continuing Your Coverage Under COBRA"). For information about COBRA coverage, contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Enrollment

The Plan offers several enrollment opportunities for eligible employees. Your first opportunity to enroll occurs when you first become eligible to participate in the Plan. Your next opportunity occurs during annual open enrollment. You may also be able to enroll before the next annual open enrollment if you have a qualified change in status or experience a special enrollment event. **Note that you must be in current employment status to enroll in the Plan (see "Current Employment Status" below).** Each of the enrollment opportunities is explained below.

Initial enrollment. When you become eligible to participate in the Plan, you will be directed to the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com, or www.benefitsfortvhires.com for information regarding Plan coverage and enrollment instructions. Most information will be distributed electronically. You and your eligible dependents must affirmatively enroll 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 and your eligible dependents do not enroll in coverage within the required 30-day period, you and your eligible dependents will give up your chance to enroll. Unless you experience a qualified change in status, you will have to wait until the next annual enrollment period to enroll yourself and your eligible dependents for coverage. See "When Coverage Begins."

Annual enrollment. The Plan conducts an annual open enrollment each year before the beginning of the next Plan Year, typically during the month of July. This is your opportunity to enroll, change, or drop coverage. Changes are effective on August 1st following annual open enrollment. You'll receive information, including instructions on how to enroll, before the annual enrollment period. Information about the annual open enrollment is posted on the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com or www.benefitsfortvhires.com. Contact the TW Ventures Inc. Benefits Department at (818) 640-9437 if you do not have access to the internet.

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

- Your legal marital status changes (*i.e.*, 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 under the Plan 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 or your eligible dependent becomes employed or unemployed.
- Eligibility for employer-sponsored health coverage is affected because you or your eligible dependent takes or returns from an unpaid 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 returns from a strike or lockout.
- The coverage options available to you change because you change residences or worksites.
- You previously waived participation in the Plan for yourself or your eligible dependent(s) because you or your dependents were covered under another group health plan and you or your dependents subsequently lose coverage under that plan 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.

- Your eligible dependent's employer-sponsored plan has a different open enrollment period and a different plan year, and you would like to make a change to correspond with an election change under your eligible dependent's plan.
- 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 Plan (CHIP) because you are or your eligible dependent is 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 Plan coverage under Medicaid or a state CHIP (you must make this change within 60 days of the determination).
- COBRA coverage under another plan is exhausted.
- There is a significant change in the employer-sponsored health coverage you have or your eligible dependent has (as determined in accordance with Internal Revenue Service guidelines).
- 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, requires 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.

Failure to change your coverage election within the 30- (or 60-) day period will result in your amended election request being denied. In addition, failure to notify the Plan of a change in marital status (such as divorce) within the 30-day period may result in termination of coverage for your ex-spouse retroactive to the date of the divorce and may result in disciplinary actions up to and including termination of employment.

Special Enrollment Events. If you 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 or your eligible dependent previously waived participation in the Plan due to coverage under another group health plan and you subsequently lose coverage under that plan because of loss of eligibility for the other coverage, termination of employer contributions for the other coverage, or exhaustion of COBRA continuation coverage, (iii) you lose or your eligible dependent loses coverage under Medicaid or a state CHIP program because of loss of eligibility for coverage, or (iv) you or your eligible dependent is determined to be eligible for assistance with the cost of Plan coverage under Medicaid or a state CHIP program, you may enroll in any of the medical coverage options that are available to similarly situated eligible employees. If the qualified change in status occurred because you or your eligible dependent lost other group health plan coverage, the other coverage must have ended either because COBRA continuation coverage was exhausted, because the prior coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or because employer contributions towards such prior coverage were terminated.

PLEASE NOTE THAT THE 30-DAY AND 60-DAY ENROLLMENT DEADLINES FOR SPECIAL ENROLLMENT EVENTS ARE EXTENDED DURING THE COVID-19 NATIONAL EMERGENCY. SEE APPENDIX A FOR DETAILS.

Current Employment Status. To enroll in the Plan, you must be in current employment status on the date your enrollment would be effective. You are in current employment status if you are an active employee on the date your enrollment would be effective.

Choosing a coverage level. You may elect one of the following coverage levels for medical, dental and vision coverage:

- Employee-only
- Employee-plus-one
- Employee-plus-family

You cannot enroll dependents for coverage that you waive for yourself. For example, you cannot choose medical coverage for your dependents if you waive it for yourself.

Independent medical, dental and vision elections. You make separate elections for medical, dental and vision coverage. For example, you may elect medical coverage without electing dental or vision coverage. You also may elect different coverage levels for each kind of coverage, but you cannot enroll dependents for coverage that you waive for yourself. For example, you may choose employee-only medical coverage and employee-plus-family dental coverage, but you cannot choose medical coverage for your dependents if you waive it for yourself.

Enrollment in Flexible Spending Account Plan. You will be automatically enrolled in the feature of the TW Ventures Inc. Flexible Spending Account (FSA) Plan that allows you to pay for your medical and/or dental coverage on a pre-tax basis.

Newborn or newly-adopted children. A newborn or newly-adopted child, or a child for whom adoption procedures have begun, will be covered automatically during the first 30 days after the birth, adoption or placement for adoption. To maintain coverage beyond that initial 30-day period, you must enroll your new child as a dependent no later than 30 days after the birth, adoption or placement for adoption, even if you already have family coverage.

How to enroll. Go to the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com, www.benefitsfortvhires.com or contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information about how to enroll.

When Coverage Begins

If you enroll within 30 days of your eligibility date, then coverage for you and your family begins on your eligibility date. For the definition of your eligibility date, see the "Initial Enrollment" discussion under "Enrollment". If you don't enroll within 30 days of your eligibility date but you decide to enroll during the annual open enrollment period, then coverage for you and your family begins on August 1st following the annual open enrollment period.

If you're electing coverage as a result of a qualified change in status, then coverage for you and your family 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.

Paying for Your Coverage

You and your Participating Employer share the cost of Plan coverage for you and your covered dependents. Your contributions for coverage for yourself and any eligible dependents who are permitted to receive non-taxable medical benefits under federal tax law are made through before-tax payroll deductions. If you elect to cover an eligible dependent who does not qualify for non-taxable medical benefits under federal tax rules (such as certain domestic partners and their children who are not your tax dependents), then the following rules apply:

- The portion of your contributions that pays for your coverage is paid through before-tax payroll deductions,
- The portion of your contributions that pays for coverage of your non-tax dependents is paid through after-tax payroll deductions,
- The portion of contributions your Participating Employer pays for coverage of your non-tax dependents is treated as "imputed income" to you and will appear as additional compensation on your Form W-2.

The amount of your contributions for coverage is subject to change and may be revised each August 1st to reflect changes in the cost of Plan coverage from year to year. Go to the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com, www.benefitsfortyhires.com or contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information about current contribution requirements.

What Happens During a Leave of Absence

Coverage continues while you are on an approved unpaid leave of absence (including illness leave and/or a leave that qualifies under the Family and Medical Leave Act (FMLA) (or similar state laws such as the California Family Rights Act and the California pregnancy disability leave law).

Military leave. Coverage generally continues while you are on National Guard or Reserve Corps duty, fulfilling routine, periodic service obligations. If you are called into active military service, you may continue coverage for yourself and your dependents for the duration of a qualified military leave, as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information about your options during a qualified 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 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 remain eligible to participate in the Plan 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, you remain eligible to participate in the Plan 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).

Paying for coverage during leave. During FMLA leave or similar leave under applicable state or local family and medical leave laws, your Participating Employer will pay both its share and your share of the cost of coverage.

For more information. Please contact the TW Ventures Inc. Benefits Department at (818) 640-9437 for more information about your Plan coverage during a leave of absence.

When Coverage Ends

For you. Your coverage under the Plan ends on the earliest of the following dates:

- The date your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, by termination of an insurance contract or agreement, or by discontinuance of contributions by your Participating Employer; or

- The end of the month in which you cease to be employed in one of the eligible tiers. This includes your death or termination of active employment.

For your dependents. Coverage for your spouse, domestic partner and other dependents terminates when your coverage terminates. Coverage for your dependents will also terminate on the earliest of the following dates:

- For medical, dental and vision coverage, the end of the month in which your dependent child attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support); or
- The end of the month in which your spouse, domestic partner or dependent child is no longer considered an eligible dependent.

For a child covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

What Happens When You Return to Work

Upon receipt of your non-union, full-time start paperwork from production, 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."

Plan Benefits

For information on the Plan's benefits, refer to the appropriate Insurance Documents issued by the applicable Insurance Carrier. The Insurance Documents include additional information on the following topics:

- For medical, dental and vision insurance coverage, the Insurance Documents describe covered benefits, cost-sharing, exclusions, limitations on covered benefits, coordination of benefits, claim and appeal procedures and the Insurance Carrier's rights of recovery, reimbursement and subrogation; and
- For basic life and AD&D insurance coverage, the Insurance Documents describe the amount of benefits, the circumstances under which benefits are paid, the conditions that apply to receipt of benefits, age reductions, benefit features, the process for designating a beneficiary and claim and appeal procedures.

A list of the applicable Insurance Carriers and contact information for each carrier appears in the section called "Plan Facts." The Insurance Documents are available by visiting the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com or www.benefitsfortvhires.com. If you have specific questions about Plan benefits, please contact the applicable Insurance Carrier.

PLEASE NOTE THAT ADDITIONAL MEDICAL BENEFITS ARE AVAILABLE DURING THE COVID-19 PUBLIC HEALTH EMERGENCY. SEE APPENDIX A FOR DETAILS.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), medical, dental and vision coverage under the TW Ventures Inc. Group Benefits Plan for you and your eligible dependents may continue past the date it would normally end. The Plan also provides COBRA-like continuation coverage for domestic partners and their children who are not your Internal Revenue Code dependents, even though it's not required under COBRA. This is a general description of your COBRA rights; you should

also review the applicable Insurance Documents for additional details. COBRA continuation coverage is not available for life insurance and AD&D benefits, however those benefits can be converted to individual policies (see the Insurance Documents for conversion rights).

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.

Notice of COBRA Continuation Rights

Introduction. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact the TW Ventures Inc. Benefits Department at (818) 640-9437.

Keep in mind that the Affordable Care Act gives you coverage options other than COBRA continuation coverage. For example, you may be eligible to enroll in an individual health insurance policy offered through a State-based or Federally-facilitated Marketplace at a lower cost than what you would pay for COBRA continuation coverage under the Plan. In addition, depending on your household income, you may be eligible for federal financial assistance to help you pay for Marketplace coverage. Before deciding to elect COBRA continuation coverage under the Plan, you should review and compare the costs and benefits of health insurance policies available to you through the Marketplace. For more information on Marketplace policies, go to www.healthcare.gov.

The Company has voluntarily elected to provide continuation coverage similar to that required by COBRA to domestic partners and their children who are not dependents of the employee as defined under the Internal Revenue Code. This notice describes both the federally-mandated COBRA continuation coverage and the COBRA-like continuation coverage offered to domestic partners and children who are not required to be offered continuation coverage under federal law (both referred to as "COBRA continuation coverage" in this notice).

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your spouse or domestic partner (the employee) dies.
- Your spouse's or domestic partner's (the employee's) hours of employment are reduced.

- Your spouse's or domestic partner's (the employee's) employment ends for any reason other than his or her gross misconduct.
- You become divorced or legally separated from your employee-spouse (or you dissolve your domestic partnership with the employee).

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parents become divorced or legally separated (or dissolve their domestic partnership).
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your Participating Employer must notify the COBRA Administrator of the qualifying event.

You must give notice of some qualifying events. For other qualifying events (divorce or legal separation of the employee and spouse, the dissolution of a domestic partnership or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator in writing within 60 days after the qualifying event occurs.

How is COBRA coverage provided? Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage under your Plan option at the time of the qualifying event will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their dependent children.

How long does COBRA coverage last? COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, dissolution of a domestic partnership, or a dependent child's losing eligibility as a dependent child under the Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months – 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Can an 18-month period of COBRA continuation coverage be extended? Yes, there are two ways in which an 18-month period of COBRA continuation coverage can be extended.

- **Disability extension of 18-month period of COBRA continuation coverage.** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last beyond the end of the 18-month period of continuation coverage. This notice must be in writing and sent to the COBRA Administrator within 60 days after the Social Security determination of disability is issued.

- **Second qualifying event extension of 18-month period of COBRA continuation coverage.** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse or domestic partner and the/or dependent children in your family, as applicable, can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given in writing to the COBRA Administrator within 60 days of the second qualifying event. This extension may be available to the spouse or domestic partner and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or domestic partner and/or dependent children to lose coverage under the Plan had the first qualifying event not occurred.

If the Company subsidizes COBRA premiums, does that extend the period of COBRA continuation coverage? If the Company decides to subsidize COBRA premiums for one or more months, the COBRA Administrator will count those months against the 18-month, 29-month or 36-month periods of COBRA continuation coverage. Your COBRA election notice will tell you when your COBRA continuation coverage begins and how long it will last.

If you have questions about COBRA continuation coverage. Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the TW Ventures Inc. Benefits Department at (818) 640-9437. For more information about your rights under the Employee Retirement Income Security Act (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 at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan informed of address changes. In order to protect your family's rights, you should keep the TW Ventures Inc. Benefits Department informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Plan contact for additional COBRA information. You can obtain further information about COBRA continuation coverage from the TW Ventures Inc. Benefits Department at (818) 640-9437.

COBRA Administrator. For Tier 1 and Tier 2 employees, the COBRA Administrator is the TW Ventures Inc. Benefits Department at (818) 640-9437.

Electing COBRA Continuation Coverage

When a qualifying event occurs, you or your dependent(s) who are qualified beneficiaries must request continued coverage. The COBRA Administrator will give you and your dependent(s) all of the details about continued coverage, including the cost, and will provide you and/or your dependent(s) with an election form. To continue coverage, the completed election form must be sent to the address shown on the form within 60 days after the latest of the date:

- You or your dependent were provided the election form, or
- Plan coverage ends.

You and each of your eligible dependents who is a qualified beneficiary have an independent election right for COBRA coverage. If you or your dependents elect to continue coverage, either you or they must pay 102% (or, in the case of an extension of continuation coverage due to a disability, 150% during the disability extension period) of the total cost of the coverage elected (including the portion previously paid by your Participating Employer). Coverage costs may change from year to year.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Payment for COBRA Continuation Coverage

If you elect to continue coverage, you must make required payments for the cost of COBRA coverage. The Company will determine the cost of COBRA coverage in accordance with applicable law. You must make your initial premium payment no later than 45 days following the date of your election to purchase COBRA continuation coverage. This payment will cover the period of coverage from the date of the COBRA election retroactive to the date of the qualifying event. Future COBRA contributions are due in advance of the period for which coverage is to be provided. If the required COBRA premiums are not paid when due, your COBRA coverage will terminate. Subsequent COBRA payments will be considered timely only if made no later than 30 days following the due date.

PLEASE NOTE THAT THE FEDERAL GOVERNMENT IS FULLY SUBSIDIZING COBRA PREMIUMS FOR A LIMITED PERIOD OF TIME (APRIL 1, 2021 THROUGH SEPTEMBER 30, 2021) FOR CERTAIN QUALIFIED BENEFICIARIES WHO LOSE COVERAGE DUE TO AN INVOLUNTARY TERMINATION OF EMPLOYMENT OR AN INVOLUNTARY REDUCTION IN HOURS.
SEE APPENDIX A FOR DETAILS.

When COBRA Continuation Coverage Begins

Your COBRA coverage will begin when the COBRA Administrator receives your timely COBRA election. If you fail to pay your initial premium within 45 days of your election, your COBRA coverage will be revoked retroactively to the date of your qualifying event.

Early Termination of COBRA Continuation Coverage

COBRA continuation coverage will stop before the end of the maximum period under any of the following circumstances:

- The required contributions are not made on a timely basis.
- Recovery from disability, if the individual is eligible for extended continuation coverage due to disability, but not before 18 months of continuation coverage.
- The Plan and any other group health plans provided by the Company terminate.
- After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (under Part A, Part B or both).

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant who is not receiving continuation coverage (such as fraud).

Responsibility to notify COBRA Administrator of change in disability status. If you have already received 18 months of COBRA continuation coverage, you are receiving extended COBRA continuation coverage due to your or a family member's disability, and the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you are required to notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Notification of COBRA ineligibility. If you provide notice to the COBRA Administrator as described in this Summary Plan Description and you are determined to be ineligible for COBRA continuation coverage or for a disability or second qualifying event extension, you will be notified in writing.

Other Information You Should Know

Filing Claims

Medical, Dental, Vision, Life and AD&D claims. For these benefits, please refer to the applicable Insurance Documents for instructions on how to file claims and how to appeal denied claims. The contact information for the applicable Insurance Carriers is in the section called "Plan Facts."

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

How Benefits May Be Forfeited or Delayed

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

- Do not file for benefits properly or on time (see "Your Rights Under ERISA").
- Do not furnish the information required to complete or verify a claim.
- Do not have a current address on file with your Participating Employer, the Insurance Carrier or the Claims Administrator.

You should also be aware that benefits are not payable for services provided to enrolled dependents after they become ineligible (*e.g.*, due to age, divorce or domestic partnership dissolution). Finally, if the Plan mistakenly pays a greater benefit than you're eligible for, or pays benefits that were not authorized by the Plan, the Plan Administrator, the Insurance Carrier or the Claims Administrator may seek any permissible remedy allowed by law to recover benefits paid in error.

Coordination of Benefits

Please refer to the Insurance Documents for information on coordination of benefits. These rules typically apply when you or a covered dependent is covered by more than one group benefit plan or covered by Medicare. The contact information for the applicable Insurance Carrier is in the section called "Plan Facts."

Qualified Medical Child Support Orders

The Plan provides benefits in accordance with the requirements of any Qualified Medical Child Support Order ("QMCSO") that provides for group health plan coverage for an employee's dependent child. The QMCSO rules permit state courts (or state agencies) to require an employer that provides dependent health coverage to make that coverage available to an employee's child, even though the child is not a legal dependent because of a separation or divorce.

A QMCSO includes a judgment, decree or order (including a settlement agreement or administrative notice) issued either by a domestic relations 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 that satisfies the QMCSO requirements in section 609(a) of ERISA, it must be honored by the Plan.

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.

States' Rights and Participants Who Are Eligible for Medicaid

Under Section 609(b) of ERISA, the Plan is subject to any state's right to reimbursement for medical benefits that the state has paid on behalf of a covered participant, if the participant is covered by a state's Medicaid program and if the benefits paid by the state would have been covered by the Plan. In providing benefits or enrolling an employee or dependent, the Plan may not take into account an individual's eligibility for medical assistance under a state's Medicaid program.

Claim Fraud

The Insurance Carriers, acting as Claims Administrators, regularly evaluate claims to detect fraud or false statements and will notify the Company regarding these matters. The Claims Administrators must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds amounts that are your responsibility under the Plan (such as your coinsurance amount) is entering into a discount arrangement with you. The Claims Administrators calculate the benefit payment based on the amount actually charged, less any discounts, rebates, waivers or refunds of coinsurance amounts or deductibles you receive. Failure to notify the applicable Claims Administrator or the Plan Administrator of such price adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan. If a claim has been submitted for payment or paid by the Plan as a result of fraudulent representations, the Claims Administrator or the Plan 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 Internal Revenue Service and the Department of Labor, and applicable current federal laws. 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, other than state laws regulating insurance.

Collective Bargaining Agreements

This Plan does not cover union employees. However, the Plan may be referred to in any 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 or their beneficiaries. Plan benefits cannot be sold, transferred or assigned for any reason except as provided by law or as described under Assignment of Benefits (under "Other Information You Should Know").

Plan Administration

Your benefits as a participant in the Plan are provided under the official Plan documents, the terms of this Summary Plan Description and the Insurance Documents. The Plan is maintained for the exclusive benefit of Plan participants and their beneficiaries. The Plan Administrator has exclusive authority and sole and absolute discretion to interpret the Plan to determine eligibility for Plan coverage, and to make any factual determination, resolve factual disputes, and decide all matters in connection with the interpretation, administration and operation of the Plan in order to determine eligibility for Plan and Plan coverage.

The applicable Claims Administrator has complete authority and sole and absolute discretion to interpret the Plan, to make any factual determination, to resolve factual disputes, and decide all matters in connection with the interpretation, administration and operation of the Plan in order to determine whether you have incurred a covered expense for which benefits may be payable under the Plan and to determine the amount of, and administer the payment of, any such benefits under the Plan.

Benefits will be paid under the Plan only if the Plan Administrator or the applicable Claims Administrator, as appropriate, determines in its discretion that the claimant is entitled to them. Decisions of the Plan Administrator and the applicable 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 the official Plan documents, this Summary Plan Description and any other documents describing the Plan) or to make any promises to you about them.

Amendment or termination of the Plan or the Plan. TW Ventures Inc. reserves the right to amend, modify, suspend or terminate the Plan, or any coverage option offered under the Plan, in whole or in part, at any time and for any reason, by action of TW Ventures Inc. Termination of the Plan will not affect benefit claims for covered services incurred prior to the termination.

Contacts

Your contact for Plan information is the TW Ventures Inc. Benefits Department at (818) 640-9437.

Your contacts for claiming benefits are the applicable Claims Administrator and the Plan Administrator. Also see Filing Claims.

Health Information Privacy

The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires group health plans (including the health care components of this Plan) to protect the privacy and security of your confidential health information. Pursuant to the HIPAA privacy rules, neither the Plan nor an Insurance Carrier or Claims Administrator will use or disclose your protected health information without your authorization, except for purposes of treatment, payment, healthcare operations, Plan administration, or as required or permitted by law. You will receive the Insurance Carrier's notice of privacy practices directly from the Insurance Carrier.

Nondiscrimination

The Plan is subject to certain 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. Group Benefits Plan
Type of Plan:	Welfare benefits plan. This Summary Plan Description describes the medical, dental, vision, basic life and accidental death & dismemberment insurance provided under the 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:	501
Plan Administrator and Named Fiduciary:	TW Ventures Inc. 3500 West Olive Avenue, Suite 1000 Burbank, CA 91505 (818) 640-9437

Insurance Carrier	The Plan has insurance contracts with the following entities: For medical and dental, the Insurance Carrier is Aetna, Inc. For vision, the Insurance Carrier is VSP. For basic life and AD&D, the Insurance Carrier is The Hartford.
Claims Administrators and Claims Fiduciaries:	The Insurance Carriers (Aetna, The Hartford and VSP) act as the Claims Administrators and Claims Fiduciaries. The address for claims submissions and contact telephone numbers are as follows: **HMO (CA only)** Aetna P.O. Box 14079 Lexington, KY 40512-4079 (800) 445-5299 **POS** Aetna P.O. Box 14089 Lexington, KY 40512-4089 (877) 204-9186 **Basic PPO** Aetna P.O. Box 14089 Lexington, KY 40512-4089 (877) 204-9186 **Life/AD&D** The Hartford 1 Hartford Plaza Hartford, CT 06155 (800) 331-7234 **Vision** Vision Service Plan Attention: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018 (800) 877-7195
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:	August 1 – July 31

Plan Funding:	This is a fully-insured, unfunded welfare plan. Eligible employees and the Participating Employers share the cost of medical and dental coverage. Eligible employees generally contribute on a before-tax basis, to the extent permitted under applicable tax law. Participating Employers pay the full cost of vision, basic life and AD&D coverage.
Financial Records:	TW Ventures Inc. maintains all records of the Plan based on a Plan Year that ends as of 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 benefits provided by the TW Ventures Inc. Group Benefits Plan are covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). 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 Plan participant or beneficiary of a Plan participant, to:

- Examine without charge all Plan documents (including collective bargaining agreements and insurance policies and/or contracts, if any, where applicable) and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure Room of the Employee and Benefits Security Administration. Corporate Employee Benefits in New York 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 healthcare coverage for yourself, your spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. In addition, the Plan voluntarily provides continuation coverage for domestic partners and their children who lose Plan coverage due to termination of a domestic partnership or divorce. You or your dependents may have to pay for such coverage. Review the "Continuing Your Coverage Under COBRA" section of this Summary Plan Description on the rules governing your continuation coverage rights.

Claims for benefits. In order to receive the benefits for which you may be eligible under the Plan described in this Summary Plan Description, you or your beneficiary may first be required to file a claim. The law allows a reasonable amount of time for:

- The applicable Claims Administrator to evaluate a claim directly related to determining whether you have incurred a covered expense for which benefits are payable under the Plan and determining the amount of, and administering the payment of, any such benefits 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 benefits 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. If you wish to make a claim for benefits in accordance with your rights under ERISA, you must do so in writing to as described below and in the Filing Claims section of Other Information You Should Know.

All claims should be directed to the applicable administrator (either the appropriate Claims Administrator or the Plan Administrator), and the entire claim procedure and appeal process, as set forth below, 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 within one year after the date of service.

Claims filed with the Claims Administrator. All out-of-network claims that must be directed to a Claims Administrator must be filed within one year after the date of service or the date of discharge after hospitalization.

Claims procedure. The Insurance Carriers are the Claims Administrators for medical, dental, vision, basic life and AD&D coverage. Please refer to the applicable Insurance Documents for instructions on how to file claims and how to appeal denied claims. The contact information for the applicable Insurance Carrier is in the section called "Plan Facts."

Special claims procedures for HMO coverage options. If you are enrolled in an HMO coverage option, the HMO provider is the Claims Administrator. The HMO provider will require that you follow certain internal claims and appeals procedures (sometimes called grievance procedures) when you request medical treatment or referral to a specialist for medical treatment and your request is denied by the HMO provider. You must follow the HMO's internal procedures in order to receive a fair hearing from the HMO provider. However, all claims and appeals requirements established by your HMO provider must meet minimum standards under ERISA.

Once you exhaust the HMO's internal claims procedures, some HMO providers might have additional appeal rules that require binding arbitration or that limit your rights to go to court. These appeal rules do not always comply with ERISA. The following is a list of HMO provider appeal rules that do not comply with ERISA. If you have reached a level of appeal that requires you to do one of the following, you should know that your ERISA rights as described in this "Your Rights Under ERISA" section will override the HMO provider requirements.

- No HMO provider may require you to submit to binding arbitration or to binding mediation. If your HMO certificate of coverage advises that you must submit to binding arbitration or binding mediation after you exhaust the HMO provider's internal claims and appeals procedure, you should know this rule does not comply with ERISA. If you voluntarily agree to binding arbitration or binding mediation, you may be giving up the right you have under ERISA to sue the HMO provider in federal court. If you have a serious claim, you should check with legal counsel before you submit to binding arbitration or binding mediation with the HMO provider.

- No HMO provider can make the statement that, by virtue of becoming covered under an HMO coverage option, you have agreed to give up any rights you have to sue, including any "constitutional rights" or any "ERISA rights."

- Generally, no HMO provider may require you to pay for any internal grievance or appeal procedure. If the HMO certificate of coverage tells you that you must pay for part or all of a grievance procedure, arbitration, mediation or any legal fees, you should know that ERISA generally does not allow this type of charge. However, under Health Care Reform requirements, the HMO provider may be permitted to charge a minimal filing fee of not more than $25 per claim (limited to $75 per year) if the claim is sent for external review after exhaustion of the HMO's internal grievance procedure. This amount must be refunded if the decision is reversed on external review and can be waived in the event of financial hardship.

- No HMO provider may require you to undergo more than two levels of appeal following the initial denial of your claim for benefits. If your HMO provider has additional levels of appeals, you may choose to follow those optional appeal procedures rather than to sue the HMO provider in federal court under ERISA. However, by submitting to these additional appeals procedures, you may negatively affect your ability to sue the HMO provider under ERISA (for example, if the

HMO provider is required under state law to provide additional levels of review, then the statute of limitations on your claim may continue to run while you pursue your appeal with the HMO provider). If you have a serious claim, you should check with legal counsel before you choose to pursue optional HMO provider appeals rather than taking your case directly to external review or to federal court.

- No HMO provider may require that you accept the decision of an independent reviewer on a benefit denial appeal. The HMO provider may be required to submit your claim to an independent external reviewer under state or federal law, and you can agree to abide by the independent reviewer's decision if you want to do so. However, before you agree ahead of time to accept the decision of an independent reviewer, make certain you first read the procedures described in the claims and appeals procedures above (applicable to the UHC and Anthem BCBS coverage options) and the rest of this "Your Rights Under ERISA" section because you may be giving up your right to sue for the benefit under ERISA.

- If you find that you want to exercise your rights as described in this "Your Rights Under ERISA" section, you should not wait too long after the HMO provider gives you its final decision when you go through the grievance procedure. This is because, under the Plan, you have 90 days following your receipt of a final decision after completing the mandatory HMO grievance process to take legal action, as described in this "Your Rights Under ERISA" section. This time limit will be suspended while you are pursuing external review, if you choose to do so.

All HMO providers are subject to state regulation. If you have a complaint about an HMO provider, you can contact the state insurance department listed in your HMO certificate of coverage. Remember, even when you contact the state insurance department with a complaint, you still have ERISA rights as explained in this "Your Rights Under ERISA" section.

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, including your Participating Employer, may discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

Provisions for legal action. ERISA specifically provides for circumstances under which you may take legal action as a Plan participant.

- 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. At the completion of that review process, you have a right to file suit in federal or state court. After exhaustion of the Plan's claims and appeals procedures described above (including external review, if available), 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. This 90-day time limit will be suspended while you are pursuing external review, if you choose to do so. If you are eligible for and decide to request external review of your claim, the deadline for filing a lawsuit or initiating any other legal proceeding is 90 days after the independent third party reviewer makes a decision on external review.

- If Plan fiduciaries misuse the Plan's funds or if you are discriminated against for asserting your rights, you have a right to seek assistance from the U.S. Department of Labor or to file suit in a federal court.

- If you submit a written request for copies of any Plan documents or other Plan information to which you are entitled under ERISA, and you do not receive those materials within 30 days of your request, you may file suit in a federal court. If a violation exists, the court may require the Plan Administrator to provide the material and to pay you up to $110 for each day's delay. This provision does not apply, however, if the requested materials were not sent to you because of reasons beyond the control of the Plan Administrator.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

In these circumstances, the court will decide who should pay court costs and legal fees. In other words, if you are successful, the court may order the party you have sued to pay these costs and fees. But if you lose, the court may order you to pay the costs and fees (for example, if the court finds that 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 use and complete the Plan's administrative claims and appeals procedure, including external review (if available), before bringing an action at law or in equity to recover under the Plan. If the Claims Administrator or the Plan Administrator denies your appeal on final review, and if your claim is denied on external review (if available) by the independent third party reviewer, you may bring a suit for benefits.

Deadline for legal action. If you choose to pursue any judicial or administrative proceeding relating to your claim, the evidence that can be presented will be strictly limited to the documents, information and other evidence timely provided to the Claims Administrator or the Plan Administrator and to the external reviewer (if applicable) in connection with the Plan's claims and appeals 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. This time limit will be suspended while you are pursuing external review, if you choose to do so. If you are eligible for and decide to pursue external review, the deadline for filing a lawsuit or initiating any other legal proceeding is 90 days after the independent third party reviewer makes a decision on external review.**

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 the TW Ventures Inc. Benefits Department at (818) 640-9437 if you should 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 N.W., 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 can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Key Terms & Definitions

Claims Administrator is the applicable carrier that reviews certain types of claims directly and is responsible for determining whether you have incurred an eligible expense for which benefits may be payable under the Plan. The Claims Administrator determines the amount of, and administers the payment of, any such benefits under the Plan. (See Plan Facts for how to contact your applicable Claims Administrator.)

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company means TW Ventures Inc. or any successor.

Current Employment Status is defined in the section "Enrollment."

Dependent is defined in the section "Who's Eligible."

Disabled or **disability** means you are under a physician's care and your illness or injury prevents you from performing the material and substantial duties of your occupation. For a dependent child, disabled or disability means the child is under a physician's care and is incapable of permanent self-support due to a physical or mental condition which is permanent.

Domestic partner is defined in the section "Who's Eligible."

Employee for TW Ventures Inc. Group Benefits Plan purposes means a regular, non-union, full-time worker, individually paid through Cast & Crew/BTL Payroll Inc. for services rendered to a Participating Employer. The term "employee" does not include:

- Temporary or "variable" employees or anyone so classified by a Participating Employer;
- Any individual who provides services for a Participating Employer as a "loan-out" (i.e., the individual is not paid individually, but is paid through a corporation such as an LLC); and
- Employees covered by a collective bargaining agreement, unless the collective bargaining agreement and the Plan, as amended, provide for Plan participation and eligibility has been extended in writing to such employees. To avoid any doubt, a union employee does not become eligible for this Plan merely because he/she receives some non-union pay.

Insurance Carrier is the applicable company that underwrites your coverage.

Insurance Documents mean the applicable documents issued by an Insurance Carrier describing the Plan's covered benefits. In the case of medical benefits, the Insurance Documents include two documents - a schedule of benefits and a related certificate of coverage. The Insurance Documents for each covered benefit are available by visiting the benefits website at tpbenefits.com, www.warnerhorizon.com/benefits, www.wagbenefits.com or www.benefitsfortvhires.com.

Fiduciaries are those individuals or entities assigned the responsibility for ensuring that the Plan operates in the best interests of the participants. Fiduciaries have ultimate decision-making authority on Plan-related matters.

Health Maintenance Organization or **HMO** is a health-care alternative to the PPO coverage options. HMOs provide a package of health services to enrolled members through a network of physicians and other health services providers within a particular geographic area.

Medicare is the health insurance program for the aged and disabled as provided under Title XVIII of the Social Security Act.

Participant is an employee or dependent who satisfies the Plan's eligibility requirements and enrolls in the Plan.

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 — See TW Ventures Inc. Group Benefits Plan.

Plan Administrator for the Plan is TW Ventures Inc.

Qualified change in status means any of the qualifying events.

Spouse is defined in the section "Who's Eligible."

TW Ventures Inc. Group Benefits Plan or **Plan** refers to the TW Ventures Inc. Group Benefits Plan, a consolidated welfare benefits plan providing insurance coverage for eligible employees and their eligible dependents.

APPENDIX A

PLAN CHANGES RELATED TO THE COVID-19 PANDEMIC

I. Changes to your medical benefits due to COVID-19

Temporary removal of cost sharing for COVID-19 testing and related services. From March 18, 2020 until the Department of Health and Human Services determines the public health emergency due to COVID-19 has ended, the Plan will offer enhanced coverage to those employees and dependents enrolled in any of the Plan's medical benefit options to the extent required by law. You will not owe any copayments, coinsurance, or deductible for approved and authorized COVID-19 testing, as well as related items and services during a visit that results in an order for or administration of a COVID-19 test. The waiver of cost-sharing applies in and out of network.

Temporary removal of cost sharing for COVID-19 treatment. The Plan waived cost-sharing (copayments, coinsurance, deductibles) for eligible inpatient medical expenses for covered services, both in network and out of network, when associated with COVID-19 diagnosis through February 28, 2021.

Temporary removal of cost sharing for telehealth services. The Plan waived cost-sharing (copayments, coinsurance, deductibles) for in-network telemedicine visits for outpatient behavioral health and mental health counseling services through January 31, 2021.

Removal of cost-sharing for COVID-19 preventive services (including COVID-19 vaccinations). Effective January 1, 2021 until further notice, you will not owe any copayments, coinsurance, or deductible for approved and authorized COVID-19 preventive services (including COVID-19 vaccinations), as well as related items and services during a visit that results in an order for or administration of a COVID-19 preventive service. The waiver of cost-sharing applies in and out of network.

II. 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 HIPAA special enrollment events, COBRA notifications, elections and payments, and certain ERISA benefit claims and appeals rules 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.

HIPAA special enrollment period. HIPAA special enrollment rights allow you to enroll yourself and/or your dependent(s) in medical, dental and vision coverage following certain circumstances.

- If you (or your dependents) lose other medical, dental or vision coverage or when a person becomes your dependent by birth, adoption, placement adoption or marriage, you generally have 30 days to enroll in the Plan.
- If you lose eligibility for coverage under a state Medicaid or CHIP program, or if you become eligible for state premium assistance under Medicaid or CHIP, you generally have 60 days to enroll in the Plan's medical benefits.

The Plan will disregard the Outbreak Period for purposes of calculating the 30-day or 60-day HIPAA special enrollment period.

COBRA continuation coverage. Your right to continue medical, dental and vision 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

- The deadline to notify the Plan of a qualifying event, such as divorce or a dependent aging off the plan, or determination of disability (normally within 60 days of the event or determination)

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. The Insurance Documents describe 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 deadline by which benefit claims have to be submitted and appealed.
- The Plan will disregard the Outbreak Period for determining when the health care runout period for purposes of submitting claims incurred during the 2019 plan year if the runout period would have otherwise ended during the Outbreak Period. The runout is extended to 30 days after the Outbreak Period.
- The Plan will disregard the Outbreak Period for determining the deadline by which a participant must file or perfect a request for external review of a medical benefits claim.

III. COBRA Premium Assistance

For a limited period of time (April 1, 2021 through September 30, 2021), the federal government is fully subsidizing COBRA coverage for qualified beneficiaries who lose coverage due to an involuntary termination of employment or an involuntary reduction of hours. If you are eligible for COBRA premium assistance, TW Ventures Inc. will notify you when you receive your COBRA election notice.