TW Ventures Inc. Flexible Spending Account Plan
SUMMARY PLAN DESCRIPTION

For Tier 1 and Tier 2 Employees

Effective January 1, 2024

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Introduction

This is the Summary Plan Description ("SPD") for the TW Ventures Inc. Flexible Spending Account Plan (the "Plan") currently available to eligible Tier 1 and Tier 2 employees of Participating Employers. As described in more detail below, the Plan provides eligible Tier 1 and Tier 2 employees of Participating Employers with the opportunity to use before-tax contributions to pay for various benefits, including health care and dependent care flexible spending accounts.

The SPD describes the major provisions of the Plan as in effect on January 1, 2024, and provides information participants are legally entitled to know. Generally, the terms "you" and "your" as used in this SPD refer to a Tier 1 and Tier 2 employees of Participating Employers who meet 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 medical, dental and/or vision programs for TW Ventures Inc. employees. See the "Who's Eligible" section of this SPD to determine if you are eligible to participate in the Plan.

This Summary Plan Description

The information in this Summary Plan Description applies to eligible Tier 1 and Tier 2 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 and the Plan.

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. TW Ventures Inc. or any successor 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 the Company. In addition, the Benefits Officer may amend the Plan on behalf of TW Ventures Inc. for changes that do not result in a significant cost to any Participating Employer or have a material effect on benefits. Please note that the Plan does not create an employment contract between you and your Participating Employer, and does not give you any right, expressed or implied, of continued employment with your Participating Employer.

Overview

The Plan offers three coverage options – a Health Care FSA option, a Dependent Care FSA option and a Before-Tax Premium option. 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 by Entertainment Partners (for any project or show currently in production) or paid by Cast & Crew (for projects or shows that started production before January 1, 2024). 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, Shed Media, WAG Pictures, Inc. or TV Affiliates, you are a Tier 2 eligible employee. For a list of the Participating Employers, visit the benefits website at tpbenefits.com, www.tpbenefits.com/my-options/unscripted, www.wagbenefits.com, www.benefitsfortvhires.com or contact the TW Ventures Inc. Benefits Department at (818) 972-0094 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 "Who's Eligible" section of this SPD.

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) option Dependent Care FSA option Before-Tax Premium option
Tier 2	Before-Tax Premium option

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

Coverage option	How it works
Health Care FSA Option **(only available to Tier 1 employees; Tier 2 employees are not eligible)**	**You can elect the Health Care FSA option to help pay for eligible medical, dental and vision expenses.** 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, your spouse, your children and your other tax dependents incur for health expenses not covered under any other health program (e.g., deductibles, coinsurance, copayments, amounts over reasonable & customary, eyeglasses, hearing aids, non-cosmetic orthodontia).
Dependent Care FSA Option **(only available to Tier 1 employees; Tier 2 employees are not eligible)**	**You can elect the Dependent Care FSA option if you have qualified dependent care expenses for eligible children and other qualified dependents.** 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 or are looking for 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.
Before-Tax Premium Option	**You are automatically enrolled in the Before-Tax Premium option if you enroll in the TW Ventures Inc. Group Benefits Plan.** For both Tier 1 and Tier 2 employees, your contributions for medical, dental and/or vision coverage under the TW Ventures Inc. Group Benefits Plan are deducted from your pay, generally on a pre-tax basis. Your coverage under the Before-Tax Premium option extends only to your dependents who are eligible for coverage under the TW Ventures Inc. Group Benefits Plan and your tax dependents.

Health Care FSA Reimbursements Limited to Dependents. The Health Care FSA can only be used to reimburse health care expenses for you and your dependents. You may not use the Health Care FSA to reimburse health care expenses for

individuals who are not your dependents including, for example, certain individuals who provide more than one-half of their support.

Internal Revenue Service (IRS) Requirements. To be eligible for the tax benefits of the Plan, there are several requirements imposed by the IRS, including the "use it or lose it" rule where you forfeit amounts in your Health Care FSA, or Dependent Care FSA at the end of the Plan Year. The Dependent Care FSA is also subject to specific non-discrimination restrictions, which can limit the elections made by highly compensated employees.

Who's Eligible

Employees. 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 regularly scheduled to work 30 or more hours per week and you are paid by Entertainment Partners (for any project or show currently in production) or paid by Cast & Crew (for projects or shows that started production before January 1, 2024).

- **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, Shed Media, WAG Pictures Inc. or TV Affiliates, you are a non-union, active full-time employee, you are regularly scheduled to work 30 or more hours per week and you are paid by Entertainment Partners (for any project or show currently in production) or paid by Cast & Crew (for projects or shows that started production before January 1, 2024).

Dependents. Your dependents are not eligible to participate in the Plan. However, the Plan includes the following features that may allow you to use pre-tax contributions to pay for certain expenses incurred by or on behalf of your spouse or dependent children:

- **Before-Tax Premium option** – If your spouse or dependent children are covered by the TW Ventures Inc. Group Benefits Plan, the Before-Tax Premium option allows you to pay the cost of their coverage on a pre-tax basis. Under IRS rules, the Before-Tax Premium option does not allow you to pay the cost of coverage on a pre-tax basis for individuals who are not your tax dependents under current Federal income tax law.

- **Health Care FSA option** – If your spouse or dependent children incur eligible health care expenses, you may submit those expenses for reimbursement under the Health Care FSA option. Under IRS rules, the Health Care FSA may not reimburse health care expenses incurred by individuals who are not your tax dependents under current Federal income tax law.

- **Dependent Care FSA option** – If you and your spouse incur eligible dependent care expenses for one or more eligible dependents, you may submit those expenses for reimbursement under the Dependent Care FSA option. For purposes of the Dependent Care FSA option, IRS rules define an "eligible dependent" very specifically – for more information see the "Who Qualifies as a Dependent for Purposes of the Dependent Care FSA?" section of this SPD.

Enrollment

FSA options. If you are a Tier 1 employee, you should be aware that participation in the Health Care FSA option and the Dependent Care FSA option is not automatic. You must affirmatively enroll for the Health Care FSA and/or the Dependent Care FSA options when you first become eligible to participate and again each calendar year. You may enroll in the FSA options at the following times:

- **Initial enrollment period.** 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 option and/or the Dependent Care FSA option 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 annual enrollment period unless you have a qualified change in status.

- **Annual enrollment period.** 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 in the FSA options within 30 days of a qualified change in status, in which case your participation begins as soon as administratively possible following your enrollment (either the first day of the month following your qualified change in status or the first day of the following month, depending on when you enroll). Your enrollment following a qualified change in status stays in effect for the rest of the current Plan Year (note that certain changes in status may give you up to 60 days to change your enrollment, see the "Election Changes Due to a Qualified Change in Status" section of this SPD).

Before-tax premium option. If you are a Tier 1 or a Tier 2 employee paid by Entertainment Partners (for any project or show currently in production) or paid by Cast & Crew (for projects or shows that started production before January 1, 2024), you are automatically enrolled in the Before-Tax Premium option if you enroll in medical, dental and/or vision coverage under the TW Ventures Inc. Group Benefits Plan. You can change your enrollment in the Before-Tax Premium option following a qualified change in status (see the "Election Changes Due to a Qualified Change in Status" section of this SPD). Your enrollment elections under the Before-Tax Premium option are retroactive to your eligibility date. Also, your enrollment elections under the Before-Tax Premium option generally continue as long as you remain enrolled in Company-sponsored medical, dental and/or vision coverage (exceptions may apply if one or more of your dependents ceases to be your tax dependent under current Federal income tax law).

How to enroll. Go to tpbenefits.com or contact the TW Ventures Inc. Benefits Department at (818) 972-0094 if you do not have access to the internet.

Election Changes Due to a Qualified Change in Status

Your elections for the Before-Tax Premium option and the FSA options generally must stay in effect until the end of the current Plan Year. Once made, you can't change these elections during the Plan Year unless you have a qualified change in status. A qualified change in status includes the following events (note that certain events permit election changes to your Before-Tax Premium and Dependent Care FSA elections but not to your Health Care FSA elections):

- Eligibility for employer-sponsored health coverage is affected because your legal marital status changes (i.e., marriage, divorce, legal separation or annulment) or you enter into or dissolve a domestic partnership. *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- Eligibility for employer-sponsored health coverage is affected because the number of your dependents changes (such as when a child becomes your dependent through birth or adoption, a covered dependent's status as an eligible dependent changes because he or she reaches the limiting age or any similar circumstance, or a dependent dies). *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- Eligibility for employer-sponsored health coverage is affected because you or your dependents become employed or unemployed (and are not rehired within 30 days). *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- Eligibility for employer-sponsored health coverage is affected because you or your dependents take or return from an unpaid work-related leave of absence. *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- Eligibility for employer-sponsored health coverage is affected because you or your dependent's employment status changes from full-time to part-time (or vice versa). *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- Eligibility for employer-sponsored health coverage is affected because you or your dependent go on strike, get locked out, or return from a strike or lockout. *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- Eligibility for employer-sponsored health coverage is affected because you or your dependent changes residences or worksites. *Election changes due to this event must satisfy the consistency rule. See "Consistency Rule" below for more information.*

- You previously waived participation in Company-sponsored group health coverage 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 lost that 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.

- You or your dependent either becomes eligible for, or loses eligibility for, Medicare or Medicaid coverage (to the extent permitted by law).

- You or your dependent loses coverage under Medicaid or a state Children's Health Insurance Program (CHIP) because you 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 your dependent is determined to be eligible for assistance with the cost of Company-sponsored group health 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 an allowable mid-year election change under a cafeteria plan or qualified benefits plan offered by you or your dependent's employer. This event permits changes to your Before-Tax Premium and Dependent Care FSA elections but not to your Health Care FSA elections. For the Dependent Care FSA, this includes an election to make or increase contributions if your spouse's employer stops your spouse's dependent care account contributions under your spouse's plan to avoid a tax code nondiscrimination testing failure.

- There is a significant change in the employer-sponsored health coverage you have or your dependent has (as determined in accordance with Internal Revenue Service guidelines). This event permits changes to your Before-Tax Premium and Dependent Care FSA elections but not to your Health Care FSA elections.

- There is a significant change in cost or coverage affecting your dependent's day care coverage. For example, you may find a new child care provider or you may need to adjust the hours of care provided by and/or the compensation paid to your child care provider. These events permit changes to your Dependent Care FSA elections but not to your Before-Tax Premium and Health Care FSA elections. Note, however, that changes to your Dependent Care FSA are not permitted if the cost changes are imposed by a dependent care provider who is your relative.

- Your dependent's employer-sponsored group health plan has a different annual enrollment period (and a different plan year), and you would like to make a change in your Company-sponsored medical, dental or vision coverage to correspond with an election change under your dependent's plan. This event permits changes to your Before-Tax Premium and Dependent Care FSA elections but not to your Health Care FSA elections.

- 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.

- Your ability to change elections during a Plan Year for the Before-Tax Premium and FSA options is restricted under Internal Revenue Code rules because contributions for this coverage are made on a pre-tax basis. These restrictions do not apply if you are enrolled in Company-sponsored medical, dental and/or vision coverage on an after-tax basis (for example, because you missed the 30-day initial enrollment period and enrolled in those coverages prospectively).

- Other events approved by the Plan Administrator, as long as such events are permitted under Internal Revenue Service guidance.

Consistency rule. Election changes for certain qualified change in status events are subject to an Internal Revenue Code consistency rule. For these events, the consistency rule says that any change in your elections must be on account of and consistent with a qualified change in status that affects eligibility for coverage under an employer plan. A change in status affects eligibility if the change results in an increase or decrease in the number of your family members. All election changes due to a qualified change in status are subject to Internal Revenue Code requirements and the Plan Administrator has discretion to determine whether your requested election change satisfies those requirements.

Limitations on election changes. If you have a qualified change in status, the Plan does not permit you to terminate or

decrease your Health Care FSA or Dependent Care FSA election to less than the amount you have contributed or the amount you have been reimbursed as of the date the termination or decrease becomes effective. Also, reimbursement of claims for expenses incurred before your qualified change in status will be limited to the amount of your prior election.

Election changes based on special enrollment rights. If you or your 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 dependent previously waived participation in Company-sponsored group health coverage due to coverage under another group health plan and 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 dependent loses coverage under Medicaid or a state CHIP because of loss of eligibility for coverage, or (iv) you or your dependent is determined to be eligible for assistance with the cost of Company-sponsored group health plan coverage under Medicaid or a state CHIP, you may enroll in any of the medical coverage options that are available to similarly situated new employees and change your Before-Tax Premium elections. If the qualified change in status occurred because you or your 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.

Transfers. 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. If you transfer from a nonparticipating employer to a Participating Employer, you are treated as a new hire and you may enroll in the Plan in accordance with the Plan's enrollment rules. See the "Initial enrollment period" discussion in the "Enrollment" section of this SPD.

How to make mid-year election changes. To make mid-year election changes based on a qualified change in status, go to tpbenefits.com or contact the TW Ventures Inc. Benefits Department at (818) 972-0094 if you do not have access to the internet.

When Participation Begins

Initial Enrollment and Annual Enrollment. If you enroll within 30 days of your eligibility date, your participation in the FSA options and the Before-Tax Premium option is retroactive to your eligibility date. Your eligibility date is the date you first satisfy the eligibility criteria described in the "Who's Eligible" section of this SPD (for example, your date of hire). If you don't enroll within 30 days of your eligibility date but you decide to enroll during the annual enrollment period, coverage starts on the following January 1.

Qualified Change in Status New Enrollment. If you're enrolling during a Plan Year as a result of a qualified change in status, coverage generally begins as soon as administratively possible following your enrollment (either the first day of the month following the qualified change in status or the first day of the following month, depending on when you enroll) as long as you enroll within 30 days of the qualified change in status event (your qualified change in status election period). However, if the 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 the birth or adoption.

Qualified Change in Status Increases and Decreases. If you're increasing or decreasing Health Care FSA or Dependent Care FSA elections during a Plan Year as a result of a qualified change in status, the increase or decrease is effective as soon as administratively possible (either the first day of the month following the qualified change in status or the first day of the following month, depending on when you submit your status change) as long as you submit your status change within 30 days of the qualified change in status event. However, if the qualified change in status involves a newborn or newly adopted child, the increase or decrease is effective on the date of birth or adoption as long as you submit your status change within 30 days of the date of the birth or adoption.

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 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) 972-0094 for more information about your options during a qualified military leave. **Eligibility for the Dependent 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 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 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 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 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 Care FSA options ends as of December 31st each year. If you wish to continue using the FSA options, you must actively enroll for the following Plan Year.

For both Tier 1 and Tier 2 employees, your participation in the Plan also ends on the last day of the month in which the earliest of the following events takes place unless your coverage is continued as described in the "COBRA Continuation Coverage" section of this SPD (note that COBRA continuation coverage applies only to the Health Care FSA option):

- Your employment terminates;
- You elect to terminate Health Care FSA or Dependent Care FSA coverage under the qualified change in status rules (the termination will be effective on the last day of the month in which the qualified change in status event occurs);
- You are no longer an eligible employee of a Participating Employer;
- You stop making required contributions;
- You are no longer eligible for an approved paid or unpaid leave of absence (including illness leave and/or leave that qualifies for the Family Medical Leave Act (FMLA) and you have not returned to work; or
- Your Participating Employer stops offering the Plan.

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

What Happens When You Are Rehired

If your employment terminated while you were a Plan participant and you are rehired by your Participating Employer or by another Participating Employer, your participation in the Plan will be governed by the following rules:

- If your rehire date is less than 60 calendar days from the last day of the month in which your employment terminated, you can re-enroll in the Plan without satisfying a new 30-day waiting period. Your Plan participation will be re-instated on the first day of the month following the date you begin work after being rehired if you re-enroll within 30 days after that date. Note that you will need to make new elections when you re-enroll – your prior elections will not be reinstated. If you do not re-enroll within the 30-day re-enrollment period, you will not be able to re-enroll until the next annual enrollment period (unless you experience a qualified change in status before the next annual enrollment period).

- If your rehire date is 60 or more calendar days from the last day of the month in which your employment terminated, you are treated as a new hire. You may re-enroll in the Plan, but you must satisfy the Plan's initial enrollment rules again, including the 30-day waiting period. See the "Initial enrollment period" discussion in the "Enrollment" section of this SPD.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Health Care FSA coverage under the Plan for you may continue past the date it would normally end. Under this law, you generally can extend participation in the Health Care FSA option on an after-tax basis until the end of the Plan Year in which your coverage would otherwise end if: (1) your contributions to the Health Care FSA have exceeded your reimbursements from that account; and (2) your loss of coverage occurs because your employment terminates for reasons other than gross misconduct.

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 Health Care FSA. This notice generally explains COBRA continuation coverage, when it may become available to you, and what you need to do to protect the right to receive it. COBRA continuation coverage is not available for the Dependent Care FSA.

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." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Under the Plan, if you elect COBRA continuation coverage, you must pay for COBRA continuation coverage.

Who is a qualified beneficiary and what are qualifying events? You will become a qualified beneficiary if you lose your coverage under the Health Care FSA because your employment ends for any reason other than gross misconduct or if your employment classification changes from a regular employee to a temporary employee.

When is COBRA coverage available? COBRA continuation coverage will be offered to you after the COBRA Administrator has been notified that a qualifying event has occurred.

Who notifies the COBRA Administrator? When the qualifying event is the end of employment, death of the employee, or reclassification from regular employee status to temporary employee status, your Participating Employer will notify the COBRA Administrator of the qualifying event.

How is COBRA coverage provided? Once the COBRA Administrator receives notice of a qualifying event and you make a COBRA election, your COBRA continuation coverage under the Health Care FSA lasts until the end of the Plan Year in which the qualifying event occurred. 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 the "When Participation Ends" section of this SPD), you must elect and pay for COBRA continuation coverage. If you choose to continue participation through COBRA, you must pay 102% of the amount you elected to contribute on an after-tax basis.

If you have questions about COBRA continuation coverage. Questions concerning your Health Care FSA and your COBRA continuation coverage rights should be addressed to the COBRA Administrator identified below. 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. To protect your rights, you should keep the Plan Administrator informed of any changes in your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or the COBRA Administrator.

Plan contact for additional COBRA information. You can obtain further information about COBRA continuation coverage from the COBRA Administrator.

COBRA Administrator. The COBRA Administrator is:

Inspira Financial
Benefits Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

Electing COBRA Continuation Coverage

When a qualifying event occurs, you must request continued coverage for your Health Care FSA. The COBRA Administrator will give all of the details about continued coverage, including the cost, and will provide you with instructions on how to enroll. To continue coverage, the enrollment must be completed within 60 days after the later of the following dates:

- The date you were provided the enrollment information, or
- The date Plan coverage ends.

If you elect to continue coverage for your Health Care FSA, you must pay 102% of the total cost of the coverage elected.

Paying for COBRA Continuation Coverage

If you elect to continue coverage for your Health Care FSA, you must make required payments for the cost of coverage as described in this COBRA election notice. 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.

Early Termination of COBRA Continuation Coverage

COBRA continuation coverage will stop before the end of the Plan Year under any of the following circumstances:

- Your required contributions are not made on a timely basis.
- The Plan and any other group health plans provided by the Company terminate.

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

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, you will be notified in writing.

General Information About Your Plan Contributions

Your Contributions Are Made by Payroll Deductions

By enrolling in the Health Care FSA option, the Dependent Care FSA option or the Before Tax Premium option, you are authorizing your Participating Employer to withhold your contributions from each of your paychecks. Your Health Care FSA and/or your Dependent Care FSA contributions will be deducted in equal installments from your pay. The amount of each deduction is based on the number of pay periods in the Plan year, which is determined by your payroll department. Each Plan account requires 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 from $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 adjustments). 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 by March 31st of the following year. After that date, you lose the unspent or unclaimed balance.

Dependent Care FSA Annual Contributions

You can contribute from $100 to $5,000 a year on a pre-tax basis to your Dependent 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 by 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, current federal income tax law imposes an annual test that may limit the amount that highly compensated employees may contribute to the Dependent Care FSA. If this test is not passed, the Company 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.

Before-Tax Premium Contributions

If you are being paid by Entertainment Partners (for any project or show currently in production) or by Cast & Crew (for projects or shows that started production before January 1, 2024) then 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 are automatically enrolled in the Before-Tax Premium option. The amount of your contributions for medical, dental and vision coverage under the TW Ventures Inc. Group Benefits Plan is announced during open enrollment each year. As required under current federal income tax law, your contributions toward the cost of coverage for any person who is not your dependent are withheld from your pay on an after-tax basis.

The amount you contribute in the form of Before-Tax Premiums is separate from any Health Care FSA or Dependent Care FSA you may make. You may not change your Before-Tax Premium contribution amount during the Plan Year unless you have a qualified change in status.

The Tax Advantages of Pre-Tax Contributions

For federal income and Social Security tax purposes, your taxable income is reduced by the amount of your pre-tax contributions under the Plan. 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.

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.

Other Issues to Consider

Here's an overview of other issues to consider when making pre-tax contributions to your FSAs:

- **Annual election only.** Under IRS rules, you must decide how much to contribute to the Health Care FSA and Dependent Care FSA for the Plan Year before each year begins during annual enrollment (or, for new hires and employees who transfer from a non-participating division to a Participating Employer, before your participation begins). You should be careful in projecting your expenses. You may make changes to your HSA contribution election at any time.

- **"Use it or lose it."** Plan your FSA 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 Care FSA by December 31st 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 Care FSA contributions to file claims. For example, if you elect to contribute $1,000 to your Health Care FSA for 2024, you have until December 31, 2024 to incur claims for $1,000 of expenses and you must submit all claims for expenses by March 31, 2025. If you have an unspent or unclaimed balance after March 31, 2025, it will be forfeited. 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.

- **Tax issues – Health Care FSAs.** 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.

- **Tax Issues – Dependent Care FSAs.** You can use both your Dependent Care FSA and the allowable federal income tax Dependent Care tax credit, but you can't claim the same expenses for both. Current federal income tax law requires you to reduce the dependent care expenses taken into account for purposes of the federal tax credit dollar for dollar by what you contribute to your Dependent Care FSA. Married couples can claim the federal tax credit only if they file a joint federal income tax return. It may be in your financial interest to take the federal income tax credit rather than participating in the Dependent Care FSA. Ask your tax advisor to help you choose the right alternative for your situation.

Keeping Track of Your FSA Accounts

In addition to seeing your deductions recorded on your paychecks, you can keep track of your Health Care FSA and Dependent Day FSA balances by logging on to www.inspirafinancial.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 Inspira 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.inspirafinancial.com. With the Inspira Mobile® app, you can:

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

The Health Care FSA Option

If you are a Tier 1 employee and you are enrolled in medical, dental and/or vision 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. Certain over-the-counter drugs that treat an illness or a medical condition (e.g., pain relievers, cold medications, allergy medications, antacids and prenatal vitamins) are eligible for reimbursement through the Health Care FSA. In addition, menstrual care products are eligible for reimbursement through the Health Care FSA. Vitamins, dietary aids, natural foods and other items for your general well-being will not be reimbursed, but certain vitamins and dietary aids needed to treat an illness or medical condition may be eligible for reimbursement if you submit a prescription from your doctor and evidence, such as a letter of medical necessity from your doctor, that the prescribed vitamins or dietary aids are related to a medical condition.

You can obtain additional information on eligible expenses, including eligible over-the-counter expenses, by visiting:

- https://inspirafinancial.com/individual/health-benefits/health-care-fsa
- IRS Publication 502, "Medical and Dental Expenses," which is available on the IRS website or by calling their toll-free number (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 following worksheet is designed to help you estimate which of your expenses can be reimbursed from your 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/partner's benefit booklets on medical, dental, vision and other health care coverage

- IRS Publication 502

Remember: You should 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.

Type of Health Care Expense	Amount of Unreimbursed Health Care Expenses	
	This Year's Unreimbursed Health Care Expenses (Use this column to get an idea of your spending habits)	**Next Year's Projected Unreimbursed Health Care Expenses** (Use this column to determine your contribution)
Total Deductibles (e.g., medical, dental and/or vision)*		
Medical Coinsurance and Copayments*		
Dental Coinsurance and Copayments*		
Eyeglasses/contact lenses/eye examination costs not covered by a vision plan or medical Plan		
Medical equipment		
Prescription drug coinsurance/ over-the-counter medications		
Other		
TOTALS		

* You should consider design changes made to your Company-sponsored group health coverage and any coverage you have through your spouse or 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 Care FSA Option

If you are a Tier 1 employee, you can use the Dependent Care FSA to reimburse yourself pre-tax for certain dependent care expenses incurred because you and your spouse, if applicable, work or are looking for work. If your spouse has no earned income for the calendar year, you can only use the Dependent Care FSA 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 for Purposes of the Dependent Care FSA?

You can use your Dependent Care FSA to cover the day care expenses of dependents, who are defined as any of the following (subject to current federal income 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 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 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 income 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 Care FSA.

Eligible Dependent Care Expenses

The Dependent 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 working, looking for work or attending school. The Dependent 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 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 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://inspirafinancial.com/individual/resources-education/faqs/health-benefits/dependent-care-fsas
- 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 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 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 Care FSA Worksheet

The following worksheet is designed to help you determine which of your expenses can be paid from the Dependent Care FSA and how much of your salary you may wish to contribute to your account. You may want to refer to your tax return and receipts from dependent care paid by you and your spouse last year.

Remember: You should plan carefully when you estimate your eligible expenses because any money you contribute to your Dependent 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.

Type of Dependent Care Service	Amount of Dependent Care Costs	
	This Year's Dependent Care Costs (Use this column to get an idea of your spending habits)	**Next Year's Projected Dependent Care 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		
TOTALS		

Before-Tax Premium Option

If you are a Tier 1 or Tier 2 employee, you can use the Before-Tax Premium option to pay your share of the cost of medical, dental and/or vision coverage under the TW Ventures Inc. Group Benefits Plan on a pre-tax basis. If you are being paid by Entertainment Partners (for any project or show currently in production) or by Cast & Crew (for projects or shows that started production before January 1, 2024), then by electing medical, dental and/or vision coverage under the TW Ventures Inc. Group Benefits Plan you are automatically enrolled in the Before-Tax Premium option. The amount of your payroll contributions for medical, dental and vision coverage each year is announced during open enrollment. 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.

Under current federal income tax law, the cost of coverage under the TW Ventures Inc. Group Benefits Plan for persons who are not your tax dependents cannot be contributed on a pre-tax basis. Therefore, if you elect medical, dental or vision coverage for individuals who are not your tax dependents, the portion of your contributions attributable to their coverage will be withheld from your pay on an after-tax basis. In addition, the amount of your Participating Employer's contribution for medical, dental and vision coverage for individuals who are not your dependents will be treated as "imputed income" to you. 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 Procedures for FSAs

How to Submit FSA Claims for Reimbursement

If you are a Tier 1 employee, you have three ways to submit FSA claims:

- **Use the Inspira Debit Card**. If you enroll in the Health Care FSA, you will be issued a debit card that can be used to pay for eligible health care expenses. For more information see "How to Use the Inspira Debit Card for Health Care Expenses." **Note that the Inspira Debit Card is not available for the Dependent Care FSA.**

- **Use the Inspira Mobile® app**. You can use the Inspira Mobile® app to submit Health Care FSA and Dependent Care FSA claims. For more information see "How to Submit FSA Claims Using the Inspira Mobile® app."

- **Submit your claim by mail or fax**. If you'd prefer not to use the Inspira Mobile® app, you can always submit your Health Care FSA and Dependent Care FSA claims by mail or fax. For more information see "How to Submit FSA Claims by Mail or Fax."

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 or your Dependent Care FSA.

For complete information on the Plan's claim and appeal procedures, see the "Claims and Appeals Procedures" section of this SPD.

How to Use the Inspira Debit Card for Health Care FSA Expenses

When you enroll in the Health Care FSA, you will be issued an Inspira Financial debit card that can be used to pay for eligible products and services. When you receive the Inspira Financial 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://inspirafinancial.com/individual/health-benefits/health-care-fsa for a list of eligible expenses.

If you don't use your debit card to pay for a health care expense, you can submit a claim to Inspira Financial online by using the Inspira Mobile® app. Alternatively, you can submit a claim by mail or fax.

Please note: Debit cards are not issued for the Dependent Care FSA. To obtain reimbursement from your Dependent Care FSA, you must use the Inspira Mobile® app or submit your claim by mail or fax.

How to Submit FSA Claims Using the Inspira Mobile® app

You can submit Health Care FSA and Dependent Care FSA claims by using the Inspira Mobile® app. You can download the app from your mobile device's app store. There's no fee to download the app and there are no fees when you use the app. After you download the app, you must set up login credentials at www.inspirafinancial.com – you'll use the same username and password for the Inspira Mobile® app. Once you log in to the app, select **Manage** to get started. To send documents with your claim, simply take a picture and upload it through the app.

How to Submit FSA Claims by Mail or Fax

FSA Claim forms are available online by visiting tpbenefits.com or you may contact the TW Ventures Inc. Benefits Department at (818) 972-0094. The forms have instructions for submitting claims by mail or fax. 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 submitting 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 provider's service(s) 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.

When submitting Dependent 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 FSA Claims Administrator will determine the qualification of the expense.

When to File FSA Claims

You can submit an FSA claim at any time on or before the March 31st deadline. Only expenses incurred during the Plan Year (January 1 through December 31) are reimbursable through your FSA 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 FSA Claims Administrator by March 31st of the year following the year in which you make your Health Care FSA and Dependent Care FSA contributions to be eligible for reimbursement.

When Your FSA Claims Are Reimbursed

Amount Available for Reimbursement. 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. Your eligible Dependent Care FSA claims 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 FSA Claims Administrator.

Claims Processing Schedules. FSA claims submitted through the Inspira Mobile® app are processed as soon as possible. FSA claims submitted through claim forms are processed no less frequently than weekly.

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 FSA Claims Administrator (by March 31st of the following year) are processed, the remaining balance will be forfeited, 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 and Dependent 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 FSA Claims Administrator within one year of the original date of issue to request that the check be re-issued.

Claims and Appeals Procedure

Overview

To receive the benefits for which you may be eligible under the Plan described in this Summary Plan Description, you may first be required to file a claim. Claims are evaluated by two different Claims Administrators, as follows:

- The FSA Claims Administrator has discretion to evaluate claims directly related to determining whether you have incurred a covered expense for which benefits are payable under the Health Care FSA or the Dependent Care FSA and determining the amount of, and administering the payment of, any such FSA benefits based on the information contained in the written claim, and
- The Warner Bros. Discovery Benefit Plans Administrative Committee (the "Administrative Committee") has discretion to evaluate all other claims. These other claims include: claims relating to your eligibility to participate in the Plan; claims relating to your eligibility for and the amount of your Before-Tax Premium contributions; and claims relating to your eligibility to make an election change based on a qualified changes in status.

Routine requests for information regarding your benefits under the Plan will not be considered benefit "claims" subject to the

Plan's claims procedure and appeals process. 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

All claims should be directed to the applicable administrator (either the FSA Claims Administrator or the Administrative Committee), 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 Benefits Department at (818) 972-0094.

How to File a Claim

Within 30 days (90 days for Dependent Care FSA claims) after you have filed a written claim with the applicable administrator, the administrator will notify you of its decision. If the FSA Claims Administrator (or the Administrative Committee, 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 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 Care FSA claims). If your claim is denied, the FSA Claims Administrator or Administrative Committee (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 appeal 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.

How to Appeal a Denied Claim

As part of the appeal 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 Care claims) after the claim is denied. Both the request and the appeal must be in writing.

In most cases, the FSA Claims Administrator or the Administrative Committee (as applicable) will review and decide on the appeal within 60 days after you file your request. For Dependent Care FSA claims only, if the FSA Claims Administrator or the Administrative Committee (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 FSA 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.

You Must Follow the Plan's Claims and Appeals Procedure Before Filing a Lawsuit

You must use and complete the Plan's administrative claims and appeals procedure before bringing an action at law or in equity to recover benefits. If the applicable Claims Administrator (either the FSA Claims Administrator or the Administrative Committee) denies your appeal on final review you may bring a suit for benefits.

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 applicable Claims Administrator in connection with the Plan's claims and appeals procedure, as described above. **No legal actions may be brought on a claim more than 90 days after the applicable Claims Administrator issues its final decision on the claim.**

IMPORTANT: You must pursue all of your claim and appeal rights under the Plan before seeking legal recourse in a court of law.

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 the "Your Rights Under ERISA" section of this SPD).
- Do not furnish information required to complete or verify a claim.
- Do not have a current address on file with your Employing Company or the FSA 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 Plan Administrator or FSA Claims 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 "COBRA Continuation Coverage" section of this SPD. 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 Benefits Department at (818) 972-0094 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") 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 a group health plan.

To get a free copy of the procedures the Plan follows in the event a QMCSO is issued, contact the TW Ventures Benefits Department at (818) 972-0094.

Claim Fraud

The FSA 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 FSA 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 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.

Collective Bargaining Agreements

The Plan may also be referred to in any collective bargaining agreements entered into by, or applicable to, your Participating Employer. Please refer to your collective bargaining agreement to confirm if this 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 determine eligibility-related issues (including eligibility for Plan coverage, eligibility for Before-Tax Premium contributions and eligibility for election changes due to a qualified change in status) and to make factual determinations, resolve factual disputes, and decide all matters in connection with the interpretation, administration and operation of the Plan in order to determine those eligibility-related issues.

The FSA Claims Administrator has exclusive authority and sole and absolute discretion to interpret the Plan, to make factual determinations, 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 an FSA reimbursement may be payable under the Plan and to determine the amount of, and administer the payment of, any such FSA reimbursements under the Plan.

Benefits will be paid under the Plan only if the Plan Administrator or FSA Claims Administrator, as appropriate, determines in its discretion that the claimant is entitled to them. Decisions of the Plan Administrator and the FSA 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

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 the Company. TW Ventures Inc. has delegated authority to execute amendments to the Plan to the Benefits Officer.

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 TW Ventures Benefits Department at (818) 972-0094.

Nondiscrimination

In addition to the limits described above in Dependent Care FSA Annual Contributions, 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. Flexible Spending Account Plan
Type of Plan:	Welfare benefits and cafeteria plan
Plan Sponsor:	TW Ventures Inc. 4000 Warner Blvd. Building 700, 7th Floor Burbank, CA 91522 (818) 972-0094
Employer Identification Number:	13-3719008
Plan Number:	502
Plan Administrator and Named Fiduciary:	Warner Bros. Discovery Benefit Plans Administrative Committee c/o Warner Bros. Discovery, Inc. 230 Park Avenue South, 7th Floor New York, NY 10003
FSA Claims Administrator:	Inspira Financial P.O. Box 4000 Richmond, KY 40476-4000 (888) 678-8242 www.inspirafinancial.com
Agent for Service of Legal Process:	Warner Bros. Discovery, Inc. c/o CT Corporation System 28 Liberty Street New York, NY 10005 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. 4000 Warner Blvd. Building 700, 7th Floor Burbank, CA 91522 (818) 972-0094

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 if there is a loss of coverage under the Plan as a result of a qualifying event. You 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.

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. 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 the review process, you have a right to file suit in federal or state court. After exhaustion of the Plan's claims and appeals procedures, 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 FSA Claims Administrator's or the Plan Administrator's final decision is rendered on the claim.

- If the 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 materials and pay you up to $110 for each day's delay. The 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 a 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 the FSA 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 in the "Claims and

Appeals Procedure" section of this SPD, within the deadlines, before you can take any legal action.

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 Executive Vice President and General Counsel, Warner Bros. Discovery, 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) 972-0094 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.

Key Terms and Definitions

Benefits Officer acts on behalf of Warner Bros. Discovery, Inc. and has certain responsibilities including the authority to execute Plan amendments. The Benefits Officer performs only non-fiduciary functions and may delegate certain functions at his/her discretion.

Company means TW Ventures Inc. or any successor.

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

Dependent means the following:

- With respect to the Health Care FSA option, the term "dependent" means the following individuals (subject to current Federal income tax law requirements):
  - Your spouse;
  - Your natural and adopted child(ren), stepchild(ren), or foster child(ren) through the last day of the month in which the child reaches age 26;
  - Your grandchild (or other descendent of your child) or your sibling (or descendent of your sibling) who is under age 19 (age 24 if a student), who is not married, 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 the individual's 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 partner or spouse who lives with you.
- With respect to the Before-Tax Premium option, the term "dependent" means the individuals identified as dependents under the TW Ventures Inc. Group Benefits Plan who are also your tax dependents under current Federal income tax law. Note that coverage for dependents under the TW Ventures Inc. Group Benefits Plan is subject to the separate dependent eligibility requirements of that plan (including dependent verification requirements).
- With respect to the Dependent Care FSA option, the term "dependent" is defined in the "Who Qualifies as a Dependent for Purposes of the Dependent Care FSA?" section of this SPD.

Employee for purposes of the TW Ventures Inc. Flexible Spending Account Plan means a regular, non-union, full-time worker, individually paid by Entertainment Partners or Cast & Crew 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.

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.

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

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.

Participant is an employee who satisfies the Plan's eligibility requirements and is enrolled 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 means the TW Ventures Inc. Flexible Spending Account Plan, as described in this Summary Plan Description.

Plan Administrator for the Plan is the Warner Bros. Discovery Benefit Plans Administrative Committee.

Plan Year means the calendar year.

Qualified change in status means any of the qualified change in status events described in the "Election Changes Due to a Qualified Change in Status" section of this SPD.

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).

Warner Bros. Discovery Benefit Plans Administrative Committee or Administrative Committee handles eligibility-related claims and appeals and is the Plan Administrator for the Plan. You can write to the Administrative Committee at the following address:

Warner Bros. Discovery Benefit Plans Administrative Committee
c/o Warner Bros. Discovery, Inc.
230 Park Avenue South, 7th Floor
New York, NY 10003