# TW Ventures Inc.

# Group Benefits Plan

## SUMMARY PLAN DESCRIPTION

Effective June 1, 2014

# Contents

# Introduction

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, "EOCs"), is intended to serve as the Summary Plan Description ("SPD"), as required by the Employee Retirement Income Security Act of 1974 ("ERISA"). The SPD describes the following benefits provided by TW Ventures Inc. Group Benefits Plan and the TW Ventures Inc. Cafeteria Plan (the "Plan") for eligible employees and their eligible dependents:

- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

TW Ventures Inc. also offers its employees of its Participating Employers the TW Ventures Inc. Cafeteria Plan intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) to provide employees Health Care and Dependent Care Flexible Spending Accounts and the opportunity to make pre-tax contributions toward certain benefits.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as Health Care Reform).

**All benefits are provided under insurance, HMO contracts or contracts with service providers. All benefits are summarized in this document and in the EOCs as defined below.**

This summary should be read in connection with the EOCs (see Appendix A for a list of EOCs). The EOCs are provided by the insurance companies, HMOs and service providers. If there is ever a conflict or a difference between what is written in this summary and the EOCs with respect to **the specific benefits provided**, the EOCs shall govern unless otherwise provided by any federal and state law. If there is a conflict between the EOCs and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will rule.

The applicable EOCs describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. A directory of participating network providers will be provided, automatically, at no cost to you. You may also access provider directories on the insurance companies' and HMOs' websites or

you can call the insurance companies or HMOs at the phone numbers indicated in the EOCs. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator.

TW Ventures Inc. reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, TW Ventures Inc. nor a Participating Employer has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by a Participating Employer or to interfere with Participating Employer's right to discharge any employee at any time.

## Keep Your Plan Informed of Address Changes

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

# Administrative Information

Below is key information you need to know about your benefit plans:

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| **Plan Name** | TW Ventures Inc. Group Benefits Plan |
| **Plan Number** | 501 |
| **Plan Sponsor** | TW Ventures Inc.<br>3500 West Olive Avenue, Suite 1000<br>Burbank, CA 91505<br>(818) 972-0787 |
| **Employer Identification Number** | 13-3719008 |
| **Plan Administrator** | The Committee that acts as the plan administrator of the Time Warner Group Health Plan<br>3500 West Olive Avenue, Suite 1000<br>Burbank, CA 91505<br>(818) 972-0787 |
| **Agent for Service of Legal Process** | General Counsel<br>TW Ventures Inc.<br>3500 West Olive Avenue, Suite 1000<br>Burbank, CA 91505<br>(818) 972-0787 |
| **Plan Year** | August 1 through July 31 |
| **Plan Type** | Welfare benefit plan providing the following types of benefits:<br>▪ Medical<br>▪ Dental<br>▪ Vision<br>▪ Basic Life Insurance<br>▪ Accidental Death and Dismemberment (AD&D)<br>▪ Health Care Flexible Spending Account<br><br>Although the Dependent Care Flexible Spending Account is described in this SPD, it is **not** an ERISA plan. |

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| **Source of Contributions** | Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from TW Ventures Inc., contributions by the employee, or will be shared by TW Ventures Inc. and the employee. The cost of Medical and Dental coverage is shared by TW Ventures Inc. and its employees enrolled in those coverages. TW Ventures Inc. pays 100% of the cost of the Vision, Basic Life and AD&D coverages. Employees pay 100% of the contributions to the Health Care and Dependent Care Flexible Spending Accounts. Where TW Ventures Inc. and employees share the cost of coverage, TW Ventures Inc. shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan.<br><br>The Plan Administrator will notify employees annually as to what the employee contribution rates will be. TW Ventures Inc., in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse TW Ventures Inc. for their contributions, unless otherwise provided in that group insurance contract or required by applicable law. |

## Claim Administrators

TW Ventures Inc. is providing Medical, Dental, Vision, Life and AD&D benefits under the Plan through contracts with the insurers listed below. The benefits of the Plan are guaranteed under contracts of insurance with the insurers listed below. The insurers administer claims for these benefits and are solely responsible for providing the benefits. TW Ventures Inc. is providing Flexible Spending Account benefits under the Plan through administrative service agreements with the Plan Administrators listed below. Aetna has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment under the Health Care Flexible Spending Account. These benefits are paid from the general assets of the Company and are not guaranteed under contracts of insurance.

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|---|---|
| **Medical HMO** | AETNA<br>PO Box 14089<br>Lexington, KY 40512-4089<br>(877) 402-8742<br>www.aetna.com |
| **Medical PPO** | AETNA<br>PO Box 14089<br>Lexington, KY 40512-4089<br>(877) 204-9186<br>www.aetna.com |
| **Dental DMO** | AETNA<br>PO Box 14089<br>Lexington, KY 40512-4089<br>(877) 238-6200<br>www.aetna.com |
| **Dental PPO** | AETNA<br>PO Box 14089<br>Lexington, KY 40512-4089<br>(877) 238-6200<br>www.aetna.com |
| **Vision** | VSP<br>Attn: Out-of-Network Claims<br>PO Box 997105<br>Sacramento, CA 95899-7105<br>(800) 877-7195<br>www.vsp.com |
| **Basic Life and Accidental Death and Dismemberment (AD&D)** | AETNA<br>PO Box 14089<br>Lexington, KY 40512-4089<br>(877) 402-8742<br>www.aetna.com |
| **Health Care and Dependent Care Flexible Spending Accounts** | AETNA<br>PO Box 4000<br>Richmond, KY 40476-4000<br>(877) 238-6200<br>www.aetnafsa.com |

## Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

## Plan Amendment and Termination

The Board of Directors (or its authorized officer) of TW Ventures Inc. reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, TW Ventures Inc. reserves the right to amend or terminate benefits, covered expenses, benefit copayments, and lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. TW Ventures Inc. also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by TW Ventures Inc. will be done in accordance with TW Ventures Inc.' normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of TW Ventures Inc., the Plan shall terminate unless the Plan is continued by a successor to TW Ventures Inc..

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to TW Ventures Inc. to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

# Eligibility

## Eligible Employees

Your eligibility to participate in the Plan depends on your employment classification with a "Participating Employer" as defined below.

**Participating Employers** include the following:

- River Tower Productions, Inc.
- TTT West Coast, Inc.
- AND Syndicated Productions, Inc.
- TP Promotion Inc., doing business as Telepictures Creative Services
- DAWN Syndicated Productions, Inc.
- WAD Productions, Inc.
- Cedarhurst Enterprises, Inc.
- ANE Production, Inc.
- AFN Productions, Inc.
- Horizon Alternative Television, Inc., doing business as Warner Horizon Alternate Television
- Horizon Scripted Television, Inc., doing business as Warner Horizon Scripted Television
- EHM Productions Inc.
- GNH Productions Inc.
- ARB Productions Inc.
- FUDD INK
- AOP Inc.
- DAFT Productions Inc.
- SNU Inc.
- Clear Sky Enterprises Inc.
- ALD Productions Inc.
- TMZ Productions, Inc.
- NZK Productions Inc.
- Adrian Court Productions Inc.
- Eldrick Productions Inc.
- Delta Blues Productions LLC

If you previously participated in the Plan and were hired prior to October 1, 2001 [1]:

- **Full-time employees** – active full-time employees regularly scheduled to work 30 or more hours per week are eligible on the first day of the month following 30 days of continuous employment; or
- **Part-time employees** – active part-time employees regularly scheduled to work 20 or more hours per week (but less than 30 hours) are eligible on the first day of the month following 90 days of continuous employment.

Employees hired on or after October 1, 2001 [1,2,3,4,5]

- **Full-time employees** – active full-time employees who are (i) employed pursuant to a written employment agreement, the total Term of which, including both Initial and Optional periods, is at least three (3) years, and are (ii) scheduled to work 30 hours or more per week during production seasons, are eligible the first day of the month following 30 calendar days of continuous employment with a Participating Employer.
- **Part-time employees** – active part-time employees who are (i) employed pursuant to a written employment agreement, the total Term of which, including both Initial and Optional periods, is at least 3 years and are (ii) scheduled to work 20 hours or more per week during production seasons are eligible the first day of the month following 90 calendar days of continuous employment with a Participating Employer.

Any employee described above who is hired by a Participating Employer within 60 calendar days of the last day of the month in which his/her employment terminated with another Participating Employer or a related entity in the Time Warner Group of Companies must re-satisfy eligibility requirements with exception of the 30-day waiting period, in which employees will be eligible for benefits under this Plan on the first day of the month following the individual's effective rehire or transfer date.

[1] A break in service for employees due to production hiatus will not impact eligibility criteria under this paragraph.

[2] With the exception of Horizon Scripted Television, Inc., Delta Blues Productions LLC and FUDD Ink employees, individuals hired by any Participating Employer after 10/1/01 without three-year employment contracts are not eligible under this Plan unless offered participation prior to 4/1/04. Horizon Scripted Television, Inc., Delta Blues Productions LLC and FUDD Ink employees are subject to different eligibility criteria. Please see Appendix B for further details.

[3] Initial eligibility is based on signing a three-year contract. If employment shifts without a break in service other than due to production hiatus, you may remain eligible to participate in the Plan.

[4] Effective October 1, 2013, non-union, non-pilot employees paid by the Participating Employer, NZK Productions Inc., may enroll in the medical, dental, vision & life plans without a 3-yr contract if they are expected to work on average 30 hours per week for the duration of the production season. Eligible job titles include, but are not limited to, Director, Producer, Manager, Coordinator, Supervisor, Accountant, Handler, Logger, Executive Assistant, regularly scheduled Production Assistants. These employees are not eligible for the Health Care or Dependent Care Flexible Spending Account Plans.

[5] Effective January 1, 2014, non-union, non-pilot employees paid by the Participating Employer, Horizon Scripted Television, Inc., doing business as Warner Horizon Scripted Television and Delta Blues Productions LLC, may enroll in the medical, dental, vision & life plans regardless of job title if they are expected to work on average 30 hours per week for the duration of the production season. These employees are not eligible for the Health Care or Dependent Care Flexible Spending Account Plans.

## Individuals Not Eligible

Ineligible employees include:

- All employees in a job classification represented for the purpose of collective bargaining unless the collective bargaining agreement specifically provides for eligibility under this Plan and such eligibility has been extended in writing to such employee;
- Leased employees unless paid through a payroll services company such as Cast & Crew or BTL Payroll, Inc., for services rendered for a Participating Employer;
- Any individual who provides services as an independent contractor even if the individual is subsequently deemed to be a common law employee for any other purpose;
- A person classified by a Participating Employer as a non-employee consultant;
- A foreign national who is temporarily working for a Participating Employer in the United States, or
- Those employees not on the payroll of a Participating Employer.

If it is determined that the classification or treatment described above was incorrect and that the individual is or has been in fact a common law employee, the individual will not be eligible to participate on a retroactive or prospective basis.

Please see the applicable EOCs for additional eligibility requirements.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

## Eligible Dependents

**The following dependents are eligible for Medical, Dental and Vision coverage offered under the Plan:**

- Your legally married spouse as defined as defined under the law of the state in which you live, including same-sex spouses where the marriage is legal under state law;
- Your domestic partner (as defined below);
- Your children or your domestic partner's children who are under age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation)

provided that the child was disabled prior to age 26. Any adult child of your domestic partner who satisfies this definition will also be eligible.

Your eligible dependents can be enrolled in the Medical, Dental and Vision coverage under the Plan only if you (the employee) are enrolled.

Your dependent children are:

- Your natural children;
- Stepchildren;
- Legally adopted children;
- Children who are placed in your home for adoption; and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

Your "domestic partner" means a domestic partner of an employee who:

- Is a member of a domestic partnership (with an employee) that is validly registered with the California Secretary of State and such registration has not been terminated; or
- In a member of a same-sex union with the employee (other than marriage) that is validly formed in another jurisdiction, is substantially equivalent to a California registered domestic partnership, and has not been terminated

**OR**

- Is at least 18 years of age, is unmarried or not legally separated from anyone else, and is not a blood relative close enough to bar marriage in the state in which you reside
- Lives with you in a mutually exclusive relationship in which you are jointly responsible for each other's welfare and financial obligations
- Has resided with you, as a committed partner, in the same principal residence for at least six months and intends to do so indefinitely

Eligible dependents can be enrolled in the Medical, Dental and Vision coverage under the Plan only if you (the employee) are enrolled. To enroll a domestic partner, you must complete an enrollment form and an ***Affidavit of Domestic Partnership*** or show that you have registered you domestic partnership with the California Secretary of State along with you completed enrollment form. Please note that there are tax consequences when you cover a domestic partner who does not qualify as your tax dependent under the Internal Revenue Code.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Please see the applicable carrier EOCs for additional eligibility requirements.

*Health Care Flexible Spending Account*

For purposes of the Health Care Flexible Spending Account your dependents include:

- Your opposite sex spouse,
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the *qualifying child* of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

*Dependent Care Flexible Spending Account*

Under IRS regulations, "eligible dependents" for the Dependent Care Flexible Spending Account include:

- A child under age 13 who is your *qualifying child*,
- A disabled spouse who lives with you for more than one half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the *qualifying child* of the employee or any other individual.

## Dependents Not Eligible

The following individuals are not eligible for Medical, Dental or Vision coverage, regardless of whether they are your tax dependents:

- A spouse, domestic partner or a child living outside the United States
- A parent of yours, or of your domestic partner or spouse

## Tax Consequences of Domestic Partners or Same

Unless your domestic partner or same sex spouse or his or her dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner or same sex spouse and his or

her dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. In general, a domestic partner or same sex spouse (or his or her child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic partner or same sex spouse and his or her dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner or same sex spouse benefit coverage.

In general, state income tax treatment of domestic partner or same sex spouse benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners or same sex spouses and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner or same sex spouse and his or her children, if any, qualify for the special state income tax treatment.

## Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of the Plan's procedures governing QMCSO determinations, free of charge, by contacting:

TW Ventures Inc.
Benefits Department
3500 West Olive Avenue, Suite 1000
Burbank, CA 91505
(818) 972-0787

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

Upon receiving a properly completed National Medical Child Support Notice (Notice) issued by a state child support enforcement agency (Issuing Agency), TW Ventures Inc. will follow the procedures established for reviewing and implementing such orders with respect to coverage under the health plan.

## Notification

If you experience a change in status (see page 20), you must notify the Benefits Department at TW Ventures Inc. within 30 days in order to make a change in your election during the year. The notice must be in writing and contain the Change in Status Event, the date of the event, and your requested change and must be sent to the Plan at the address in the following paragraph.

In addition, you must notify the Benefits Department at TW Ventures Inc., 3500 West Olive Avenue, Suite 1000, Burbank, CA 91505-4628 in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage in order for you and your dependents to elect COBRA coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

## Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the EOCs provided by the applicable insurance companies and/or service providers.

# Enrollment and Effective Date of Coverage

## New Employees

When you begin working for a Participating Employer, you will be directed to our benefits website at www.telepicturestv.com/hr for information regarding Plan coverage and enrollment instructions. All information will be distributed electronically. If you elect Medical, Dental or Vision coverage, you are eligible for and will be automatically enrolled in Life and AD&D coverage provided under the Plan. You and your eligible dependents must affirmatively enroll in Medical, Dental and Vision coverage within 30 days of your eligibility date. If you and your eligible dependents do not enroll in Medical, Dental and Vision coverages within the required period, you and your eligible dependents give up your chance to choose benefits for the Plan Year. Unless you experience a change in status, you will have to wait until the next Open Enrollment Period to enroll yourself and your eligible dependents for coverage for these benefits.

Your coverage under the Plan will begin on the date you are eligible. However, any pre-tax deductions will be effective as of the first payroll check following completion of your Enrollment Form if submitted after your eligibility date. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the necessary time period.

If you enroll yourself or a dependent in the Medical, Dental and Vision benefits midyear due to a change in status, coverage will be effective as of the date of the change in status event (if the change is due to adding a dependent due to birth, adoption or placement for adoption of your child) or the first of the month following the date the Benefits Department at TW Ventures Inc. receives your timely request for enrollment due to a change in status event. Changes due to divorce will occur at the end of the month in which you submit your change in enrollment.

## Current Employees

Open Enrollment is held prior to the beginning of the next plan year. This is your opportunity to enroll, change, or drop coverage. Changes are effective on August 1 following Open Enrollment. You'll receive information, including instructions on how to enroll, before Open Enrollment each year. Open Enrollment information is posted on our benefits website at www.telepicturestv.com/hr. Contact the Benefits Department if you do not have access to e-mail.

## HIPAA Special Enrollment Events

If you decline enrollment in the health plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in some coverages in the health plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

TW Ventures Inc. will also allow a special enrollment opportunity if you or your eligible dependents either:

- lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days – instead of 30 days – from the date of the Medicaid/CHIP eligibility change to request enrollment in the TW Ventures Inc. group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact TW Ventures Inc., Benefits Department, 3500 West Olive Avenue, Suite 1000, Burbank, CA 91505-4628 (818) 972-0787

*Note: If you decline coverage (for yourself or any dependent), you must state in writing whether the coverage is being declined due to other health coverage in order to preserve your special enrollment rights.

# Cost of Coverage

## Employee Contributions

In general, participants in the Medical and Dental coverages provided under the Plan are required to make contributions for coverage on a pre-tax basis (see below for more information). The level of contribution will be decided by TW Ventures Inc. Contributions shall be made by automatic payroll deductions. Contributions will be deducted from employees' paychecks based on their elected level of coverage. Employees who are on leave/or on hiatus are not required to make contributions.

## Section 125 Plan – Premium Conversion

TW Ventures Inc. has established a premium conversion plan under Internal Revenue Code section 125 in order for you to be able to pay your contributions for the Medical and Dental coverages provided under the Plan on a pre-tax basis. All your contributions for coverage for your and your eligible dependents' coverage will be deducted on a pre-tax basis, unless your enrolled dependent is your domestic partner who is not your federal tax dependent. If your enrolled domestic partner is not your federal tax dependent, you will pay your contributions for his/her coverage on an after-tax basis.

If you elect Medical and Dental coverage for your eligible domestic partner, you will be asked if he or she is your federal tax dependent at the time of enrollment. If you do not indicate that he or she is your federal tax dependent, you will be required to pay contributions for domestic partner coverage on an after-tax basis, and the amount contributed toward your domestic partner's coverage will be treated as imputed income. The amount of your imputed income will be added

to your paychecks each payroll period and will be subject to income tax withholding. In addition, the annual amount of this imputed income will be reported on your W-2 Form at the end of each year. Before enrolling your domestic partner, you should talk to your tax advisor about the tax implications for you.

Please note that you will not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

## Special State Tax Treatment of Domestic Partner Benefits

As discussed in the Tax Consequences of Domestic Partner Benefits section above, certain benefits for domestic partners who are not your federal tax dependent may be eligible for special state income tax treatment in a few select states. We recommend that you speak with your tax advisor regarding whether your domestic partner qualifies for the special state income tax treatment. If he or she does qualify, you must notify your employer immediately in writing of this special state income tax status.

## Making Changes to Your Coverage During the Year

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the plan year in which you are enrolled. Elections you make at Open Enrollment generally remain in effect for the following Plan Year (August 1 through July 31). However, you may be able to change your Medical, Dental and Vision coverage during the Plan Year if you experience a change in status. Please note that in order to change your benefit elections because of a change in status event, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, divorce decree). These rules apply to elections you make for your Medical, Dental and Vision coverages. The following is a list of changes in status event that may allow you to make a change to your elections (as long as you meet the consistency requirement, as described below).

- **Legal martial status**: Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment
- **Change in domestic partnership status**: Commencement or dissolution of a domestic partnership
- **Number of eligible dependents**: Any event that hat changes the number of your eligible dependents, including birth, death, adoption, legal guardianship, and placement for adoption
- **Employment status**: any event that changes your or your eligible dependents' employment status and results in gaining or losing eligibility for coverage. Examples include:

- Beginning or ending employment
- A strike or lockout
- Starting or returning from an unpaid leave of absence
- Changing from part-time to full-time employment or vice versa and
- A change in work location

- **Dependent status**: Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances
- **Residence**: A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents' living outside your Medical, Dental and Vision Plans' network service area
- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage which qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA)

Effective August 1, 2011, permitted changes in status will include change in status events affecting nondependent children under age 27, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

## Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid or lose entitlement to certain other governmental group Medical, Dental and Vision programs, you may make a corresponding change to your Medical, Dental and Vision coverages and Health Care Flexible Spending Account elections.

## Qualified Medical Child Support Orders (QMCSOs)

If a QMCSO requires the Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire.

If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

## The Consistency Requirement

Except for election changes due to a HIPAA special enrollment, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy the "consistency

rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.

- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

## Cost of Coverage Change Events

In some instances, you can make elections if the type of coverage or cost of coverage changes. **These rules do not apply for purposes of a Health Care Flexible Spending Account.** Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

### Cost Changes

If TW Ventures Inc. determines there is a significant increase or decrease in the cost of Medical, Dental and Vision coverages, you may be permitted to revoke your election and make a corresponding new election. Any change in the cost of your plan option which TW Ventures Inc. determines is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

### Coverage Changes

The following are additional situations in which you may change your current coverage.

- **Restriction or loss of coverage** — If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.
- **Addition to or improvement in coverage** — If TW Ventures Inc. adds a coverage option or significantly improves a coverage option during the year and you elected a different option providing similar coverage, you may revoke your existing election and elect the newly added or newly improved option.

- **Changes in coverage under another employer plan** — If your spouse or dependent child(ren) are employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family

coverage during his or her employer's open enrollment period, you may request to end your coverage under the Plan.

- **Loss of other group health plan coverage –** If you or your spouse or dependent child(ren) loses coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (SCHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for yourself, your spouse and your dependent children for coverage under this Plan.

### Dependent Care Flexible Spending Account Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you)
- You choose a different dependent care provider who charges a different amount, or
- You make a change to you or your spouse's regular work schedule that increases or decreases your need for dependent care.

## Time Period for Making Changes

If you experience one of the events described above and want to make a change to your coverage due to such event, you must notify TW Ventures Inc. Benefits Department within 30 days of the event. If you do not notify TW Ventures Inc. within the 30-day period, you will not be able to make any changes to your coverage until the next Annual Open Enrollment Period or until you experience another Change in Status Event.

## Coverage During Leave of Absence

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Benefits Department.

### Approved Leave

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of unpaid leave each year to:

- Care for your newborn child or a child placed with you for adoption or foster care; or
- Care for yourself, your spouse, domestic partner, child, or parent due to a serious health condition.

FMLA also allows eligible employees to take up to 26 weeks of unpaid leave each year for:

- Care for your spouse, domestic partner, child, parent, or next of kin (nearest blood relative) who is a service member and has a serious injury or illness resulting from active duty in the Armed Forces; or

- To address qualifying exigencies that result from a spouse's, domestic partner's, child's or parent's active duty (including an order or call to duty in the Armed Forces).

If you take an FMLA leave, your group health coverage will continue. If you take a leave of absence during which you are not paid by a Participating Employer and the leave qualifies under the federal Family and Medical Leave Act (FMLA) or California Pregnancy Disability Leave (PDL), you may continue participation in the Health Care Flexible Spending Account by paying your contributions on an after-tax basis or increase your payroll deductions prior to your leave. Participation in your Dependent Care Flexible Spending Account may be suspended during your leave. If you do not wish to make your contributions on an after-tax basis or pre-pay before your leave begins, your participation in the Health Care Flexible Spending Account will terminate. If your participation terminates during your leave and you return to work in the same Plan Year, you will have two options to choose from when you return from your leave:

- You can resume contributions to the Health Care Flexible Spending Account at the same level in effect before your leave (the amount available for reimbursement for the year will be reduced by the amount of missed contributions); or
- You can "make up" for contributions you missed during your leave period up to your original election amount for the year by increasing your weekly contributions upon your return to work.

Regardless of whether you choose to resume your former contribution level or make up for missed contributions, you may not retroactively elect Health Care Flexible Spending Account coverage for expenses incurred during your leave after your coverage terminates. In other words, expenses incurred during your leave will not be eligible for reimbursement unless you continue contributions during your unpaid leave on an after-tax basis.

If you experience a Change in Status Event while you are on leave or upon your return from leave, you may make appropriate changes to your Health Care Flexible Spending Account and your Dependent Care Flexible Spending Account elections (for example, if you have a baby and want to increase contributions).

Contact your Benefits Department for additional information on FMLA leaves.

If you experience a Change in Status Event while you are on leave or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverage amount.)

Your Life and AD&D coverages will continue during an FMLA leave.

If you do not return to work at the end of your FMLA leave, you may be entitled to purchase COBRA continuation coverage (see page 46).

## Production Hiatus

If you go out on a production hiatus, your Medical, Dental and Vision benefits may continue. Please check with your Production to find out if your benefits will continue. (For Tier 1 employees, see page 30 for the rules on continuing your Health Care Flexible Spending Account during production hiatus).

## Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental and Vision and Health Care Flexible Spending Account coverage for up to 24 months as long as you make the required contributions and give Participating Employer advance notice of the leave (with certain exceptions). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from Participating Employer, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

All other coverages will continue during your military leave.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extend benefits for less than 18 months (see page 46). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period. If you take a military leave but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies.

COBRA continuation coverage will run concurrently with military leave continuation coverage, under USERRA, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave, you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See COBRA continuation of coverage section.) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

## Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

## Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

## Designation of Primary Care Providers

The TW Ventures Inc. Group Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

## Access to OB/GYN

You do not need prior authorization from the TW Ventures Inc. Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved

treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurer.

### Covered and Non-covered Services

Refer to the EOCs provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

## The Health Care Flexible Spending Account

The Health Care Flexible Spending Account may be of interest to you if you are paying for health care expenses that are not covered by your health (Medical, Dental and Vision) coverage or under your spouse's employer plan.

This section explains how the Health Care Flexible Spending Account allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will be reimbursed for eligible health care expenses with pre-tax dollars set aside from your regular pay. The pre-tax deductions form your salary reduce the amount of taxable income you receive and, therefore, reduces your taxes.

### Covered Dependents

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed on page 28. There are also special rules defining dependents in the case of multiple support arrangements where no single person provides more than half of the dependent's support, children of divorced parents, and persons living outside the United States.

### Eligible Expenses

The Health Care Flexible Spending Account is an account that allows you to put aside pre-tax dollars to reimburse yourself for eligible health care expenses during the Plan Year. Expenses must be incurred during the Plan Year and while you were covered by the Plan. You may submit a request for reimbursement for any "eligible" health care expense. Eligible health care expenses are those incurred for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

Eligible expenses include amounts that are not paid by the TW Ventures Inc.-sponsored health care plan, such as deductibles, copayments, expenses in excess of plan dollar limits, or those that exceed customary and reasonable fees. You may also submit bills for Medical, Dental and Vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care Flexible Spending Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting

any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except smoking cessation programs) are not eligible for reimbursement.

Over-the-counter medications (except insulin) are no longer eligible for reimbursement without a prescription. You will need a doctor's prescription indicating that the medications are medically necessary in order to be reimbursed from the Health Care Flexible Spending Account. Insulin may continue to be reimbursed without a prescription. You may still submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care Flexible Spending Account. These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

Below is a partial list of expenses eligible for reimbursement under the Health Care Flexible Spending Account:

- **Medical expenses**
  - Deductibles
  - Copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the "customary and reasonable" limits
  - Expenses not covered by the Medical, Dental and Vision Plan due to a pre-existing condition, or exclusion by the insurance company
  - Drugs requiring a doctor's written prescription which are not covered by insurance
  - Over-the-counter items as permitted under applicable law or regulation
  - Over-the-counter drugs, if obtained with a prescription, and only as permitted under applicable law or regulation
  - Insulin (which may be reimbursed without a prescription)
  - Smoking cessation programs and related medicines
  - Physician-prescribed weight loss programs to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by the Medical, Dental and Vision Plan which qualify as a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures, artificial limbs, wheelchairs and crutches)

- **Dental expenses**
  - Deductibles
  - Copayments
  - Expenses that exceed the maximum annual amount allowed by your dental plan
  - Charges over the "reasonable and customary" limits

- Orthodontia treatments that are not strictly cosmetic

- **Vision and hearing expenses**
  - Vision examinations and treatment not covered by insurance plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries

- **Transportation** - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

## Ineligible Expenses

Below is a list of some of the expenses ***not*** eligible for reimbursement under the Health Care Flexible Spending Account:

- **Premiums**
  - Premiums paid by the employee, a spouse or other dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for Long Term-Care Insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.

- **Over-the-counter drugs** or items without a prescription unless specifically permitted under applicable law or regulation

- **Cosmetic procedures and plastic surgery** that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery, are not an expense for medical care.

- **Expenses related to general health** - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense that is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.

- **Long-term care expenses**

## Contributions

In general, you must contribute to the Health Care Flexible Spending Account through pre-tax contributions. However, if you are participating during an unpaid leave of absence, production hiatus, or on account of COBRA, then your contributions must generally be made on an after-tax basis.

## Contribution Limits

You may contribute any whole-dollar amount of not more than **$5,000** per year of your own money to your Health Care Flexible Spending Account. Effective January 1, 2013, the maximum contribution amount permitted by law will be $**2,500**. You must contribute at least $100 to the Health Care Flexible Spending Account if you want to participate.

## Restrictions

It is important that you not contribute more than the health care expenses you expect to incur. Contributions you make to your Health Care Flexible Spending Account must be used to pay for health care expenses you incur during the Plan Year (January 1 to December 31).

IRS regulations also stipulate that you must use the full amount of money in your Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year, or forfeit what remains. Your request for reimbursement must be filed by March 31 after the end of each Plan Year for expenses incurred during the Plan Year. **Any funds remaining in your Account after that date will be forfeited.** You may not carry over any unclaimed funds in your Account for the next year and you may not transfer any of the Health Care Flexible Spending Account funds to your Dependent Care Flexible Spending Account.

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Health Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year, or you will lose it.

## Filing a Claim

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for the expense. Claims can be submitted on a daily basis and must be at least $50 or more, unless you are submitting claims after the end of the Plan Year. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator before the last day of March after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Health Care Flexible Spending Account is:

AETNA
P.O. Box 4000
Richmond, KY 40476-4000
(877) 238-6200
Fax (888) 238-3539
www.aetnafsa.com

# The Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

This section explains how the Dependent Care Flexible Spending Account allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive reimbursement for eligible dependent care expenses that would otherwise be your regular pay. This also reduces your taxable income and, therefore, reduces your tax liability.

## Qualified Dependents

Your dependents who qualify for the Dependent Care Flexible Spending Account are defined on page 15.

## Eligible Expenses

Eligible expenses for reimbursement under the Plan include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you're married, you and your spouse – to work, or incurred because your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred and paid during the current Plan Year, and while you are enrolled; must otherwise be eligible to be deducted or credited on your individual federal income tax return; and must not exceed the contribution limits below.

An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

## Ineligible Expenses

You cannot use the money in your Dependent Care Flexible Spending Account to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
  - Your spouse or children under age 19 (whether or not they are your tax dependents)
  - Anyone you (or your spouse, if married) could claim as a legal dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home, unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible.
- Expenses for which you claim IRS child care credit when you file your tax return
- Dependent care services that cost more than the amount of the income you earn as a result of being able to use those services. For example, the IRS will not allow $5,000 of dependent day care services that enable your spouse to obtain a job paying $4,000 a year

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Dependent Care Flexible Spending Account.

## Contributions

Contributions to the Dependent Care Flexible Spending Account shall be suspended during an unpaid leave of absence or production hiatus.

## Contribution Limits

The IRS limits the amount you may contribute to your Dependent Care Flexible Spending Account. There is an overall annual maximum of **$5,000** (or **$2,500** each if you and your spouse file separate income tax returns). But another limitation also applies. **If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.** You must contribute at least $100 annually to the Dependent Care Flexible Spending Account if you want to participate. Furthermore, if you are

considered a “Highly Compensated Employee” under the Internal Revenue Code, the amount you may contribute may be further limited. You will be notified if you are affected.

For example: During 2012, Mary will earn $41,500 from her job. Her husband will earn $3,600 from his job. Mary's reimbursement from her Dependent Care Flexible Spending Account will be limited to $3,600. She can choose to contribute no more than $3,600 in total to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse’s actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse’s actual income (if any) or $500 a month.

## Restrictions

It is important that you not contribute more than the dependent care expenses that you are sure to incur. Money that you contribute to your Dependent Care Flexible Spending Account must be used to pay for dependent care expenses you incur during the Plan Year (January 1 to December 31).

IRS regulations also stipulate that you must use the full amount of money in your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year, or forfeit what remains. Your request for reimbursement must be filed prior to March 31 following each Plan Year for expenses incurred during the Plan Year. **Any funds remaining in your Account after that date will be forfeited.** You may not carry over any unclaimed funds in your Dependent Care Flexible Account to the next year and you may not transfer any of those funds to your Health Care Flexible Spending Account.

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year or you will lose it.

## Filing a Claim

Claims for reimbursement can be submitted to the Claims Administrator on a weekly basis and must be for at least $50 or more, unless the claim is submitted after the end of the Plan Year. You must submit a reimbursement request form along with the invoice or receipt for the expense, indicating the name(s) of the child(ren) or your adult dependent and dates of care. In addition, you must provide the tax identification or Social Security number of the care provider for your expense to be reimbursed. You will be reimbursed as soon as administratively practicable. All claims for a Plan Year must be submitted to the Claims Administrator before the last day of March after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator. **Unlike with the Health Care Flexible Spending Account, you will receive reimbursement only for the amount available in your account at the time of your request.**

The Claims Administrator for the Dependent Care Flexible Spending Account is:

AETNA
P.O. Box 4000
Richmond, KY 40476-4000
(877) 238-6200
www.aetnafsa.com

## Special Rules Affecting Dependent Care Accounts

Several special rules apply to the Dependent Care Flexible Spending Account. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

- The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Dependent Care Flexible Spending Account. **Some employees will receive more tax relief by taking the tax credits, while others will do better by contributing to the Dependent Care Flexible Spending Account. Please consult your tax advisor or carefully review your situation before making a choice.**

- The money in your Dependent Care Flexible Spending Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least 5 months each year. See Contribution Limits, above, for more information.

- If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Flexible Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

## "Highly Compensated" Employees

In addition to the annual Dependent Care Flexible Spending Account contribution limits described above, the amount you may contribute may be further limited if you are a considered a "Highly Compensated Employee" under the Internal Revenue Code. Federal law prohibits the Plan from discriminating in favor of Highly Compensated Employees. If, in the judgment of the Plan Administrator, the Plan discriminates, the Plan Administrator shall have the right to reduce the contributions of Highly Compensated Employees and request a refund of reimbursements made above the revised limit, adjust the W-2 statements of Highly Compensated Employees to reflect additional taxable income of contributions above the revised limit, or both. You will be notified if you are affected.

# Claims and Appeal Process

This section provides general information about this claims and appeals procedures applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements, and if so, those rules will apply. See the EOCs for more information.

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules would not apply to standalone dental or vision claims or health care flexible spending account claims.

## Filing a Claim

The claims filing procedures are set forth in the EOCs, which are listed in Appendix A. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. (See page 9 for a list of Claim Administrators.) When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

## Claim-Related Definitions

**Claim**: Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

**Urgent Care Claims**: "Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or that, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

**Pre-service Claims**: "Pre-service claims" are claims for approval of a benefit if it is required that the approval be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

**Post-service Claims**: "Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

**Concurrent Care Claims**: "Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you

sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

**Adverse Benefit Determination**: If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay (in whole or in part) for a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual's being ineligible to participate in the Plan;
- Utilization review;
- A service's being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

## Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

## TimeFrames for Initial Claims Decisions

Timeframes generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously approved treatments.) Notices of benefit determinations generally may be provided through in-hand, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health Care Flexible Spending Account claims are considered non-urgent "post-service" claims.

| | Medical, Dental and Vision **and** **Health Care Flexible Spending Account Plans** | | | | **Life Insurance, Dependent Life Insurance, and AD&D** |
|---|---|---|---|---|---|
| | ***Urgent Care Claims*** | ***Non-Urgent "Pre-Service" Claims*** | ***Non-Urgent "Post-Service" Claims*** | ***"Concurrent Care" Decision to Reduce Benefits*** | |
| **Time frame for Providing Notice** | Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours after receipt of the claim by the Plan.<br><br>If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. | Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days. | Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days. | Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated. | Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days after receipt of the claim by the Plan. |

| Medical, Dental and Vision **and** **Health Care Flexible Spending Account Plans** | | | | | **Life Insurance, Dependent Life Insurance and AD&D** |
|---|---|---|---|---|---|
| | ***Urgent Care Claims*** | ***Non-Urgent Pre-Service Claims*** | ***Non-Urgent Post-Service Claims*** | ***Concurrent Care Decision to Reduce Benefits*** | |
| **Extensions** | If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination. | The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.* | The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.* | N/A | The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends. |
| **Period for Claimant to Complete Claim** | You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information). | You have at least 45 days to provide any missing information. | You have at least 45 days to provide any missing information. | N/A | No rule. |
| **Other Related Notices** | Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan). | Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan). | N/A | N/A | |

## Appealing a Denied Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the timeframes described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator set forth in the Administrative Information section, beginning on page 7.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 41. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims);
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims); and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

## Timeframes for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the EOC for that benefit. Please consult the EOC for the specific benefit involved. Where not otherwise covered by the EOCs, the following procedures will apply.

The timeframe for filing an appeal starts when you receive written notice of adverse benefit determination. The timeframe for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

| | **Medical,/Vision Dental and Health Care Flexible Spending Account Plans** | | | **Life Insurance, Dependent Life Insurance, and AD&D** |
|---|---|---|---|---|
| | Urgent Care Claims* | Non-Urgent Care Pre-Service Claims* | Non-Urgent Care Post-Service Claims* | |
| **Period for Filing Appeal** | You have at least 180 days. | You have at least 180 days. | You have at least 180 days. | You have at least 60 days. |
| **Time frame for Providing Notice of Benefit Determination on Review** | As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review. | Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal. | Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal. | Within a reasonable period, but not later than 60 days from receipt of request for review. |
| **Extensions** | None. | None. | None. | Additional 60 days if special circumstances require extension. |

## Acts of Third Parties

When you or your covered dependent are injured or becomes ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (Medical, Dental and Vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

"Subrogation" means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A "right of recovery" means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;

- May appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and

- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is caused by result of the action of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been "made whole" or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including an attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;

- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;

- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.

- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.

- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information and authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Parties" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Parties" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right-of-recovery provisions in the insurance contract will govern.

## Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you,

the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

## Non-assignment of Benefits

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and TW Ventures Inc. to the extent of such payment.

## Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

# When Coverage Ends

Your active coverage will terminate on the earliest of the following dates:

- The date your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or discontinuance of contributions by your employer
- The end of the month in which you cease to be employed in one of the eligible classes. This includes your death, reduction in hours, or termination of active employment
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the Military Leave section above.

Coverage for your spouse and other dependents (including your domestic partner) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the EOCs. In addition, their coverage will terminate:

- For Medical, Dental and Vision coverage, the end of month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- The end of the month on which your legally married spouse, domestic partner or child is no longer considered an eligible dependent;
- The end of the pay period in which you stop making contributions required for dependent coverage.

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

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your EOCs for more information on conversion.

# Special Provisions for Group Health Plans: COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called "qualifying events") when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

TW Ventures Inc. will extend COBRA coverage to your domestic partner and his or her covered children.

COBRA applies to Medical, Dental and Vision and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan (such as Life or AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this SPD is intended to expand your rights beyond COBRA's offerings.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

For additional information about your rights and obligations under the Plan and under federal law, you should contact TW Ventures Inc. (the "Plan Administrator"):

TW Ventures Inc.
Benefits Department
3500 West Olive Avenue, Suite 1000
Burbank, CA 91505-4628
(818) 972-0787

## What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event". After a qualifying event occurs and any required notice of that event is properly provided to TW Ventures Inc., COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including open

enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

## Who Is Covered

**Employee**: If you are eligible for the benefits offered by TW Ventures Inc., you will have the right to elect COBRA if you lose your group health coverage under the Plan because of either one of the following qualified events:

- A reduction in your hours of employment at a Participating Employer
- The termination of your employment at a Participating Employer (for reasons other than gross misconduct on your part)

**Spouse or Domestic Partner**: If you are the spouse or domestic partner of an employee at a Participating Employer, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse or domestic partner
- The termination of your spouse's or domestic partner's employment at a Participating Employer (for reasons other than your spouse's or domestic partner's gross misconduct) or reduction in your spouse's or domestic partner's hours of employment with TW Ventures Inc. or a Participating Employer; or
- Divorce or legal separation from your spouse or domestic partner. Also, if your spouse or domestic partner (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

**Dependent Children*:*** If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events happen:

- The death of the parent-employee;
- The termination of the parent-employee's employment at a Participating Employer (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

**FMLA*:*** If am employee takes a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and does not return to work at the end of the leave, the employee (and the employee's spouse or domestic partner and dependent children, if any) will have the right to elect COBRA if (1) they were covered by group health coverage under the Plan on the day

before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and (2) they lose group health coverage under the Plan because the employee does not return to work at the end of the leave. COBRA coverage will begin on whichever of the following occurs earlier: (1) the employee definitively informs the employer that he or she is not returning at the end of the leave; or (2) the end of the leave, assuming the employee does not return to work.

**Newly Eligible Child:** If you, the former employee, elect COBRA coverage and then have a child (by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing a Participating Employer (see contact information below) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify TW Ventures Inc. or a Participating Employer within the 30 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

**QMCSO*:*** A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by TW Ventures Inc. or a Participating Employer during the covered employee's period of employment with TW Ventures Inc. or a Participating Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

## When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries.

If the qualifying event is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify TW Ventures Inc. (see contact information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice. The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;

- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, printed name and contact information of the individual sending the notice.

In addition, you must to provide documentation supporting the occurrence of the qualifying event if TW Ventures Inc. requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to TW Ventures Inc. at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to TW Ventures Inc. within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

## How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to TW Ventures Inc. at the address listed below under Contact Information. (An election notice will be provided to qualified beneficiaries at the time of the qualifying event.) Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan.

Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA. If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

**Separate Elections:** Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

**Coverage:** If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated employee" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

**Medicare and Other Coverage:** Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

When you complete the election from, you must notify TW Ventures Inc. if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

## Health Care Flexible Spending Account COBRA Coverage

COBRA coverage for the Health Care Flexible Spending Account, if elected, will consist of the Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care Flexible Spending Account annual coverage limit and a separate COBRA premium.

## Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. **If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan.** Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period**). If you fail to make a monthly payment before the end of**

**the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to TW Ventures Inc. at the address listed below under Contact Information.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact TW Ventures Inc. to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

## Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months **before** termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred. COBRA coverage for the Health Care Flexible Spending Account can not be extended under any circumstances.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

## 29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify TW Ventures

Inc. in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months each. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify TW Ventures Inc. in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The names and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- The name and address of the disabled qualified beneficiary
- The date that the qualified beneficiary become disabled
- The date that the Social Security Administration made its determination of disability
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to TW Ventures Inc. at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to TW Ventures Inc. within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify TW Ventures Inc. of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

## Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18 months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notifies TW Ventures Inc. in writing of the second qualifying event within 60 days after whichever is later: (a) the date of the second qualifying event or (b) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The names and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event
- The second qualifying event
- The date of the second qualifying event
- The signature, name and contact information of the individual sending the notice

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to TW Ventures Inc. at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to TW Ventures Inc. within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

## Trade Reform Act of 2002

The Trade Reform Act of 2002 created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends. Although it is unlikely that a TW Ventures Inc. employee would qualify, you may contact the Benefits Department at TW Ventures Inc. (see Contact Information below) for additional information, or you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. More information about the Trade Reform Act is also available at www.doleta.gov/tradeact.

## Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- TW Ventures Inc. no longer provides group health coverage to any of its employees of Participating Employers
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period)
- The individual first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee), but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of an individual have been exhausted or satisfied
- The individual first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, TW Ventures Inc. reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects

you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You must notify TW Ventures Inc. in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage (after exhaustion or satisfaction of any pre-existing condition limitation). TW Ventures Inc., the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify TW Ventures Inc. in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the individual is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

## Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

TW Ventures Inc.
Benefits Department
3500 West Olive Avenue, Suite 1000
Burbank, CA 91505-4628
(818) 972-0787

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa

## Special COBRA Rights for California Employees

If you are enrolled in a medical HMO or insured medical coverage in California at the time of your initial qualifying event, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months, measured from the date of the original qualifying event. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost).

This special California continuation benefit is provided by the HMOs and insurance companies and is not TW Ventures Inc.' responsibility. Contact your HMO or insurance carrier to find out whether you are eligible for this continuation benefit and how to obtain it.

## Converting Coverage After Termination

If you are eligible to convert your coverage to an individual policy, you will be sent a conversion notice within the last 180 days of COBRA coverage. Contact the applicable HMO or insurance

company for information on converting to an individual policy. HMOs and insurance companies will sometimes permit you to continue membership or equivalent coverage under an individual policy. Conversion rights may also be available to your spouse and/or dependent child(ren). However, the cost of conversion coverage is usually high, and conversion coverage often will not offer the same comprehensive coverage as the Plan.

For more information about conversion rights, contact the applicable HMO or insurance company.

### Certificates of Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you and your spouse and dependent child(ren) who lose group health coverage must receive certification of your coverage under the Plan. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You, your spouse, your domestic partner, and/or dependent child(ren) will receive a coverage certificate when your Plan coverage terminates, again when COBRA coverage terminates (if applicable and if you elected COBRA), and again upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certificate to your insurer at that time as well.

## ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that you, and all other participants, shall be entitled to:

### Receive Information about Your Plan and Benefits

You can:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report (SAR).

## Continue Group Health Plan Coverage

You may continue health care coverage for yourself, your spouse and/or your dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. If you request one before losing coverage, or up to 24 months after losing coverage, the Plan should provide you with a certificate of creditable coverage, free of charge when:

- You lose coverage under the Plan,
- You become entitled to elect COBRA continuation coverage, or
- Your COBRA continuation coverage ceases.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after you enroll in a plan that imposes a pre-existing condition exclusion.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

## Enforce Your Rights

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

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

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

### Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Plan Administration and Other General Plan Information

TW Ventures Inc. is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an EOC. TW Ventures Inc. has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and TW Ventures Inc. will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor TW Ventures Inc. will be liable in any manner for any determination made in good faith.

TW Ventures Inc. may designate other organizations or persons to carry out specific fiduciary responsibilities for TW Ventures Inc. in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping

- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility

TW Ventures Inc. will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

## Power and Authority of the Insurance Company

The Medical, Dental, Vision, Life and AD&D benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between TW Ventures Inc. and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not TW Ventures Inc. or any Participating Employer.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan; and
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

## Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your EOCs or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

# Appendix A — Evidence of Coverage Documents

This summary should be read in combination with the insurance contracts and evidence of coverage documents (together and individually referred to as "EOCs") provided by the insurance companies and service providers.

The EOCs are intended to describe the TW Ventures Inc. benefits available to you as an employee of TW Ventures Inc., and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the EOCs for details of Plan benefits.

For additional information or for copies of the EOCs, please contact the Plan Administrator.

| Coverage | Evidence of Coverage Name |
|---|---|
| **Medical HMO** | **Aetna HMO Evidence of Coverage (EOC)** |
| **Medical PPO** | **Aetna OAMC POS Summary of Coverage (SOC) and Booklet Certificate (Cert)** |
| **Dental DMO** | **Aetna DMO Evidence of Coverage (EOC)** |
| **Dental PPO** | **Aetna PDO Evidence of Coverage (EOC)** |
| **Vision** | **VSP-Member Benefit Summary** |
| **Basic Life Insurance/ Accidental Death and Dismemberment (AD&D) Insurance** | **Aetna Group Insurance Certificate** |
| | |

# Appendix B — Eligibility: Horizon Scripted Television, Inc., Delta Blues Productions LLC and FUDD Ink employees

Individuals who are considered non-union, non-pilot, and who provide services to Horizon Scripted Television, Inc. doing business as Warner Horizon Scripted Television, and Delta Blues Productions LLC, who are in the following job classifications and who are subject to all the other eligibility rules are not required to have an employment contract of three (3) years or more in order to be considered Eligible Employees: Accounting Assistants, Accounting Clerks, Production Assistants, Art Department Coordinator, Art Department Production Assistant, Casting Assistants, Executive Assistant, Non-Union Casting Associate, Non-Union Assistant Coordinators, Non-Union Production Coordinators, Office Assistant, Post Production Coordinators, Post Production Supervisor, Post Production Assistant, Producer's Assistants, Production Secretary, Production Supervisor, Script Coordinators, Set Production Assistant, Second Assistant Accountant, Writer's Assistants.

Additionally, individuals who are considered non-union, non-pilot and who provide services to FUDD Ink and who are subject to all the other eligibility rules are required to have an employment contract of one (1) year or more in order to be considered Eligible Employees.