
Gunderson Dettmer Stough Villeneuve Franklin &
Hachigian, LLP

Health and Mental Welfare Plan

Master Summary Plan Description

Amended/Restated Effective January 1, 2026

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"DCAP" means a dependent care assistance program that may be established by the Firm under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Firm who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Firm as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Firm" means Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"Health FSA" means a health flexible spending account plan that may be established by the Firm under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP Health and Mental Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Firm.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Firm maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a “Benefit Description”). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP Health and Mental Welfare Plan
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	January 1 to December 31.
Plan Number:	502
Effective Date:	January 1, 1996. The Plan has been amended several times since its original effective date, most recently as of January 1, 2026.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Firm and insurance companies or HMO. The insurance companies and/or HMO, not the Firm, are responsible for paying claims with respect to these programs. The Firm shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.

For benefit programs which are self-funded, the Firm is responsible for processing and paying appropriate claims. The Firm may hire a third party administrator (a "TPA") to process claims.

Premiums for Employees and their eligible family members may be paid in part by the Firm out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable.

The Firm provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.

Plan Sponsor:

The employer is the Plan Sponsor.

Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP
550 Allerton St.
Redwood City, CA 94063
(650) 463-5282

**Plan Sponsor's Employer
Identification Number:**

77-0409988

Insurance Companies/HMO:

See a complete list under the heading Plan Provider Information later in this document.

Plan Administrator:

Attention: Human Resources
Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP
550 Allerton St.
Redwood City, CA 94063
(650) 463-5282

Named Fiduciary:

Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP
550 Allerton St.
Redwood City, CA 94063
(650) 463-5282

**Agent for Service of Legal
Process:**

President
Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP
550 Allerton St.
Redwood City, CA 94063
(650) 463-5282

Service for legal process may also be made on the Plan Administrator.

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description contact the Plan Administrator at (650) 463-5282.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Firm. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Firm, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Firm will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage.

Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment. However, you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Firm. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. **Always make sure the Firm has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.**

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Firm determines full-time status using the Look-back” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire 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 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Firm, any insurance Firm or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-

funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Firm contributions and in part by pre-tax and/or post-tax employee contributions. The Firm will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Firm reserves the right to change that determination.

The Firm will make its contributions, if any, in an amount that (in the Firm's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Firm will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Firm's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Firm contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered "Creditable Coverage" under Medicare Part D. The attached documents provide details regarding this coverage and an annual

notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of 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 of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Cigna HMO (CA)
- Cigna PPO (CA)
- Cigna HDHP (CA)
- Kaiser HMO (CA)
- BCBS POS (MA)
- BCBS PPO
- BCBS HDHP

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the 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.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Firm as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Firm to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan,

with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: HSA, Cafeteria Plan, DCAP.

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);

- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Firm or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Firm if the Firm so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Firm shall retain a right to recover paid benefits which are forfeited in such a manner.

The Firm, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Firm shall be entitled to deduct the amount of the lien from

any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Firm unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Firm shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

- ☐ Considered an asset of the Firm, not the Plan. The Firm does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Firm can use such a rebate for the Firm's own purposes
- ☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Firm contributions shall not be considered a Plan asset. The Firm will have the ability to make certain assumptions or minor changes (such as rounding to the nearest \$1 or \$10) when determining the amount which is considered a plan asset. The Firm shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Firm. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.
- ☐ The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
Medical PPO/HDHP/HMO (CA)	Fully-Insured / Cigna	3163568	Full time employees in California working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Cigna Healthcare at: (800) 844-6224 Mycigna.com
Medical HMO (NCA)	Fully-Insured / Kaiser	35375	Full time employees in Northern California working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Kaiser Permanente at: (800) 464-4000 Csu.ca@kp.org Kp.org
Medical HMO (SCA)	Fully Insured / Kaiser	235359	Full time employees in Southern California working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Kaiser Permanente at: (800) 464-4000 Csu.ca@kp.org Kp.org

¹ Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Medical POS (MA)	Fully-Insured / BCBS of MA	8001925	Full time employees in Massachusetts working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	BCBS of MA at: (800) 262-2583 Bluecrossma.com
Medical PPO/HDHP (MA, GA, MI, TX, NY)	Fully-Insured / BCBS of MA	8001925	Full time (+ remote) employees in Massachusetts (HDHP only), Georgia, Michigan, Texas, or New York working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	BCBS of MA at: (800) 262-2583 Bluecrossma.com
Dental	Self-Funded / Cigna	3163568	Full time employees working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Cigna Healthcare at: (800) 844-6224 Mycigna.com
Vision	Fully-Insured / VSP	12031425	Full time employees working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated.	Vision Service Plan at: (800) 877-7195 vspwestern@vsp.com Vsp.com
Basic Life/AD&D/ LTD	Fully-Insured / Unum	950418	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Unum at: (800) 421-0344 askunum@unum.com unum.com
Voluntary Life/AD&D	Fully-Insured / Unum	931120	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Unum at: (800) 421-0344 askunum@unum.com unum.com

Employee Assistance Program (EAP)	Fully-Insured / Spring Health	N/A	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Spring Health at: (240) 558-5706 careteam@springhealth.com springhealth.com
Healthcare Flexible Spending Account (FSA)	Self-Funded / Igoe	N/A	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Igoe at: (800) 633-8818, opt 2 flex@goigoe.com goigoe.com
Dependent Care Flexible Spending Account (DCFSA)	Self-Funded / Igoe	N/A	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Igoe at: (800) 633-8818, opt 2 flex@goigoe.com goigoe.com
Fertility HRA	Self-Funded / Maven	N/A	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Maven at: support@mavenclinic.com mavenclinic.com
Business Travel Accident (BTA)	Fully-Insured / Zurich	GTU 0553655	Full time employees working 25+ hours per week.	Date of hire	Date of termination	N/A

Expat Medical, Dental, and Vision	Fully-Insured / GeoBlue	4EL-8339-22	Full time employees outside of the United States working 25+ hours per week.	Date of hire, as long as elections are made within 30 days of hiring.	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	GeoBlue at: US: (855) 282-3517 Outside US: (610) 254-5304 claims@geo-blue.com geo-blue.com
Health Savings Account (HSA)	Self-Funded / Igoe	N/A	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Igoe at: (800) 633-8818, opt 2 flex@goigoe.com goigoe.com
Commuter Benefits	Self-Funded / Health Equity	N/A	Full time employees working 25+ hours per week.	Date of hire	Date of termination	Health Equity at: (877) 353-9236 Healthequity.com

¹ Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Additional Information on ACA FT Status Determination

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as long as you enroll within 30 days of your hire date.

New employees hired to work a part-time, variable hour or seasonal schedule. If you are hired into a part-time position, a position where your hours vary and Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee. Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 130 or more hours a month over that 12 month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees. Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP uses the look-back measurement method to determine [group health /medical/health] plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which [Employer/plan sponsor name] counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP uses the standard measurement period and associated stability period annual cycle set forth below.

Measurement Period	October 1 – September 30
Stability Period	January 1 – December 31

Appendix A: COBRA GENERAL NOTICE + STATEMENT OF INITIAL RIGHTS

Welcome! This COBRA General Rights notice explains the rights you may have if you lose active employee health coverage. It is important that you read this notice thoroughly and contact your Human Resources department if you have questions or would like to request more information.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA is a continuation of health benefit(s) under the Group Health Plan (Plan) coverage based on a specific change in your life situation. This change is called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost due to the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage each month.

If you're the employee of Gunderson, you'll become a qualified beneficiary if you, as the primary benefit holder, lose your coverage under the Plan as a result of one of the following qualifying events (these events would also impact coverage for your dependents):

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

If you're the spouse of an employee, you'll become a qualified beneficiary and may elect COBRA if you lose your coverage under the Plan as a result of one of the following qualifying events:

- Your spouse (the primary benefit holder) dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events (the parent-employee is the primary benefit holder):

- The parent-employee dies;
- The parent-employee's hours of employment are reduced; APD{1234}
- The parent-employee's employment ends for any reason other than his or her gross

misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Under USERRA and COBRA rules, a military reservist who is called to active duty may choose COBRA continuation for up to 24 months. This should be discussed in detail with your employer.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide a written notice to:

550 Allerton St.

Redwood, CA 94063

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

If you lose your health benefit coverage under the circumstances listed above, and you or your employer have notified the Plan Administrator, a COBRA Qualifying Event Election Notice will be mailed to you. The notice will be mailed to the most recent address on file with your employer or Plan Administrator. You and/or each of your dependents who are also qualified beneficiaries will have an independent right to elect COBRA continuation coverage. Each individual will be allowed to elect on their own, or as a family unit. Additionally, covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of work hours. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. This will all be outlined in the COBRA Qualifying Event Election Notice.

The following includes information about extending the 18-month period of COBRA:

Social Security Disability Extension:

If you or anyone in your family covered under the Plan is determined by Social Security to be

disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. It is imperative that notification of a Social Security disability is reported timely and includes a copy of the SSI Notice of Disability.

Second Qualifying Event extension:

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, your spouse and dependent children may qualify for up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child is no longer eligible under the Plan as APD{1234} a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan, had the first qualifying event not occurred.

You may have other options available to you if you lose your group health coverage. For example, you may be eligible to purchase an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Relationship Between Medicare and COBRA

In general, if you don't enroll in Medicare Part A or B when eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage, should you decide to enroll in Part B at a later date. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage.

However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after you elect COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit <https://www.medicare.gov/medicare-and-you>.

To protect your family's rights, let the Plan Administrator for your Group Health Plan know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Cal-COBRA Continuation Coverage for Certain California Insured Plans

Insured medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

Appendix B: Medicare Part D Notice

Important Notice from Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP has determined that the prescription drug coverage offered by the Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP Health and Mental Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP Health and Mental Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to

enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information at (617)-246-3812. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit [medicare.gov](https://www.medicare.gov)

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained

creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2026
Name of Entity/Sender: Gunderson Dettmer Stough Villeneuve Franklin & Hachigian LLP
Contact-Position/Office: Employee Benefits Manager
Address: 550 Allerton Street, Redwood City, CA 94603
Phone Number: (650) 463-5282 (direct)

Appendix C: Cafeteria Plan and FSA Provisions

This Flexible Benefit Plan is intended to qualify as a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, (the “Code”) and the benefits that a Participant elects to receive under the Plan are intended to be excludable from the Participant’s income under Code Section 125(a), and other applicable sections of the Code.

The Health Flexible Spending Account provided under this Plan is intended to qualify as a self-insured medical reimbursement plan under Code Section 105, and the Medical Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants’ gross income under Code Section 105(b).

The Dependent Care Flexible Spending Account provided under this Plan is intended to qualify as a dependent care assistance program under Code Section 129, and the Employment-Related Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants’ gross income under Code Section 129(a).

The HSA funding feature described herein is not intended to establish an ERISA plan or to otherwise be part of an ERISA benefit plan.

Although both contained within this document, the Health Flexible Spending Account and the Dependent Care Flexible Spending Account are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Health Flexible Spending Account is also a separate plan for purposes of applicable provisions of ERISA, HIPAA, and COBRA.

This Appendix A, and the benefits set forth herein, are hereby incorporated into and made a part of the Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP Health and Mental Welfare Plan.

ARTICLE I DEFINITIONS

In addition to the definitions set forth in the Plan’s Article II, the following terms, when capitalized and used in this Appendix A, which sets forth the terms of the Flexible Benefit Plan Benefit, shall have the meaning specified below unless the context clearly indicates to the contrary:

1.1 **“Benefit” or “Benefit Options”** means any of the optional benefit choices that a Participant may elect as outlined in Section 4.1 of this Appendix A.

1.2 **“Cafeteria Plan Benefit Dollars”** means the amount available to Participants to purchase Benefit Options as provided under Section 3.1 of this Appendix A. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.3 **“Election Period”** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee’s Initial Election Period is defined pursuant to Section 5.1 of this Appendix A.

1.4 **“Eligible Employee”** means any Employee who satisfies the eligibility requirements for a Covered Benefit, except that any self-employed individual (including a partner) shall not be an Eligible Employee under this Appendix A.

1.5 **“Health Savings Account”** or **“HSA”** means the health savings account, as defined in Code Section 223, established by a Participant.

1.6 **“High Deductible Health Plan”** or **“HDHP”** means coverage that meets the definition of a high deductible health plan under Code Section 223(c)(2).

1.7 **“Key Employee”** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.8 **“Plan Year”** means the twelve-month period beginning each January 1 and ending each December 31.

1.9 **“Prior Cafeteria Plan”** means the Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP Cafeteria Plan (the “Plan”), which was incorporated into the Gunderson Dettmer Stough Villeneuve Franklin & Hachigian, LLP Health and Mental Welfare Plan as of January 1, 2017, and which is herein amended and restated effective January 1, 2025.

1.10 **“Premium Expenses”** or **“Premiums”** mean the Participant's cost for the Benefits described in Section 4.4 of this Appendix A.

1.11 **“Salary Redirection”** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1 of this Appendix A. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V of this Appendix A.

1.12 **“Salary Redirection Agreement”** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Appendix A and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder on the date the Eligible Employee is eligible for Covered Benefits or Benefit Options described in Section 4.1 of this Appendix A. Any Eligible Employee who was a Participant in the Prior Cafeteria Plan on the effective date of the amendment and restatement of this Plan shall continue to be eligible to participate under this Appendix A.

2.2 TERMINATION OF EMPLOYMENT

(a) **Rehire.** If a Participant is re-hired by the Employer less than thirty (30) days after a termination of employment, the Participant shall automatically be reinstated in the Plan on the date of re-hire with the pre-termination elections in effect as of the date of re-hire.

(b) **Dependent Care Flexible Spending Account.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for Employment-Related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within ninety (90) days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(a) **Health Flexible Spending Account.** With regard to the Health Flexible Spending Account, the Participant may submit, within ninety (90) days after termination, claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B.

ARTICLE III

CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under this Appendix A shall be financed by Salary Redirections sufficient to support the Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under this Appendix A.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account.

ARTICLE IV BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect (a) and/or (b), and shall automatically have his or her Compensation applied toward (c), below:

- (a) Health Flexible Spending Account, in which case Article VI of this Appendix A shall apply;
- (b) Dependent Care Flexible Spending Account, in which case Article VII of this Appendix shall apply; and

(c) Each Participant covered under any Covered Benefits listed in Schedule I shall be deemed to have elected the payment of Premiums for the Covered Benefits. On behalf of each Participant who makes such election, the Plan Sponsor shall contribute Salary Redirections toward the Premiums in an amount equal to the Premium corresponding with the Covered Benefit coverage.

(d) A Participant who has elected coverage under the High Deductible Health Plan option may elect to have amounts withheld from his or her compensation on a pre-tax basis to be contributed by the Plan Sponsor to the Participant's Health Savings Account. The maximum amount that may be credited to a Participant's Health Savings Account for any taxable year of a Participant is: (a) \$4,300 (for 2025, which amount is subject to adjustment pursuant to Section 223(g) of the Code) if the Participant is enrolled in employee-only High Deductible Health Plan coverage, or (b) \$8,550 (for 2025, which amount is subject to adjustment pursuant to Section 223(g) of the Code) if the Participant is enrolled in High Deductible Health Plan coverage other than at the employee-only level. The foregoing amounts are subject to adjustment pursuant to Section 223(g) of the Code. Participants who are age 55 or older (or will attain age 55 before the end of the tax year) may make an additional catch-up contribution of \$1,000 (for 2025, which amount is subject to adjustment pursuant to Section 223(g) of the Code). The maximum annual contribution will be reduced by any matching (or other) contribution made the Plan Sponsor on the Participant's behalf (if any). Any contribution made by the Plan Sponsor shall be considered to have been made through a "cafeteria plan" within the meaning of Code Section 125.

4.2 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which is not discriminatory pursuant to Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include Benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among self-funded Covered Benefits.

ARTICLE V

PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Eligible Employee who first meets the eligibility requirements on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he or she elects to do so during the initial election period ("Initial Election Period"). The Initial Election Period shall be the period determined by the Plan Administrator. Otherwise, initial elections must be made as provided in Appendix A Section 5.2(a), except to the extent allowed in Section 5.4 of this Appendix A.

Notwithstanding the foregoing and unless the Eligible Employee elects not to participate in the Plan during the Election Period, an Employee who is eligible to participate in this Plan and who elects to become covered by the Covered Benefits shall automatically become a Participant to the extent of the Premiums for such Benefits.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the annual Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election form to be provided by the Plan Administrator, which spending account Benefit options he or she wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Annual Election Period. With regard to subsequent annual elections, the following options shall apply:

- (a) A Participant or Eligible Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the annual Election Period;
- (b) An Eligible Employee who does not elect to participate for the Plan Year following the annual Election Period will have to wait until the next annual Election Period before again electing to participate in the Plan, except as provided for in Section 5.4 of this Appendix A.

5.3 FAILURE TO ELECT

With regard to the Health Flexible Spending Account, Dependent Care Flexible Spending Account, and Health Savings Account, any Participant who fails to complete a new election form pursuant to Appendix A Sections 5.1 or 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Health Flexible Spending Account, the Dependent Care Flexible Spending Account and/or the Health Savings Account for the remainder of or during the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the Plan Year for such Benefits.

5.4 PERMITTED ELECTION CHANGES

(a) A Participant may change or revoke a Benefit election after the Plan Year has commenced and make new elections for the remainder of such Plan Year provided that such change, revocation, or new election is permitted under Treasury Regulation Section 1.125-4.

(b) An Eligible Employee with respect to the Health Savings Account benefit may modify or revoke his or her election prospectively at any time, effective as soon as administratively feasible after the election change is made in accordance with the procedures required by the Plan Administrator, provided such change is consistent with Code Section 223 and the regulations issued thereunder.

ARTICLE VI

HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 HEALTH FLEXIBLE SPENDING ACCOUNT

(a) This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

(b) A Participant who elects coverage under the Health Flexible Spending Account for a Plan Year will be enrolled in the General Purpose Health FSA provided he or she does not enroll in the High Deductible Health Plan option. Any unused amounts remaining in a Participant's General Purpose Health FSA or Limited Purpose Health FSA at the end of the preceding Plan Year that are available for carryover as provided in Section 6.3(b) will be automatically carried over to the Participant's General Purpose Health FSA for use in the current Plan Year.

(c) A Participant who elects coverage under the High Deductible Health Plan option and elects coverage under the Health Flexible Spending Account for a Plan Year will be enrolled in the Limited Purpose Health FSA for that Plan Year. Any unused amounts remaining in the Participant's General Purpose Health FSA or Limited Purpose Health FSA at the end of the preceding Plan Year that are available for carryover as provided in Section 6.3(b) will be automatically carried over to the Participant's Limited Purpose Health FSA for use in the current Plan Year.

6.2 DEFINITIONS SPECIFIC TO THE HEALTH FLEXIBLE SPENDING ACCOUNT

For the purposes of Article VI of this Appendix A, the terms below have the following meaning:

(a) **"General Purpose Health Flexible Spending Account" or "General Purpose Health FSA"** means a Health FSA that is not a Limited Purpose Health FSA as defined herein.

(b) **"Health Flexible Spending Account" or "Health FSA"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed. The Health Flexible Spending Account benefit includes two options: the General Purpose Health FSA and the Limited Purpose Health FSA.

(c) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

- (1) one of the 5 highest paid officers;
- (2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
- (3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(d) **“Limited Purpose Health Flexible Spending Account” or “Limited Purpose Health FSA”** means a Health FSA that reimburses only eligible dental care, vision care, or preventive care benefits as defined in Code Section 223(c)(1).

(c) **"Medical Expenses"** will vary depending on whether a Participant is enrolled in a General Purpose Health FSA or a Limited Purpose Health FSA. For Participants enrolled in a General Purpose Health FSA, Medical Expenses are expenses Incurred by a Participant, or by the Spouse or Dependent of a Participant, for medical care as defined in Section 213(d) of the Code, including without limitation amounts paid for hospital bills, doctor and dental bills, and drugs. Medical Expenses include expenses Incurred by the Participant, or the Participant's Spouse or Dependent for:

- (1) medicines or drugs, including over-the-counter medicines or drugs, which are for the diagnosis, cure, mitigation, treatment, or prevention of disease, regardless of whether the item is prescribed or available for prescription;
- (2) insulin;
- (3) over-the-counter products, such as crutches, bandages and blood-sugar test kits, without a prescription where the product is for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and
- (4) menstrual care products.

For Participants enrolled in a Limited Purpose Health FSA, Medical Expenses must be only for vision care, dental care, or preventive care as defined in Code Section 223(c)(1).

Medical Expenses shall not include: (a) any premium paid for health coverage under any plan maintained by the Employer or any other employer or any plan provided on an Exchange or Marketplace created by the Affordable Care Act; (b) any amount which is covered, paid, reimbursed, or eligible to be reimbursed from any source other than the Plan; or (c) any amount taken as a deduction on the Participant's federal income tax return in any year.

A Medical Expense shall be deemed to be “incurred” at the time the services to which the expense relates are rendered or when the supply giving rise to the expense is received. The Administrator or its designee shall have the sole and complete discretion to determine whether an expense is a Medical Expense. A Participant who elects the high deductible health plan for a Plan Year will be automatically enrolled in the Limited Purpose Health FSA for that Plan Year, and unused amounts remaining in the Participant's General Purpose Health FSA or Limited Purpose Health FSA at the end of the preceding Plan Year that are available for carryover as provided in Section 6.3, if any, will be automatically carried over to the Participant's Limited Purpose Health FSA.

6.3 FORFEITURES

(a) **General.** Except as provided below, if any balance remains in a Participant's Health FSA for any Plan Year after all reimbursements have been made, the balance shall not be carried over to reimburse the Participant for Medical Expenses Incurred during a subsequent Plan Year, nor shall it be available to the Participant in any other form or manner. The Participant shall forfeit all rights with respect to such balance. Forfeitures will be used to defray experience losses, to offset the Employer's reasonable expenses of administering the Plan, and thereafter in any manner consistent with ERISA and the Code.

(b) **Health FSA Carryovers.** Notwithstanding Section 6.3(a), and subject to Sections 6.1(b) and 6.1(c), if a Participant has an unused balance in his or her Health FSA as of the end of a Plan Year, the unused balance (up to a maximum of twenty (20) percent of the maximum allowed salary reduction amount under Code Section 125(i)(2), as permitted by IRS Notice 2020-33 (\$640 for the carryover into the 2025 Plan Year), shall be carried over to the next Plan Year and credited to the Participant's Health FSA and made available to reimburse claims Incurred during that Plan Year.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum annual limitation on allocations to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is \$3,300 for the 2025 Plan Year, as may be adjusted for cost of living pursuant to Code Section 125(i)) (the "Annual Maximum").

(b) In no event shall allocations to the Health Flexible Spending Account exceed the Annual Maximum. The adjusted maximum amount in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year.

(c) In the event of a Plan Year of fewer than 12 consecutive months for all Participants, the Annual Maximum shall be prorated based on the number of months in the Plan Year. If a Participant enters the Health Flexible Spending Account mid-year or wishes to increase his or her election mid-year as permitted under Section 5.4, then there will be no proration rule – i.e., the Participant may elect salary redirection up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the requirements of Internal Revenue Code Section 125(i).

(d) All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the Annual Maximum. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total health flexible spending account contributions under all of the plans are limited to the Annual Maximum. However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the Annual Maximum under each employer's health flexible spending account.

(e) Amounts carried over to the next Plan Year pursuant to Section 6.3(b) shall not affect the Annual Maximum for that next Plan Year.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to

the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

6.6 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to this Section 6.6 of Appendix A, even though the submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Plan Administrator shall direct the reimbursement to each Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. A Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Plan Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Plan Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within ninety (90) days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within ninety (90) days after termination of employment.

6.7 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Plan Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Plan Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card termination.** Such card shall be cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(b) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Plan Administrator following Internal Revenue Service guidelines.

(c) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Plan Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(d) **Correction methods.** If such purchase is later determined by the Plan Administrator to not qualify as a Medical Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

- (1) Repayment of the improper amount by the Participant;
- (2) Withholding the improper payment from the Participant's wages or other Compensation to the extent consistent with applicable federal or state law; and
- (3) Claims substitution or offset of future claims until the amount is repaid.

ARTICLE VII

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Appendix A, Article VII, the terms below shall have the following meanings:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period during which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the

Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

- (1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) of this Appendix A (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) of this Appendix A (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;
- (2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and
- (3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of nineteen (19) or to an individual who is a Dependent of such Participant
- (d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,
 - (1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age thirteen (13);
 - (2) a Participant's Dependent who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
 - (3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he or she has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Appendix A Article V.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Appendix A, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he or she is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.11 of this Appendix A) shall be forfeited. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article VII to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of: (a) the maximum amount allowed by law; or (b) such other limitation as the Employer may establish from time to time that shall be communicated to Participants in writing during the Election Period through the Salary Reduction Agreement or another document.

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate pursuant to Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Plan Administrator shall direct the payment of all such Dependent Care Flexible Spending Account claims to the Participant upon the presentation to the Plan Administrator of documentation of such expenses in a form satisfactory to the Plan Administrator. However, in the Plan Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Plan Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Plan Administrator may require that each Participant who desires to receive reimbursement for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- (a) The Dependent or Dependents for whom the services were performed;
- (b) The nature of the services performed for the Participant, the cost of which he or she wishes reimbursement;
- (c) The relationship, if any, of the person performing the services to the Participant;
- (d) If the services are being performed by a child of the Participant, the age of the child;
- (e) A statement as to where the services were performed;
- (f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- (g) If the services were being performed in a day care center, a statement:
 - (1) that the day care center complies with all applicable laws and regulations of the state of residence,
 - (2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
 - (3) of the amount of fee paid to the provider.
- (h) If the Participant is married, a statement containing the following:
 - (1) the Participant's spouse's salary or wages if he or she is employed, or
 - (2) if the Participant's spouse is not employed, that
 - (A) he or she is incapacitated, or
 - (B) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

If a Participant fails to submit a claim within ninety (90) days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Plan Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within ninety (90) days after termination of employment.

7.12 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Plan Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Plan Administrator and the Plan for payment of Employment-Related Dependent Care Expenses, subject to the following terms:

- (a) **Card termination.** Such card shall be cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Flexible Spending Account.

(b) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Plan Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(c) **Correction methods.** If such purchase is later determined by the Plan Administrator to not qualify as an Employment-Related Dependent Care Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Plan Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

- (1) Repayment of the improper amount by the Participant;
- (2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
- (3) Claims substitution or offset of future claims until the amount is repaid; and
- (4) if paragraphs (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VIII

CLAIMS AND APPEALS

8.1 CLAIMS FOR BENEFITS UNDER APPENDIX A

(a) **Dependent Care Flexible Spending Account Claims.** Any claim for Dependent Care Flexible Spending Account Benefits shall be made to the Administrator. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (1) specific references to the pertinent Plan provisions on which the denial is based;
- (2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
- (3) an explanation of the Plan's claim procedure.

Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

- (1) request a review upon written notice to the Administrator;
- (2) review pertinent documents; and
- (3) submit issues and comments in writing.

A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(b) **Health Flexible Spending Account Claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 90 days after termination of employment. Once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (1) The specific reason or reasons for the denial.
- (2) Reference to the specific Plan provisions on which the denial was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
- (5) A statement that the claimant is 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.
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the claim determination;
- (2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

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 claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

(c) Health Savings Account Benefit Claims. Claims for benefits under the Health Savings Account will be governed by the procedures set forth under the Participant's Health Savings Account; accordingly, claims for benefits thereunder will be filed with and subject to review by the Health Savings Account trustee/custodian.

Appendix D: Notice of HIPAA Privacy Practices

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information; (4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

(Version 02/16/2026)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Office: 550 Allerton St. Redwood City, CA 94063

Telephone: (650) 463-5282

E-mail: dpaduveris@gunder.com

Address: 550 Allerton Street Redwood City, CA 94063

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

Healthcare FSA

Fertility Benefit

Dental

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **February 16, 2026**, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;

- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes and substance use disorder counseling notes we hold only with your authorization.

If we receive substance use disorder treatment records created by a federally assisted program or health care provider under 42 CFR Part 2, we may only use or disclose such records in accordance with the written consent you provided to the program or provider. If such records were disclosed to us with your written consent for treatment, payment, and health care operations, we may further disclose the records for these purposes without obtaining an additional written consent.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct

identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Prohibited Uses and Disclosures: If we receive substance use disorder records created by a federally assisted program or health care provider under 42 CFR Part 2, we may not use or disclose such records, or testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceedings against you unless based on your specific written consent or a court order. We may only use or disclose records based on a court order after:

1. a notice and an opportunity to be heard is provided to you or the holder of the record, where required by 42 CFR part 2; and
2. the court order is accompanied by a subpoena or other similar legal requirement compelling the disclosure.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request **in writing** to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request **in writing** to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and
2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. **You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.** You should submit your request **in writing** to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You

may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint _____ to act on my behalf

[name of Authorized Representative]

or on behalf of _____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

☐ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

Claimant's signature

Date

Accepted: _____

Authorized Representative's signature

Date

Witness: _____

Witness signature

Date