SUMMARY OF MATERIAL MODIFICATIONS
TO
THE GATES MATCHMAKER PLAN

The Gates Matchmaker Plan (the "Plan") has been amended effective as of the dates provided below. This is a brief summary of the amendment. The Plan document will govern all situations concerning the provisions of the Plan. This summary is not a part of the Plan document.

Your Summary Plan Description ("SPD") is modified to reflect: a change to the name of the trustee; updates to the hardship distribution provisions to comply with certain changes required by law; and clarifications to the claims procedures.

Effective January 1, 2020, the sub-section titled "Plan Trustee" under the section titled "Plan Administration" is modified to read as follows:

Plan Trustee[2]
The Plan is administered under a written plan and trust agreement, with Charles Schwab Trust Bank as the trustee. The trustee can be contacted at 2360 Corporate Circle, Suite 400, Henderson, NV 89074.

Effective January 1, 2019 the following is added to the end of the sub-section titled **"Hardship Distributions**" under the section titled **"Distribution of Benefits"** to read as follows:

Notwithstanding the foregoing, the following changes apply for hardship distributions taken on or after the first day of the first plan year beginning after December 31, 2018:

Changes to the List of Financial Circumstances for Which Hardship Withdrawals are Available

- If you are taking a hardship distribution for expenses for the repair of damage to your principal residence that would qualify for a casualty deduction, the loss does not need to be attributable to a Federally declared disaster and also does not need to exceed 10% of your adjusted gross income.
- You may also take a distribution to pay for a financial hardship caused by the following additional circumstances:
    - Expenses and losses (including loss of income) you incur on account of a disaster declared by the Federal Emergency Management Agency (FEMA) provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster; or
    - Any other distribution which is deemed by the Commissioner of Internal Revenue to be made on account of immediate and heavy financial need as provided in Treasury Regulations.

Changes to the Rules for Demonstrating Need for Hardship Withdrawals

- You are no longer required to take a participant loan available under this Plan or any other plan maintained by us prior to taking a hardship distribution. However, you are still required to take any other distribution available under this or any other plan maintained by us.
- For hardship distributions taken on or after the effective date noted above, you are no longer prohibited from making any Employee Contributions to the Plan for 6 months after you take a hardship distribution.

[2] Trust, custody and deposit products and services are available through Charles Schwab Trust Bank.

Effective for Disability-related benefit claims filed after April 1, 2018, the sub-sections titled **"Notice of Denial**" and **"Review on Appeal**" under the sub-section **"Review of Disability Benefit Claims"** under the section titled **"Claims Procedure"** are modified to read as follows:

- **Notice of Denial.** If your claim is denied, the notice will contain the following information: (a) the specific reasons for the denial; (b) reference to the specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; (e) either (1) if the claim denial is based on an internal rule, guideline, protocol, or other similar provision, a copy of the specific rule, guideline, protocol, or other similar criterion relied upon, or (2) an affirmative statement that the claim denial is not based on an internal rule, guideline, protocol, or other similar criterion; (f) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation is available upon request, free of charge; (g) a discussion of the decision, including an explanation for disagreeing with or not following (1) the views you presented of health care professionals who treated you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied on in making the determination; and (3) any Disability determinations made by the Social Security Administration; (h) a description of the review (i.e., appeal) procedures, the time limits applicable to such procedures, and in the event of an adverse review decision, a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (i) a statement that if you request a review of the Administrator's decision and the review is adverse to you, that there is no further administrative review following such initial review, and that you have a right to bring a civil action under ERISA §502(a). The notice will also include a statement advising you that, within 180 days of the date you receive the notice, you may obtain review of the decision as explained in the next paragraph.

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- **Review on Appeal.** In general, your appeal will be reviewed within 45 days of the date it is received by the Administrator (unless special circumstances require an extension to 90 days and you are so notified before the end of the 45-day review period). The reviewer will conduct a full and fair review of the Administrator's decision denying your claim for benefits and will render its written decision. If the reviewer anticipates denying your appeal, whether in whole or in part, based on new or additional evidence or a new or additional rationale, the reviewer must provide you with (i) the new or additional evidence considered, relied upon, or generated by or at the direction of the Plan, the insurer, the reviewer, or any other person making the benefit determination and/or (ii) the new or additional rationale for the determination. The information must be provided to you free of charge and as soon as possible so that you have a reasonable opportunity to review the information and submit a response before the reviewer is required to render its decision. If the reviewer decides for whatever reason to deny, whether in whole or in part, your appeal of an adverse benefit determination, the reviewer's decision will be provided in a culturally and linguistically appropriate manner and contain the following: (a) the specific reasons for the denial; (b) reference to specific Plan provisions on which the denial is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; (d) either (1) if the claim denial is based on an internal rule, guideline, protocol, or other similar criterion, a copy of the specific rule, guideline, protocol, or other similar criterion relied upon, or (2) an affirmative statement that the claim denial is not based on an internal rule, guideline, protocol, or other similar criterion; (e) if the claim

denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation is available upon request, free of charge; (f) a discussion of the decision, including an explanation for disagreeing with or not following (1) the views you presented of health care professionals who treated you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied on in making the determination; and (3) any Disability determinations made by the Social Security Administration; (g) a statement describing any voluntary review procedures and your right to obtain copies of such procedures; and (h) a statement that you have a right to bring a civil action under ERISA §502(a).

These summary pages should be filed with the Summary Plan Description booklet that has previously been distributed.