GINKGO BIOWORKS, INC.

CONSOLIDATED WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Effective: January 1, 2021

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PLAN INFORMATION

Plan Name:	Ginkgo Bioworks, Inc. Consolidated Welfare Benefits Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	January 1 through December 31
Plan Number:	501
Effective Date of this Summary:	January 1, 2021
Original Effective Date of Plan:	January 1, 2019
Funding Method:	Funded through fully-insured contracts and self-insured arrangements
Source of Contributions:	From Ginkgo Bioworks, Inc.'s general assets and Employee contributions, when required
Plan Sponsor and Plan Administrator:	Ginkgo Bioworks, Inc. People Operations Manager 27 Drydock Ave Boston MA 02210 877-422-5362
Plan Sponsor's Employer Identification Number:	26-3118890
Agent for Service of Legal Process:	CT Corporation System 155 Federal St Ste 700 Boston MA 02110
Contract Administrator for IRC Section 125 Plan, HSA, and COBRA:	Discovery Benefits 4321 20th Ave S Fargo ND 58103-7194 877-765-8810

INTRODUCTION

Ginkgo Bioworks, Inc. maintains the Ginkgo Bioworks, Inc. Consolidated Welfare Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses and eligible dependents.

These benefits are provided under various insurance contracts entered into between Ginkgo Bioworks, Inc. and Insurance Companies or service providers (Issuers) as well as through self-insured plans funded by the general assets of Ginkgo Bioworks, Inc.

The benefit plans offered under this Plan and their contract issuers or contract administrators are listed in Appendix A. Detailed information on the benefits listed in Appendix A may be found in the insurance contracts, evidence of coverage, or official plan documents for each benefit (Plan Documents).

This document, together with the plan documents for each benefit, constitutes the Summary Plan Description for the Plan. If the terms of this Summary Plan Description conflict with the terms of the related documents, the terms of the related documents will control, unless superseded by applicable law.

Certain of the benefits provided by this Plan are Health Plans and thereby subject to the Provisions of the Health Insurance Portability and Accountability Act of 1996 including regulations effecting the maintenance, creation or use of Protected Health Information. Please refer to the Notice of Privacy Practices issued by your health plan for a description of how medical information about you may be used and disclosed and how you can get access to this information.

SPECIFIC PLAN INFORMATION

(a) ***Eligibility Rules.*** Please refer to Appendix C of this Summary Plan Description to determine your eligibility for participating in each particular benefit program. The specific Plan Document will also define eligible dependents (if applicable) and the terms under which you may participate (including the definition of an eligible employee and a description of any waiting period which may precede the date your coverage begins).

(b) ***Cessation of Participation.*** Unless otherwise stated in the Plan Document your coverage will cease upon the earliest of the following:

1) the date the Plan is terminated;
2) the date your eligible class is eliminated;
3) the date you cease to be a member of an eligible class; and
4) the date you cease to pay any required contributions toward the cost of the Plan.

(c) ***Benefits Provided.*** Each Plan Document will contain a complete description of the benefits available and any limitations or exclusions applicable to those benefits.

(d) ***Contributions.*** Ginkgo Bioworks, Inc. at its discretion may require employee contributions as a condition of participation in any particular benefit plan.

ADDITIONAL HEALTH PLANS PROVISIONS

FMLA: Family and Medical Leave Act of 1993. Notwithstanding the above rule regarding termination of participation or any other provision to the contrary in this Plan, if you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), Ginkgo Bioworks, Inc. will continue to maintain your health benefits on the same terms and conditions as though you were still an active employee. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time. Except as otherwise provided in the FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse Ginkgo Bioworks, Inc. for the cost of the coverage Ginkgo Bioworks, Inc. provided you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on).

FMLA: Military Family Leave. The Family and Medical Leave Act of 1993 shall include the following additional leave rights:

- Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, parent, or next of kin of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation, as defined by regulations.
- An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member.

USERRA: Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Look-back Measurement Method for Eligibility Determinations

Effective January 1, Ginkgo Bioworks, Inc. uses the look-back measurement method to determine who is a full-time employee for purposes of Plan coverage. The look-back measurement method is

based on Internal Revenue Service (IRS) guidance under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The rules for the look-back measurement method are very complex. Ginkgo Bioworks, Inc. intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact Christine Fusco, Employee Benefits.

Special Open Enrollment Rights for Certain Individuals. 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 and your dependents in one of the health care options offered by the Plan Sponsor, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you otherwise decline to enroll, you may be required to wait until the group's next open enrollment to do so. You also may be subject to additional limitations on the coverage available at that time.

Furthermore, if you are an employee who is eligible for coverage but not enrolled, you shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid, Children's Health Insurance Plan (CHIP); or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

Qualified Medical Child Support Orders. This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA § 609(a) or National Medical Support Notice, and provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children or children of your beneficiaries, in accordance with ERISA§ 609(c). For a copy of Ginkgo Bioworks, Inc.'s procedures applicable to such notices, please contact the Plan Administrator.

Newborns' and Mothers' Health Protection Act 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).

The Federal "Women's Health and Cancer Rights Act of 1998" requires coverage of treatment related to mastectomy. If you or your dependent are eligible for mastectomy benefits under this coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

(a) Reconstruction of the breast on which mastectomy has been performed;

(b) Surgery and reconstruction on the other breast to produce a symmetrical appearance;
(c) Prostheses; and
(d) Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under your plan.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this 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 because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

WHO IS ENTITLED TO ELECT COBRA COVERAGE?

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

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

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

- Your spouse 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 any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under 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."

WHEN IS COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employees becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the 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 in writing within 60 days after the later of (1) the date of the qualifying event and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event.

You must provide this notice to:

Ginkgo Bioworks, Inc.
People Operations
27 Drydock Ave
Boston MA 02210
877-422-5362

HOW IS COBRA ELECTED?

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

HOW LONG DOES COBRA COVERAGE LAST?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employees lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended. COBRA coverage under a Health FSA can last only until the end of the year in which the qualifying event occurred—see the paragraph below entitled "Health FSA." The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods for several reasons, which are described in the plan documents of the component plans.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period for continuation coverage. You must provide notice to us of receipt of a determination by Social Security of total disability within 60 days of the date of the notice, the name of the qualified beneficiary who has become disabled, a copy of the determination letter, and the original date of disability.

You must provide this notice to:

Ginkgo Bioworks, Inc.
People Operations
27 Drydock Ave
Boston MA 02210
877-422-5362

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

HEALTH FSA

COBRA coverage under a Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

Plan Contact Information

Ginkgo Bioworks, Inc.
People Operations
27 Drydock Ave
Boston MA 02210
877-422-5362

PLAN ADMINISTRATION

IN GENERAL

Ginkgo Bioworks, Inc. is the Plan Administrator of the Plan and a Named Fiduciary within the meaning of such terms as used in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Marcus Clegg, 16 Middle St Unit 501, Portland ME 04101-5166 is the Plan's agent for service of legal process.

Ginkgo Bioworks, Inc. has the duty and authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each Employee shall, from time to time, upon request of Ginkgo Bioworks, Inc., furnish to Ginkgo Bioworks, Inc. such data and information as Ginkgo Bioworks, Inc. shall require in the performance of its duties under the Plan.

Ginkgo Bioworks, Inc. may designate any individual, partnership or corporation as the Administrator to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

Ginkgo Bioworks, Inc. may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

Ginkgo Bioworks, Inc. will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

AMENDMENT AND TERMINATION

Ginkgo Bioworks, Inc. intends to maintain the Plan indefinitely, but is under no obligation to continue the Plan and can terminate the Plan by providing written notice to the Plan participants. In terminating or amending the Plan, Ginkgo Bioworks, Inc. cannot retroactively reduce the benefits to which a Participant is entitled prior to the termination or amendment.

CLAIMS AND APPEAL PROCEDURES

NON-HEALTH, NON-DISABILITY CLAIMS

For purposes of all non-health, non-disability insured welfare plan coverage (life, AD&D, etc.) please refer to the certificate booklet provided by the issuer for a detailed description of the issuer's claims submission rules and claims appeal procedures.

DISABILITY CLAIMS

All claims and appeals for disability benefits under the Plan are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) are not made based upon the likelihood that the individual will support the denial of benefits.

To the extent that the terms of these claims procedures are inconsistent with the claims provisions of any other plan document, certificate, policy or summary, as applicable, these claims procedures shall govern.

Initial Claim

A Participant may initiate a claim for benefits by contacting the Plan Administrator. The Plan Administrator will inform the Participant of the information needed to complete the claim, which may vary depending on the claim, and which may include:

A completed claim form, in a form provided by the Plan Administrator;

- Reasonable documentation from the Participant's physician or other provider or official describing and/or verifying the injury, illness, or other condition or event giving rise to the Participant's claim;

Claims should be filed with the Plan Administrator within 60 days of the date the disability began. Except as otherwise provided herein, benefits are based on the Plan's provisions on the date the disability began. Claims filed later than 60 days after that date may be denied or reduced unless:

(a) it is not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date the disability began.

The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Participant. The Plan reserves the right to have a Participant seek a second medical opinion. Any request for Plan benefits will be considered a claim, and it will be subject to a full and fair review.

Timing of Initial Decision

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures set forth above, without regard to whether all of the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

If the claim is denied in whole or in part, the Participant will receive written notification within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the Participant is notified, before the end of the initial 45-day period of the circumstances requiring the extension and of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, the Participant will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. Any extension notice will explain the standards on which the Participant's entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the Participant must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information.

Notice of Initial Adverse Benefit Determination

If your claim is denied, the Plan Administrator will furnish you with a written notice of the Initial Adverse Benefit Determination. The written notice will set forth the following information, in a manner calculated to be understood by the Participant:

(a) The specific reason or reasons for the Initial Adverse Benefit Determination;

(b) Specific reference to those Plan provisions on which the Initial Adverse Benefit Determination is based;

(c) A description of any additional information or material necessary to perfect the claim and an explanation of why such material or information is necessary;

(d) Appropriate information as to the steps to be taken if you wish to submit the claim for review;

(e) A statement indicating that the Participant shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

(f) The internal rule, guideline, protocol, or other similar criterion relied upon in making the Initial Adverse Benefit Determination; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; or, if applicable, a statement that specific internal rules, guidelines, protocols, standards or other similar criteria for making the Initial Adverse Benefit Determination do not exist;

(g) If the Initial Adverse Benefit Determination 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 Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(h) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: the views presented by health care professionals treating the Participant and vocational professionals who evaluated the Participant; the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with an Adverse Benefit Determination; and any Social Security Administration disability determination regarding the Participant and presented by the Participant to the plan;

(i) A statement that the Participant 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 Participant's claim for benefits; and

(j) The notification shall be provided in a culturally and linguistically appropriate manner.

Appeals of Initial Adverse Benefit Determination

If you disagree with a claim determination after following the above steps, you may contact the Plan Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan or a claim for disability benefits, the Plan will identify, upon request to the Plan Administrator, any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Initial Adverse Benefit

Determination, without regard to whether the advice was relied upon in making the benefit determination.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator. The review of your appeal shall not afford deference to the Initial Adverse Benefit Determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual. Said named fiduciary shall identify any medical or vocational experts whose advice was obtained in connection with the Initial Adverse Benefit Determination, whether or not that advice was relied upon in making the benefit determination.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

Before the Plan may issue an adverse benefit determination on review, the Plan Administrator shall provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the benefit determination on review is required to be provided (see below) to give the Participant a reasonable opportunity to respond prior to that date.

Before the plan may issue an adverse benefit determination on review based on a new or additional rationale, the Plan Administrator shall provide the Participant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which Final Benefit Determination is required to be provided (see below) to give the Participant a reasonable opportunity to respond prior to that date.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted below due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

The Plan Administrator shall notify you of the Plan's benefit determination on review not later than 45 days after receipt of your request for review by the Plan, unless the Plan Administrator

determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

In the case of a Plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the above paragraph shall not apply, and, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify you of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

In certain circumstances, the Plan Administrator may extend the timeframes described above in its discretion. In addition, the Plan Administrator may request that you voluntarily agree to allow the Plan Administrator additional time extensions. You may allow or deny these additional "voluntary" extensions in your discretion.

Manner and Content of Notification of Benefit Determination on Review

The Plan Administrator shall provide a Participant with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination (a "Final Adverse Benefit Determination"), the notification shall set forth, in a manner calculated to be understood by the Participant:

(a) The specific reason or reasons for the Final Adverse Benefit Determination;

(b) Reference to the specific Plan provisions on which the Final Adverse Benefit Determination is based;

(c) A statement that the Participant 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 Participant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Participant's right to obtain the information about such procedures;

(e) A statement of the Participant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, and any applicable contractual limitations period that applies to the Participant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(f) The internal rule, guideline, protocol, or other similar criterion relied upon in making the Final Adverse Benefit Determination and a statement that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; or, if applicable, a statement that specific internal rules, guidelines, protocols, standards or other similar criteria for making the Final Adverse Benefit Determination do not exist;

(g) If the Final Adverse Benefit Determination 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 Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(h) A discussion of the decision, including an explanation of the basis for disagreeing or not with following: the views presented by the Participant of health care professionals treating the Participant and vocational professionals who evaluated the Participant; the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with an Adverse Benefit Determination; and any Social Security Administration disability determination regarding the Participant and presented by the Participant to the plan;

(i) The notification shall be provided in a culturally and linguistically appropriate manner;

(j) A statement indicating that the Participant shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits.

Authorized Representatives

Any reference in these procedures to "you" or the "Participant" is also a reference to your or the Participant's authorized representative making a claim on your or his or her behalf. The Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your and/or the Participant's behalf.

Questions About Your Claims and Appeal Rights

For questions about your rights, these claims procedures, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

HEALTH CLAIMS

For purposes of health care claims, the following rules will apply in the event that the issuer's written claims submission and claims appeal procedure fail to comply with current Department of Labor regulations.

For purposes of the Health Claims and Claims Appeal Procedure contained in this SPD, the term "Administrator" will mean either the carrier or the contract administrator depending upon the policy or plan the claim has been filed under.

You must follow the procedures outlined below to obtain payment of health benefits under this Plan.

You should direct all claims and questions regarding health claims to the Administrator. The Administrator shall have final authority for adjudicating all claims and a full review of the decision on such claims in accordance with the following provisions and with ERISA.

As an individual claiming benefits under the Plan, you shall be responsible for supplying, at such times and in such manner as the Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Administrator in its sole discretion shall determine that you have not incurred a covered expense or that the benefit is not covered under the Plan, or if you have failed to furnish such proof as is requested, no benefits shall be payable to you under the Plan.

Under the Plan, there are four types of claims: Urgent Pre-service, Non-urgent pre-service, Concurrent Care and Post-service.

- ***Pre-service Claims:*** A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if you need medical care for a condition which could seriously jeopardize your life, there is no need to contact the Plan for prior approval. You should obtain such care without delay.

Further, if the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a Post-service Claim.

- ***Concurrent Claims:*** A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) you request an extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Administrator to request an extension of a course of treatment.

You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a Post-service Claim.

- ***Post-service Claims:*** A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Administrator within 90 days of the date charges are incurred for the service. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied, unless it is shown that it was not reasonably possible to file within 90 days, but in no event later than twelve (12) months from the date on which covered charges were incurred.

The Plan, upon receipt of a written notice of a claim, will furnish to the Participant a form for filing proof of loss. If such forms are not furnished within 15 days after notice is given, the Participant will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Administrator:

(a) The date of service;
(b) The name, address, telephone number and tax identification number of the provider of the services or supplies;
(c) The place where the services were rendered;
(d) The diagnosis and procedure codes;
(e) The amount of charges;
(f) The name of the Plan;
(g) The name of the covered employee; and
(h) The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrator will determine if enough information has been submitted to adjudicate the claim.

If not, the Administrator may request more information. The Administrator must receive the additional information within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from your receipt of the request for additional information. Failure to do so may result in claims being declined or benefits reduced.

TIMING OF CLAIM DECISIONS

The Administrator shall notify you, in accordance with the provisions set forth below, of a denial (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following time periods:

- ***Pre-service Urgent Care Claims:*** If you have provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. You will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded you to provide the information.

- ***Pre-service Non-urgent Care Claims:*** If you have provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You will be given at least 45 days from receipt of this notice within which to provide the specified information.

- ***Concurrent Claims:***

Plan Notice of Reduction or Termination. If the Administrator is notifying you of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as you make the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If you submit the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the

timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

- ***Post-service Claims:*** If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

- ***Extensions - Pre-service Urgent Care Claims.*** No extensions are available in connection with Pre-service Urgent Care Claims.

- ***Extensions - Pre-service Non-Urgent Care Claims.*** This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- ***Extensions - Post-service Claims.*** This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- ***Calculating Time Periods.*** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

CLAIMS APPEAL PROCEDURE

Nature of Denial: The notice of a denial of a claim shall be written in a manner calculated to be understood by you and shall set forth:

(a) The specific reason for the denial;
(b) Specific references to the pertinent Plan prov1s1ons on which the denial is based, including a copy of any internal guideline used in the benefit determination or notice of where and how you can obtain a copy free of charge;
(c) 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;
(d) An explanation of the Plan's claims appeals procedures;

(e) Your right to bring a civil action under ERISA Section 502(a);
(f) If your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how you can obtain a copy free of charge; and,
(g) For purposes of pre-service urgent care, a description of the expedited review process.

Timing of an Appeal:

Pre-Service Claims: Special Rule. For Pre-service Urgent Care Claims, if you choose to appeal, please refer to Appendix 8 for a listing of names, addresses and phone numbers for each issuer.

All Other Claims. Within 180 days after the receipt of the above material, you shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your duly authorized representative may:

(a) Request a review by providing written notice to the Administrator;
(b) Submit written comments, documents, records and other information relating to the claim; and,
(c) Upon request, have reasonable access to and copies of all documents, records, and other information relevant to the claim.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Administrator shall notify you of the Plan's benefit determination on review within the following timeframes:

- ***Pre-service Urgent Care Claims:*** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

- ***Pre-service Non-urgent Care Claims:*** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- ***Concurrent Claims:*** The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.

- ***Post-service Claims*:** Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

- ***Calculating Time Periods:*** The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

REVIEW AND DECISION

Full and Fair Review. The Administrator, as Plan Fiduciary, shall take into account all comments, documents, and other information submitted by you without regard to whether the information was submitted with the original claim and without deference to the original determination. The decision shall be based in whole or in part on a medical judgment, with consultation with the appropriate independent health care professionals, if the claim involves investigational or experimental treatment, or issues of medical necessity, and shall identify such professionals.

Decision. The decision of the Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. You also have a right to bring a civil action under ERISA Section 502(a) following the denial of your appeal. If your appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, you will receive an explanation of the scientific or clinical judgment applied on the benefit determination, or notice of where and how you can obtain a copy. If your health plan is subject to California law, you have a right to a voluntary independent medical review of denials for medical necessity or experimental/investigational services through the Department of Managed Care and/or the Department of Insurance. Please refer to your health plan booklet or evidence of coverage for details.

Second Appeal. Should you receive an adverse determination of the appeal, you have the right to file a second appeal. The second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The timing of response to the second appeal shall be made in accordance with the same time guidelines as those outlined for the first appeal.

STATEMENT OF ERISA RIGHTS

As a participant in Ginkgo Bioworks, Inc.'s Consolidated Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

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 your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request if before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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, DC, 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.

OTHER IMPORTANT INFORMATION

PRIVACY OF INFORMATION

In the administration of this Plan, Ginkgo Bioworks, Inc., or of one of its Business Associates may be required to use or disclose protected information for purposes of paying or causing to be paid benefits under this Plan. Ginkgo Bioworks, Inc. has established the following policy regarding the use and disclosure of protected information. Ginkgo Bioworks, Inc. hereby agrees to:

- Not use or disclose protected health information other than as permitted or required by the plan document or by law;
- Ensure that any agents to whom it provides protected health information agrees to the same restrictions and conditions that apply to the plan sponsor;
- Not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
- Report to the group health plan any use or disclosure of protected health information inconsistent with plan provisions;
- Make protected health information available as required under other privacy rules provisions;
- Make internal practices and records regarding protected health information available to the HHS Secretary; and,
- Where feasible, return or destroy all protected health information received from the group health plan then no longer needed for the purpose for which disclosure was made.

Please refer to the Plan's Notice of Privacy Practices for details.

CONTROLLING DOCUMENTS

The information contained in this Summary Plan Description is only a general discussion of the relevant provisions of the Plan found in the official Plan Document. In all events, the provisions of the official Plan Document shall control with regard to all matters concerning the administration and operation of the Plan. The official Plan Document is available for your review at Ginkgo Bioworks, Inc..

APPENDIX A

GINKGO BIOWORKS INC.
CONSOLIDATED WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Insurance Policy Issuers and Contract Administrators

Plan:	Issuer Name and Address	Policy No.	Type of Benefit
• *Life and Disability Coverage* • *PLAN 1* • *Basic*	Metropolitan Life Insurance Company 4150 N Mulberry Dr Ste 300 Kansas City MO 64116	05940476	Life, AD&D,
• *Life and Disability Coverage* • *PLAN 2* • *Basic* •	Metropolitan Life Insurance Company 4150 N Mulberry Dr Ste 300 Kansas City MO 64116	05940476	LTD, STD
• *Life and Disability Coverage* • *PLAN 3* • *Voluntary*	Metropolitan Life Insurance Company 4150 N Mulberry Dr Ste 300 Kansas City MO 64116	05940476	Life and AD&D
• *Health Care Coverage / Medical* • *PLAN 1 & 2*	Blue Cross Blue Shield of Massachusetts 101 Huntington Ave Ste 1300 Boston MA 02199-7611	8068076	PPO, HMO
• *Health Care Coverage / Dental* • *PLAN 1 & 2*	Metropolitan Life Insurance Company 4150 N Mulberry Drive, Suite 300 Kansas City, MO 64116	05940476	High Plan, Low Plan
• *Health Care Coverage / Vision* • *PLAN 1*	Metropolitan Life Insurance Company 4150 N Mulberry Drive, Suite 300 Kansas City, MO 64116	05940476	Vision
• *Additional / Other Coverage* • *PLAN 1*	Metropolitan Life Insurance Company 4150 N Mulberry Dr Ste 300 Kansas City MO 64116	05940476	Accident Insurance

Contract Administrators		Type of Benefit
Discovery Benefits 4321 20th Ave S Fargo ND 58103-7194 877-765-8810	3rd Party Administrator	Section 125, HSA, COBRA

APPENDIX B

GINKGO BIOWORKS INC.

CONSOLIDATED WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Claims Appeals Contact Information

Plan	Issuer Name and Address	Telephone/Facsimile
• *Life and Disability Coverage* • *PLAN 1* • *Basic*	MetLife - Group Life Claims PO Box 6100 Scranton PA 18505-6100	Ph: 800-638-6420 Option #2 Fax: 570-558-8645
• *Life and Disability Coverage* • *PLAN 2* • *Basic*	MetLife - Disability PO Box 14592 Lexington, KY 40512-4592	Ph: 844-380-0569 Email:disabilityappeals@metlife.com
• *Life and Disability Coverage* • *PLAN 3* • *Voluntary*	MetLife – Group Life Claims PO Box 6100 Scranton PA 18505-6100	Ph: 800-638-6420 Option #2 Fax: 570-558-8645
• *Health Care Coverage / Medical* • *PLAN 1 &2*	BCBSMA Member Appeal & Grievance Program One Enterprise Drive Quincy, MA 02171-2126	Fax: 617-246-3616 Email:grievances@bcbsma.com
• *Health Care Coverage / Dental* • *PLAN 1 & 2*	MetLife Dental Claims Group Claims Review PO Box 14589 Lexington, KY 40512	Ph: 888-466-8673 Fax: 859-389-6505
• *Health Care Coverage / Vision* • *PLAN 1*	MetLife Vision PO Box 385018 Birmingham, AL 35238-5018	Ph: 800-428-4833
• *Additional / Other Coverage* • *PLAN 1*	MetLife Insurance Co. 4150 N Mulberry Dr Ste 300 Kansas City MO 64116	https://online.metlife.com/

Contract Administrators		Telephone/Facsimile
Discovery Benefits Claims Processing 4321 20th Ave S Fargo ND 58103-7194	3rd Party Administrator	Ph: 877-765-8810

APPENDIX C

GINKGO BIOWORKS INC.

CONSOLIDATED WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Line of Coverage	Effective Date of Eligibility	Definition of Full Time
Life, AD&D, LTD, STD, Accident	Date of Hire	30 hrs. per week
Medical	Date of Hire	30 hrs. per week
Dental	Date of Hire	30 hrs. per week
Vision	Date of Hire	30 hrs. per week