

THIS IS A SUMMARY PLAN DESCRIPTION FOR THE CONFLUENT, INC. SHORT TERM DISABILITY PLAN. THE PROVISIONS OF THIS SUMMARY APPLY TO DISABILITIES BEGINNING ON OR AFTER JANUARY 1, 2025. THIS PLAN COMPRISES PART OF THE CONFLUENT, INC. WELFARE BENEFITS PLAN.



INTRODUCTION

The purpose of the Confluent, Inc. Short Term Disability (STD) Benefit Plan (“Plan”) is to assist you in meeting your reasonable income needs in the event you suffer a short-term disability and are unable to work.

What follows is a Summary Plan Description (SPD) that is required by the Employee Retirement Income Security Act (ERISA). (Read your ERISA rights on page 4 of this Summary). Because this summary has been written to conform to Department of Labor (DOL) regulations, it does not contain a complete explanation of each and every provision and term contained in the more comprehensive Plan Document. If your particular circumstances are not described within this summary or if you do not understand something

described in this summary, a copy of the entire Plan Document is available for your review at <https://confluentbenefits.com/united-states/index.php/resource-library/>.

Confluent, Inc. (the Company) has contracted with The Larkin Company (the Claims Administrator) to process claims in accordance with the Plan Document. The Claims Administrator has been given the ultimate authority to determine whether or not you are entitled to Plan benefits.

The Company intends to continue the Plan indefinitely but reserves the right to change or terminate the Plan at any time. If the Plan is terminated, benefits will continue to be payable for any covered disability which began before the termination date.

Certain capitalized terms used in this summary have the meanings set forth on page 5.

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PARTICIPATION

Who may participate? You, provided you are a regular Confluent employee who is scheduled to work 30 or more hours per week at a Company location within the United States of America or its territories. Seasonal employees and individuals performing services for the Company as independent contractors or through an employment or leasing agency are not eligible to participate.

How do I enroll? You don’t need to. Once you satisfy the eligibility requirements (30 or more hours per week, etc.) you are automatically enrolled. You must be at work on the day that your participation in the Plan begins. If you are not at work on that day, your participation will be delayed until you are back at work.

When does my participation in the Plan end? As of midnight (at the beginning of the day) when any of the following occurs:

- you cease to be an eligible employee. For example, your scheduled work week is reduced to fewer than 30 hours per week;
- you are no longer employed by the Company;
- you are laid off (provided, however, a temporary shut-down initiated by the Company is not a layoff for the purposes of this Plan);
- on the date you begin an unpaid leave of absence (unless you are on an approved leave under FMLA or similar state or local law); or,
- the Plan terminates.

What is it going to cost me? Nothing. The Company pays for all Plan costs.

Benefits from this Plan are taxable. Benefits paid and taxes withheld will be included on the W-2 you receive from Confluent Payroll.

DISABILITY

What is a disability? For the purposes of the Plan, you are unable to work due to any of the following:

- you suffer an injury or illness (physical and/or mental) that prevents you from performing the material duties of your regular and customary occupation (or any reasonably related occupation);
- your pregnancy, child birth or a related medical condition prevents you from performing the material duties of your regular and customary occupation (or any reasonably related occupation). This is called a Pregnancy Disability;
- you contract or are exposed to a communicable disease (e.g., TB, chickenpox), and your Physician or Practitioner (or a bona fide health official) states, in writing, that you must stay away from work; or
- you are under treatment for alcohol or drug abuse. To qualify for benefits you must participate in an accredited residential program or an approved outpatient program that requires your attendance for a minimum of 5 days per week for a minimum of 8 hours

per day. Benefits for alcohol or drug abuse treatment are limited to a maximum of 90 days.

You will not be considered disabled if you are doing work of any kind for the Company or any other employer (including self-employment) for pay or profit without first obtaining approval from the Plan Administrator. You will not be considered disabled if you turn down alternative employment offered by the Company that is within your capabilities and is comparable in status and pay to your regular job.

Who determines when I am disabled? The Claims Administrator, based on a certificate from your Physician or Practitioner based on Objective Medical Evidence and any other information that the Claims Administrator considers to be relevant.

BENEFITS

When will my benefits begin? Your benefits begin on your first (1st) day of disability, provided (i) you are disabled for at least 8 consecutive, calendar days, and (ii) you have seen a Physician or Practitioner during that 8-day period.

Successive periods of disability due to the same or related causes are considered one disability unless separated by a return to your normal work schedule for more than 60 days.

How are benefits determined? Benefits are based on your earnings. "Earnings" means your base salary as reported by Confluent, in effect just prior to the date your disability begins. Earnings do not include bonuses, commissions, overtime, or any other type of compensation.

If your disability begins while you are on an approved unpaid leave of absence, "Earnings" means your base pay as reported by Confluent, in effect just prior to the start date of your leave. Earnings do not include bonuses, commissions, overtime, or any other type of compensation.

An increase in your Earnings during a period of continuous disability will increase your benefit amount.

How much will I receive? If you are disabled (other than a Pregnancy Disability) you will be paid 100% of your weekly Earnings through your fourth (4th) week of disability. Thereafter you will be paid 67% of your weekly Earnings to a weekly maximum of \$3,500 for the duration of the benefit period.

For a Pregnancy Disability, you will be paid 100% of your weekly Earnings through your eighth (8th) week of disability. Thereafter you will be paid 67% of your weekly Earnings to a weekly maximum of \$3,500 for the duration of the benefit period.

Partial weeks are paid at a daily rate that is 1/5th of your weekly benefit.

You may choose to redirect a portion of your weekly benefit to cover all or part of the cost of employee-paid group health insurance premiums.

To execute this option, you must designate in writing, on a form available from The Larkin Company, the amount to

be redirected. This redirection may be initiated at the time you apply for benefits or at any time while you are receiving benefits. You may terminate or change the terms of the redirection at any time while you are receiving benefits.

Will I still be eligible for benefits if I return to work on a part-time basis? If you return to work on a part-time basis while eligible for disability benefits, your weekly benefit will be reduced by 80% of the income you earn from part-time employment. (While eligible for disability benefits you must obtain the approval from the Plan Administrator before engaging in employment.)

What is deducted from my benefit? Any of the following for which you are eligible: (i) temporary or permanent disability payments (whether total or partial) or vocational rehabilitation payments and any other amounts awarded or allocated under workers' compensation or similar occupational disease law; (ii) benefits under a state disability plan, paid family and medical leave law, or a Company plan providing disability benefits in place of a state plan; and (iii) benefits under any other plan, fund, arrangement, by whatever name known, providing disability benefits pursuant to a compulsory act or law of any government. If you are (or might be) entitled to these benefits but do not apply for them your benefits from this Plan will be reduced by the amount the Plan Administrator believes you would have been entitled to receive. If you have applied but not yet received these other benefits you will be required to sign an agreement to reimburse this Plan.

Can benefits be suspended? Yes. The Claims Administrator may request that a Physician or Practitioner examine you at the Company's expense. Your benefits will be suspended as of the date of the examination. However, if the examination establishes that you are still disabled, your benefits will resume retroactive to the examination date. If you fail to furnish information about your disability within 30 days following a written request by the Claims Administrator, your benefits will be suspended. Finally, if you leave your Physician's or Practitioner's care, or you reject the treatment plan recommended by your Physician or Practitioner, your benefits will be suspended. Benefits will resume once you comply with these requirements. In no event will you be paid benefits for the period when you were out of compliance with the Plan.

When do benefits end? Benefits are not payable beyond your 90th day of disability. However, if your disability ends before then (or in the event of your death), your benefits will end as of that day.

With respect to a disability that commenced while you were covered under this Plan, benefits will not terminate solely because you cease to be an employee of Confluent.

EXCLUSIONS

Are there conditions under which I will not be eligible for benefits? You will not receive benefits if:

- you were not a Plan participant when your disability began;

- your illness or injury was self-inflicted unless your underlying injury or illness is otherwise covered by the plan and results from a documented medical condition, i.e., depression or mental illness;
- you became disabled because of your commission or your attempted commission of a felony or other illegal occupation;
- you are incarcerated (in jail or any other facility) as a result of a criminal conviction;
- you are injured in a war (as a civilian or soldier), riot, insurrection, or rebellion;
- you are no longer under the care of a Physician or Practitioner, unless the Claims Administrator determines that your disability does not warrant such attention;
- you are receiving unemployment compensation under any federal or state program;
- you receive Company-paid sick leave (PTO) or salary continuation pay during your period of disability, unless the combination of sick leave pay or salary continuation and your benefits does not exceed your regular weekly covered Earnings;
- your disability is caused by or results from gainful self-employment or employment elsewhere; or
- you are receiving pay under the Worker Adjustment and Retraining Notification (WARN) Act or in-lieu-of-notice pay.

CLAIMS

How do I file a claim? You or your authorized representative, if any, must notify Confluent's leave and Claims Administrator, The Larkin Company, at (650) 938-0933, toll-free at (866) 923-3336 or via email at confluentleaves@thelarkincompany.com as soon as reasonably possible following the commencement of a disability. The Larkin Company will send you an information packet including claim forms. Fill out the disability forms and return them to The Larkin Company. (See Claims Administrator information on page 5). You must notify the Plan Administrator of your authorized representative, if any, in writing. To avoid losing some or all of your benefits, your claim for benefits must be filed not later than 45 calendar days after the date you would have been eligible to receive benefits (unless you can show it was not reasonably possible for you to comply with this requirement); otherwise, you may lose some or all of your benefits. No claim will be accepted if filed more than 6 months after benefits were payable.

What must I provide to have a valid claim? You must submit a claim that includes a certificate from your Physician or Practitioner. The certificate must include the medical facts of your disability, including his or her opinion as to the probable duration of your disability. The certificate must include a diagnosis or diagnostic code prescribed in the International Classification of Diseases. If no diagnosis has been made, a statement of symptoms must be included. All of the above must be based on a

physical examination and documented medical history. In order to qualify for benefits, the Claims Administrator may require that you submit other information relevant to your claim.

Time limit for a claim decision The Claims Administrator must make a determination no later than 45 days after receipt of your claim. If a decision cannot be made in that period, the Claims Administrator may extend that period up to 60 days (in 30-day increments) provided you are notified, in writing, prior to the expiration of the deadline(s), of the cause of the delay, of the standards on which entitlement is based, of any unresolved issues or additional information needed to resolve those issues, and the date that a decision is expected. If additional information is needed, you will have 45 days in which to provide it.

How and When Will I be Paid? After you have submitted all the needed information, your claim will be evaluated. If it is approved, the amount of your benefit will be calculated, and The Larkin Company will issue you a voucher. The voucher will show you the period covered and the amount of your benefit. Confluent, Inc. payroll will also be notified of the period covered and the benefit amount – your benefits will be included in the payment(s) you receive from Confluent, Inc. on or near your next regularly scheduled payroll date(s).

Overpayments In the event you are paid benefits by the Plan in excess of those to which you are entitled, the Plan has a right to recover the overpayment. The Claims Administrator will make reasonable arrangements for you to repay the Plan. In no event will you be required to repay more than the amount of benefits paid to you.

Disputing a denied claim If your claim is denied, in a culturally and linguistically appropriate manner, you will receive written notice, including: (i) the specific reason for the denial; (ii) references to the specific Plan provisions on which the denial is based; (iii) a description of any additional material necessary to perfect your claim and an explanation of why such material or information is necessary; (iv) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (v) if applicable, the rule (or similar criterion) on which the denial was based or, if the denial was not based on a rule (or similar criterion), a statement that these were not used; (vi) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such an explanation is available, on request, free of charge; and (vii) an explanation as to why the Plan disagreed with the views of your treating Physician or Practitioner, medical or vocational experts, or the Social Security Administration, if applicable.

If you receive notice that your claim has been denied, you have 180 days following receipt of the denial to file a written request for a review. You may submit any documentation you feel will support your claim including any comments, documents, or other information that you feel are relevant to your claim. You are entitled to a copy of the Plan

Document and other documents relevant to your claim. Send your written request for a claim review to: **Claims Administrator, Confluent Inc. Short Term Disability Benefit Plan, The Larkin Company, 1420 E Roseville Pkwy, Ste 140-393, Roseville, CA 95661.**

Claim review time limit and notification requirements

The Claims Administrator will render a written decision within 45 calendar days of receipt of your request. The review of your claim will: (i) give no weight to the initial denial; (ii) be of your entire file including any new material and arguments you submit; (iii) provide you, free of charge, with any new or additional evidence considered as soon as possible and sufficiently in advance of the end of the 45-day period; (iv) be done by an individual or individuals who neither made the initial denial nor is a subordinate of that individual; and (v) be made with the consultation of a health care professional (with the appropriate training and experience) who was not the health care professional consulted on the initial denial nor a subordinate of that health care professional, if the initial denial was made in consultation with a health care professional or was based in whole or in part on a medical judgment. If new or additional evidence is received and relied upon while your claim is being reviewed, you will be provided with that evidence as soon as possible and sufficiently in advance of the date on which the review of the adverse determination is due and you will be afforded the opportunity to respond.

If a decision cannot be reached within 45 days, you will be notified, in writing, prior to the expiration of that deadline. The notice will include the reason for the delay and the date a decision is expected. In no event will the decision process take more than 90 calendar days from the date your request for review was received.

If, on review, your claim is denied, in a culturally and linguistically appropriate manner, you will receive a written notice, including: (i) the specific reason(s) for the denial; (ii) reference(s) to the specific Plan provision(s) on which the denial is based; (iii) a statement that you are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents relevant to your claim; (iv) a statement that you have the right to file a civil suit under Section 502(a) of ERISA no later than 6 months after the date of the final determination; (v) the calendar date on which the 6 month deadline will expire; (vi) if applicable, the rule (or similar criterion) on which the denial was based, or, if not applicable, a statement that these were not used; (vii) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such explanation is available on request, free of charge; (viii) if applicable, the identity of any medical or vocational experts whose advice was obtained during the decision process; and (ix) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the Participant's Physician(s), Practitioner(s) or vocational experts, the views of the medical or vocational experts whose advice was obtained on behalf of the plan, and the disability

determination presented by him or her to the Plan made by the Social Security Administration.

ERISA INFORMATION

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. If you wish to examine any of these documents, contact the Confluent Benefits Department.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual financial report.

Prudent Action 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a Plan 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 this 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 the Plan documents or the latest annual report 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 which is denied or ignored, in whole or in

part, you may file suit in a state or 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.

- If you receive this document through electronic means, you have the right to request, free of charge, a paper copy of this document.

Assistance with Your Questions

If you have any questions about the Plan, contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office (listed in your telephone directory) of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. EBSA also has a national toll-free number: 1-866-444-EBSA. You may also contact EBSA by writing to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

DEFINITIONS FOR KEY TERMS

"Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, X-rays, MRIs, EEGs, ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a functional limitation. Objective Medical Evidence does not include Physician's or Practitioner's opinions based solely on the acceptance of subjective complaints (e.g. headache, fatigue, pain, and nausea), age transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community.

"Physician" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner, who is duly licensed or certified in the state or foreign country in which he or she practices and is acting within the scope of his or her practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two years of clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of Health Service Providers in Psychology.

"Practitioner" means a Nurse Practitioner or physician assistant (provided the or physician assistant has

performed a physical examination and collaborated with a Physician or surgeon) duly licensed or certified by the state or foreign country in which he or she practices and is acting within the scope of his or her license or certification. With regard to Disability resulting from pregnancy, childbirth, or postpartum conditions, Practitioner will also include a midwife, Nurse Practitioner, or nurse midwife acting within the scope of his or her license. "Nurse Practitioner" means a licensed nurse practitioner who has completed a transition to practice in their licensed state of a minimum of three (3) full-time equivalent years of practice or 4,600 hours.

MISCELLANEOUS

Confluent' Short Term Disability Benefit Plan does not provide job protection or return to work rights. You may have job protection rights if you are eligible for a leave under the federal Family and Medical Leave Act (FMLA) and/or any other applicable state leave law that provides for such protections. These protections (if eligible) will run concurrently with any approved disability benefits.

PLAN INFORMATION

Plan Name

Confluent, Inc. Short Term Disability Plan
Part of the Welfare Benefits Plan

Type of Plan

Welfare benefit plan providing temporary disability benefits.

Funding

All Plan benefits and costs are paid out of the Company's general assets.

Plan Administrator and Agent for Service of Legal Process

Confluent, Inc., Attention: Benefits Department
899 West Evelyn Avenue
Mountain View, CA 94041

Employer ID Numbers

47-1824387
85-2654484

Plan Number

501

Plan Year End

December 31

Claims Administrator

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